Sheffield Health and Social Care

NHS

NHS Foundation Trust

Sheffield City Council

Annual Report and Accounts
2010-11

Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 2010/11

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

Contents

1 Statement from the Chair and Chief Executive

We have come to the end of our third year as an NHS Foundation Trust and we are delighted to take this opportunity to share with you, in the pages that follow, highlights of some of our achievements as well as the changes and challenges that we have experienced in delivering services to the people that need them.

Like everyone else in the NHS Community, the Trust continues to operate in an adverse climate. The global financial crisis has produced significant strains on the provision of public services and our local Primary Care Trust (PCT) is experiencing its share of those strains. However, the demand for our services continues to grow (in some cases because of the current adverse economic climate). These circumstances constantly remind us that the resources from which we provide services to the people that need them are limited and getting more so.

Our hopes and optimism however remain undiminished. It is the strength of this positive spirit and mindset throughout the organisation that has guided us through these difficult times and will serve us well until the current storm passes. As a result, we have maintained the Trust's services and continue to make significant improvements to them whilst achieving a healthy financial balance.

We have also had to review those services in order to continue providing them in an efficient manner, without compromising their quality. In addition, we are very pleased to welcome some of the services formerly provided by the local PCT but which have now been divested from them as part of the national process of 'Transforming Community Services'. Through this process, we were successful in securing £7.7m of additional income from 1st April 2011, which will be generated from a range of primary care services including four GP practices that we have named the 'Clover Group'.

We welcomed the way in which the Care Quality Commission (CQC), which is the body responsible for regulating the quality of services that we provide, undertook a planned review of our 11 healthcare sites. As a result of that review, the CQC expressed only some minor concerns without placing any restrictions on our service provision. In response, we swiftly produced an action plan to address these concerns. We have maintained our CQC registration to provide both health and social care services and now have added the community and primary care services that have been transferred to the Trust from the local PCT. It was pleasing to know that whilst we had certified ourselves as operating at a low standard in certain areas, the CQC disagreed and increased the score in those areas. This is a testament not only to the Trust's candour but to the fact that we take an uncompromising approach to the delivery of high quality care.

The Trust continues to increase its membership and we are proud to have increased this to 11,694, excluding staff. The maintenance of a membership body which is representative of the community that we serve is highly important. It provides Governors with the opportunity to speak with various people representing diverse local communities and their views inform the Board of Directors in its decision-making and implementation of future strategy. Our Annual Members' Meeting in September last year was attended by over 200 people and the Trust has maintained this level of engagement on a number of occasions. Our Governors are tireless in their valuable efforts that help to provide a positive contribution to improving the quality of our services and in monitoring and engaging in our development plans, offering much needed advice and support.

This report provides us with the opportunity to briefly share some of the Trust's recent successes and outline plans for the coming year in terms of what is being done to develop as an organisation.

Some of the major developments in 2010/2011 included:

- The Board of Directors' approval of the Service User Involvement Framework. This occasion was marked

> ""The Trust continues to increase its membership and we are proud to have increased this to 11,694, excluding staff. The maintenance of a membership body which is representative of the community that we serve is highly important.""

by the Board hearing the story of a service user's experience with the Trust's services and how they have, from recovery, gone on to make a positive contribution to the Trust through their involvement as a service user volunteer. The Board listened to another account from a service user who has played an active part in developing the Service User Involvement Framework. These positive stories are symbolic of our real commitment to service user involvement

- The setting up of "Busters" Café at one of the Trust's establishments. This project has played a significant part in the lives of the people who use our services by offering them employment as a means of aiding their recovery. This helps them to prepare for re-entering the wider employment market and is a key plank of our strategy in fighting the stigma attached to the people who suffer from mental illness. It will remain an essential part of our commitment to support their social inclusion

- The Improving Access to Psychological Therapies (IAPT) service has continued to make significant strides to the wide acclaim of our primary care partners. It remains as a prized asset and provides the Trust with a strong partnership in the provision of community and primary care services

- The Trust has maintained 'Level 1' in the inspection by the National Health Service Litigation Authority (NHSLA) which allows us to provide services covered by their insurance. We are committed to moving to level 2 and then level 3 over the coming years. This is likely to become mandatory with the CQC's governance requirements

We want to take this opportunity to thank Karen Tomlinson who was the Trust's Chief Nurse from its inception as an NHS Foundation Trust. Karen played a significant and much valued part in helping the Trust to attain Foundation Trust status. We wish her well in her new role. We welcome Liz Lightbown who has been with us on secondment for this last year and was appointed to replace Karen and in the

full knowledge of the significant workload that lies ahead. We extend the same warm welcome to Dean Wilson who was appointed as the Trust's new Associate Director of Human Resources. These two significant appointments make up the full complement of the Executive Directors' Group.

It goes without saying that the next few years are going to be the most significant and enduring in relation to how we deliver services with less funding and increased demand. This is especially challenging for Mental Health, Learning Disability and Substance Misuse services as there will be a considerable increase in the number of people in need of these services.

So, despite the adverse climate that we find ourselves in, the Trust remains determined in its resolve to maintain and improve the quality of its services and in seeking new and innovative ways of delivering them. With the careful marshalling of our finances and the indispensable support of all our staff, we remain confident in our ability to protect the services that we provide to the many vulnerable people who need them. The ability to rise above adversity is the spirit upon which the National Health Service was founded and it is that tenacity that will ensure that the Trust's services are both protected and developed in the future.

Kevan Taylor
Chief Executive

Professor Alan Walker
Chair

2 About Us

This Annual Report outlines the developments and improvements in our services over past 12 months. 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 1st July 2008, we were 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 £117 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 psychological services 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 inpatient 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 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 to 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 provider of integrated health and social care, we work in partnership with Sheffield City Council and have formal agreements with the Council to provide a range of social care services on its behalf. Through these arrangements, we have made good progress in developing the integrated services that we deliver to the people of Sheffield - an important goal that is shared by ourselves and the City Council.

"We attach great importance to working in partnership with other organisations. This has enabled us to work effectively in meeting the needs of the diverse communities that make up the population of the City 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 also 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 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 Performance Review

4.1 Performance Overview

Contracted Service Provision

The contracts we have with those who purchase our services set a range of activity targets that we are expected to meet. The table below provides an overview of our performance in 2010/11 against the targets set out in our contract with NHS Sheffield, the main purchaser of our services.

Quality Overview - Standards and Targets

	How did we do 2008-09	How did we do 2009-10	This year's target	How did we do this year 2010-11	Monitor*
Improving Access to Psychological Therapies • Number of people accessing services • Number of people returning to work • Number of people achieving recovery Data source: Local reporting systems	Service started in year 1,937 17 people 38%	6,292 276 people 42%	5,364 89 people 50%	9,036 419 people 41%	
Routine referrals • People to access support/ treatment within 8 weeks of referral Data source: Local reporting systems	Not measured	42.2% of people received treatment in 8 weeks	Increase to 50% by Quarter 3	62.9% (in Q3) & 67.8% (in Q4) of people received treatment in 8 weeks	
Early intervention • People should have access to early intervention services Data source: Omnibus	147 new clients accessed services	285 new clients accessed services	90 new cases per year	129 new clients accessed services	Yes
Access to assessments when in crises • People to access an assessment within 4 hours of referral when in a crisis Data source: Local reporting systems	Not measured	59% of referrals assessed within 4 hours	Increase to 80% by Quarter 3	78.3% assessed in 4 hours by Q3 83.1% in Q4	
Access to home treatment • People should have access to home treatment when in a crisis as an alternative to hospital care Data source: Omnibus	1,249 episodes of home treatment provided	1,365 episodes of home treatment provided	1,202 episodes to be provided	1,361 episodes provided	

	How did we do 2008-09	How did we do 2009-10	This year's target	How did we do this year 2010-11	Monitor*
'Gate keeping' • Everyone admitted to hospital is assessed and considered for home treatment Data source: Omnibus	93.1% of admissions gate-kept	94.6% of admissions gate-kept	90% of admissions to be gate-kept	97.3%	Yes
Delayed transfers of care • Delays in moving on from hospital care should be kept to a minimum Data source: Local reporting systems	6.9% of inpatients experienced a delay	6.4% of inpatients experienced a delay	No more than 7.5%	6.9%	Yes
7 day follow up • Everyone discharged from hospital should receive support in the community within 7 days of being discharged Data source: Omnibus	97% of patients followed up	97.2% of patients followed up	95% of patients to be followed up in 7 days	96.4%	Yes
Annual care reviews • Everyone on CPA should have an annual review with their care coordinator • Everyone on CPA should have a formal review of their care plan Data source: Local reporting systems	Not measured 85%	Not measured 89%	95% 90%	99.3% 91-93%	Yes No
Access to equipment • Community equipment to be delivered within 7 days of assessment Data source: Local reporting systems	94.3% of items delivered within 7 days	97.2% of items delivered within 7 days	95% of items to be delivered within 7 days	95.7%	
Substance misuse treatment • Problematic drug users retained in treatment for 12 weeks or more Data source: NTDMS	91% of people still in treatment at 12 weeks	93% of people still in treatment at 12 weeks	90%	89% (year to Sept 10)	
Data quality • Data completeness - client identifiers • Data completeness - client outcomes Data source: Local reporting systems	Not measured	Not measured	99% 50%	98.2% 78.8%	Yes Yes
Employment • People with severe mental health problems in employment Data source: Omnibus	Not measured	6.9% of people on CPA in employment at Q4	8.02% by Q4	6.1% YTD at Q3	
Choice and control • People accessing direct payments to purchase their own social care packages Data source: Local reporting systems	Not measured	Not measured	n/a	115 people receiving payments by Q4 Further 149 actively exploring	

*Monitor standard
Monitor (the independent regulator of all NHS Foundation Trusts) requires all NHS Foundation Trusts to achieve these standards.

Our Commissioners

The Trust provides a range of services, covering direct care services, training, teaching and support functions. The main commissioners of our clinical services are NHS Sheffield, Sheffield City Council and other NHS Primary Care Trusts.

The non-patient care services are commissioned by NHS Sheffield, Foundation Trusts, NHS Trusts and Whole Government Accounts (WGA) organisations, along with other NHS Primary Care Trusts.

The Strategic Health Authorities, Primary Care Trusts and Department of Health commission education, training, research and development.

Housing Associations commission our residential care services.

Where Our Money Comes From

£285.00   £18,694.20   £12,181.00   £3,064.00   £6,455.56   £82,914.44

- Income from Local Authorities
- Income from NHS Foundation Trusts
- Income from Training
- Income from NHS Trusts & DOH
- Income from Central Government WGA Bodies
- Other Income
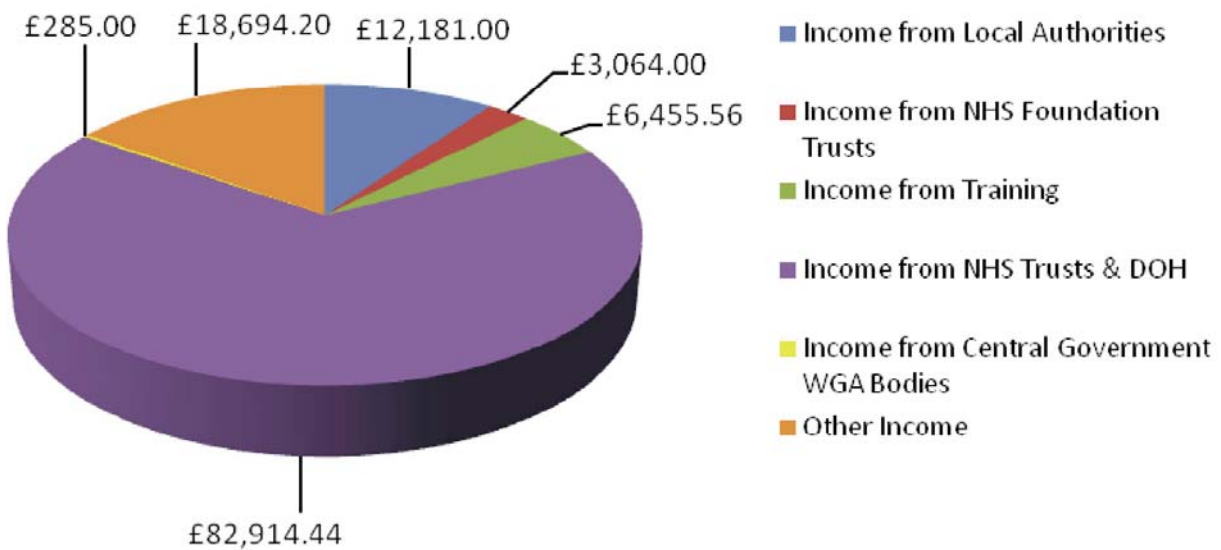
How We Spend Our Money

The main areas of expenditure within the Trust are shown in the charts below:

£4,774.00   £2,327.00   £1,704.00   £11,126.41   £94,834.00

- Pay Related Expenditure - See breakdown below
- Drug Costs
- Supplies & Ser vices
- Premises
- Other Expenditure

Total Expenditure £114,765.41
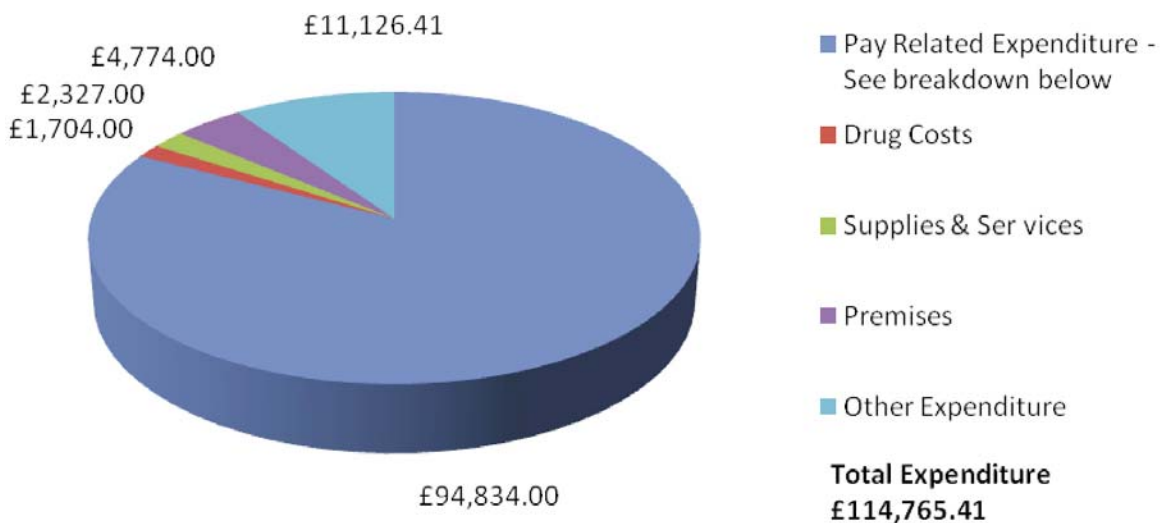
Trust Staff Pay Expenditure

- Consultants
- Other Medical
- Nursing Staff
- Scientific, Therapeutic & Technical
- Other Clinical
- Non Clinical Staff
- Agency

£1,994.23
£5,900.87
£17,167.40
£6,296.58
£4,203.32
£19,710.18
£39,561.42
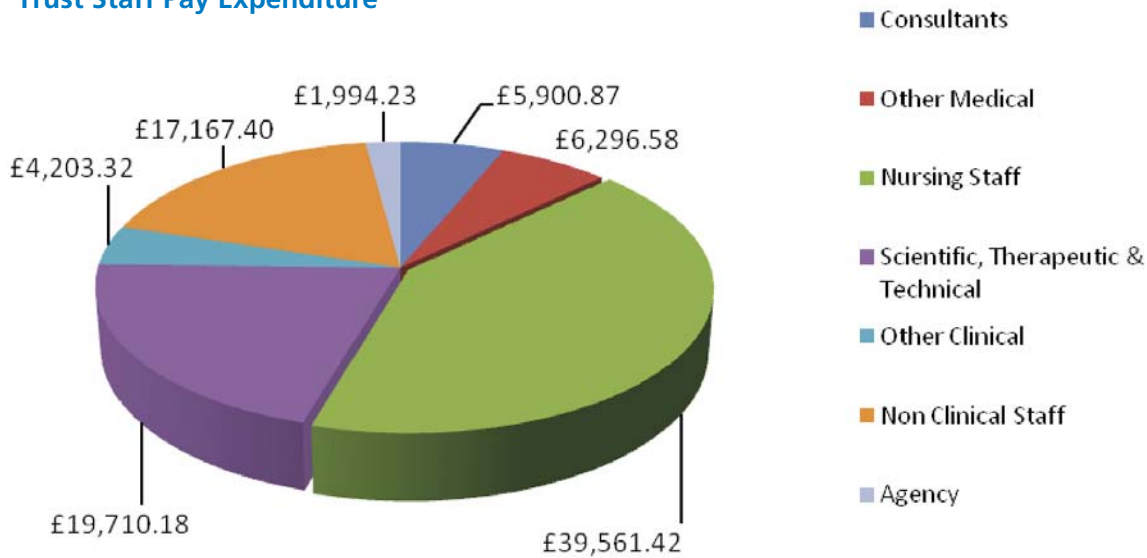
Regulatory Ratings

	Annual plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Green

	Annual plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	4	4	4	4	4
Governance risk rating	Amber Green	Amber Green	Amber Red	Amber Green	Amber Red

In our annual assessment for the year 2010/11, the Trust expected to experience challenges with the following indicators over the first part of the year:

- Care Programme Approach - service users receiving an annual review
- Data Quality - data outcome recording in relation to employment and settled accommodation

During the year the Trust performed well on these 2 indicators and they did not prove to be an ongoing challenge or area of concern.

The Trust did experience challenges during the year in respect of the following issues:

- **Care Programme Approach - 7 day follow up:** This has previously been an area of strength and strong performance within the Trust. In the previous year we attained 97.2 per cent. However during quarter 1 - 2 the Trust only achieved 93.7 per cent of follow up within 7 days, with 9 service users not being seen in the first week following their discharge. Improvement plans were introduced to provide more proactive reminders and notifications to team members and for the second 2 quarters performance improved to 98.5 per cent.

- **Delayed Discharge of Care:** Additional challenges were experienced during the year. In the previous year our rates were 6.4 per cent. During quarter 1 - 2 rates increased to 8.5-

8.7 per cent. Work with commissioners to improve decision-making processes around after care packages, along with new step down services developed by the Trust resulted in improvements during quarter 4 where the rates had decreased to 5.2 per cent.

- **Data Quality (data completeness in relation to service users' marital status):**
  This was a new indicator introduced during the course of the year. This information has not traditionally been prioritised or considered important by the Trust, and for this reason we did not perform well. The Trust scored 99+ per cent on 6 of the data quality indicators, but around 85-90 per cent in relation to service users marital status

- **Quarter 4:**
  Based on our performance during quarter 4, we would have expected a rating of Amber Green. However, following the report from the care Quality Commission and the compliance actions required within our development plan, we will remain rated as Amber Red until the improvement work under way reaches a satisfactory conclusion. We expect this to be toward the end of Q2 in 2011/12.

4.2 Partnerships with staff

Staff Survey
The Trust employs around 3,000 people and as part of our responsibility towards enhancing staff loyalty and motivation, we carry out an annual NHS Staff Survey programme. We then develop action plans that are based on the outcomes of this survey and share details with all staff through our regular communication channels.

The NHS Staff Survey provides us with feedback on the Trust's performance across a range of relevant areas. The results are focused on the pledges to staff contained in 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 management 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 and the services they provide, as well as empowering them to put forward ways to deliver better and safer services.

The NHS Staff Survey attempts to identify the major factors contributing to staff engagement and motivation. By focussing on these, the Trust aims to enhance the high quality care it offers to the people who use its services.

Survey Results
The survey revealed that in 2010/11, the Trust consistently exceeded the national average within the four top indicators, as follows:

- Staff satisfaction with the extent to which the Trust values their work
- The Trust's clarity of communication on what it is trying to achieve
- Whether the Trust helps staff balance work and home life
- Whether the care of the people who use its services is the Trust's top priority

An important point to note is that a higher percentage (63 per cent compared with 59 per cent nationally) of staff would be happy for a friend or relative to be treated by the Trust. A smaller number of staff (just 24 per cent compared with the national average of 28 per cent) think about leaving their jobs, which is a good indication of workforce stability.

A higher percentage of staff (68 per cent at the Trust, compared with 53 per cent nationally) would recommend the Trust as a place to work.

Two main areas for positive action are appraisals and health and safety training, including infection control. We have already seen improvements in the delivery

of well structured appraisals and the implementation of development plans for staff. This was previously highlighted in the Care Quality Commission's registration process and still remains a challenge.

Teams are monitored closely to ensure that staff are aware of their objectives and the part they play in delivering the Trust's commitment to the care of the people who use the Trust's services. Staff are given feedback through formal appraisals, supervision and support by their line managers in order to ensure that they have the right skills for their jobs.

The Trust has recently reviewed its learning and development programme to focus more clearly on undertaking essential training activity, which now underpins our service delivery and ensures safe and competent staff.

The staff survey indicates that health and safety and diversity training are areas of poor performance when compared with other mental health trusts. This will be an area on which we aim for improvement in the 2011/12 financial year.

Table 1: NHS Staff Survey Summary

	2010/2011		2009/10		Trust Improvement / Deterioration
	Trust	**National Average**	**Trust**	**National Average**	
Response Rate	56%	54%	56%	55%	No change
Top 4 Ranking Scores					
Satisfied with the extent the Trust values their work	45%	37%	38%	37%	Better than last year
Trust communicates clearly what it is trying to achieve	52%	45%	46%	45%	Better than last year
Trust helps staff balance work and home life	55%	49%	52%	49%	Slightly better than last year
Care of patients is the Trust's top priority	62%	57%	61%	57%	Slightly better than last year
Bottom 4 Ranking Scores					
Received equality / diversity training in last 12 months	29%	49%	28%	42%	No significant change in Trust, worse when compared nationally
Received infection control training in last 12 months	51%	67%	54%	67%	Slightly worse than last year
They or a colleague have reported physical violence	94%	90%	85%	82%	Worse than last year
Percentage of staff receiving appraisal in last 12 months	75%	77%	48%	67%	Much better than last year but still below national average

Listening to Our Staff

Staff Governors, staff representatives and staff themselves are involved in initiatives that are focused on delivering quality services. As an organisation, we encourage local teams to take ownership and improve their services wherever possible. This is facilitated by supervisors and managers attending the Leadership Development Forum to discuss objectives, service developments and key improvement opportunities across the Trust.

The Trust's Chief Executive produces a bulletin several times a year and regularly uses other communication media to keep staff fully informed of developments. Feedback and suggestions are 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 consultation and negotiation forums with staff representatives. The Trust's Strategic Leadership Group continues to focus on service improvement, as well as engaging clinicians and managers, in a drive to deliver proactive change to clinical services within our Joint Leadership model.

Equal Opportunities

Sheffield Health and Social Care NHS Foundation Trust believes in fairness, equal opportunity and above all, values diversity in all aspects of its work.

The Trust is committed to eliminating discrimination and to treating everyone with fairness taking into account, amongst other things, their gender, race, colour, ethnicity, ethnic or national origin, citizenship, religion, disability, mental health needs, age, domestic circumstances, social class, sexual orientation, beliefs or trade union memberships.

If unfair discrimination occurs it will be taken very seriously and may result in formal action being taken, including disciplinary action.

Everyone who comes into contact with the Trust can expect to be treated with respect and dignity and to have proper account taken of their personal, cultural and spiritual needs.

The Trust also aims to ensure that it employs and develops a healthcare workforce that is diverse, non-discriminatory and appropriate to deliver modern

"The Trust is committed to eliminating discrimination and to treating everyone with fairness"

healthcare. Valuing the differences of each team member is a fundamental component of the Trust. It enables its staff to create respectful work environments.

In this way the Trust is able to deliver quality care and services whilst giving service users the opportunity to reach their full potential.

4.3 Partnerships with the People who use our Services and their Carers

The Trust views working in partnership with people who use or who have used its services, and their carers, as fundamental to its aim of improving the quality of the services that it provides. In this regard, we brought about the following specific developments in 2010/2011:

Service User Involvement Framework

To demonstrate our commitment to ensure that the services we provide meet the needs of the people that use them, we have been working with a wide group of people who have experience in using our services to finalise a Service User Involvement Framework.

The purpose of the Service User Involvement Framework is to ensure that the Trust has a coherent way of providing a platform for service users, their families and carers to positively influence the way the Trust delivers its services to them. This involvement and feedback from service users is crucial as it helps us to ensure that we continue to improve and develop our services with a view to meeting the changing needs of the people of Sheffield.

The framework was first introduced at an "Improving Quality" event which was held in December 2010. The event focused on developing an action plan to take

forward the principles of Positive Involvement which are at the heart of the Framework.

The Service User Involvement Framework was formally approved by the Board of Directors in February 2011. Following the Board's approval of the framework, we are now in the process of developing a related action plan to be approved by the Board's Quality Assurance Committee before it is referred to the Board for final approval and subsequent implementation in the organisation.

Trust City Strategy - Carers' Action Plan

Carers are frequently involved in the Trust's activities, sometimes as representatives of service users or sometimes in their own right. Both aspects of involvement are important and valued by the Trust.

The distinct needs of this group are addressed through the city-wide Carers' Strategy. The Strategy was developed by carers in partnership with several organisations that work with them. As part of our commitment to support the implementation of the Strategy, we produced a Carers' Action Plan which took into account the priorities of the city-wide Carers' Strategy. This Action Plan was launched at the "Improving Quality" event that took place in December 2010. We also set up a Carers' Strategy Implementation Group to ensure that the Carers' Strategy is taken forward.

Listening to Service Users and Carers

In 2010/2011, we carried out a detailed review of all the methods that the Trust uses to measure and respond to feedback from service users and carers. We plan to carry out further work in 2011/12 to review all of the ways in which feedback from service users and carers is obtained and used. We want to ensure that this is done consistently and effectively across the organisation, taking into account the diversity of the people that we serve.

Our commitment to providing a positive experience for the people who use our services and their carers is evidenced by the fact that we have put in place a strategy and action plan to support the Trust's ability to deliver that commitment.

During 2010/2011, the Trust not only supported but also organised a wide range of activities to encourage service users to increase their involvement in the Trust. Details of these activities are set out below:

- We supported service user involvement in the city's anti-stigma campaign linked to 'Time to Change', which is England's biggest ever campaign aimed at ending the stigma attached to people suffering from mental illness

- We held a Sharing Good Practice event, which focused on service user and carer feedback. The event included presentations about the Trust's Quality and Dignity project, which involves service user volunteers meeting with inpatient service users to discuss feedback on their experiences

- Service users and carers have attended regular training sessions on recruitment and selection, along with staff. They continue to take part in interview panels for a wide range of posts, including executive and consultant positions

- The Trust's Partners in Improving Quality Group took part in ward reviews for the first time. The work of this group forms an important part of the Trust's efforts to ensure that it continues to deliver high quality and safe services that meet standards set by the Care Quality Commission. This group draws on the participation of people from across the whole of Trust's services

- As part of our Improving Quality programme, we aim to reach out to those people whose viewpoints are less often heard. To this end, we held a successful event during 2010/11 that was attended by service users and carers. It provided us with excellent feedback which has helped to inform the Trust's future plans for improving the quality of its services

- Service users and carers are now involved in our corporate induction process. They share stories of

their individual journeys as part of the 'Corporate Welcome' for new members of staff

- The Creative Arts Steering Team (CAST), which aims to promote art as a pathway to mental health and wellbeing, has been involved in a wide range of different activities. These have included displaying their work at various sites across Sheffield. CAST members have held exhibitions as part of the 'Storying Sheffield' project, an initiative of the University of Sheffield led by one of the Trust's Service User Governors. It is aimed at producing, recording and collecting the stories and many other diverse representations of the lives of the people of Sheffield. CAST members have also worked in collaboration with Weston Park Museum to showcase their work within the museum

- In March 2011, carers from black and minority ethnic (BME) backgrounds took part in creating 'Digital Stories'. This was a project that focused on capturing stories of their experiences as carers

- Two service users, alongside a number of staff members, are taking part in the Read to Lead training programme which is aimed at training volunteers who will lead reading groups for both inpatients and service users living in the community. When implemented, the Read to Lead programme will involve the trained facilitators reading great literature to a small groups of service users as a way of maintaining and improving their mental health and wellbeing

4.4 Learning Disabilities

The Joint Learning Disabilities Service, which is a partnership between the Trust and Sheffield City Council, provides a single joined-up service in Sheffield to adults with learning disabilities. A selection of the Trust's achievements through the Joint Learning Disabilities service during 2010/11 includes the following:

- We worked with our NHS partners to support and enable improved access to health services for people with learning disabilities. For example, 78 per cent of Sheffield GP practices have chosen to take part in the Direct Enhanced Services, providing health checks for 1,745 people with moderate or severe learning disabilities, with advice and support from Community Learning Disability Teams

- The SeeAbility project has enabled its beneficiaries to access mainstream health services for eye care. This project is aimed at encouraging people who have multiple disabilities and are also blind or partially sighted to achieve their full potential. The improved access to health services which the project has provided to its beneficiaries was positively reflected in Sheffield's Health Self Assessments. The Yorkshire and Humber Strategic Health Authority also awarded the Trust with four commendations and stated that the Trust was the only organisation to achieve 'green' for all targets rated for success or failure on a 'red, amber, green' traffic light rating basis, with green being an indicator of success

- During the last 12 months, 30 people attended the Expert Patient programme. This is a six week course specifically designed for people with learning disabilities and long term health conditions. It is aimed at helping participants to manage their condition better on a daily basis. Service users who accessed the course gained confidence, skills and knowledge on how to help themselves to improve their health

- Access to the Trust's multi-disciplinary teams has been improved with the development of a single point of access for health and social care. The development of care and support pathways is also underway. This is helping to provide improved access to specialist services. In addition, access to universal services has also been enhanced by Speech and Language Therapists from the Community Learning Disability Teams. The teams have trained Communication Development Workers who are now supporting people with profound and multiple learning disabilities (PMLD) to take advantage of universal leisure and other services

- The Assessment and Treatment Unit has introduced people with a learning disability to work as peer advocates. In addition to working with individuals, the peer advocates meet on a regular basis with the Service Manager and other team members to give feedback and discuss progress or other issues

- The business case for development of the new Assessment and Treatment Unit from which Intensive Support Service will be provided was agreed. This will result in the adoption of a nationally recognised exemplar of good practice, providing more intensive and complex support for individuals

whose behaviour presents challenges for both their carers and the services that they use. The new Assessment and Treatment Unit will create a bedded inpatient facility for individuals with learning disabilities who present complex and challenging behaviour

- The Accommodation Development Team has started comprehensive reviews for all existing accommodation schemes. This review forms part of a reconfiguration programme aimed at improving the way in which the accommodation needs of service users are met. This work is being carried out by the team in close collaboration with service users

- We held our fifth WiLD (Working in Learning Disabilities) Awards, which recognise professional nurses, therapists, rehabilitation practitioners and support staff who have demonstrated an outstanding level of awareness and understanding of the needs of service users in their respective areas of expertise. This year, there were 30 nominations across the Joint Service, some from staff and managers, but many from carers and service users

4.5 Substance Misuse Services

The Trust's Substance Misuse Service helps Sheffield residents aged over 18 who are experiencing substance misuse problems to engage in clinical treatment interventions. It is a city-wide service that links with all hospitals, community mental health teams, prisons, and rehabilitation placements within Sheffield. The service operates in the community and within hospital settings and has a number of dedicated beds for inpatient admission for detoxification.

2010/11 has been another effective year for the Trust in its delivery of Substance Misuse services. The highlights of some of our achievements, in this regard, include the following:

- Sheffield Drug and Alcohol Action Team (DAAT) awarded the Trust with a new contract to provide a Single Entry and Assessment Point (SEAP) to alcohol treatment services. This has enabled us to act as a 'front door' to alcohol treatment services through which we offer support, advice and information to people who want to make changes to their drinking habits and thereby giving them access to alcohol treatment services within Sheffield.

> **"*We have succeeded in minimising delays experienced by service users between assessment and treatment and this is evidenced by our achievement of the targets set in national key performance indicators for access waiting times and retention in treatment.*"**

We assess the needs of individuals who come through this service and either provide brief interventions, where this is necessary, or refer them to the appropriate specialist services. We also provide outreach services to encourage hard-to-reach groups to access alcohol treatment services.

Staff who were formerly employed by the previous provider of this service were successfully transferred into the Trust's employment in September 2010.

Our success in securing the provision of this new service follows on from our achievement, last year, in securing contracts for the delivery of specialist services for prescribing drug and alcohol substitutes along with harm reduction services across Sheffield

- The Substance Misuse service has radically reorganised the way in which it delivers care to service users by working in Community Care Groups staffed by doctors, nurses, drug / alcohol workers, social workers and harm reduction workers. The Care Groups are led by a Consultant and Team Leader and aim to deliver consistent, multi-disciplinary monthly appointments to all service users needing treatment
.
- We have succeeded in minimising delays experienced by service users between assessment and treatment and this is evidenced by our achievement of the targets set in national key performance indicators for access waiting times and retention in treatment. This level of success in providing quick access to treatment along with ensuring that service users complete their treatment programmes should result in significant positive outcomes for the people who use our services

- We continue to collaborate with other agencies including Sheffield Drug and Alcohol Action Team, Sheffield City Council, Turning Point, Sheffield Teaching Hospitals NHS Foundation Trust, the Police and Ambulance services in order to provide seamless high quality care to the people who use our services

- We have continued to successfully negotiate better packages with residential rehabilitation service providers to support abstinence-based models of recovery. This has not only led to an increase in the availability of these service models but also to improvements in their quality as well

- Through the efforts of the Harm Reduction Team, we achieved city-wide targets for the delivery of screening and vaccination programmes for blood borne viruses

- The Trust has secured funding for a time limited post of an Accident and Emergency (A&E) Alcohol Liaison Nurse to work alongside clinicians at the Sheffield Teaching Hospital NHS Foundation Trust (STHFT). This will help to increase the awareness and referral pathways for those attending the A&E services with alcohol related injuries and/or physical health conditions. The post will not only help to navigate service users into treatment services but it will, through training and support, help to increase alcohol awareness amongst STHFT staff

- We continue to make excellent progress in clinical performance and service innovations. This has resulted in our implementation of new multi disciplinary service delivery structures for the benefit of service users receiving drug and alcohol treatment. These structures comprise Care Groups made up of nurses, doctors, drug / alcohol workers, social workers and administrative staff. They aim to provide consistency and continuity of care delivery for some of the most vulnerable service users in the city

   As we seek to align our service provision with the government's policy of focusing on recovery and abstinence, we aim to increase the frequency of support that we provide to the people who use our services by:

- proactively working in support of the national Recovery agenda which seeks to shift the focus of substance misuse services from getting people into treatment to helping them to lead successful drug-free lives

- implementing the new national Drug & Alcohol Strategy, which is aimed at supporting people to live drug-free lives

- continuing to build the whole service so that it is recognised as a model of excellence, both locally and nationally

- identifying further opportunities for expanding the Trust's provision of substance misuse services in Sheffield and beyond

- providing specialist alcohol awareness sessions as part of the implementation, in Sheffield, of a new Fine Waiver Scheme for alcohol related offences. Through this scheme, people who have been issued with a fixed penalty notice for being drunk and disorderly can have their fine of £80 waived if they attend two brief interventions within our service

- listening to feedback from service user volunteers in order to help us evaluate the impact of any service changes we may consider proposing

- introducing guidelines for GPs across Sheffield on detoxification packages and carrying out training events linked to the Recovery agenda

- continuing to work proactively with NHS Sheffield in order to improve dual diagnosis plans for substance misuse services providers in the voluntary sector

4.6 Acute and Community Care (Adult Mental Health)

The Trust's Adult Mental Health Service for people under 65 is divided into two directorates consisting of the Acute and Community Care Directorate and the Recovery, Rehabilitation and Specialist Service Directorate.

The Acute and Community Team has continued to meet the consistently high demand for mental health services across the city of Sheffield.

During 2010/11, the Team has:

- dealt with over 2,700 referrals and has a caseload of 1,300 service users

- provided support for over 1,000 service users during a period of crisis through the Crisis Resolution and Home Treatment Service

- provided 580 service users with acute care through its four inpatient wards and has managed 60 episodes of care through the intensive treatment ward

- provided over 5,000 appointments to service users through the Psychotherapy Service

- managed a caseload of over 100 service users alongside providing consultation to mental health professionals across Sheffield

- been working to improve the quality of care through a range of initiatives

The Acute Care Pathway was introduced in December 2009. In the last year, the pathway has been embedded into practice and the monitoring of standards has identified areas for development. There have been improvements in the delivery of acute care, including: increasing the number of inpatients who receive physical health checks within 72 hours of admission; the allocation and involvement of care co-ordinators during admission to hospital and; the timeliness of crisis assessments.

The Productive Ward initiative aims to improve the quality of inpatient care provision by encouraging ward teams to work with their consultant team members in order to ensure clear planning of ward rounds and that the ward rounds are quicker and more consistent. Stanage Ward commenced this programme in 2009 and has started to see improvements as a result. The ward has worked at enhancing the care environment, freeing up nursing time which is redirected to caring for service users and improving communication on the ward. The project on Stanage Ward is ongoing and has now been extended to Maple Ward. There are plans to extend the Productive Ward initiative to all the inpatient wards in the Trust.

The Intensive Treatment Service has signed up to the Royal College of Psychiatrists' programme of accreditation of psychiatric intensive care units. This development has enabled the service to be benchmarked against national standards and thereby ensure that the provision of intensive care services in Sheffield is in line with national best practice.

Psychotherapy services have been reconfigured to provide specialist teams for anxiety, depression, personality disorder and obsessive compulsive disorder/body dysmorphic disorder. The aim of this reconfiguration was to bring about the delivery of services in line with best practice identified by the National Institute for Health and Clinical Excellence (NICE).

The Acute and Community Directorate has focussed on improving communication and feedback to staff by setting up ongoing monthly sessions to review their practices. There has been a drive to ensure that all staff are given an annual appraisal, which includes the creation of a personal development plan.

The Directorate has continued to share good practice between teams using the Acute Care Forum and the Community Mental Health Team Forum, which reports alongside the Trust's wide governance structures. A joint initiative with the Recovery, Rehabilitation and Specialist Directorate has resulted in the development of the SUN:RISE group, which is a forum for service users to share experiences, learn about services and provide feedback with the aim of making improvements wherever possible. The word SUN:RISE is an acronym for Service User Network: Relevant Inclusive, Supportive, Exciting, which aptly captures the essence of this group.

4.7 Recovery, Rehabilitation and Specialist Services (Adult Mental Health)

The Recovery, Rehabilitation and Specialist Services forms the other half of the Trust's Adult Mental Health Services (for people under 65).

2010/11 has been another effective year for this part of the Trust's services and this is highlighted by the following key activities:

- Detailed planning was undertaken on the development of a Scheduled Care Pathway with access to Secondary Mental Health care in order to improve quality of service and efficiency. This will work alongside the already developed Acute Care Pathway and will be piloted in the Community

Mental Health Team (CMHT) in the South East of the city from March 2011

- The service has given focused attention to Self Directed Support (SDS), which is a new way in which funding and support is organised for service users who are eligible for funded social care. SDS aims to give service users much more choice and greater control over the support they receive to meet their social care needs. This is part of a government policy initiative to create greater personalisation in health and social care and covers the whole range of user groups, including older people, as well as those with learning or physical disabilities.

As a provider of integrated health and social care services, the Trust has been implementing the assessment and support planning processes around SDS within its Community Mental Health Teams. There are now over 180 people in Adult Mental Health Services who are within the SDS process and 80 individuals with an agreed support plan. As well as giving service users greater choice and control, SDS enables them to look at much more imaginative ways of having their social care needs met. Social care services currently include home care, home support, day and community services, respite care and residential care.

The introduction of SDS will result in the removal of the Trust's guaranteed block income which funds our provision of social care services. However, the Trust is fully prepared for this prospect and we remain confident that the services we provide will still be chosen by service users who will, under SDS, purchase our services through Direct Payments

- Many service users with complex needs can find it difficult to access structured programmes of psychotherapy. This is the reason why we are training a wide range of staff in Cognitive Behavioural Therapy (CBT) informed practices. Over the last year, we implemented a training plan for staff in Community Teams that use CBT and Family Interventions with people suffering from psychosis. This will enable them to develop ways of bringing about positive outcomes for people with the most serious mental health problems

- A pilot scheme in Family Interventions has been taking place over the last year, with a focus

*" **The Trust has now been awarded funding for 2011/12 to develop a more intensive Day Service that can support those with the most serious eating disorders and reduce the need for their admission into hospital.** "*

particularly on service users within the Early Intervention Service. This has resulted in a number of service users receiving significant help through the application of this approach

- The Trust made a successful bid for the Sheffield Pathways and Access Community Engagement Service (SPACES). This is a newly commissioned Community Recovery Service that was previously known as Day Services. It aims to provide service users with opportunities for social activity, education and employment. It has supported a number of service users to take up volunteering roles whilst also helping others to take up paid employment within the service. SPACES has now been operating successfully since April 2010 and has developed many partnerships with other voluntary sector and community groups.

Two members of staff from SPACES, Suzanne Horan and Laura Bayliff, won the Trust's annual Clinical Excellence Awards for their work with the Bi-Polar Management Group

4.8 Specialist Services: Eating Disorders Service

The Trust's Eating Disorders Service is a specialist community outpatient service, providing assessment and psychologically-based interventions to people with severe eating disorders.

Over the last year, the Trust has been in discussions with NHS Sheffield over its plans for improving the Eating Disorders Service and how this could assist in reducing the use of more expensive out-of-city placements. The Trust has now been awarded funding for 2011/12 to develop a more intensive Day Service that can support those with the most serious eating disorders and reduce the need for their admission into hospital.

4.9 Dementia (Older Adults)

The Trust's Dementia Services Directorate provides a range of inpatient and community services for people with dementia. Dementia is a term used to cover a range of diagnoses which cause progressive deterioration of memory and other aspects of mental functioning. It affects five percent of people over the age of 65 and rises with increasing age to up to 20 per cent of people over the age of 80. The most common cause of dementia is Alzheimer's disease.

We provide a range of services to support early diagnosis and intervention in addition to help, advice and support for more complex problems that are associated with dementia. We offer a memory service that is run from two sites. We have Rapid Response and Home Treatment Teams that meet the needs of service users in the places where they live. We also have a Resource Centre that provides respite, day, flexible and interim emergency care. Our members of staff also provide care for people who live in two nursing homes that are paid for by NHS Sheffield.

In 2008, a strategic review was carried out on the way in which services were delivered by the Dementia Directorate. The positive impact of the changes brought about as a result of that review continue to play a key part in the Trust's delivery of high quality care to very vulnerable individuals with complex and challenging needs.

Highlights of the Trust's activities in the Dementia Service during 2010/11 include the following:

- The Rapid Response Teams (which were developed as part of the 2008 strategic review) continue to grow from strength to strength. They deliver a valued service with a city-wide reach. The Teams successfully prevented 24 long term care admissions, thereby providing a viable alternative to admission in those cases. This has helped to ensure the efficient use of specialist assessment beds. The success of the Rapid Response Teams has also led to proposals for a Rapid Response/Discharge Team to work with the casualty and medical admissions unit at the Northern General Hospital in order to reduce lengths of stay in hospital and prevent unnecessary admissions

- The Memory Service has worked hard to achieve national accreditation under the auspices of the Memory Services National Accreditation

"We provide a range of services to support early diagnosis and intervention in addition to help, advice and support for more complex problems that are associated with dementia."

Programme. This prized service accreditation was attained in October 2010

- The Trust is working with commissioners to address the lengthy waiting list for first assessments. Waiting times which stood at 40 weeks in January 2010 have already been considerably reduced to 19 weeks as at January 2011

- Due to above average levels of sickness that were prevalent amongst staff, the Directorate introduced FirstCare, an external sickness monitoring system. Since then, the Directorate witnessed a reduction in sickness levels from 8.3 per cent January 2010 to 6.3 per cent by the end of this financial year. This reduction has been helped by the close collaborative efforts between managers in the Dementia Directorate and the Trust's Human Resources Directorate. The drop in the levels of staff absence due to sickness has also led to the realisation of cost savings as the Trust has reduced its reliance on the use of temporary staff cover

- As part of the Trust's commitment to continuous improvement, the Dementia Directorate is carrying out staff development programmes which are formalised through Personal Development Reviews (PDR)

- NHS Sheffield commenced a consultation process in which it set out its proposals to close the two nursing homes at Birch Avenue and Woodland View. The outcome of the consultation is expected to be presented to the board of directors of NHS Sheffield in June 2011 for a final decision. Since the Trust provides the staff serving in these two nursing homes, it is developing a workforce plan that will seek to secure the redeployment of as many of them as possible in the event of NHS Sheffield deciding to close the two homes

- A reconfiguration programme of the Resource Centre has led to the realisation of 8 per cent savings that were required of the Trust by Sheffield City Council. The reconfiguration programme is also expected to bring about improvements in service user and carer choice. These improvements are expected to take effect from as early 1st April 2011

The table below shows the effect which service changes have had in key performance areas by comparing data for 2010 to that of 2011.

	April 2009-March 2010	April 2010-March 2011
Patients returning home	15	4
Acute dementia admissions into inpatient wards	58	39
Number of service users seen by the Rapid Response Teams	253	286
Violent incidents	149	133
Memory service waiting list weeks	40	19
Staff sickness rates overall (%)	8.33%	6.3%

4.10 Functional Mental Illness and Community Services (Older Adults' Mental Health)

The Functional Mental Illness Directorate hosts the Trust's Older Adult Community Mental Health Teams (CMHTs), which provide assessment, care and treatment for older adults with either a functional mental illness or dementia. The term "functional mental illness" is used to describe mental illnesses affecting the functioning of the brain which are found in people of any age. They include conditions such as anxiety, depression, schizophrenia or bi-polar disorder. These illnesses are different from dementia which arises from organic changes in the brain, and which occurs mostly, but not exclusively, in older people.

The CMHTs, which provide health and social care services, are the single point of access for all referrals of older adults into the Trust. In addition to the

CMHTs, the Directorate has two acute inpatient wards, a Discharge and Rehabilitation Team (DART), two day hospitals, two social care day centres, and Kirkhill Resource Centre. The Directorate is also responsible for provision of the Electro-Convulsive Therapy (ECT) services to Sheffield and Barnsley and for ancillary services such as cleaning, caretaking and catering services on the Longley Centre site.

A key objective for the Directorate this year is to seek to improve the experience of service users from minority communities. To address this, the Trust has built links with the Pakistani Centre, the Yemeni community and the Irish men's group

The Yemeni community is planning an event to raise awareness of our services and to advise us on what the Trust needs to be doing differently. In addition to this, the Trust's staff are being trained on how to develop culturally appropriate care plans. Information leaflets about diets and where to purchase foods have also been prepared and a web page is being set up to provide further information for staff.

Feedback from people using our services is key to ensuring that we continue to improve and to this end, every person discharged from each of our two wards by our discharge team is offered the opportunity to respond to an exit questionnaire. As part of our commitment to continuous improvement, we act on as many of the recommendations that we receive as we possibly can. Feedback about user experience on the two Functional Mental Illness wards has been very positive.

Nev Wheeler, one of the Trust's Governors and Nicola Cartwright, an Occupational Therapist within the Trust, are currently undertaking a partnership programme run by the Yorkshire and Humber Improvement Partnership. They have developed a project to raise awareness of the needs of older people in relation to employment, recovery, social inclusion and the breaking down of age barriers. The Trust successfully secured funding for the production of a leaflet aimed at promoting the benefits of voluntary/paid work opportunities for older people with mental health difficulties.

The Trust has a Psychological Treatments Strategy for the Functional Mental Illness Directorate. Part of this strategy involves focusing on increasing staff skilled in delivering psychological treatments to older people in addition to a number of other packages. We have increased the availability of places in psycho-educational

groups for depression and anxiety in our day hospitals and have piloted a successful older adult specialist electronic Psychosocial Interventions (PSI) programme, which is now being rolled out nationally.

4.11 Therapy Services

The Trust's Therapy Services delivers Occupational Therapy, Art and Music Therapy and Integrated Complementary Therapy into a range of areas within the health and social care community.

Key activities undertaken by the Trust through the Therapy Services Directorate during 2010/11 are set out below:

• Our Lead Occupational Therapy services have been instrumental in developing the SUN:RISE group. This is a service user involvement group which aims to improve the ways that service users can become better informed and more actively involved with the Trust. Our work with SUN:RISE is an indication of the Trust's commitment to involving as many service users as possible from a wide range of backgrounds

• We created an Occupational Therapist post within the Gender Dysphoria Service in order to give service users access to specialist Occupational Therapy support on lifestyle adjustment around self-care, leisure and employment, among other benefits

• We piloted the use of a dietitian across the Trust for six months in order to assess the Trust's processes on menus and nutritional screening of service users and to provide training and advice to staff. The recommendations that emerged from the evaluation of this pilot exercise led to the successful development of a business case for the employment of a qualified dietitian to work on a two day basis. The dietitian is expected to start working in the middle of 2011. This expert support will enable the Trust to enhance its ability to support service users with their nutritional needs and provide them with advice on malnutrition and obesity management

• The Board of Directors approved the Trust's Arts and Health Strategy which aims to develop pathways and information around art therapies and arts activities that promote access and inclusion for the people who use our services.

> *"The Trust has provided leadership in its use of employment as a means of promoting the social inclusion and recovery of service users suffering from some of the most severe mental health conditions."*

The presentation of the Strategy to the Board was attended by members of the Creative Arts Steering Team (CAST) who also shared with the Board members some highlights of the positive work that they are carrying out within the Trust

• The Trust has provided leadership in its use of employment as a means of promoting the social inclusion and recovery of service users suffering from some of the most severe mental health conditions. To this end, the Trust is committed to supporting the Public Sector Agreement (PSA) outcomes on tackling exclusion and promoting equality. This is demonstrated by the Trust having successfully met the national performance targets aimed at securing an increase in the proportion of the most socially excluded adults in employment. These targets are set under the PSA performance framework. The Trust's success in this regard has enabled it to secure 12 months' funding for a full-time Occupational Therapist and has thereby strengthened its capacity to create increased opportunities for the people who use its services to get back on the path to leading more successful lives

• The Trust's Director of Therapy Services undertook a short term secondment to the Yorkshire and Humber Strategic Health Authority as the Yorkshire & Humber NHS Health and Wellbeing Champion. This represented an important part of the Trust's commitment to participate in regional efforts aimed at encouraging the sharing of ideas on how to promote the health and wellbeing of NHS staff as recommended by the Boorman Review

Across the wider health and social care community of Sheffield, the Trust:

- acted as an effective city wide champion of the Mindful Employer principles. The Mindful Employer initiative is aimed at raising awareness of mental health at work and providing support for businesses in recruiting and retaining staff. The Trust, NHS Sheffield, Sheffield City Council and Sheffield Teaching Hospitals NHS Foundation Trust are the key public sector bodies in Sheffield that have signed up to this initiative. In May 2010, the Trust successfully led in organising a successful Mindful Employer event at which information, advice and practical support was provided to people whose mental health affects their ability to find or remain in employment, training, education and voluntary work

- created Mental Health Occupational Therapy posts within the Intermediate Care Services. The Trust also created a new post for a Falls Prevention Occupational Therapist to be based within Sheffield Teaching Hospitals NHS Foundation Trust where they will support older people at risk of falls

- has been contributing to the city-wide work on Transforming Community Services (TCS) through its senior therapy services staff. TCS is a government programme which aims to bring about the delivery of modern, responsive and high quality care in the community

Other developments that have taken place during the last 12 months include:

- the planned closure of Integrated Complementary Therapy Services after 18 years of service provision. These plans were brought about following NHS Sheffield's decisions to withdraw funding for this service

- maintaining ongoing focus on staff development and training initiatives as part of the Trust's commitment to offer the highest quality of service. This will include: the conduct of three half day sessions on leadership for therapy staff; two members of staff undertaking a regional evidence-based practice course with positive impact on service delivery; two senior members of staff finalising research modules for their masters degree courses and; one senior member of staff starting a masters degree course in leadership

The key developments and challenges that are expected in 2011/12 will include the following:

- From April 2011, the Trust will welcome new professionals into the Therapy Services Directorate. These will include physiotherapists, dietitians and speech and language therapists. This will require detailed planning to ensure that the integration of new staff does not adversely affect the services that the Trust currently offers

- We will be required to temporarily host Long-Term Neurological Conditions Services, as they move over into the Trust as part of TCS scheme in April 2011.

Chaplaincy and Spiritual Care

The Chaplaincy and Spiritual Care Department is part of the Therapy Services Directorate. It offers Trust-wide support around spiritual care, faith, and religious concerns to service users, their relatives and carers and to members of staff. The Department serves both those who belong to an established faith community as well as those who do not regard themselves as belonging to any faith. The Department continues to ensure that its objectives support the Trust's overall strategic vision of developing and improving services based around the needs of the people of Sheffield.

The work of the Chaplaincy is increasingly being recognised at the national level for its innovative approach and for its research into spiritual care.

The Spirituality Strategy Group has developed with increased membership from staff, service users and governors and now includes three workstreams, namely: spirituality champions; training/research and; faith community relations/events.

The Trust's key activities and achievements through the Chaplaincy Department during 2010/11 are set out below:

- We held a very successful membership event, All about Spiritual Healthcare. The event was aimed at promoting a deeper understanding of the needs of service users and their carers for a holistic experience of care. Participants shared their views on what they felt was important in delivering high quality spiritual care. The event was held at the Sheffield United football grounds and was attended by about 80 people

- At the Annual Members Meeting in September 2010, the Chaplain Team Leader received a Staff Excellence Award in recognition of his inclusive and innovative work in seeking to embed spirituality in the organisation

- Professor Peter Gilbert from Staffordshire University attended one of the Trust's Leadership Development Forum meetings as a facilitator. The meeting was aimed at exploring the place of holistic spiritual care in the organisation and

> **"At the Annual Members Meeting in September 2010, the Chaplain Team Leader received a Staff Excellence Award in recognition of his inclusive and innovative work in seeking to embed spirituality in the organisation"**

how senior managers could provide leadership in this regard

- The Department developed a research based assessment framework capable of enabling it to respond effectively to the spiritual needs and strengths of service users

Key plans and challenges for 2011/12 include the following:

- The Department is planning to make a presentation on Spiritual Healthcare to the Trust's Board of Directors later this year. This will help to sustain the strategic profile that spirituality occupies within the Trust and add momentum to the Board's commitment to ensuring that the Trust achieves the milestones on spirituality contained in its Annual Plan for 2011/12 to 2012/13. It will also highlight the need for the Trust to align its work with the recent recommendations made by the National Spiritual and Mental Health Forum in its Report on the Place of Spirituality in Mental Health

- The Department will seek to improve communications between the Trust and the faith sector, so as to increase the Trust's capacity for engaging with and supporting service users in the community

4.12 Psychological Services

The Trust's Psychological Services Directorate provides services to communities, mainly in Sheffield and Rotherham, aimed at improving psychological health and wellbeing, minimising psychological distress and enabling people to live their lives as fully as possible.

Highlights of the Trust's key achievements and activities through this Directorate during 2010/11 are set out below:

- The Trust has been commissioned to provide new posts for Clinical Psychologists to serve adults in Rotherham who have learning disabilities and for people in Sheffield with mild traumatic brain injuries. The Trust will also provide a weight management service and create new posts for Psychologists to meet the needs of people of Sheffield. The Trust has also reorganised the tertiary Psychotherapy Service and it will be served by a Trauma Team

- Our Psychologists are involved in leadership roles to provide more focused service delivery across the Trust and into other Trusts, where service level agreements exist. This includes the Sheffield Joint Learning Disabilities Service, where we are taking a lead role in developing care and support pathways across a range of areas of need. This is being done by providing training and supervision to clinical assistants who offer assessments and interventions that may previously have been delivered by qualified clinicians

- Staff from the Psychology Services' Adult Mental Health Division have provided leadership in the development of the Sheffield Personality Disorder Strategy Project. This project works with a variety of agencies including the police and the probation service, among others, with the aim of bringing together a detailed strategic plan for a personality disorder service that will meet the needs of the people of Sheffield who need this service. The project was partly funded by the Regional Pathway Development Service which works across the Yorkshire and Humber region to improve the responsiveness of personality disorder services

- The Trust's Clinical Psychologists, in collaboration with their colleagues in the Improving Access to Psychological Therapies (IAPT) Service and other key stakeholders, have taken a leading role in coordinating the initial scoping and development of services for people with Medically Unexplained Symptoms

- Psychological Services actively contributed to the success of an event organised by the Trust for its members. The event, which was called All About Talking Treatments helped to promote awareness amongst the Trust's members of talking treatment services available within the Trust, the benefits of these treatments and how they can be accessed

- Clinical Psychologists in Psychological Services continue to play a leading role in the development and delivery of staff training initiatives across a wide range of subjects

4.13 Improving Access to Psychological Therapies (IAPT)

The IAPT service provides access to psychological therapies for people suffering from mild to moderate depression and anxiety. The service is delivered by our Counsellors, Cognitive Behavioural Psychotherapists and Psychological Wellbeing Practitioners. The service is available in Sheffield at every GP practice.

2010/11 has been a challenging year for IAPT, as the expected third year of growth funding was not passed on by NHS Sheffield. This has meant that the service has grown to a little under 80 per cent of the capacity that was initially planned for Sheffield.

Nevertheless, a number of significant developments have taken place during the last 12 months and these are set out below:

- A city centre base for IAPT services has been opened along Carver Street. This is a service into which people refer themselves and it complements the IAPT services that have already been available through GP practices and the voluntary sector

- Our programme of Healthy Living workshops has been expanded and a full series of these workshops is now regularly available in the North and South-East of Sheffield. These are in addition to the long standing programme of such workshops that we have been running in the West of the city. These workshops cover subjects such as sleep problems, assertiveness, understanding stress and anxiety and managing low mood. They are available to anyone across the city and are easily accessible by people booking themselves into them. We have also collaborated with our partners in the voluntary sector to provide bespoke workshops for specific groups in the community such as Yemeni men.

We are looking to continue to expand this in 2011/12

• Our Stress Control classes continue to be popular, and around 400 people have attended one of the eight courses that we have run this year. We will be expanding the number of courses available in 2011/12 and our first course in the North of the city begins in May 2011

• We have successfully trained a further 16 Cognitive Behavioural Therapists and 10 Psychological Wellbeing Practitioners who provide guided self help and other Cognitive Behavioural Therapy support to people suffering from depression and anxiety. An additional number of 11 members of staff are currently receiving training in order to increase the number of Cognitive Behavioural Therapists and Psychological Wellbeing practitioners that will be available to the service

• We have worked in partnership with Job Centre Plus by training around 50 job centre advisors. This will help to ensure they are able to provide good quality information to their customers on being referred to IAPT. In view of the close association between worklessness and mental health problems, our partnership work with Job Centre Plus is a key part of our remit to help people to get back into work

• We have continued to work with Sheffield Occupational Health Advisory Service (SOHAS), a voluntary sector partner, to provide employment support to IAPT service users

• We have more than doubled the usage of computerised Cognitive Behavioural Therapy, an intervention recommended by the National Institute for Health and Clinical Excellence (NICE), which has enabled us to engage with a large number of young people, who typically would not access our service

• In order to support the range of choices now available in the IAPT service, both in GP practices and in the community, we have developed a website, www.sheffieldiapt.shsc.nhs.uk, which provides information on all of our services and how people can access them

• Around 8,000 people have entered into treatment with IAPT this year, outperforming our targets by over 33 per cent

> *"Our Stress Control classes continue to be popular, and around 400 people have attended one of the eight courses that we have run this year."*

4.14 Corporate Services

The Facilities Management Directorate
The Facilities Directorate is responsible for: capital development and estates strategy; estate management including grounds and gardens maintenance; fire safety and security; transport services and a range of other 'soft' facilities management services such as hotel and site services and; the Sheffield Community Equipment Loan Service (SCELS).

The Directorate continued to work with NHS Sheffield via the Facilities Management Partnership, providing estate management and transport services. With the implementation of Transforming Community Services (TCS), work is actively underway to support the transfer of services (previously provided by NHS Sheffield) to the three NHS Foundation Trusts in Sheffield, by ensuring that buildings and related services are provided in a seamless way after the end of March 2011.

A Sustainable Future
All organisations have an impact on the environment. Supplying heat, light and the running of equipment in buildings contributes to the emission of greenhouse gases that bring about climate change.

In an effort to reduce the adverse effects of climate change, the UK Government has introduced the Climate Change Act 2008, with a target to cut greenhouse gas emissions by at least 80 per cent on 1990 levels by 2050.

The Trust has an important role to play in reducing carbon emissions. These efforts have the added benefit of helping to bring about financial savings for the Trust which can be re-invested directly into the care of the people who use our services.

The Trust remains committed to reducing its impact on the environment and to conserving natural resources wherever possible. As part of this commitment, we have made significant progress in the last 12 months in reducing our greenhouse gas emissions and in improving the sustainability of our operations. To this end, we have introduced several schemes and initiatives including a battery recycling scheme and the installation of high frequency lighting, resulting in a reduction in CO2 emissions of 12.3 tonnes and a cost saving of £3,200. Our steam plant at the Longley Centre has been replaced with dedicated gas-fired boilers and the Trust has significantly increased its recycling of paper and plastics. These, along with other initiatives are detailed in Section 5.0 of this report.

Estates Strategy, Rationalisation and Capital Development
The Trust commissioned a feasibility study in December 2010 to explore single site options for the provision of main inpatient services. This supported the Trust's clinical services reconfiguration programmes and Quality Innovation Productivity and Prevention (QIPP) initiatives.

In addition, the Trust has investigated options for the re-use of buildings clustered around the Sheffield University area to provide accommodation for new-style Community Teams and other day services such as Eating Disorders and Psychotherapy Services. The consultancy firm we have retained to carry out this study is expected to prepare a report for the Board of Directors' consideration in April 2011 and after consulting with a wide range of key stakeholders. The outcomes of this study will form the basis of the Trust's future estate strategy. It is anticipated that there will be wide-ranging rationalisation, including disposal of at least one major site.

In the meantime, the Trust continues to identify and dispose of other surplus properties, such as Coalbrook House and Stockarth Lane. Capital raised from the disposal of these assets will be reinvested in future developments and the realised revenue savings will contribute towards the Trust's cost improvement programme targets.

> *In 2010, all environment and food scores were revealed as being 'Good' or above, whilst all sites achieved an outcome of 'Excellent' for privacy and dignity.*

The Facilities Management Directorate is also supporting the Joint Learning Disabilities Service via a capital scheme to provide a new Assessment and Treatment Unit to replace the existing facility.

The other main capital scheme to be undertaken during 2011/12 is the redevelopment of part of Fulwood House to provide alternative training facilities and make better use of site capacity by incorporating a large conference room. This will enable the Trust to cease renting external meeting rooms for key events and, in the longer term, act as a source of income generation for the organisation.

Patient Environment
The Trust has continued to achieve commendable results as part of the Patient Environment Action Teams (PEAT), which is an annual assessment of inpatient healthcare sites in England that have more than 10 beds. In 2010, all environment and food scores were revealed as being 'Good' or above, whilst all sites achieved an outcome of 'Excellent' for privacy and dignity. The Facilities Management Directorate has developed an Action Planning system to ensure that issues identified via the PEAT assessments are addressed year-on-year.

The Human Resources Directorate
During 2010/11, the Trust further embedded the Human Resource Directorate's (HR) Business Partner model. This is an initiative which has led to members
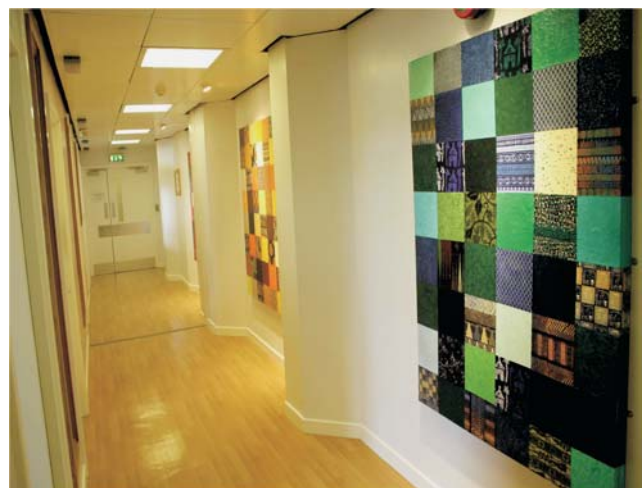
of the HR team working very closely with the Trust's other directorates on a wide range of organisational change projects. These have included projects in Intermediate Care, Substance Misuse, the Psychology Directorate and various Corporate Directorates, among others. Currently and in the future, further major changes to services are on-going specifically relating to the Quality Innovation Productivity and Prevention programmes that are underway within the Trust.

There are major changes planned in Transforming Community Services, Self Directed Support and in requirements and organisational relationships from the various commissioning bodies. To help underpin this important work, the HR Directorate has, in conjunction with Staff Side partners, developed policies relating to Organisational Change and Redundancy. These policies have been tailored to sustain the Trust's commitment to exploring redeployment opportunities and minimising as far as possible the adverse impact of any organisational changes on staff. In conjunction with these two new policies, the Redeployment Policy has been revised and updated to create a set of complementary documents.

The employment legislation agenda has presented challenges particularly in the form of the additional requirements of the Equality Act, 2010. Consequently, the Trust's Equal Opportunities and Dignity At Work Policies have been updated, along with its other associated policies and guidance. Further updates include a revised Bullying and Harassment Policy, as well providing Managers' Guides on various policies.

All of these work streams build on the other equality opportunities that are growing within the Trust. They include the development of the Black and Minority Ethnic (BME) networks and the increased involvement of service users and carers in our recruitment process.

In further recognition of our wish for staff to have greater flexibility in childcare arrangements and involvement alongside their partners, we have updated our policies on Paternity and Parental Leave and Maternity and Adoption.

The Trust has continued its focus on the management of sickness absence. This included the commissioning of an audit report into the operation of the Trust's new Managing Sickness Absence Policy and its recommendations have been fully considered and disseminated to managers. Furthermore, this has been augmented by an ongoing review of the Occupational Health service which the Trust receives. The issue of sickness absence will continue to be an area of greatly increased scrutiny in the future. The recommendations of the Boorman Review into the Health and Wellbeing of NHS staff have been further considered and included within the context of our strategy for 'Fulfilled Working Lives'. Our work continues in this area and will be taken forward over the next 12 months.

The Trust has taken steps to enhance the provision of education, training and the development to its staff. A new Mandatory Training Policy has been introduced and it includes additional training opportunities for all staff. The structure of the commissioning of various elements of training at a regional level means that the HR Directorate will be working closely with providers to ensure that the organisation is ahead of any changes, including those being made to funding arrangements. One of the outstanding challenges we face is to ensure

a more comprehensive coverage and reporting of Performance and Development Reviews (PDRs), possibly electronically, and to build on the improvements made in the last 12 months.

The HR Directorate has overseen the distribution of the first phase of the Pension Choice Exercise being undertaken nationally, to relevant staff who are aged 50 years or over.

This year has seen the undertaking of a 'data cleanse' project for all staff to ensure that the information we hold is up to date on Electronic Staff Records (ESR).

We have developed our work on the Mindful Employer, which is an employer led initiative aimed at increasing awareness of mental health at work and providing support for businesses in recruiting and retaining staff. To this end, we held an event in partnership with NHS Sheffield and Sheffield City Council to promote the adoption of the Mindful Employer initiative amongst other public sector organisations in Sheffield.

The Trust's celebrated apprenticeship scheme has won regional recognition and provided a springboard to further opportunities for many of the apprentices themselves. Through this scheme, the Trust managed to produce case studies of individuals who have received high profile exposure through NHS Jobs, NHS Careers and media interviews. Apprenticeships continue to play a key role in supporting the Trust's workforce needs, as they raise skills and address future workforce requirements as well as providing employment opportunities for participants in the scheme.

Apprentices undertake a wide variety of roles within the Trust and we work in partnership with Sheffield City College to provide learning and accreditation through NVQs and Technical Certificates. Apprenticeships are accessible for all ages and are used to train both new and existing staff.

Going forward, the Trust will be responding to the results of this year's Staff Survey to ensure the further development of a well-trained, responsive and flexible workforce consistent with its Workforce Strategy.

As part of the review of our staffing requirements and the need to ensure the continued efficiency and effectiveness of our human resources, the Trust has purchased an electronic rostering system which is currently being piloted within the organisation. This is a vital system which will enhance the Trust's capacity to effectively manage its workforce by enabling managers to ensure that staff are on duty at the right time.

4.15 Financial Performance

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

The Accounts for the period 1st April 2010 to 31st March 2011 are included in full under Section 15 of this Annual Report.

Overview of Financial Performance
Sheffield Health and Social Care NHS Foundation Trust has now been established as an NHS Foundation Trust for over two years and has successfully maintained a financial risk rating of 4.

This rating has come about due to the effective delivery of the Trust's Annual Plan objectives and focus on the Integrated Business Plan, which we submitted as part of our Foundation Trust application. Both the Annual Plan and the Integrated Business Plan objectives have been delivered. Whilst the targets of our Cost Improvement Plans have been delivered, some of this delivery (9.37 per cent) has been through non-recurrent measures.

The Trust has exceeded its planned forecast of a £1,745,000 surplus and achieved a surplus of £2,373,230 with Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £6,445,933.

The NHS Foundation Trust enablement to retain cash has allowed us to create a healthy bank balance. This will remain so for the coming year, although the Trust's commitment to achieving its National Efficiency Savings targets over the next three years will involve capital spending.

Our compliance with the national Better Payment Practice Code, which requires the organisation to pay all valid non-NHS invoices within 30 days of receipt, or their due date, is 86.7 per cent in terms of the number of invoices paid and 88.1 per cent in terms of the value of invoices paid.

Income

In the 12 months covered by this report, the Trust generated income totalling £117,147,000 (including profit on the sale of assets).

	Total 1st Apr 10 - 31st Mar 11 (£'000)	Total 1st Apr 09 - 31st Mar 10 (£'000)
Income from Activities	80,579	77,140
Other Operating Income	36,560	38,716
Total Income	**117,139**	**115,856**
Operating Expenses	(112,737)	(111,434)
Profit on disposal of fixed assets	8	293
Interest and other financial costs	72	35
Public dividend	(2,109)	(2,337)
Asset Impairment	0	(286)
Surplus for the year	**2,373**	**2,127**

Financial Performance

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

It is pleasing to note that the surplus is slightly higher than that identified in the Annual Plan, and this has been achieved through rigorous expenditure control and tight management of our efficiency programmes. From 2011/12 onwards, the Trust will maintain surpluses to enable it to achieve a minimum financial risk rating of 3.

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 continues to be in line with Foundation Trust requirements, which are based on commercial cash management arrangements.

The cash balance at the end of March 2011 was £14.7 million and the Trust has an agreed working capital facility of £2.5million. During the year, the Trust did not need to use its working capital facility.

Capital Investment

The Trust's investment in capital expenditure for 2010/11 was £0.790 million. The spending of capital has been minimal this year, as the organisation undertook a review of its existing strategy.

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. Capital funds are therefore being saved until the whole estate has been reviewed as part of this work.

Long Term Borrowing

Monitor, the Independent Regulator for NHS Foundation Trusts, sets the approved prudential long term borrowing limits for all NHS Foundation Trusts from the date of their authorisation. These limits are revised every year. The Trust's approved long-term borrowing limit for 2010/11 was set at £21.6 million. During the year, the Trust has not borrowed against this limit.

Key Financial Risks

Part of the NHS Foundation Trust governance process requires NHS Foundation Trusts to submit to Monitor an Annual Plan and quarterly and other ad hoc 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 NHS Foundation Trust.

The risk ratings are designed to indicate the risk of an NHS Foundation Trust's failure to comply with its terms of authorisation, which form the basis upon which they derive their 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 an NHS Foundation Trust's terms of authorisation.

Sheffield Health and Social Care NHS Foundation Trust has achieved a financial risk rating of 4 throughout the year 2010/2011, as planned.

The Trust has a rigorous monitoring performance system in place through the structure of its 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.

Counter Fraud and Corruption
The Trust has a nominated Local Counter Fraud Specialist (LCFS) who reports both to the Head of Internal Audit Service and the Trust's Executive Director of Finance. The role involves attendance at the Board's Audit and Assurance Committee, along with Internal and External Audit colleagues.

The LCFS has a high profile within the Trust and a dedicated 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. 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 Challenges for 2011/12
Along with all other NHS organisations operating in the current economic climate, the Trust will be facing a series of challenges for the coming year. The main challenges are:

- Achieving a further Cost Improvement Plan (CIP) target of around £4.5m in 2011/12 (around £10m over next and the subsequent 2 years)

- Ensuring that we deliver the sign off for savings required for our efficiency plan, which is integral to the delivery of our targets for Cost Improvement Plans/Cash Releasing Efficiency Savings

- Providing a robust business case for services which are to be tendered for, including further assisting NHS Sheffield to reduce its out of town

placements for mental health services by reviewing other areas of commissioning funds

- Introducing Service Line Reporting within the organisation. Service Line Reporting will improve the strategic and clinical decision-making by providing a breakdown of the operational and financial performance of each service

- Implementing 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 2010/2011 financial year are £6,393,413 (5.61 per cent of income). These are calculated in accordance with Department of Health guidelines.

Director's Statement as to Disclosure to Auditors
For each individual who is a Director at the time that this Annual Report was approved, so far as the Director is aware, there is no relevant audit information of which the Trust's auditors are unaware and the Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Going Concern
After making enquiries, the Directors have a reasonable expectation that Sheffield Health and Social Care NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing the Accounts.

Summary
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 improvement efficiency savings year on year. This has become even more important in view of the general conditions prevailing 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 2011/12, with a further higher efficiency target on Corporate Services.

5 Sustainability and Climate Change

Sustainability Strategy

As one of the world's largest organisations, the NHS has an important role to play in reducing carbon emissions and driving forward good practice on sustainability. The NHS Carbon Reduction Strategy for England sets a target of reducing the NHS' carbon footprint by 10 per cent over 2007 levels by 2015.

As part of this effort, the Trust has produced a Sustainable Development Management Plan, which will be implemented in 2011/12 subject to Board approval. The Plan identifies a number of carbon reduction and sustainability objectives, which would mitigate the adverse effects on the environment of our activities and improve the Trust's ability to:

- meet legislative, regulatory and strategic requirements
- contribute to the NHS Carbon Reduction target
- demonstrate the Trust's sustainable development commitment to other organisations
- better engage with and inform staff who can then actively contribute to our Sustainable Development Management Plan

The objectives of our Plan are linked to seven specific areas, namely:

- energy and utility usage
- procurement
- service development and delivery
- staff involvement
- utilisation and rationalisation of the estate
- capital development plans
- recycling

Key developments during 2010/11 are set out below:

The Trust has initiated and/or completed a number of schemes to reduce its carbon footprint or improve general environmental performance, which has involved:

- a collection service for used batteries to meet the Waste Batteries and Accumulator Regulations, 2009

- a 'Spend to Save' scheme involving the installation of energy saving lights. The scheme has resulted in a reduction in CO_2 emissions of 12.3 tonnes and cost savings of £3,200 over the past 12 months. This has included the introduction of high frequency lighting (at the Michael Carlisle Centre and Forest Lodge)

- the replacement of the steam plant at the Longley Centre with dedicated gas-fired boilers which was completed in early 2011. The impact of this will be assessed in 2011/12

- a significant increase in paper and plastics recycling at our larger sites which we intend to increase and extend across the Trust. This has resulted in a reduction of black bag waste going to landfill or incineration, as well as a saving of £1,000 per annum on waste disposal costs.

- establishing plans to appoint a new waste contractor in April 2011. The new contractor aims to recycle 90 per cent of all waste collected. In addition, this is expected to generate a cost saving of approximately £4,000 per annum.

- the reaffirming our commitment to obtain our energy from renewable sources. The Trust's electricity contract is with Scottish & Southern Energy, which guarantees a minimum of 25 per cent of electricity consumed to have been generated from renewable energy sources

- working with a specialist consultancy which has enabled us to introduce a variety of water saving measures, including urinal controls, WC cistern 'dams' (to reduce the flushing volume), along with a survey of meters across the Trust. Where appropriate, these are replaced with smaller capacity versions, which, in turn, result in a lower charge

rate for water consumed. We expect the outcome for a full 12 months to result in a water consumption saving of about 6,736 m³, which is equivalent to a saving of 2.69 tonnes of carbon dioxide

- rolling out a vehicle tracker system which will enable the Trust's Transport Service to implement more efficient routes, identify wasteful practices (such as leaving engines running unnecessarily) and taking steps to eliminate these. The Trust is also considering a vehicle replacement programme aimed at acquiring more environmentally efficient vehicles

- the planned disposal of two domestic-type properties (Coalbrook House and Stockarth Lane) in line with estates rationalisation which we expect to complete in 2011/12

- the submission of business cases for two more 'Spend to Save' schemes for:

    - the pilot of voltage optimisation at the Trust's Fulwood House site, which is expected to reduce consumption of electricity; and

- the replacement of the existing legionella management control system at the Michael Carlisle Centre with a chlorine dioxide dosing unit. This, combined with the revision of water flushing procedures, is expected to reduce the Trust's water consumption

- Estates Strategy/Rationalisation:

    - The Trust has commissioned a feasibility study on the potential future use of key properties within its current estate, linked to the Quality Innovation Prevention and Productivity programmes for its clinical services. In the longer term, this is expected to result in the disposal of one or more larger sites and the redevelopment of others. It is a requirement that any large scale new builds or refurbishments comply with Building Research Establishment Environmental Assessment Method (BREEAM) standards, which are specifically geared to improving the environmental performance of buildings

Summary Performance Metrics

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data £K	Financial data £K
		2009/10	2010/11		2009/10	2010/11
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	487 Tonnes	447 Tonnes	Expenditure on waste disposal	£ 81.68	£86.25
Finite resources	Water	43904 cubic metres	40188 cubic metres	Water	£109.96	£103.68
	Electricity	2129.5 Tonnes CO2	1809.8 Tonnes CO2	Electricity	£355.94	£320.81
	Gas	2351.2 Tonnes CO2	2327.0 Tonnes CO2	Gas	£273.04	£251.84
	Other energy consumption	60.9 Tonnes CO2	62.7 Tonnes CO2	Other energy consumption	£12.86	£14.06

6 Equality and Diversity

Introduction

Equality, diversity and human rights are key aspects of the Trust's Quality Framework and form an important part of the Trust's overall strategic objectives. Further details on the Trust's achievements against its chosen Single Equality Scheme Action Plan along with a full range of range of other data and information can be found in the Trust's Equality and Human Rights Reports, which are published on our web site annually.

Our Performance in 2010/11

In 2010/11, we identified four priority areas and have taken action during the year to progress these. The details are set out below:

1. We said we would develop data collection and use this in governance to inform improvements in quality:

- We undertook a refresh of staff data and the results of this are currently being collated. Through the Trust's Black and Minority Ethnic (BME) Community Engagement Group, we have identified a new set of data that we intend to use to inform the actions that the group will take forward. The group has started some work associated with why people from some backgrounds have longer lengths of stay in inpatient services. This work was based on data that was collected and reviewed in inpatient services

2. We said we would work creatively and more effectively with people who use our services but are seldom heard. Some examples of how we took this forward are as follows:

- We held two Improving Quality events during the last 12 months. One of these events had the specific objective of reaching a wider group of people. Feedback from both events was very positive (Further details are provided in Section 4.3 of this report)

- The Trust attended three stalls at the Sheffield Pride event. This is an annual event that celebrates gay, lesbian bisexual and transgender life in Sheffield. One of our stalls at the event focused on the Time to Change national anti-stigma campaign; the second stall was used to recruit potential members of the Trust from amongst the members of the public and to distribute information on the benefits of being a member of the Trust and; the third stall was used to promote public awareness of the work of the Trust's Improving Access to Psychological Therapies (IAPT) Service

- We hosted an African and Caribbean celebratory event for the fourth year running during the summer of 2010. The aim of this and similar events was to provide an opportunity for past and current service users from inpatient wards, their carers, staff and members of the public to celebrate African Caribbean culture. The event was organised by the Sheffield African Caribbean Mental Health Association (SACMHA) in partnership with the Trust. About 100 to 150 people attended the event

3. We said we would maintain an intelligent and active approach to equality impact assessment. This approach continues to be undertaken on all of our policies and in particular on the Quality Innovation Productivity and Prevention (QIPP) projects that have been ongoing in the Trust since 2010

4. We said we would respond to changes in equality legislation. We are confident that we have carried out this commitment to a high level during the last 12 months by:

- reviewing the impact of the changes associated with the Equality Act, 2010 which came into force in October 2010

- attending engagement events which have been held as part of introducing the NHS Equality Delivery System

- responding to the government's consultation on the Equality Act Public Sector Duty Regulations

Our Priorities for 2011/12

Our main priorities for 2011/12 are as follows:

- Between 2011 and 2012, the Trust will develop new Equality Objectives which will be focused on the Equality Delivery System that is proposed for the NHS. The NHS Equality Delivery System is aimed at: improving the delivery of personalised, fair and diverse services to service users and patients across the NHS; to providing equal opportunity and treatment of staff and; to supporting the NHS in demonstrating its compliance with the Equality Act, 2010. The Trust will work in partnership with communities of interest, commissioners and other health and social care providers, wherever possible, in setting and delivering its new equality objectives

- The Trust's Single Equality Scheme comes to an end in 2012. The implications of new legislation are such that the Trust will no longer publish an Equality Scheme but will instead publish its Equality Objectives which will form part of a four year Equality Strategy. The Trust plans to publish its Equality Strategy by April 2012

- The Trust will revise its current Equality Impact Assessment process in order to ensure that it is in line with new Equality Regulations and the Equality and Human Rights Commission's guidance. Our new process will continue to emphasise the use of Equality Analysis in order to ensure that our policies promote equality and do not discriminate

	Staff			Membership		Sheffield Population (Census)
	2008	2009	2010	2008	2010 (% known ethnicity)	
Ethnicity						
White British	76.44%	75.59%	**79.74%**	84.87%	**86.76%**	89.19%
White Irish	0.91%	0.85%	**0.90%**	0.61%	**0.80%**	0.65%
Any Other White Background	1.95%	1.87%	**1.78%**	1.38%	**1.52%**	1.39%
White & Black Caribbean	0.55%	0.54%	**0.65%**	0.37%	**0.37%**	0.72%
White & Black African	0.84%	0.82%	**0.47%**	0.22%	**0.23%**	0.14%
White & Asian	0.19%	0.19%	**0.29%**	0.27%	**0.25%**	0.41%
Any Other Mixed Background	0.84%	0.76%	**0.80%**	0.39%	**0.45%**	0.34%
Indian	1.72%	1.68%	**1.66%**	0.68%	**0.79%**	0.59%
Pakistani	0.58%	0.79%	**1.09%**	1.63%	**1.78%**	3.09%
Bangladeshi	0.19%	0.16%	**0.22%**	0.74%	**0.75%**	0.37%
Any Other Asian Background	0.55%	0.66%	**0.69%**	0.91%	**0.89%**	0.51%
Caribbean	1.53%	1.58%	**1.37%**	1.09%	**1.14%**	1.01%
African	3.25%	3.64%	**1.59%**	2.09%	**2.61%**	0.64%
Any Other Black Background	0.52%	0.51%	**0.47%**	0.51%	**0.52%**	0.13%
Chinese	0.26%	0.22%	**0.25%**	0.25%	**0.24%**	0.40%
Any Other Ethnic Group	0.78%	0.82%	**0.72%**	1.14%	**0.90%**	
Not Stated	8.87%	9.31%	**7.30%**	2.84%		
Disability						
Yes	1.82%	2.25%	**4.23%**			
No		10.07%	**42.00%**			
Not Declared		0.13%	**2.79%**			
Undefined		87.56%	**50.98%**			

7 The Council of Governors and the Trust's Membership

The Council of Governors comprises 43 seats, 32 of which are elected from the membership. Since April 2010, there have been a number of changes to the membership of the Council.

There were 15 new Governors who joined the Council replacing a similar number that left either for personal reasons or because their tenure of office came to an end. A vacancy remains for a Young Service User/Carer Governor. There have been no changes to the composition of the Council of Governors during 2010/11, which is as follows:

Council of Governors	
A total of 8 elected Public Governors	2 Sheffield North East
	2 Sheffield North West
	2 Sheffield South East
	2 Sheffield South West
A total of 16 elected Service User/ Carer Governors and	10 Service Users
	4 Carers
	2 Young Service User/Carers
A total of 8 elected Staff Governors	1 Nursing
	1 Support Worker
	1 Allied Health Professional
	1 Medical and Clinical
	1 Central Support Staff
	1 Psychology
	1 Social Worker
	1 Clinical Support Staff
A total of 11 Appointed Governors from partner organisations	4 Voluntary, Community & Faith Sector
	1 NHS Sheffield (Commissioners)
	1 Sheffield Hallam University
	1 University of Sheffield
	3 Local Councillors
	1 Staff Side (Trade Unions)

Governors play a vital role in the affairs of the Trust. They primarily carry out their role through the meetings of the Council of Governors, of which there were 6 in 2010/11.

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 or the whole of any Council meeting.

Whilst responsibility for the exercise of the powers of the Trust and the oversight of its management and performance rests with the 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 the other Non-Executive Directors
- The power to appoint, from amongst the Non-Executive Directors, the Vice Chair of the Trust
- The power to set the remuneration and other terms and conditions of appointment of the Trust Chair and the 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

These powers provide important checks and balances between the power and influence of the Board of Directors and that of the Governors, who represent the Trust's members.

The Council of Governors plays other important roles in 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 interests of members and partner organisations
- providing feedback to members
- developing the Trust's membership strategy

In doing all these things, the Council of Governors ensures that the Board of Directors is held to account in the performance of its role.

In 2010/11, the Council of Governors appointed Professor Alan Walker as the Trust Chair and set his remuneration and terms and conditions of office. This followed a rigorous and openly competitive recruitment process that was led by the Council of Governors' Nominations and Remuneration Committee. The Committee retained the services of an external professional recruitment firm to conduct the Chair recruitment campaign.

During 2010/11, the Council maintained its focus on developing an effective collaborative relationship with the Board of Directors. Governors were actively encouraged to attend Board meetings so that they could have an informed view on the performance of the Chair and Non Executive Directors, as well as see how effectively the Board operated.

A development session took place in which members of the Council and Non Executive Directors participated. This session was aimed at promoting a better understanding by the participants of their respective roles, identifying common ground in those

> *During 2010/11, the Council maintained its focus on developing an effective collaborative relationship with the Board of Directors.*

roles as well strengthening the working relationship between the Board and the Council.

A further development session took place between the Board and the Council which provided a platform for Governors to review the Trust's performance over the previous year and to question Board members on specific issues. It also initiated the process of identifying priorities and quality objectives for the year ahead. Governors were able to discuss and question the Trust's plans. Issues that emerged from this development session were then conveyed by the Governors to members of the Trust at a meeting that was open to members of the public. This session between the Governors and the members was well attended and it generated detailed feedback on the Trust's priorities and quality objectives. This feedback was conveyed to the Board by the Governors.

The Council of Governors undertook a self appraisal in 2010 to identify its strengths and areas where it required further development. The overall outcome was positive, with the Council expressing confidence in its ability exert a positive influence on the affairs of the Trust. The Council felt well supported and able to ask for help if needed. The appraisal did highlight the need for the Board to provide more clarity on how Governors had influenced the Trust's plans.

Governors have a wide range of interests. This is demonstrated by the large number of groups, committees and projects in which they are involved, both within and outside of the Trust. Some of these include:

- Membership & Communication Sub Group
- Mental Health Partnership Board
- Spirituality Group
- Creative Arts Steering Team
- Training Junior Doctors
- Carers' Board
- Learning Disabilities Partnership Board
- Steering group on strategy and treatment for people diagnosed with complex trauma
- Storying Sheffield
- Read to Lead

- Developing training materials for clinicians about the experience of depression
- Dementia Directorate Management meetings
- Improving Quality Events
- Safety Group
- Physical Health Group
- Transcultural Interest Group

Through this wide variety of groups, Governors make sure that their views, and the views of the Trust's members are heard.

The Nominations and Remuneration Committee of the Council of Governors

Whilst the appointment of the Trust Chair and other Non-Executive Directors is the responsibility of the Council of Governors, the process of selecting suitable candidates to be recommended for appointment by the Council is delegated to a committee of the Council of Governors known as the Nominations and Remuneration Committee (the Committee). In addition, the Trust's Committee has responsibility for monitoring the performance evaluation of the Trust Chair and the Non-Executive Directors.

The Trust Chair presides over the meetings of the Committee, except in instances where there would be a conflict of interest, in which case, the Reserve Chair (who is a member of the Council of Governors) presides.

This year, the Committee has been preparing to launch a recruitment campaign for two Non-Executive Directors to fill the vacancies that could arise on the expiry of the terms of office of two existing Non-Executive Directors.

During 2010/11 the following changes have taken place in the Committee:

- two of the Committee's members (including the Reserve Chair / Lead Governor at the time) retired from their membership of the Committee at the end of their respective terms of office as Governors

- the Council of Governors approved revised terms of reference of the Committee which reconfigured the composition of its membership

- an existing member of the Committee was appointed by the Council of Governors as the Reserve Chair/Lead Governor to replace the one who had retired from the Committee

- three new members joined the Committee

The attendance of the members of the Committee at its meetings that were held last year is shown as follows:

Name	Position	Number of meetings attended out of the total number of those that could possibly be attended by each Committee Member
Alan Walker	Chair	4/4
Jim Monach	Committee Member and Reserve Chair	5/5
Julie Forrest	Committee Member	4/5
Matthew Flinders	Committee Member	2/5
John Kay	Committee Member	5/5
Brandon Ashworth	Committee Member	4/4
Lindsay Oldham	Committee Member	3/4
Susan Wood	Committee Member	1/4
Lyn Mansfield	Committee Member (Retired)	1/1
Linda Tonner	Committee Member and Reserve Chair/Lead Governor (Retired)	1/1

Note: The Committee held a total number of five meetings during the period covered by this report.

Membership Strategy

The Membership and Communication Subgroup has delegated responsibility from the Council of Governors to develop and monitor the membership strategy. This strategy outlines how the Trust will communicate and engage with all its members and how it plans to make sure that the membership is representative of the Sheffield population. An action plan accompanies the strategy and the Membership and Communication Subgroup reviewed and updated the action plan throughout 2010/11. More details about the activities of this group and membership matters in general are contained further below.

The Council of Governors maintains a register of interests, which details where the fulfilment of Governors' duties could potentially conflict with their other interests. The register of interests is regularly updated and is available for inspection through the office of the Foundation Trust Company Secretary, who can be contacted on 0114 271 6310 or by emailing: foundation.trust@shsc.nhs.uk

The table overleaf shows a complete list of Governors (as at the end of March 2011), their tenure of office and their Council meeting attendance record for 2010/11. Six Council meetings were held between 1st April 2010 and 31st March 2011. Please note that Governors whose term began partway through the year were not able to attend all of the six meetings.

Name	Governor Category	Term Began	Term Ends	Date Left (if before end of term)	Total Attendance
Dorothy Cook	Public South East	01.07.2010	30.06.2013		5/6
Audrey Croft	Public South East	01.04.2010	30.06.2011		2/6
Brandon Ashworth	Public South West	01.07.2010	30.06.2013		1/3
Jim Monach	Public South West	01.04.2008	30.06.2011		2/6
Julian Oakley	Public South West	01.04.2009	30.06.2010		3/3
Paul Harvey	Public North West	01.04.2008	30.06.2011		3/6
Susan Wood	Public North West	01.07.2010	30.06.2013		4/6
Ruth Mitchell	Public North East	01.04.2008	30.06.2011		4/6
Michael Whittington	Public North East	01.10.2009	30.06.2010		1/3
Anne Wood	Public North East	01.07.2010	30.06.2013	18.01.2011	1/2
Bill Andrews	Service User	01.04.2008	30.06.2011		0/6
Dean Chambers	Service User	01.07.2010	30.06.2013		1/3
Albert Crookes	Service User	01.07.2010	30.06.2013	26.10.2010	1/1
Alan Dallman	Service User	01.07.2008	30.06.2010		1/3
Stephanie de-la-Haye	Service User	01.07.2008	30.06.2011		3/6
Jo Dobson	Service user	01.07.2010	30.06.2013		2/3
Peter Firth	Service User	01.07.2008	30.06.2010		2/3
Marie Harris	Service User	01.07.2008	30.06.2011		4/6
John Kay	Service User	01.07.2010	30.06.2013		6/6
David Shine	Service User	20.03.2009	30.06.2010		0/3
Brendan Stone	Service User	01.04.2008	30.06.2011		2/6
Myra Wilson	Service User	01.07.2008	30.06.2011		4/6
Nev Wheeler OBE	Service User	01.07.2010	30.06.2013		5/6
Nicholaus Hall	Young Service User/Carer	01.07.2008	30.06.2011	12.04.2010	0/0
Gemma Wake	Young Service User/Carer	01.07.2010	30.06.2013		1/3
Lewis Atkinson	Carer	01.07.2008	30.06.2011		4/6
Ian Downing	Carer	01.07.2010	30.06.2013		2/3
Elizabeth Draper	Carer	01.07.2008	30.06.2011		4/6
Lyn Mansfield	Carer	01.07.2008	30.06.2010		3/3
Lindsay Oldham	Carer	01.07.2010	30.06.2013		2/3
Linda Tonner	Carer	01.07.2008	30.06.2010		2/3
Rudwan Abdul-Al	Staff	01.09.2009	30.06.2011	05.06.2010	0/2
Alick Bush	Staff	01.07.2008	30.06.2011		4/6
Tony Farrington	Staff	01.07.2010	30.06.2011		4/4
Julie Forrest	Staff	01.07.2008	30.06.2011		5/6
Elliott Hall	Staff	01.07.2008	30.06.2011		6/6
Gill Hancock	Staff	01.08.2009	30.06.2011		4/6
Greg Harrison	Staff	01.07.2008	30.06.2011	18.05.2010	1/1
Julie Leeson	Staff	01.07.2008	30.06.2011		4/6
Julia Walsh	Staff	01.07.2008	30.06.2011		3/6
Councillor Penny Baker	Sheffield City Council	20.05.2009	30.06.2011	25.05.2010	0/1
Councillor Mary Lea	Sheffield City Council	01.07.2008	30.06.2011		3/6
Councillor Denise Reaney	Sheffield City Council	01.07.2010	30.06.2013		1/3
Councillor Pat White	Sheffield City Council	13.08.2009	30.06.2011	20.04.2010	1/1
Helen Best	Sheffield Hallam University	01.07.2008	30.06.2011		3/6
Matt Flinders	University of Sheffield	01.08.2008	30.06.2011		1/6
Sue Highton	Staff Side	01.07.2008	30.06.2011		0/6
Sheila Paul	NHS Sheffield	12.09.2008	30.06.2011		2/6
Rosalind Eve	VCFS (Age UK)	01.09.2009	30.06.2011		1/6
Janet Sullivan	VCFS (Mencap)	01.03.2010	30.06.2011		3/6
Dr Abdul Rob	VCFS (PMC)	24.01.2011	30.06.2011		1/1
Tariq Kataria	VCFS (PMC)	01.09.2009	30.06.2011	01.11.2010	0/3
Ashton Wynter	VCFS (SACMHA)	01.07.2008	30.06.2011		2/6

Non Executive Directors are also invited to attend Council meetings. A record of their attendance is shown below.

Name	Total Attendance
Martin Rosling	3/6
Mervyn Thomas	5/6
Mick Rooney	3/6
Susan Rogers	2/6
Tony Clayton	3/6

Governor Elections

During 2010/11, one full election and one by-election was held. The full election took place in June 2010 with the results shown in the table below.

Constituency Type	Public North East
Date of Election	14/06/10
Number of Candidates	2
Number of Votes Cast	652
Turnout	32.17%
Number of eligible voters	2,027

Constituency Type	Public South West
Date of Election	14/06/10
Number of Candidates	3
Number of Votes Cast	858
Turnout	30.87%
Number of eligible voters	2,779

Constituency Type	Service Users & Carers
Date of Election	14/06/10
Number of Candidates	7
Number of Votes Cast	216
Turnout	40.37%
Number of eligible voters	535

There were also five uncontested categories of Governors as shown in the table below

Constituency Type	No of seats	No of seats Filled
Public South East	1	1
Public North West	1	1
Service User	5	5
Young Service User/Carer	2	1
Staff (Clinical & Medical)	1	1

A by-election was held in November 2010 for two constituencies. These were the Young Service User/Carer Governor and the Staff Governor (Clinical Support Staff) constituencies. There were no candidates for the Young Service User/Carer Governor constituency and one uncontested staff candidate, which meant that no elections were held.

Elections for 21 seats began in January 2011 for Governors whose tenure ends on 30th June 2011. These elections were ongoing at the point of writing this report and their outcome will be reported on the Trust's website, in the membership magazine, at the Annual Members' Meeting September 2011 and in our next Annual Report.

The Membership

At the end of March 2011, there were a total of 11,694 members (excluding staff) compared to 10,911 at the same time last year. This shows an increase in membership of just over a 7 per cent, which is 2 per cent higher than the recruitment target of 5 per cent that we had set for 2010/11. The charts below show how the membership is comprised and its ethnicity profile.

	Membership as at 31.3.11	Sheffield Demographic
White	89.05	91.2%
Mixed	1.32	1.6%
Asian or Asian British	4.21	4.56%
Black or Black British	3.50	1.78%
Other	1.92	0.86%

	Public	Service User	Carer	Young Service User/Carer
1st April 2010	85.62%	8.49%	4.88%	0.10%
31st March 2011	85.73%	8.44%	4.85%	0.98%

In terms of representation of people from minority ethnic groups, the Trust has a higher percentage of its membership comprising people from minority ethnic groups (which stands at 10.95 per cent) compared to the average percentage of people from such groups in the population of Sheffield (which stands at 8.8 per cent). However, when the mix of people from minority ethnic groups in the Trust's membership is similarly compared to the pattern of people belonging to minority ethnic groups in the Sheffield population, this comparison shows that there is an over-representation in the Trust's membership of people categorised as belonging to the 'Black/Black British' groups and those categorised as belonging to 'Other' groups and a slight under-representation in the 'Mixed' and 'Asian/Asian British' category.

In terms of constituency representation, there have been only minor shifts in each grouping, with increases in public membership outstripping other service-user and carer categories. Because of the age parameters in the Young Service User/Carer class, each year, a significant percentage moved into either the service user or carer class.

Through the Membership & Communications Sub-group, the Trust's membership activities are monitored and guided to ensure that they reach out to Black and Minority Ethnic (BME) groups and hard to reach communities. Some areas for the action plan have been to reach out to younger people and, when possible, to focus on areas of Sheffield which have a higher BME community. These are recurrent actions and the Trust has made inroads by having regular input with student nurses and developing links with BME networks.

Membership Activities

Throughout the year, there have been a number of community activities and events in which the Trust has participated in order to engage its members and recruit new ones. The Trust works in partnership with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's Hospital NHS Foundation Trust to recruit and engage members. Governors have played an active role in these events, which include:

- BME Network Annual General Meeting
- Whit Fayre
- Learning Disabilities Information Day
- Sheffield Pride
- Sheffield Mental Health Day
- Sheffield Fayre
- Firvale Festival
- Abbeyfield Festival
- Hillsborough Play Day
- African Caribbean Event
- Art at the Jessop Suite
- Student Nurse Induction (held in September and January)
- Firth Park Christmas Festival
- St Patrick's Day Festival
- Older People's Roadshow

In addition to these community events, the Trust has hosted two membership events during 2010/11, one on Talking Treatments and the other on Spirituality. Both were very well attended and offered members information on specific areas of the Trust as well as giving people a chance to ask questions. The Spirituality event invited members to participate in the Spirituality Strategy Group.

> **" The Trust relies on its Involve magazine as the main channel of communication to members. Both Governors and members sit on the magazine's editorial group in order to ensure that its content consistently focuses on those issues that are important to members. "**

In July, an event commemorating the Sheffield Mental Health Day took place in Barkers Pool. It helped to promote the many organisations, from the public and voluntary sectors, that support people in mental health. Many of the Trust's Governors participated in the event by talking to members of the public, seeking their feedback on services provided by the Trust and encouraging them to take a more active interest in the Trust and its affairs. In October 2010, there were several events held to mark World Mental Health Week, which included those aimed at supporting arts in mental health along with other activities aimed at promoting wellbeing.

These events provide the Trust with an invaluable opportunity to raise public awareness on issues connected to the event themes and to gain feedback from the public. They also provide the Trust with opportunities to actively engage with its members.

The Trust relies on its Involve magazine as the main channel of communication to members. Both Governors and members sit on the magazine's editorial group in order to ensure that its content consistently focuses on those issues that are important to members. The editorial group ensures that the magazine gives information on all aspects of the Trust's services.

The Trust's website provides members with updated information and ensures that they can easily communicate with both the Trust and Governors if they wish.

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.

8 Meet the Board

Powers of the Board of Directors

The responsibility for exercising the powers of the Trust rests with the Board of Directors. 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 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 is responsible for:

- promoting the success of the Trust by directing and supervising the organisation's affairs
- providing active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed
- setting the Trust's strategic aims and ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives
- overseeing the organisation's progress towards attaining its strategic goals
- monitoring the operational performance of the organisation

Composition of the Board

The Board comprises six Non-Executive Directors (including the Trust Chair) and five Executive Directors (including the Chief Executive). During 2010/11, the Board met every month (except August) in meetings which were open (in part) to members of the public. Elements of the Board's business that were of a confidential nature and/or commercially sensitive were transacted in private, and the Board has been very open about the need to do this.

All Board members use their expertise, experience and interest to help set the strategic direction of the Trust, as well as to monitor its management and performance.

A full list of all the Directors who have served on the Board during 2010/11 (including details of their qualifications and experience) is set out below.

The Chair

Professor Alan Walker is the Trust Chair and Mrs Susan Rogers is 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 setting the remuneration of the Chief Executive and (with the Chief Executive's advice) the other Executive Directors

The Senior Independent Director is responsible for leading the Non-Executive Directors in the performance evaluation of the Trust Chair. The Trust Chair is responsible for carrying out the performance evaluation of the Non-Executive Directors. Both processes are overseen by the Council of Governors' Nominations and Remunerations Committee.

Associate Directors

There are three Associate Directors and a Foundation Trust Company Secretary 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 its external relationships and strategic 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
- corporate governance and administration of the Board's affairs

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

Directors' attendance at the Board's meetings during 2010/11 is shown in the table below:

Name	Position	Number of meetings attended out of the total number of those that could possibly be attended by each Director
Professor Alan Walker	Chair	10/11
Kevan Taylor	Chief Executive	10/11
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	11/11
Clive Clarke	Executive Director of Operational Delivery and Social Care	10/11
Liz Lightbown	Executive Director of Nursing and Quality	10/11
Professor Tim Kendall	Medical Director	5/11
Martin Rosling	Non-Executive Director and Senior Independent Director	9/11
Councillor Mick Rooney	Non-Executive Director and Vice Chair	11/11
Anthony Clayton	Non-Executive Director	11/11
Mervyn Thomas	Non-Executive Director	11/11
Susan Rogers	Non-Executive Director	11/11
Karen Tomlinson*	Executive Director of Service Development and Chief Nurse	0/0

Note:
*Karen Tomlinson left the Trust (on secondment to another Trust) before the first Board meeting of the year. In the course of the year, she took up a substantive appointment in that other Trust.

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 regard to the Trust's circumstances.

The Committee has only met once during 2010/11 and the details of members' attendance is shown below:

Name	Position	Number of meetings attended out of total number of those that could possibly be attended by each Committee Member
Professor Alan Walker	Chair	1/1
Councillor Mick Rooney	Committee Member and Non-Executive Director	1/1
Susan Rogers	Committee Member and Non-Executive Director	1/1
Mervyn Thomas	Committee Member and Non-Executive Director	1/1
Anthony Clayton	Committee Member and Non-Executive Director	1/1
Martin Rosling	Committee Member and Non-Executive Director	1/1

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

Further details relating to remuneration of the Board of Directors is provided within the Remuneration Report contained in Section 9 of this report.

The Audit and Assurance Committee
The Audit and Assurance Committee provides independent and objective oversight on the effectiveness of the governance, risk management and internal control systems of the Trust.

The Committee's membership comprises all the Non-Executive Directors of the Board (excluding the Trust

"The Audit and Assurance Committee provides independent and objective oversight on the effectiveness of the governance, risk management and internal control systems of 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 seven occasions during 2010/11 and details of members' attendance at its meetings are as follows:

Name	Position	Number of meetings attended out of total number of those that could possibly be attended by each Committee Member
Martin Rosling	Committee Chair and Non-Executive Director	6/7
Anthony Clayton	Committee Member and Non-Executive Director	7/7
Mervyn Thomas	Committee Member and Non-Executive Director	7/7
Councillor Mick Rooney	Committee Member and Non-Executive Director	7/7
Susan Rogers	Committee Member and Non-Executive Director	3/7

Also in attendance at the Committee's meetings are the Executive Director of Finance, the Foundation Trust Company Secretary and, as and when necessary, other Executive Directors (except for the Chief Executive), the Trust's internal and external auditors 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. There is an option to extend the term of appointment for a further year subject to satisfactory service and performance.

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

The Committee members' attendance at its meetings for 2010/11 is shown as

Name	Position	Number of meetings attended out of total number of those that could possibly be attended by each Committee Member
Anthony Clayton	Committee Chair and Non-Executive Director	11/11
Mervyn Thomas	Committee Member and Non-Executive Director	10/11
Susan Rogers	Committee Member and Non-Executive Director	10/11
Mick Rodgers	Committee Member and Executive Director of Finance/Deputy Chief Executive	11/11
Clive Clarke	Committee Member and Executive Director of Operational Delivery and Social Care	10/11
Liz Lightbown*	Committee Member and Executive Director of Nursing and Quality	0/9

Note: * Liz Lightbown was only co-opted into the committee after it had held two of its meetings.

Quality Assurance Committee:

In response to the recommendations contained in the Francis Report (on the service failures at Mid-Staffordshire NHS Foundation Trust), the Board established another Committee known as the Quality Assurance Committee and appointed Mervyn Thomas to be the Committee's Chair. The Committee's remit is to provide assurance to the Board on the effectiveness of the Trust's systems and processes for safeguarding and improving the quality of its services. Members of the Committee include all the Non-Executive Directors (except for the Trust Chair), the Executive Medical Director, the Executive Director of Nursing and Quality, the Executive Director of Finance and the Executive Director of Operational Delivery and Social Care. The Committee will start operating from April 2011.

Executive and Non-Executive Directors' Qualifications and Experience

Professor Alan Walker
BA (Hons), D.Litt, Hon D.
Soc Sci, AcSS, FRSA
Chair

Professor Walker is a widely celebrated and published academic in social policy with a very high global standing. He has extensive experience in the health service, having served as a Non-Executive Director and Chair in the Community Health Sheffield and the Sheffield Care Trust.

His wide academic and NHS board level experience give him an intimate understanding of the challenges which the Trust must face to meet the needs of the people who use its services. This experience is a highly valued part of Professor Walker's ability to lead the Board in setting the organisation's priorities.

The appointment of Professor Walker for a term of three years from 1st July 2010 followed a rigorously competitive recruitment and selection process. It also demonstrates the Council of Governors' confidence in his ability to provide clear leadership to Board and the Council.

Prior to his recent appointment, Professor Walker served as the Trust's initial Chair from 1st July 2008 (for a term of one year which was extended for another period of 12 months).

Among other awards that he has received, Professor Walker is the recipient of the Social Policy Association's Lifetime Achievement Award (2007).

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 National Institute for Health Research (NIHR) School for Social Care

Tenure of office
1st July 2010 to 30th June 2013

Kevan Taylor
BA (Dual Honours) Degree in Sociology and Social Administration
Chief Executive

Appointed as the Trust's initial Chief Executive with effect from 1st July 2008, Kevan Taylor has a firm base of NHS executive directorship experience.

Prior to his appointment as the Trust's Chief Executive, he served as the Executive Director of Planning and Performance Management of the Sheffield Care Trust and prior to that, as Head/Director of Commissioning of the Sheffield Health Authority. He holds a Bachelor of Arts (Dual Honours) Degree in Sociology and Social Administration. He is a participant in the NHS Top Leaders Programme. Kevan is also a Football Association Club Welfare Officer (Junior Football) and a former chairman of a school governing body.

Declarations of Interest:
- Wife is a Trust employee

Mick Rodgers
CPFA, MAAT, MIHSM
**Executive Director of
Finance and Deputy
Chief Executive**

Mick Rodgers was appointed as the Trust's initial Executive Director of Finance with effect from 1st July 2008. He has over 40 years experience in NHS Finance and General Management.

Mick has served as an NHS Executive Director of Finance for more than 21 years and as Deputy Chief Executive for Sheffield Care Trust since 2001. His professional qualifications include membership of the Chartered Institute of Public Finance and Accountancy (CIPFA), the Association of Accounting Technicians (AAT) and the Institute of Health Service Managers (IHSM). Mick also serves as an advisor to the board of Age Concern, Sheffield.

Declarations of interest:
- Member of the Institute for Health Management
- 'Critical Friend' in respect of governance issues, Age Concern Sheffield

Clive Clarke
Diploma in Social Work, CQSW (Certificate in the Qualification of Social Work), Mental Health Nurse
**Executive Director of
Operational Delivery
and Social Care**

Clive Clarke was appointed as an initial Executive Director of the Trust with effect from 1st July 2008. A qualified nurse and social worker, Clive Clarke brings the benefit of more than 26 years experience in health and social care provision.

He has served as Director of Adult Mental Health Services and as Head of Social Services in the Sheffield Care Trust. Clive's professional qualifications and experience as a nurse and social worker provide him with a clear understanding of the operational aspects of the Trust's business of health and social care provision. He serves as an effective link between the Board and one of the Trust's strategic partners, the Sheffield City Council. Clive was a participant in the 2001 King's Fund Top Managers Programme.

Declarations of Interest:
- Governor of Carfield Primary School, Sheffield

Professor Tim Kendall,
MB ChB, B Med Sci, FRC
Psych.
**Executive Medical
Director**

Professor Kendall was appointed as the Trust's initial Executive Medical Director with effect from 1st July 2008, when the organisation attained Foundation Trust status.

Prior to that, he served as Executive Medical Director of the Sheffield Care Trust since 2003 and has practiced as a Consultant Psychiatrist within Sheffield Care Trust (and, subsequently, the Foundation Trust) since 1992. He is also Director of the National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists, and visiting Professor at University College London.

Professor Kendall previously chaired the first National Institute for Health and Clinical Excellence (NICE) guideline launched in December 2002 on the management of schizophrenia. Since then, the NCCMH has produced more than 20 NICE guidelines covering most of mental health. Professor Kendall has a national and international reputation and some of his work has been adopted in other countries, including Australia, California and Italy. Professor Kendall recently chaired the first National Quality Standard (Dementia), and has recently completed work with NICE International in Turkey and Georgia, which represents the first NICE guideline and quality standard developed outside the UK.

His work extends to Holland and other European countries where he collaborates on the production of international guidelines. He has published articles and papers in a range of medical, scientific and social science journals, magazines and other publications. He also represents the NCCMH, NICE or the Royal College of Psychiatrists in the media. In 2004, Professor Kendall, along with others from the NCCMH, were awarded the "Lancet Paper of the Year" for publishing work on Selective Serotonin Reuptake Inhibitors (SSRIs) and the Treatment of Childhood Depression.

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
- Council Member of the 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 (circa £75,000)
- Wife is a Clinical Director for Rehabilitation and Recovery Directorate
- Daughter employed by the Trust as a Drug Support Worker

Liz Lightbown
Msc Health Planning and Financing, Bsc Behavioural Sciences, Diploma in Public Health, Registered Mental Health Nurse
Executive Director of Nursing and Quality

Liz Lightbown joined the Trust on 21st April 2010 on secondment. She replaced the Trust's former Executive Director for Service Development and Chief Nurse, Karen Tomlinson.

She is a Registered Mental Health Nurse and holds a Bachelor of Science Degree in Behavioural Sciences, a Masters Degree in Health Planning and Financing and a Diploma in Public Health. She was a participant on the King's Fund National Nursing Leadership Programme and is Prince 2 (Project Management) qualified.

Declarations of Interest:
• None

Susan Rogers
MBE, BA (Hons) History, Certificate of Education
Non-Executive Director (Vice-Chair)

Sue Rogers has extensive experience in the teaching profession, as well as industrial relations. She has served at the highest level of NASUWT (National Association of Schoolmasters Union of Women Teachers), the largest teachers' trade union in the United Kingdom, both as President and Treasurer. From 2005 to 2009, Sue served as the Chair of AQA (Assessment and Qualifications Alliance), the largest unitary awarding body for public examinations in the United Kingdom.

Sue was recently awarded an MBE for her services to the Trade Union movement. She currently serves as a member of Employment Tribunals and continues to work for international solidarity for trade union development in Iraq. Her appointment with effect from 1st September 2009 (for a term of three years) has enhanced the Board's ability to address the organisation's human resource needs and its strategic capacity in general. She holds a bachelor of Arts (Honours) degree in History and a Certificate of Education.

Declarations of Interest:
• Past President 1991-92 and National Honorary Treasurer of NASUWT 2002-2009
• Member TUC General Council 2002-2009
• MBE

Tenure of office
1st September 2009 to 31st August 2012

Councillor Mick Rooney
Non-Executive Director
(Senior Independent
Director)

Councillor Mick Rooney was appointed as an initial Non-Executive Director of the Trust when it attained Foundation Trust status on 1st July 2008.

As a serving Councillor for Sheffield City Council, he brings to his role a wealth of experience in local government. He is actively involved in the work of other bodies that seek to promote the health and wellbeing of the people of Sheffield.

Councillor Rooney is currently the Chair of the Health and Community Care Scrutiny Board and a member of the South-East Community Assembly.

Councillor Rooney's extensive experience in dealing with health and social care issues gives him an excellent understanding of the breadth of the Trust's services. He is able to use this experience to help shape the strategic direction of the Trust.

Declarations of Interest:
• Sheffield City Council Councillor, Labour
• Chair of the Sheffield City Council Health Scrutiny Committee
• Member of Darnall Area Panel

Tenure of office
1st July 2008 to 2nd July 2011

Martin Rosling, CPFA
Non-Executive Director
(Chair of the Audit and
Assurance Committee)

A qualified accountant by profession, Martin Rosling was appointed as an initial Non-Executive Director of the Trust with effect from 1st July 2008 up to 31st October 2010, which was extended for a further period of 12 months.

Martin Rosling has held a range of senior financial roles in the public and commercial sectors. His strong career track record is supported by his professional membership of the Chartered Institute of Public Finance and Accounting (CIPFA). Martin's financial expertise is invaluable to the Board where he currently serves as Chair of the Audit and Assurance Committee.

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

Tenure of office
1st July 2008 to 31st October 2011

Anthony Clayton,
MBA, MSc in Marketing
Practice, DMS
Postgraduate Diploma in
Management Studies, DCR
Diploma to the College of
Radiographers
**Non-Executive Director
(Chair of the Finance
and Investment
Committee)**

Anthony Clayton was appointed with effect from 1st September 2009 (for a term of three years) and brings to the Board the benefit of his extensive commercial experience gained from working at senior managerial and directorship levels in organisations operating in domestic and international healthcare markets.

His strong commercial flair and outlook has added strength to the Board's ability to reap the commercial advantages which Foundation Trust status offers. Tony's commercial strengths are buttressed by his firm academic credentials, being a holder of a Master of Business Administration (MBA) Degree, a Master of Science Degree in Marketing Practice, a Postgraduate Diploma in Management Studies and a Diploma to the College of Radiographers.

Declarations of Interest:
• None

Tenure of office
1st September 2009 to 31st August 2012

Mervyn Thomas
BA (Hons) Politics, MA Social
Policy, CQSW (Certificate in
the Qualification of Social
Work), FRSA
**Non-Executive Director
(Chair of the Quality
Assurance Committee)**

Appointed with effect from 1st September 2009 (for a term of three years), Mervyn Thomas brings a wealth of experience from the health and social care sectors, giving him a perfect fit with the strategic needs of the Trust.

His experience as a serving Non-Executive Director in two other organisations in the health and probation services is complemented by his extensive past experience at senior managerial levels in local government. Mervyn Thomas holds a Bachelor of Arts Degree in Politics, a Master of Arts Degree in Social Policy and a Certificate of Qualification in Social Work. He is also a Fellow of the Royal Society of the Arts.

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

Tenure of office
1st September 2009 to 31st August 2012

Former Directors:

Karen Tomlinson
Msc, Health Policy and Organisation, Certificate in Health Service Management, State Registered Nurse

Executive Director Service Development and Chief Nurse

Karen Tomlinson was appointed as an initial Executive Director of the Trust 1st July 2008. She left the Trust in April 2010 to take up a secondment post in another organisation where she was subsequently offered and accepted a substantive post. Karen has since been replaced by Liz Lightbown. Whilst she served in the Trust, Karen brought the benefit of her extensive experience as a very senior manager in the NHS which included serving as 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 (part-time role)

In addition to being a State Registered Nurse, Karen holds a Master of Science Degree in Healthcare Policy and Organisation and a Certificate in Health Service Management. She was also a participant in the Kings Fund Leadership Programme.

Declarations of Interest:
- Non Executive Director for Riverside Housing Association, Midlands's branch (as at the time of her departure from the Trust).

Board evaluation

The Board carried out an annual evaluation of its performance. Each Board member completed a questionnaire eliciting their responses to several questions that sought their assessment on Board's effectiveness in carrying out a range of its functions. The general picture that emerged from the responses to the board evaluation questionnaire was that …the Board is confident that it effectively carries out its functions… in relation to each of the areas that were covered in the questionnaire.

> *" The Board is satisfied that the composition of its membership is balanced, complete and appropriate. "*

A similar evaluation process was carried out in relation to the Board's Audit and Assurance Committee and its Finance and Investment Committee and the responses to these questionnaires also revealed the effectiveness of these Committees in discharging their respective functions. A formal evaluation of the Board's Remuneration and Nominations Committee was not carried out as this Committee only met once in the year.

The Trust Chair also carried out performance evaluations of each Non-Executive Director and the outcome of his evaluations were reported to the Council of Governors' Nominations and Remuneration Committee which noted that all the Non-Executive Directors were carrying out their individual roles effectively. The evaluation of the Executive Directors is carried out by the Chief Executive during his monthly one-to-one meetings and annual reviews with them.

As the Trust Chair was a candidate in an openly competitive recruitment process which involved a rigorous scrutiny of all the candidates by the members of the Board, the Council of Governors and the Council of Governors' Nominations and Remuneration Committee (NRC), the NRC agreed that this process sufficed as the evaluation of the Chair's performance for this year. The Senior Independent Director was also informed of the NRC's decision.

In the light of the above statements and the information contained in this Section of this Annual Report, the Board is satisfied that the composition of its membership is balanced, complete and appropriate.

9 Remuneration Report

Executive Directors' Remuneration

There is a Remuneration and Nominations Committee of the Board of Directors comprising all Non-Executive Directors (including the Trust Chair). 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. These terms and conditions are determined by the Committee and include all aspects of remuneration, provisions for other benefits (such as pensions and cars) and arrangements for termination of employment or other contractual terms.

The Committee is responsible for monitoring 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. Details of the Committee's meetings during the past year are reported in Section 8 of this report.

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 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 Terms (Years to age 65)
Kevan Taylor	February 2003	15
Mick Rodgers	April 2003	5
Clive Clarke	April 2003	18
Karen Tomlinson	Substantive May 2007 to March 2010 Secondment (other Trust) April 2010 to October 2010	12
Liz Lightbown	Secondment (SHSC) April 2010 to March 2011	21
Dr Tim Kendall	April 2003	12

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.

The Board's Remuneration and Nominations Committee reviews the remuneration of Executive Directors annually, taking into account 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 effect an increase of 2.25 per cent for all Executives. This was the same rate of increase that was applied to the remuneration of all other members of 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 a Nominations and Remuneration Committee of the Council of Governors whose responsibility, amongst 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 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, taking into account the recommendations made to it by the Nominations and Remunerations Committee.

It is the responsibility of the Council of Governors' Nominations and Remuneration Committee to monitor the performance of the Trust 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 activities of the Nominations and Remuneration Committee's activities for the past year are reported on in Section 7 of this report.

Last year, the Nominations and Remuneration Committee of the Council of Governors embarked upon a successful Trust Chair recruitment exercise with the successful candidate taking office in July 2010. The Committee retained the services of an external professional adviser to carry out a market-test of remuneration level of the Trust Chair, following which the remuneration was, by a resolution of the Council of Governors, set at £40,000 per annum. This increased level of remuneration will apply to the office of Trust Chair with effect 1st July 2010.

Details of the remuneration paid to the all of the Directors during 2010/11 are shown in the table below. The Non-Executive Directors' duration of office is reported in Section 8 of this report.

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 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.

Directors' Remuneration and Pension Entitlements
Salary and Pension Entitlements of Senior Managers
A) Salaries and Allowances

Name & Title	Period 1.4.10 to 31.3.11			Period 1.4.09 to 31.3.10		
	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			25 - 30		
A Barney, Non-Executive Director	0			0 - 5		
E Jones, Non-Executive Director	0			0 - 5		
Cllr. M Rooney, Non-Executive Director	10 - 15			10 - 15		
M Rosling, Non-Executive Director	10 - 15			10 - 15		
A Clayton, Non-Executive Director	10 - 15			5 - 10		
M Thomas, Non-Executive Director	10 - 15			5 - 10		
S Rogers, Non-Executive Director	10 - 15			5 - 10		
K Taylor, Chief Executive	130 - 135			130 - 135		
M Rodgers, Deputy Chief Executive/ Executive Director of Finance	105 - 110			105 - 110		
Dr T Kendall, Executive Medical Director	60 - 65	125 - 130		60 - 65	115 - 120	
C Clarke, Executive Director of Operations and Social Care	100 - 105			95 - 100		
K Tomlinson, Executive Director of Governance, Performance and Nursing	0			95 - 100		
E Lightbown, Executive Director of Governance , Performance and Nursing	80 - 85			0		

Notes
K Tomlinson left the Trust 31.3.10
L Lightbown on secondment from Barnsley PCT from 24.4.10
A Barney and E Jones left the Trust in 2009/10

B) Pension Benefits for 2010/11

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

Name & Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 £000 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 £000 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 £000 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £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	40 - 45	120 - 125	695	725	(51)	0
M Rodgers, Deputy Chief Executive / Executive Director of Finance	0 - 2.5	2.5 - 5.0	50 - 55	160 - 165	0	1,323	0	0
Dr T Kendall, Executive Medical Director	2.5 - 5.0	7.5 - 10.0	45 - 50	135 - 140	859	843	(9)	0
C Clarke, Executive Director of Operations and Social Care	(2.5) - 0	(2.5) - 0	10 - 15	40 - 45	214	242	(34)	0
L Lightbown, Executive Director of Governance, Performance and Nursing	5.0 - 7.5	17.5 - 20.0	15 - 20	55 - 60	256	188	62	0

Notes

The accrued CETV for Mick Rodgers was not provided by NHS Pensions as he is of pensionable age (1995 scheme)

The real increase in CETV has reduced in most cases as NHS Pensions are now using Consumer Price Index (CPI) in pension calculations instead of Retail Price Index (RPI). In accordance with the Chancellor's budget 22.6.10 public sector pensions will be uplifted by CPI instead of RPI.

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.
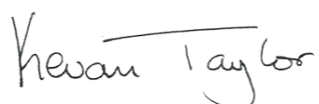
Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes into account the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses 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 of State for in England and Wales. As a result, it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities.

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

Kevan Taylor
Chief Executive

10 The NHS Foundation Trust Code of Governance

Our Commitment to Good Governance
The Board of Directors recognises the importance of upholding the principles of good corporate governance and is committed to improving corporate governance standards 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 of 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 on 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 above, the Board of Directors considers that it has complied with the requirements of the Code.

Disclosure of corporate governance arrangements
In accordance with the disclosure requirements set out in the Code, the Board of Directors makes the following disclosures:

The statement on how the Board of Directors and the Council of Governors operate, including high level statements on the types of decisions to be taken by each one of them and those which are to be delegated to the management by the Board of Directors is contained in Sections 7 and 8 of this report.

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 Sections 7 and 8 of this report.

The number of meetings of the Board of Directors, its Committees and the attendance by individual Directors are shown in Section 8 of this report.

The Board considers the following Non-Executive Directors to be independent in character and judgment:

i)   Professor Alan Walker
ii) Martin Rosling
iii) Anthony Clayton
iv) Mervyn Thomas
v)   Susan Rogers
vi) Councillor 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 as no such is 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

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

Other information relating to the directors is as follows:

- A description of each Director's expertise and experience is contained in Section 8 of this report
- A statement on the Board of Directors' balance, completeness and appropriateness is contained in Section 8 of this report
- The names of the Governors and details of their constituencies, whether they are elected or appointed and the duration of their appointment is contained in Section 7 of this report
- The number of meetings of the Council of Governors and the individual attendance by Governors and Directors is contained in Section 7 of this report
- The Trust Chair's other significant commitments and any changes to them during the year are contained in Section 8 of this report
- The work of the Nominations and Remunerations Committee of the Council of Governors, 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 Section 7 of this report
- A statement on how the performance of the Board, its Committees and individual Directors was evaluated is contained in Section 8 of this report
- 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
- An explanation from the Directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities is contained in Sections 4, 12 and 14 of this report
- A statement from the Directors that the business is a going concern, together with supporting assumptions or qualifications as necessary, is contained in Section 4 of this report
- A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls is contained in Section 13 of this report
- The Council of Governors has not refused to accept the recommendation of the Audit and Assurance Committee on the appointment of an external auditor, and this matter is therefore not reported on
- The Trust's auditors do 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 or the Trust's Company Secretary
- Non-Executive Directors attend meetings of the Council of Governors and Board members are further informed of the views of the Governors at their monthly board meetings. Updates on the affairs of the Council of Governors and the Trust's members are a standing item on the Board's agenda. During the year, members of the Board of Directors and Council of Governors held joint development sessions at which they shared ideas on how the two groups could enhance their collaboration. Details of these are disclosed in Section 7 of this report. There is 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

11 Quality Report

Part 1
Statement on Quality from the Chief Executive

I am very pleased to introduce Sheffield Health and Social Care NHS Foundation Trust's third annual Quality Account. This account tells you about the quality of care and treatment provided by the Trust: it provides a balanced picture of our services and introduces the Trust's quality objectives for the year ahead.

We have developed this account in partnership with the Trust governors and members, as part of our processes for looking back on the year that has passed and looking forward to the year ahead. Our quality objectives have been decided through consultation with staff, governors, members and partners in the city of Sheffield.

In Sheffield Health and Social Care Trust (SHSC) we feel strongly that quality must lie at the heart of our business. Our vision of quality is 'health and social care that is service user centred, safe, effective and promotes equality and inclusion' (SHSC Quality Framework 2009). We see the interaction between service users, carers and staff as the key to making sure the services are of good quality.

I was delighted that this year we have adopted a new Service User Involvement Framework, which describes how we will work together with service users to improve quality. Two service users presented the Framework to the Trust Board and we were inspired by their stories of how they had worked with the Trust to make improvements in very different ways. You can hear Tim's story for yourself if you follow this link to our website www.shsc.nhs.uk: Patients voices - Tim's story.

We are not forgetting carers. One of our quality objectives for 2011/12 will be to improve the experiences of carers. Although carers may often represent or advocate on behalf of service users, they have their own needs too, and we intend to continue to respond to carers' needs in the year ahead.

The safety of service users is always our priority. My colleagues and I review all the serious incidents and complaints which are reported during the year, looking for any recurring themes or indications of problems in the overall high standard of care we provide. We have set up in-depth reviews of any areas of the Trust where we think there may be a problem. As a result of these efforts, we have introduced a new programme of staff training in clinical risk assessment and management for all staff with responsibilities for the care and treatment of service users.

We have strengthened our systems for staff appraisal and professional development, and we are making significant improvements to our staff training systems. Having skilled, well-motivated staff with a positive attitude is absolutely essential for maintaining and improving quality. On my visits to teams and services I have been able to see for myself how much effort staff throughout the organisation put into providing the best possible care. I was pleased to see my views supported by positive results from the Care Quality Commission (CQC) annual staff survey in 2010; the Trust was in the highest category (top 20% of mental health trusts in the country) for staff who would recommend the Trust as a place to work or to receive treatment.

The Trust reviews and considers the recommendations of national reports and inquiries, so that it can learn from elsewhere to improve its practice. For example, the Trust Board has reviewed the recommendations of the Francis Report, the inquiry into the Mid Staffordshire Hospital NHS Foundation Trust, and is making some changes to its governance structures as a result. From 1st April 2011, a new Board Sub-committee, the Quality Assurance Committee, will make sure that quality has the highest priority within the Trust and is high on the agenda of all Board meetings.

We received a Care Quality Commission (CQC) Planned Review of our healthcare regulated activities across 11 locations in 2010/11: this was one of the first planned reviews in the country under the CQC new procedures. The new CQC quality and safety outcomes are forming the basis for routine quality assessment in the Trust, informing team governance reports. We have set up a rolling Quality Check process to make sure we are compliant with the outcomes. During the Planned Review, the CQC found much to be positive about, for example in the ways in which we involve service users and carers in services. They also found some areas where we need to make improvements, for example in recording patient care. We will be pursuing the improvements we need to make vigorously over the next few months.

During 2010/11 there has been a focus on improving the quality of care and treatment for people with mental health problems through the developments of the Acute Care Pathway and the Scheduled Care Pathway. People in crisis are now seen more quickly than ever before. This work will progress further in 2011/12. We are promoting a Recovery approach to mental health care. It was great to see the Sheffield Pathways and Community Engagement Services (SPACES) launched this year - moving away from a traditional day service model to more flexible support with the aim of supporting people to be full members of their local communities. We support the development of self directed support and want to promote independence, choice and a positive and healthy life for everyone using our services. I have been delighted to see that the Improving Access to Psychological Therapies (IAPT) service, which provides talking therapies for people with common mental health problems in primary care, has been able to help so many people return to work and make a full recovery.

Learning disability services have also been working on improving the care pathways of people with learning disabilities in the city, so that people get the right help at the right time and quickly, whether their needs are for care from community learning disability teams or specialist support for people with challenging behaviour or additional mental health problems.

We will be putting a new emphasis on care for people with dementia and setting dementia care standards as a new quality objective for 2011/12. Research from the Alzheimer's Society this year has found that more people in Sheffield are being diagnosed with dementia than the national or regional average; 53% of people with dementia have received a diagnosis compared with 40% nationally. This means that we are in a strong position to get help to people with dementia and their families quickly.

Through the award of a new contract, Substance Misuse Services have secured the gateway for drug and alcohol services. This will make single entry points for drugs and for alcohol, so that people can find their way to the right service quickly. It will be easier to help people make choices about their care and treatment.

Finally, there will be big changes in the year ahead as colleagues from the former Primary Care Provider Services join us. We will become the provider of services in primary and community care. I am delighted to welcome our new colleagues. I am looking forward to us working together to make further improvements to quality, safety and service user experience across care pathways in the city.

My view of the quality of care and treatment provided by the Trust comes from my own experience of visiting teams and talking to staff and service users and carers on many different occasions - as well as reading reports and studying the data. I am confident that we provide good care with some excellent practice, but that there is always room for further improvement. I want to see a consistently excellent quality of care and treatment in every part of the Trust. My colleagues on the Trust Board and I are very motivated to make the services even better, and we believe that by working together as staff, service users and carers we will be able to make this happen.

I declare that to the best of my knowledge, the information contained in this document is accurate.

Signed

Kevan Taylor
Chief Executive

Part 2
2A Priorities for Improvement for 2011/12

The Trust takes action in a number of ways to improve the quality of the care and treatment it provides.

- It runs a number of quality improvement projects which are described in these accounts
- It reviews the information it holds about the quality, safety and effectiveness of care and about service user and carer experience. It looks at this information throughout the Trust, from Board to team level
- Every team in the Trust reviews its quality of care and service user experience in a team governance report at least once each year, and sets targets for improvement. This team governance process is the bedrock of quality in the Trust
- It shares good practice and learning from inside and outside the organisation
- It tries to learn when things have gone wrong, investigating carefully and taking action when needed after serious incidents or complaints
- It listens to feedback from its partners and stakeholders - its commissioners and regulators
- Above all, it tries to listen properly to what service users and carers are telling it about the quality of their care and treatment, and to use this feedback to make further improvements

During 2010/11, all these aspects of quality were considered in deciding on the priority objectives for the year ahead. There was an extensive and repeated consultation process with senior staff, governors, members and stakeholders. Governors were able to represent the views of service users, carers and staff as well as the wider public. From this process 4 new quality objectives have been developed for the year ahead. They are:

1. To improve nutritional support for service users, develop a Nutrition Strategy, reduce the risk of malnutrition and obesity and improve the quality and experience of meals provided by the Trust
2. To improve the quality of care for people with dementia and their families, by delivering the standards set out in the National Institute for Health and Clinical Excellence (NICE) Quality standard for dementia and reducing waiting times for assessment
3. To assess the needs of carers (in their own right) through surveys and interviews, and to develop

and implement a carers' action plan to improve the quality of support they receive
4. To continue work on improving the experience of people from Black and minority ethnic groups who receive care and treatment from the Trust

1. To improve nutritional support for service users, develop a Nutrition Strategy, reduce the risk of malnutrition and obesity and improve the quality and experience of meals provided by the Trust

Why we have chosen this objective
The Trust Board and Governors believes that improving the physical health of people with mental health problems, learning disabilities and substance misuse must remain a key focus in 2011/12. It is a key patient safety issue to prevent malnutrition and the health risks from obesity. They also believe that having good and nutritious food and drinks is an important component of a good patient experience.

We want to keep up the work on nutrition in the year ahead, and continue rolling out the use of the standardised Malnutrition Universal Screening Tool (MUST) across the Trust.

We wish to improve the nutritional quality of meals in areas where it is required.

As a result of screening assessments, we have identified a problem with obesity on the adult mental health wards. A brief audit in January 2011 suggested that over 50% of service users on the adult wards were overweight or obese. This represents a significant risk to service users' health and wellbeing. We want to begin a new work stream to tackle the problem.

How we will measure progress
- Use of the MUST (Malnutrition Universal Screening Tool) on admission or soon after in all inpatient areas (100% target)
- Recording of weight, height, body mass index and waist circumference - each directorate to set appropriate targets for every team in the Trust and monitor completion, showing improvements made. We believe local targets are most appropriate because the risks of obesity and malnutrition are different for different groups of service users.
- Patient Environment Action Team (PEAT, an annual self-assessment of inpatient sites in England) assessments on food to stay 'good' and aim for 'excellent'
- Quality and Dignity Survey results on acute mental

health wards to show more service users report the food is good and fewer say it is bad. Local surveys on other wards to maintain high satisfaction rates with meals. Target to be 80% satisfaction rate

- Compliance with nutritional standards in all areas where the Trust provides the meals (Audit results: to aim for 100%)

What we will do (including lead and timescales)
The leadership for this work will remain with the NICE Nutrition Group (Lead is Senior Nurse Jane McKeown). A permanent dietician appointment is to be made to support the work.

Actions will include:

1. The development of a Trust Nutrition Strategy

2. To continue the roll out of the MUST (malnutrition screening tool) including training staff in its use

3. Directorates to set appropriate team targets on nutrition at the start of 2011/12 as part of the team governance process, including:

- MUST screening (which includes weight/height/body mass index (BMI))
- Nutritional assessment of meals (where provided)
- Service user feedback on meals (where provided)

   To monitor the delivery of these targets in reports to directorate senior management teams at least every 6 months.

4. To develop and implement a care pathway for obesity, including treatment options such as weight management groups in some areas

5. To continue PEAT assessments, Quality and Dignity Survey and local team surveys, to collect and collate service user feedback on the quality of food and drinks (where these are provided by the Trust)

7. Nutritional assessments of meals provided by the Trust to be completed for all inpatient areas. In any areas where the daily menu does not meet nutritional standards, actions plans to be developed and implemented to raise the quality of the meals

2. To improve the quality of care for people with dementia and their families, by delivering the standards set out in the National Institute for Health and Clinical Evidence (NICE) Quality Standard for dementia and reducing waiting times for assessment

Why we have chosen this objective
Consultation with governors, the Local Involvement Network (Sheffield LINk) and the Health and Wellbeing Scrutiny Board of Sheffield City Council all highlighted dementia care as an area to prioritise. The city has an increasing elderly population and awareness of the needs of people with dementia and their families has been growing. The National Institute for Health and Clinical Excellence (NICE) published a Quality Standard for dementia in 2010/11, which applies across the care pathway. The Trust wants to make sure it is able to meet the criteria in the NICE standard for dementia, in collaboration with other partners in the city in health and social care.

NICE Quality Standard for Dementia
There are 10 quality statements in the NICE Quality Standard for Dementia:

1. People with dementia receive care from staff appropriately trained in dementia care.
2. People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.
3. People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.
4. People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care co-ordinator and addresses their individual needs.
5. People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of advance statements, advance decisions to refuse treatment, Lasting Powers of Attorney, Preferred Priorities of Care.
6. Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions, identified by a care plan, to address those needs.

7. People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in the care plan.
8. People with known or suspected dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.
9. People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.
10. Carers of people with dementia have access to a comprehensive range of respite/short break services that meet the needs of both the carer and the person with dementia.

How we will measure it
The NICE Dementia Quality Standard includes a number of ways of measuring outcome and we will adopt these (see www.nice.org.uk)

Key success indicators for the Trust will include:
• Current performance defined and analysed across the criteria in the Standard to provide baseline assessments. (Audit results: to aim for 100%)
• Improvements achieved in year for
   - Staff training - with 100% of defined staff receiving training relating to the care of someone with dementia
   - Access to memory assessment services - with a 25% increase in the number of people accessing an assessment compared to previous years
   - Advance statements - with 100% of clients having the opportunity to discuss future care and treatment
   - Waiting times for access to memory assessment reduced to 12 weeks by quarter 3 onwards

What we will do (including lead and timescales)
The Dementia Directorate senior management team will lead this work with support from the central services (leads Dr Peter Bowie, Clinical Director, Tony Bainbridge, Assistant Clinical Director; support from Paul Reeves, Planning and Performance Manager and Brian Hockley, Project Manager).

The Trust will work with its partners in health and social care across the city and play a full part in striving to provide health and social care for people with dementia and their carers that meets the Quality Standard.

An action plan for the implementation of the NICE standard for dementia is being developed. It will include an assessment of current provision and baseline audit as a first step, to see how the services match up against the standards and benchmarks. Following the audit, targeted plans will address any areas where improvements are needed. Progress will be monitored through the Quality Assurance Committee.

3. To assess the needs of carers (in their own right) through surveys and interviews, and to develop and implement a carers' action plan to improve the quality of support they receive

Why we have chosen this objective
During 2010/11 we focused on service user experience as a quality objective, and work in this area will continue throughout the Trust. In the year ahead we wish to make sure we focus on the needs of carers too. Carers can be seen as representatives of service users, and as an essential part of planning for their care, but they have needs in their own right too. In 2011/12 we will assess these needs and then develop a realistic and clear plan to meet them.

The whole city of Sheffield signed up to a Carers' Strategy in 2010 and we believe the time is right to turn the strategy into actions. The Trust's governors and Local Improvement Network (LINk) partners were keen to see actions on carers' needs included in this year's quality objectives.

Sheffield City-wide Carers Strategy
The City-wide Carers' Strategy sets objectives to improve the support for carers which include:
• To develop the Trust's infrastructure and improve joint working between partner organisations so that carers are better supported
• To identify hidden carers and raise awareness of carers and their caring responsibilities within organisations and in the wider community
• To provide information, advice and advocacy to enable carers to make informed choices
• To sustain carers in their caring role and prevent carer breakdown

- To involve carers individually and collectively in shaping, commissioning, monitoring and evaluating services and support for them and the people for whom they care
- To promote support for employees who have caring responsibilities
- To ensure that carers have a life of their own outside of their caring role
- To enable young carers to have the same life chances as other young people, and prevent young carers from taking on inappropriate caring roles

Monitoring of the use of carers' assessments in adult mental health services showed that 82.5% of carers were offered a carer's assessment in 2010/11, and 70.8% received a carer's assessment. (Figures are based on data for the end of Feb 2011).

How we will measure it
The success of the process will be measured by:

1. Completion of a Review of Carers' Needs and Views with a report produced for September 2011
2. Audit of staff carers to establish numbers and views on the information and support available by August 2011
3. These two pieces of work will inform decisions on targets for improvement and how these will be monitored.
4. Development and implementation of an action plan by December 2011
5. A baseline will established and indicators identified and in place for monitoring the delivery and impact of agreed action plan by January-March 2012
6. Monitoring of the implementation of the action plan will be through Quality Assurance Committee, with appropriate reports on carer employees to HR and Workforce Group
7. Continued review and monitoring of current carer assessment rates for people on Care Programme Approach (CPA):
- To establish baseline figures for other service user groups
- To show an improvement on the baseline figures of 82.5% of carers being offered a carers' assessment and 70.8% receiving an assessment.

What we will do (including lead and timescales)
This work will be led by Liz Johnson, Head of Patient Experience, Inclusion and Diversity and will involve carers in its development and delivery. Ian Hall will lead from HR on the delivery of a Carer Friendly Employee action plan

The Review of Carers' Needs and Views and the Staff Carer Audit will be completed by the end of quarter 2 (September 2011) and the linked action plans by the end of quarter 3 (December 2011) to ensure there will be a minimum of one quarter's monitoring of implementation before the end of 2011/12.

4. To continue work on improving the experience of people from Black and minority ethnic (BME) groups who receive care and treatment from the Trust

Why we have chosen this objective
This is an existing priority for the Trust where we plan to carry on developing the work in the year ahead. We believe it is still a priority for the Trust because there is continuing evidence that people from Black and minority ethnic groups are more likely to experience negative elements of care and less likely to experience more positive aspects. We have made improvements to the quality of the staff training we provide on equality and diversity, but we want to see a greater rate of progress in this area, and more staff receiving the training.

We have set up systems to review service user information by ethnicity, gender, age and other characteristics. From this work, we have found that people from Black and minority ethnic groups tend to have more repeat admissions (defined as more than 5 in 3 years.) In the next year, we want to understand why and take steps to improve the situation.

We also want to continue the important work that we have begun on improving how we respond to violence and aggression on the wards and implement a new approach to restraint, Respect. We began this work in response to critical feedback from the Maat Probe service user group. Although it came out of work with people with acute mental health problems from Black African and African Caribbean backgrounds, we believe that changes will have benefits for service users across the Sheffield communities and in other areas of the Trust. Respect is a philosophy of care which is about

empowering and enabling service users to prevent aggression in the first place, thereby reducing the amount of physical intervention required. We are trying to look at factors leading up to incidents of violence and aggression in a systematic way. This work has always previously been carried out with an individual service user perspective as part of a treatment, risk management or care plan. We have begun the analysis of incidents and assaults and verbal abuse on the wards by ethnicity, gender and age of victims and perpetrators, and we will be reporting on these issues in 2011/12.

The CQC Staff Survey 2010 and our own figures showed that we are still not training enough staff in equality and diversity. We will continue to roll out the improved training in equality and diversity and make sure it reaches more staff.

How we will measure it

- We will monitor and report on staff training in Equality and Diversity: our aim is that all targeted staff will have received the new training over the next 2 years. We hope to see an improvement in the CQC staff survey results with more staff reporting that they have received training in equality and diversity.

- We will audit the care pathways looking at length of stay and repeat admissions, and develop and implement an action plan from these findings. Delivery of the action plan will be monitored through the Quality Assurance Committee

- We will improve the routine monitoring of incidents of violence and aggression on wards with a more detailed breakdown of the information held, to make sure we have sound baseline measures. We will then set a target for reduction in the number of such incidents

- We will analyse length of stay, repeat admissions and incidents of violence and aggression by ethnicity, age and gender, to ensure that the planned actions and improvements result in an improved experience for men and women of all ages from all ethnic groups. We hope to see a significant improvement for people from BME groups.

- We will monitor and report on staff training in Respect. We intent to see an improvement on the baseline figure derived from the number of staff attending Managing Violence and Aggression courses during 2009/10. We also hope to report on the impact of the different approach provided by the Respect training.

What we will do (including lead and timescales)
The work on this objective will be led by the Black and Minority Ethnic Group/Community Engagement Group, chaired by the Executive Director of Operations, Clive Clarke. The project lead will be Kim Parker, Senior Nurse for Quality Improvement.

Work on the data analysis is already in place; monitoring the resulting reports will take place quarterly during the year, including reports on the number of staff trained in equality and diversity.

The care pathway audit will be completed by October 2011 and an implementation plan developed by December 2010 so that implementation can start next year.

Our goal is to implement the Respect approach throughout the organisation over the next 2-3 years. The plan for next year is to start training staff in pilot areas. A detailed implementation plan with timescales will be completed by July 2011.

Monitoring progress on the 4 quality objectives
Progress on all the objectives will be reported to the Quality Assurance Committee, a new Board committee, for assurance and exception reports.

Implementation reports and sharing good practice across the Trust will take place in the monthly Quality Improvement Group on a rolling programme during the year.

2B Feedback on Last Year's Quality Objectives

Last year the Trust set 4 quality objectives:
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
2. To improve the satisfaction of people from Black and minority ethnic groups with the cultural appropriateness and respect of the services they receive
3. To make sure we are collecting, listening to and acting on views and feedback from service users and carers
4. To improve the support, advice and care we provide to service users with regard to their nutritional needs

It has monitored progress on these objectives during the year and presented reports back to the Board, to senior staff and to Governors.

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.

We chose this target because service users, carers, governors and our commissioner, NHS Sheffield, all told us how important it was to them that service users did not have to wait for long when they most needed help, in a crisis.

What we found
The introduction of the new acute care pathway during the year has had the hoped for impact in reducing the length of time people in crisis have to wait for an assessment, with waiting time reducing quarter by quarter during 2010/11. A target of 80% of people of working age being seen within 4 hours was set for the year. Performance improved each quarter and the target was achieved by the end of the year. We will continue to work on timely access and monitor how long people wait in 2011/12.

Table 1 Waiting times for crisis assessment for working age adults: Percentage of adults assessed within 4 hours of referral over the last 2 years. Data from Yorkshire and the Humber CQUIN returns (Insight data)

% adults assessed within 4 hours of referrral
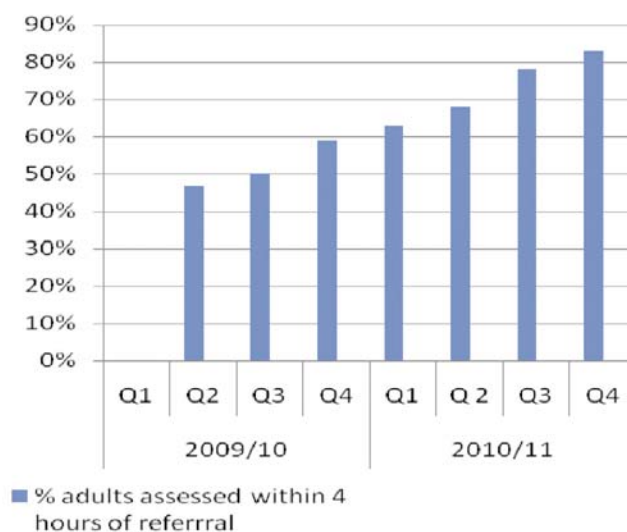
The Trust has been working in partnership at a senior level with colleagues in South Yorkshire Police and Sheffield Teaching Hospitals NHS Foundation Trust to try to smooth the care pathways of people with mental health needs in extreme crisis and reduce time waiting for a bed. As a result of this, an extended weekend service has been introduced at Accident and Emergency to respond to people who are waiting for urgent mental health assessments.

The Trust also worked on baseline figures for waiting times in a crisis for other groups of service users during 2010/11.

People with dementia in urgent need of care and support receive a service from the Trust's Rapid Response Team. The current target is that contact will be made by the service for triage and initial assessment within 24 hours. At the end of the year this target had been met in 100% of cases. The challenge of a 4 hour response will be picked up in the work planned for 2011/12 to deliver the NICE quality standard for dementia.

Through the year, the Learning Disability Service have designed and developed a range of evidence based care pathways, drawing on NICE guidelines for a range of conditions, service user and carer feedback and the needs of people with learning disabilities. The pathways include access criteria and set standards for how long people might wait for a service, including urgent or

crisis services. The service has developed implementation plans and begun implementing these care pathways as part of service redesign. Progress against the standards will be monitored in 2011/12 and reported to the Board.

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

The work on this objective had a focus on four areas:

1. Making sure people from Black and minority ethnic groups were able to access help at an early stage
2. Reducing negative experiences such as being restrained or secluded
3. Increasing positive experiences such as access to talking therapies and positive activities
4. Improving staff training

What we found

Important work has developed positively over the last year to help us improve the experience and satisfaction of people from BME communities who use our services. We have completed a fundamental review into how we approach the management of violence and aggression within our inpatient services, and have developed new training programmes. We have considerable work still to do to improve experiences, and the positive progress we have made over the last 12 months puts us in a strong position to make real progress.

1. Access to services at an early stage and increasing access to talking therapies

There was good access to the Early Intervention Service by people from Black and minority ethnic groups. In 2010/11, 55% of EIS service users were White British, 6.5% Somali, 6.2% British Pakistani, and the remainder from other minority ethnic groups. This is a similar picture to the previous year (59% White British, 6.9% British Pakistani, 6.3% Somali). It means that young people with psychosis from Black and ethnic minority groups are getting early diagnosis and treatment, and hence the best prospect of recovery.

However, we found out that people from Black and minority ethnic groups were less likely than White British people of the same age to be referred to IAPT

(Increasing Access to Psychological Therapies) the primary mental health services that provide cognitive behaviour therapy and other evidence-based interventions for people with common mental health problems. In 2010/11, 88% of people accessing IAPT were White British (and including the old 'White' category), the same percentage as the previous year. The IAPT service is monitoring the effectiveness of its service for people from different ethnic groups, but the numbers are as yet too small for any firm conclusions to be drawn.

The IAPT service has set up a number of interventions to improve access for people from Black and minority ethnic groups:

• Extended the service into voluntary sector organisations with a strong BME focus (Roshni, Yemeni Community Association, Sharrow Community Forum)
• Recruited additional bilingual staff who are based in areas with high BME populations but can take referrals across the city
• Promoted the service in the local Polish language media

However, at the end of the year, although the number of people accessing IAPT had gone up overall, there was as yet no evidence for an increased uptake by people from Black and minority ethnic groups in particular.

Another service historically less likely to be accessed by people from Black and ethnic minority groups is the service for older people with mental health problems. The Older Adults Functionally Mentally Ill (FMI) Directorate have been working proactively through the Seldom Heard Working Group to engage more effectively with Black and minority ethnic communities. Following the FMI Governance Away Day in April 2010, all teams have been working to implement changes in service areas. Staff have been attending a range of visits and attending events to improve links. Every team is monitoring the percentage of service users from different ethnic backgrounds on its caseload.

Overall, 6% of FMI service users in 2009/10 were from Black and minority ethnic group backgrounds and 5% in 2010/11. The Directorate will be reviewing this result and what it needs to do to improve access for people from Black and minority ethnic groups in 2011/12.

2. Reducing negative experiences

The Trust is continuing to monitor the comparative rates of detention under the Mental Health Act, use of seclusion, restraint and length of stay for the 4 mental health acute wards as part of the CQUIN scheme.

**Table 2: Detention, use of seclusion, length of stay on acute wards by ethnic group.
Data from Yorkshire and Humber CQUIN returns (Insight data)**

	2010/11	2009/10
1. Number of people admitted to the wards		
White British	422	404
Black and minority ethnic group communities	142	168
Total	564	572
2. Number of people detained under the Mental Health Act		
White British	219	195
Black and minority ethnic group communities	110	102
Total	329	297
3. Number of people secluded		
White British	27	71
Black and minority ethnic group communities	14	40
Total	41	111
4. Number of people restrained		
White British	22	15
Black and minority ethnic group communities	8	12
Total	30	27
5. Average length of stay		
White British	52.8 days	53.5 days
Black and minority ethnic group communities	49.2 days	52.9 days

Table 2 shows that although slightly fewer people were admitted to the wards in 2010/11 in comparison with previous years, the number of people detained under the Mental Health Act went up. 58% of all those admitted during the year were detained under the Mental Health Act. (More people have been receiving treatment at home.)

People from Black and minority ethnic groups are still more likely than White British people to be detained under the Act. 55% of White British people admitted in 2010/11 were detained under the Act, in comparison with 77% of people admitted who were from Black and minority ethnic groups. In the previous year, 48% of White British people were detained in comparison with 61% of people from Black and minority ethnic groups.

People from Black and minority ethnic groups continued to have a slightly shorter length of stay on average.

There was a large overall drop in the number of people secluded from the previous year. People from Black and minority ethnic groups, however, were still more likely to be secluded. 10% of people from these groups were secluded on occasion during their time in hospital, in comparison with 6% of White British people. In the previous year, 24% of people from Black and minority ethnic groups were secluded at least once and 17% of White British people.

The overall figures for restraint showed a small increase on the previous year, with the rise being in the number of White British people who were restrained and drop in the number of people from Black and minority ethnic groups.

Following feedback from the MAAT Probe group, the Trust has reviewed its approach to restraint and to managing violence and aggression on the wards. A new system, Respect, is being introduced, which service users report is more respectful and positive. Trainers

have been retrained in this approach and will be training their colleagues in the new approach in the year ahead.

'Loved every minute of it, looking forward to doing the Instructor Course'

'This has been a revelation to me, a very different course-in a good way!'

'Thank you - very useful and thought provoking. Service User involvement is very powerful.'

'The entire course was excellent from the physical techniques to the philosophy behind it.'

Comments from staff trainers attending the Respect 'train the trainers' course

3. Improving staff training

We have introduced new training programmes about diversity that have been well received by our staff. Induction training in diversity has been improved and a new Race Equality and Cultural Capability (RECC) training introduced. However, during this developmental period we have not been able to show an increase in the number of staff trained overall (see Table 3), and the CQC annual staff survey (2010) results showed that many staff were still reporting a lack of training in this important area. The Trust fell into the lowest 20% of mental health trusts on this item in the CQC 2010 staff survey and we are clear that we need to make more progress.

We therefore wish to continue to have a focus on improving the provision of staff training about diversity in the year ahead.

Table 3: Numbers attending Equality & Diversity Training (Data from ESR and training records)
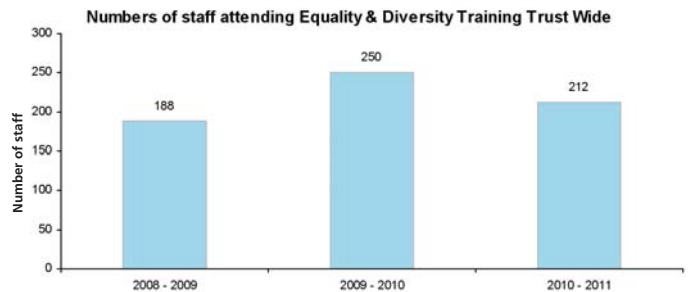
3. To make sure we are collecting, listening to and acting on views and feedback from service users and carers

All teams in the Trust have a team governance process. This involves reviewing the quality of care and treatment provided by the team and setting targets for improvement. Each team meets regularly to look at the quality of care and produces a team governance report at least annually. Teams were asked in 2010/11 to make sure they were collecting service user feedback and using it as part of their team governance process.

An audit of service user feedback in teams took place in November 2010. This was the first full Trust-wide audit of the topic. All team managers were contacted by email and followed up with phone calls. 58 out of the 61 clinical teams responded (a response rate of 95%). Of the 58 teams that responded, 55 (95%) said that they had collected service user feedback in the last 12 months. 40 out of the 55 teams had used a service user survey and others had held meetings such as tenants' groups or community meetings, or collected face-to-face feedback. The overwhelming majority of teams had found collecting feedback useful,

and 46 of the 58 teams who responded (82%) had used the service user feedback in their team governance reports. Teams were asked about any barriers they had experienced and problems such as communication difficulties of service users with dementia or learning disabilities were mentioned. Staff also suggested new ways of collecting feedback and involving service users in team governance.

After this audit, the Trust held a Sharing Good Practice Day for staff and service users in February 2011. At this event, posters and talks showed many different ways of collecting feedback and involving service users. These included the Quality and Dignity Surveys carried out by service user volunteers on the acute mental health wards; simple surveys of people with dementia, carried out by staff from West Wing, Grenoside; and how work involving service users receiving crisis resolution and home treatment had benefitted the staff team as well as the service users.   Staff leaving the event reported they had ideas and inspiration to take back to their teams with comments such as 'Really useful thought provoking day'.

The Trust will continue to place the experience of service users and carers at the heart of improving quality in the year ahead. Team governance reports will include service user feedback, and we hope to make it easier to compare across teams by using the same questionnaires or surveys in similar teams. Using service user volunteers to interview staff is another area we hope to continue and expand.   In 2011/12, we will have a new focus on carers' experience, setting this as one of the Trust's quality objectives for the year ahead.

Service User Feed-back In Action - the Quality and Dignity Surveys
This project has service user volunteers talking to service users on the adult mental health wards, using semi-structured interviews to find out about their experiences of care and treatment on the wards. The service user volunteers are trained with the Trust induction process and supported by the Trust's PALS Officer. 200 service users on the wards have been interviewed since the start of the project in November 2009. Results are fed back to staff on the wards and used in team governance both to note good practice and to identify areas where action is needed to improve quality. Posters showing the findings have been displayed on the wards.

79% of the service users interviewed said they preferred to give feedback to a service user volunteer, rather than a member of staff.

Examples of improvements to services as a result of the Survey are:

• Advocacy services - the awareness of advice and advocacy from service users and staff has significantly gone up - 43% of service users were aware of advice or advocacy services (April-November 2010), up from 26% in 2009/10
• More service users are reporting that they know who their contact nurse is (up from 63% in 2009/10 to 80% in the period April-November 2010)
• An increase in people's awareness of the Recovery Folder (up from 34% in 2009/10 to 46% in the period April-November 2010). A Recovery Folder is a personalised resource full of information about mental health services and the service user's journey to recovery. The Recovery Folders are now being promoted as part of the Acute Care Pathway

The Quality and Dignity Surveys have been shared as an example of good practice regionally at an event on service user feedback organised by the Yorkshire and Humber Quality Observatory in March 2011.

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

This objective had four aims:

• 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

Work during the year
During the past 12 months the following work has been undertaken:

1. The introduction of best practice nutritional screening

Following a Trust-wide review of current screening processes, it was decided to implement the

Malnutrition Universal Screening Tool (MUST) which is a validated tool recommended by the National Institute for Healthand Clinical Excellence (NICE) Nutrition Guidance and a more systematic approach to screening than previous measures used. Initial

staff training and implementation has taken place in older adult areas where service users are at the greatest risk of malnutrition, and the MUST was introduced in the second quarter on admission and in the third quarter on discharge.

Table 4: Malnutrition screening using the MUST each quarter
Data from Yorkshire and Humber CQUIN submission (Insight data)

| Malnutrition screening using the MUST | 2010/11 | | | |
	Q1	Q2	Q3	Q4
% older adult in-patients screened on admission	Data not collected	97%	100%	100%
% older adult inpatients screened on discharge	Data not collected	Data not collected	68%	97%

By the end of 2010, 100% of older adult service users were being screened on admission, using the MUST, and 97% on discharge. One person was not screened on discharge because they were on leave when they were discharged. 4 people were found to be at risk of malnutrition when they left the older adult wards, and they all had a care plan in place to address this concern.

This best practice screening tool is now being rolled out to other parts of the Trust, to supplement the existing practice of weighing and measuring people on admission to adult wards and learning disability inpatient and respite services.

2. Protected mealtimes

Protected mealtimes have been introduced to all areas through the NICE nutrition implementation group. This ensures that service users can enjoy their mealtimes without interruptions from visitors, whilst recognising that some family members may wish to assist their relatives at mealtimes. Recent Patient Environment Action Team (PEAT) visits reported that all areas were aware of protected mealtimes and most were displaying notices informing relatives of the initiative.

3. Staff training

Training requirements for staff around nutrition have been identified. All staff who work with service users are expected to have an awareness of healthy eating. A validated course for meal planners is to be run in May 2011, and if successful will be offered on an annual basis.

A business case was made and funding agreed to recruit a permanent dietician to the Trust, who will

play a vital role in staff development as well as offering support for service users. The dietician will be asked to deliver focussed training to staff working with service users who are overweight or obese.

4. Meal planning and food standards

A review of mealtimes across the Trust by a dietician on secondment identified some areas where improvements were needed to the nutritional standards of meals. This will require a more planned and managed approach to menu planning in the future.

Older adult in-patient wards have undertaken a benchmarking exercise against the Essence of Care (2010) Food and Drink standards, using questionnaires. The results have gone back to the wards, and action plans are being developed for any weak areas found.

5. Mealtime experience

Service users are asked about meals in PEAT visits and in the Quality and Dignity surveys carried out by service user volunteers on adult acute mental health wards.

The surveys have shown that food preferences are personal and diverse. Respondents to the Quality and Dignity interviews, for example, showed a wide range of responses, some describing the food as excellent while others on the same ward said it was inedible. Overall 74% said the food was usually good, 13% said it was not usually good and the remainder did not express a firm opinion (Quality and Dignity Survey Report for April-December 2010).

The most recent annual PEAT surveys showed a 'good' score for food in all areas where food was provided. A new service user questionnaire has been piloted on one ward and the NICE Nutrition group plan will pilot it more widely in 2011.

2C How the Trust is developing its capacity to Assess, Improve and Assure Quality

The Trust's Quality Framework states that the heart of quality lies in the interaction between service users and all the staff of the Trust. Quality systems must run throughout the organisation, from the daily contacts between service users and staff in teams to the Board.

In SHSC, quality assessment, improvement and assurance is built on a team governance process. Every team in the Trust produces a team governance report at least annually, which is reviewed by their directorate senior management team. A review of team governance during 2010/11 showed that the process was embedded and working well, and the CQC assessor gave positive feedback as to how useful they were in providing evidence for the CQC planned review that took place in 2010/11. The team governance review found some variability in the content and quality of the team reports; during 2011/12 good practice and ideas for the further development of team governance will be shared between the directorates through the Quality Improvement Group.

The Trust has been implementing the Productive Ward and Productive Community Team on a rolling programme. The Productive series is an innovative approach with the goal of releasing more time for staff to spend in care and treatment with service users.

The Productive Programme
The Productive Series was developed by the NHS Institute for Innovation and Improvement and aims 'to release more time to care'. It is a team led improvement process. Using a 2 year modular approach with a range of tools and techniques, teams can focus on their systems and processes to enable them to become more efficient, resulting in safer and more reliable care. Staff can spend more time with patients. In Sheffield Health and Social Care Trust 6 wards, 3 community teams and the memory services are all taking part in the Productive Programme.

Key achievements to date are:
*   One ward team timed how long some of the most frequently performed tasks took. By creating

a tidier and simplified system they reduced one task from 51 seconds, to 5 seconds on average. Over a year this will release over 56 hours of nursing time.
*   One ward reviewed and then introduced an individualised system for ordering patient care products. Patients now receive more individualised and comfortable care with less disruption and increased comfort. Almost £2,000 was saved in the first month and an estimated £100 per week from then on.
*   One ward increased their direct care time from 23% to 35% by reviewing the amount of time spent on administrative tasks and reducing walking distance.
*   The latest technology has been trialled on one ward to create a clinical dashboard that improves access to patient information and links to Insight and the Acute Care Pathway
*   Dignity Walks are completed by each ward which involves walking through the ward with a service user or carer and viewing the ward through their eyes and then making improvements where issues are identified.

Four more teams will begin the Productive Programme in May 2011. The Productive series is a good example of how small changes, driven by staff on the ground, can make a real difference to patient care.

Major service improvement plans for the Trust, such as the Acute Care Pathway development, have built quality measurement in from the start. The Acute Care Pathway sets standards for the timeliness of access, the inclusion of service users, the use of care plans and risk assessments etc. and measures to see if these standards are met. The re-provision of learning disability services for people with challenging behaviours and mental health problems has involved and included people with learning disabilities using the existing services, peer advocates and family members.

During 2010/11 the Trust reviewed its systems and structures for governance in the light of the recommendations of the Francis Inquiry Report, with a particular focus on the Board's role in understanding and assuring quality. From this work, a number of significant changes are being made which will come

into operation from 1st April 2011. A new Board committee, the Quality Assurance Committee, is being instituted to make sure that quality issues receive the same attention from the Board as financial issues. The new Board committee structure will enable the Trust to provide the Board with the assurance and information it needs on quality, as well as demonstrate compliance with the regulations provided by Monitor (in its proposed new Compliance Framework) and the Care Quality Commission.

The Board has reviewed the learning from the Audit Commission Report Taking It on Trust and adopted a new model and format for the Board Assurance Framework, which links monitoring of the most serious and strategic risks to service delivery with an outcomes and impact monitoring approach. The robustness of these systems in keeping the focus on quality will be very important in the years ahead as health and social care services enter a period of funding constraint and transition.

At senior manager and clinician level, a new Quality Improvement Group is replacing the former Operational Management Group, with a clear remit to focus on quality improvement across the whole organisation. The new operational quality group will make sure there is better sharing and problem-solving across specialties, professional groups and service areas, breaking down silo approaches to quality. It will aim to share best practice to improve the quality of care in all the services we provide.

The Trust adopted a new Service User Involvement Framework in February 2011 which describes the Trust's

vision and values for involvement and how the Trust will continue to support service user involvement in many different ways. The Board has a new re-engagement with the vision of service user and carer experience as lying at the heart of quality, and is making sure that it hears service user and carer views and listens to their experiences.

Examples of service user involvement and the use of service user feedback were on display at a Trust Sharing Good Practice Event in February 2011. Posters were on display including one from the Sun:Rise group:

Creative approaches to Service User Experience: Poster from Sun:Rise group

The Trust has set up a new web-based quality and performance data system, called Inform. This draws information from the 5 databases in the Trust which cover service user information (Insight), staff information (Electronic Staff Record or ESR), risk, safety, complaints and PALS information (Ulysses Safeguard) and financial information (Integra). It uses the information to report on quality and performance indicators at Board, directorate and team level. Inform will form the basis of clinical governance and quality reports and will grow further in the year ahead. It is leading to improvements in data quality as each indicator in Inform has a clear definition which applies at all levels of the organisation, and the date and time at which a report is generated is recorded so that uncertainty is removed about time period to which the data applies.

The Trust is making further improvements to the use of clinical audit as a tool for service improvement and quality assurance. It already uses clinical audit extensively to monitor and show progress towards compliance with National Institute for Health and Clinical Excellence (NICE) guidance.

Effectiveness - the Implementation of NICE guidance

A full programme of NICE implementation continued during the year. The Trust is very committed to NICE implementation as a key part of improving quality. All relevant technology appraisals were implemented within the timescales in the year, and 13 active NICE guideline implementation groups are in place. The NICE depression guideline implementation group is working across the Trust, for example, to improve the effectiveness of treatment for depression of all types and at all ages. It carries out regular audits, alerts the teams to any gaps in NICE compliance, provides staff training and development on depression and information for service users about depression.

The Falls NICE guideline implementation group has made significant progress in reducing harmful falls by introducing a standard falls risk assessment and guidelines for managing suspected fractures. The older adults Functionally Mentally Ill wards in particular have done a lot of work to reduce falls - improving the environment, training staff and developing new treatments such as falls health promotion groups. The Trust is still a high reporter of falls, as staff are very conscious of the negative impact falls can have, but the number of falls resulting in a fracture has dropped from between 17 and 26 each year between 2006 and 2009 to 8 in 2010.

During 2010/11 the Trust laid out its plans to make significant changes to the investigation and management of serious untoward incidents. A number of improvements have already been made to support incident reporting and management. In the CQC Annual Staff Survey in 2010, staff responses put the Trust in the top 20% for the fairness and effectiveness of its incident reporting procedures, a significant increase since 2009.

We have worked on the timeliness of the Trust's reporting of serious incidents to NHS Sheffield and on to the national reporting system, and to improve the quality of investigation reports. The Trust has improved the documentation and guidance for the staff who produce the serious incident reports, using the National Patient Safety Agency incident reporting template. It has introduced an additional screening for all serious incident reports by the Executive Director for Nursing and Quality. Outstanding reports have been completed and 44% of reports met the 12 week completion target by the end of the year. Further improvements to timeliness and quality will take place in 2011/12, with close monitoring through the Quality Assurance Committee and with NHS Sheffield.

A new programme of training in clinical risk assessment and management started during the year. The Trust aims to ensure all its staff receive the training during the next year, and will then make sure similar training is provided routinely from then on.

Patient safety - staff training in clinical risk assessment and management

During 2010/11 the Trust set up a new clinical risk training programme for all health and social care staff who are responsible for the care and treatment of service users. 180 staff had completed the training by 31st March 2011. By the end of 2011/12, all of the targeted staff will have been trained in best practice in clinical risk assessment and management, including working with service users and their families to plan head ahead and keep people safe.

New Patient Safety and Health and Safety committees are being set up in 2011/12 to make sure progress on safety and risk management is sustained and developed further.

The Health and Safety Committee will include trade union representatives, and will address staff training in health and safety as a priority, following the disappointing results in the 2010 CQC staff survey on the numbers of staff reporting they had received training in health and safety.

2D Statements Relating to the Quality of Services Provided

(The content and wording of this section of the quality accounts is prescribed by the Department of Health and the regulator, Monitor).

1. Review of Services

During 2010/11 Sheffield Health and Social Care NHS Foundation Trust (SHSC) provided and/ or sub-contracted 109 NHS Services.

SHSC has reviewed all the data available to them on the quality of care in all of these NHS Services. The Trust reviews data on the quality of care with NHS Sheffield, PCTs, Sheffield City Council and the specialist commissioners in regular contract and performance meetings. Commissioners who have relatively small contracts with the Trust have agreed to accept the quality reviews provided through and accepted by NHS Sheffield, as our main commissioner.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by SHSC for 2010/11.

These figures are derived from specific service headings in the 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. Cost per case and non-contract 'permission to treat' requests have also been excluded.

The data reviewed includes patient safety, clinical effectiveness and patient experience and the amount of data available for review has not impeded this objective.

Table 5: Services commissioned where quality is reviewed

Commissioner	Services Commissioned	Number of services commissioned	Services formally reviewed with Commissioners	Services reviewed by the Board / Governance Structures
NHS Sheffield - mental health and learning disabilities	Directly Commissioned patient services	39	39	39
NHS Sheffield - substance misuse commissioned via Drug and Alcohol Action Team (DAAT)	Directly Commissioned patient services	3	3	3
Sheffield Local Authority	Directly Commissioned patient services	5	5	5
Other NHS Primary Care Trusts	Directly Commissioned patient services	52	52 reviewed (either via commissioner or via NHS Sheffield quality reviews)	52
Specialist Commissioners	Directly Commissioned patient services	2	2	2
Housing Associations	Residential Care services	8	8	8

2. Participation in Clinical Audits

During 2010/11, there were seven national clinical audits and 1 national confidential enquiry that were applicable to NHS services that Sheffield Health and Social Care NHS Foundation Trust (SHSC).

During that period SHSC participated in all 7 (100%) of the national clinical audits and the one (100%) national confidential enquiries, which it was eligible to participate in. The Trust participated in an additional 5 national audits which do not appear on the Department of Health list for inclusion in quality accounts (see www.dh.gov/qualityaccounts); these audits provide valuable opportunities for the Trust to benchmark its practice against other providers. It also participated in 49 local audits.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in and participated in during 2010/11 are as follows:

Table 6: Participation in national clinical audits and national confidential enquiry

Name of audit or enquiry	SHSC participation	Number of cases submitted	Number of cases as % asked for
National audit of psychological treatments (IAPT only)	Yes	1626	100%
Prescribing Observatory for Mental Health in the United Kingdom (POMH-UK) Topic 7Lithium monitoring	Yes	24	100%
POMH-UK Topic 8 Medicines reconciliation	Yes	14	100%
POMH-UK Topic 6 Side effects of depot antipsychotics	Yes	102	100%
POMH-UK Topic 2 Metabolic side effects of antipsychotics	Yes	122	100%
POMH-UK Topic Antipsychotic use in learning disabilities	Yes	21	100%
National audit of schizophrenia	Will participate once audit starts August 11	150 required	Not yet submitted
National confidential enquiry into suicide and homicide by people with mental illness	Yes	14	100%

The results of the national audits which are listed in the guidance for the Quality Accounts, and the action taken as a result, are shown in the table below:

Table 7: Results of listed national clinical audits and action taken

Name of Audit	Findings	Action taken or planned
National audit of psychological treatments (IAPT)	Data submitted to Royal College of Psychiatrists for analysis - results not yet available	To review results when available and agree actions.
POMH-UK Topic 7 Lithium monitoring	89% patients with documented evidence of renal function test conducted before lithium prescribed 89% patients with evidence of thyroid function test conducted before lithium prescribed 62% patients with evidence of weight, BMI (body mass index) or waist circumference measurements taken before lithium prescribed 75% patients with evidence of ECG (Echo cardiogram) conducted before lithium prescribed	For all POMH-UK audits: POMH UK audits are presented both locally and at the Trust-wide Audit meeting. Clinical teams put the findings of projects in their team reports. Individual pharmacists feed back to teams the results of audit through governance meetings. POMH UK also supply the Trust with a plethora of interventions including BNF (British National Formulary) prescribing cards for staff and information leaflets for service users and carers. These interventions are distributed to each clinical area. In addition to these interventions ICE (In case of emergency) lab reports have also been made available on the Insight system.
POMH-UK Topic 8 Medicines reconciliation	The Trust performed at a similar standard to other Trusts in the following areas: -documenting details about medication before admission -documenting details regarding adherence to medication - proportion of patients having 2 or more sources checked for reconciliation purposes within 24 hours of admission (result down from previous year)	In addition to the above interventions, there have also been changes to the acute care pathway on medicines reconciliation.
POMH-UK Topic 6 Side effects of depot antipsychotics	Assessment of side effects of depot antipsychotics fell from 31% to 26% There was a reduction in documenting side effects rating scale, blood tests relating to side effects and physical examinations However, patients with no formal or informal assessment of side effects had improved from 31% to 24%	In addition to the above interventions, there have also been a series of training sessions to Community Mental Health Teams (CMHTs) on the monitoring of side effects.
POMH-UK Topic 2 Metabolic side effects of antipsychotics	The Trust's compliance to the standards was 40% for all 4 aspects of metabolic syndrome	In addition to the above interventions, there have also been a series of training sessions to CMHTs on the monitoring of side effects.
POMH-UK Topic: Antipsychotic use in learning disabilities	Results for this audit were generally positive: 100% documented indication for antipsychotic 100% reviewed need for antipsychotic reviewed (100%) 100% general assessment of side effects 100% lipid monitoring assessed 78% assessment of extra-pyramidal side effects 78% documented weight change 78% blood pressure monitored 78% blood glucose assessed	In addition to the above interventions, Pharmacy are also continually monitoring high dose and combination antipsychotics.
National audit of schizophrenia	To begin data collection June 2011	

The Trust chose to participate in five additional national audits:

Table 8: Results of additional national clinical audits and action taken

Name of Audit	Findings	Action taken or planned
NHS Litigation Authority Records Audit	The third annual records audit showed improvements in ten areas but weaknesses in the recording of risk assessments and management plans.	A programme of clinical risk training was developed. This was implemented from January 2011. In addition to this team results fed back to teams and local improvement actions taken.
National Patient Safety Agency (NPSA) Suicide Prevention toolkit	The audit was completed on two wards. It found that staff had not received clinical risk training for some time.	All of the staff on these wards have now been trained in clinical risk assessment and management.
Royal College of Psychiatrists Memory Services National Accreditation Programme (MSNAP)	The Trust's Memory Service met 131/147 standards and is now an accredited service under the Programme.	Recommendations for further improvement were: -to reduce the waiting time for appointments -to offer copy letters to referrers, service users and carers -to improve staff supervision and training -to conduct a survey of referrers' experience of the service
Falls - Royal College Physicians	Data has been submitted to the Royal College.	
Essence of care - food and nutrition	The audit identified that patients were not receiving a nutritional assessment on discharge.	New screening tool (MUST) has been implemented and a dietician has been appointed

On a quarterly basis the Board review the findings and progress of the 13 national audits. They also review the progress of 49 other local audits. In total 30 of local audits (61%) had reached the 'action' stage.

Some examples of improvements made following local clinical audits are given below:

Examples of improvements made following local audits:

1. Antipsychotic prescribing in the rapid response team
Following an audit done in the dementia rapid response and home treatment team there are now low levels of prescribing of antipsychotics in accordance with NICE guidelines.

2. Challenging behaviour audit
An audit of staff knowledge of challenging behaviour has led to a 75% reduction in the use of medication on one unit.

3. Audit of self-directed support
A baseline audit of self-directed support has led to all community mental health teams receiving three day training on how to deliver self-directed support. The audit will be repeated to see if the training results in increased uptake of self-directed support

Full details are available in the Trust's Annual Clinical Audit Report.

Following its review of governance systems this year, the Trust will be maximising the effective use of clinical audit to provide assurances to the Board and the new Quality Assurance Committee. New criteria for selecting clinical audit topics will ensure that national and strategic interests are addressed in the programme.

Changes will also be made to the Trust's Clinical Audit Group in the year ahead so that the audit capacity of doctors in training can be used to best effect for the benefit of the Trust as well as forming a key part of their training, and so that the Clinical Audit Group has more involvement from a wider range of professions.

3. Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust between 1 April 2010 and 31 March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 163.

Sheffield Health and Social Care NHS Foundation Trust was involved in conducting 20 clinical research projects which aimed to recruit patients to studies in mental health, dementias and neuro-degeneration, stroke and

general health services research, although not all studies recruited patients between 1 April 2010 and 31 March 2011.

Developing participation in research has been identified as a priority for the Trust, which recognises the potentially beneficial effects on quality of care and the recruitment and retention of skilled staff. The world-class stature of the University of Sheffield and Sheffield Hallam University in various areas of health-related research (e.g. psychological treatments and neuropsychiatry) provides the opportunity for Trust staff to partner with highly regarded researchers to develop the quantity and quality of research with which SHSC is involved.

One of the barriers to engaging with researchers was the length of time taken to give NHS approval to research projects. The Research Development Unit has prioritised this and approval times for national portfolio research projects have improved from an average of 70-80 days in October 2010 to approximately 20 days at the end of March 2011. A new Trust Director of the Research Development Unit was appointed In November 2011. He is establishing a new Research Committee to identify capacity and capability for research and promote participation in research working with established research partners.

Example of a research project carried out in the Trust - how it helps to improve the quality of care and treatment

Improving Quality and Effectiveness of Services, Therapies and Self-management of longer term depression (IQuESTS)

IQuESTS is a South Yorkshire project in conjunction with the University of Sheffield which aims to improve care for service users with long term depression.

It has three work programmes:

* System modelling of the care pathway and self management
* Understanding self-management by learning from service users
* Testing systems improvements

The programme will follow people who are receiving care for long-term depression over several years to better understand their experience of living with and managing depression. At the same time a clinical

research service will test out aids for self-management for service users and clinicians.

Staff from the Trust are involved in the IQuESTS work. They will be able to bring the expertise they gain in treating depression and supporting people with long term depression in self management approaches to the work of mental health teams and services.

4. Goals Agreed with Commissioners: Use of CQUIN Payment Framework

A proportion of Sheffield Health and Social Care NHS Foundation Trust income in 2010/11 was conditional on achieving quality improvement and innovation (CQUIN) goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In total £1,034,332 was conditional on meeting the CQUIN goals during 2010/11 and £719,394 (70%) had been retained at year end.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at http://www.shsc.nhs.uk/about-us/annual-plan-report/cquin.

5. What Others Say about the Trust: Statements from the Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered, without conditions, for all regulated activities in all locations for both health and social care.

The Care Quality Commission (CQC) has not taken enforcement action against the Trust in the year ending 31st March 2011.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period. However, it has taken part in a planned review of its healthcare provision.

Following the planned review of all 11 healthcare locations during 2010/11, the CQC required the Trust to take 9 compliance actions (against 6 Essential

Standards of Quality and Safety outcomes) and 1 improvement action, across 3 locations. The CQC found no problems in the remaining 8 locations, from the evidence it reviewed.

The Commission made a number of positive comments about the care and treatment provided by the Trust in its reports.

"On the site visit performed 11 January 2011 we found that both Maple and Rowan wards along with the Intensive Treatment Service (ITS), despite them being fully occupied, had a positive, calm and welcoming atmosphere. We found staff members to be competent, knowledgeable, friendly and helpful and had a positive commitment to the care of patients on the ward. We found systems and processes in place to ensure people who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or where they are moved between services.

"We found people who use services and people who work in the location are in safe, accessible surroundings that promote their wellbeing. We found evidence to demonstrate that people who use services would have their health and welfare needs met by competent staff".

Some comments made by service users to the Care Quality Commission during their visits to wards in January 2011:

"Definitely had 100% good care on this ward since I've been here, staff been more than helpful…They come and tell us when they come on duty who has been assigned to me for the shift".

"Lots of activities to keep me busy. Enjoy going to OT pottery, baking."

"Feel safe and staff do a good job".

"I really believe they are really lovely staff. I couldn't do their job and be as calm and patient as them".

"My experience is that I have had a brilliant time here, in comparison to other services they are brilliant"

The Trust is implementing an action plan to make sure it addresses the compliance and improvement actions which resulted from the visit. The table below shows the concerns raised by the Care Quality Commission (red-amber-yellow-green rated for the seriousness of the concern identified), the actions planned and the progress made by the end of 2010/11.

Key: Seriousness of gap in compliance - level of risk

■ Major concern
■ Moderate concern
■ Minor concern
■ Compliant but action needed

Table 10: Progress on action plan following CQC Planned Review

Compliance actions Area for action				
Outcome	Location	Action needed	Action planned	Action taken by 31 March 2011
2: Consent to care and treatment	Michael Carlisle and Longley Centres	To improve recording of assessments of capacity to make decisions	Adult inpatient consultants and Mental Capacity Act lead have agreed best way to record medical conversations and capacity decisions. An action plan to implement the changes required is to be agreed and implemented by September 2011	Capacity to consent and SOAD decision forms have been developed and sent out. Action plan has been shared with consultants.
		To improve recording by medical staff of explanations of risks, benefits and alternative treatment options		
4: Care and welfare of people who use services	Michael Carlisle and Longley Centres	To improve systematic individualised risk assessment	Establish training programme on clinical risk assessment and management. Establish use of risk assessment tool Basic Risk Assessment, BRAM and Detailed Risk assessment, DRAM) Establish audit programme in use of risk assessment tools and quality of risk assessments.	Training programme in place. 180 staff trained (84 in acute services) as at 31st March.

Outcome	Location	Action needed	Action planned	Action taken by 31 March 2011
Compliance actions Area for action				
		To improve the involvement of service users in the development of their care plans	Acute Care Forum (which has service user representation on it) to discuss the issue and formulate an improvement plan Monitor and review service user involvement in care planning Alter systems to enable patients the option to be included in MDT discussions	Discussion has taken place and actions agreed. Improvement plan in progress. Continuous monitoring through quality and dignity survey and feedback reports Ward managers / consultants contributed to independent review of service user involvement in ward rounds undertaken by Sheffield Advocacy Service
	Longley Centre	Review arrangements for single sex accommodation on Rowan ward	Relocate male patient occupying room in female area Review disabled facilities on the ward and develop business plan for the creation of additional disabled room in male area Options paper re: improving mixed sex accommodation to be developed for Executive Directors Group to evaluate and agree	Completed Reviewed facilities. Business plan not yet completed.
		Work with partners to improve section 136 detentions - find a more suitable location or manage the impact of detentions in a way that has less impact on the ward	Review arrangements for receiving patients under section 136.	
	Michael Carlisle Centre	Review arrangements for single sex accommodation	Ward walk rounds to be completed with PCT representative present. Implement action plan Options paper re: improving mixed sex accommodation to be developed for Executive Directors Group to evaluate and agree	Completed and action plan produced
		Respond to concerns raised by service users to CQC inspectors about attitude of a member of staff	Review complaints processes on ward. Review past complaints to identify any themes about member of staff	Completed Completed with no themes / issues identified.
		Continue to work on lessening impact of high bed occupancy	Introduce step down beds as part of pilot Evaluate impact of step down bed pilot Develop alternatives to admission in partnership with PCT. Review discharge process Review bed management processes	Completed - initial reduction in bed occupancy realised Completed - have reduced need for dual assessment pre discharge. Completed.
8: Cleanliness and infection control	Longley Centre	Improve cleanliness of seclusion room on ward	Amend cleaning schedules and review toilet and washing facilities available.	Completed

Compliance actions Area for action				
Outcome	Location	Action needed	Action planned	Action taken by 31 March 2011
10: Safety and suitability of premises	Longley Centre	Replace clear glazing on link corridor and fire exit doors to improve privacy Review and improve heating	Obscure film to be fitted to glass Bleed all radiators Install pressurised gas fired boiler and low surface temperature radiators	Completed Completed
13: Staffing	Grenoside	Review permanent staffing arrangements to make sure there are sufficient staff to meet the needs of service users	Ward evaluation to include sections on staffing levels and skill mix. Review of flexible staffing arrangements Recruit additional staff	Evaluation commissioned - report expected May 2011 Review completed - implementation of revised system started Interviews for 3x30 hours Band 5 nurses and 2 x 37.5 Band 5 nurses have taken place.
20: Records	Michael Carlisle and Longley Centres	Improve medical records systems (paper and electronic) to make sure key issues are recorded and subsequently accessible	Pilot and evaluate e-records in ITS Review content and accessibility of care records system via clinical summit. Review indexing of electronic care records and train staff in use of electronic records. Remove/scan or archive as appropriate all paper patient records and move to total electronic care records	Completed

Improvement actions				
Outcome	Location	Action needed	Action planned	Action taken by 31 March 2011
13: Staffing	MCC	To review locum cover and suitability of locum arrangements		Completed. Substantive postholder has returned to work

Recommendations				
Outcome	Location	Action needed	Action planned	Action taken by 31 March 2011
14: Supporting workers	Fulwood	Review discrepancy in PDR recording arrangements	Review individual team figures against those held centrally in the Electronic Staff Record	All teams reminded to include PDR rates in their team governance reports

6. Data Quality: Statement on the relevance of data quality and Trust actions to improve data quality

Data quality is important because it enables information to be shared that is accurate, timely and appropriate. The Trust is taking the following actions to improve data quality:

- We use both internal and external reports to monitor the quality of key indicators e.g.

  - NHS Sheffield monitor our data quality via nationally submitted datasets and discuss their findings with us
  - We have procedures in place to check the quality of data and correct inaccuracies and omissions before the submission of national datasets
- We make use of the external data quality reports generated by the Information Centre to assess data quality internally
- We wrote clear and consistent definitions for indicators in the Trust's new Inform system, a web-based data-store for quality and performance information

- Inform enables staff such as team managers or directors to assess the accuracy of the data held about their service quickly and address any anomalies identified as a result of this feedback loop
- We intend to place more key performance indicators relevant to data quality in the further development of Inform
- The Insight system has built-in routines to validate data as it is entered
- The Commercial Relations Department check details before submitting their returns to GP practices
- We make regular submissions to the Demographics Batch service to identify or verify NHS numbers, which helps to prevent the creation of duplicate client records and identify and remove existing duplicates
- Staff have access to the Summary Care Record/Personal Demographics Service so they can check NHS number, registered GP and address details. We are working to automate checking of registered GP for Insight clients

- We use the Enhanced Reporting Service to identify deaths of service users and keep the Insight system up-to-date

The data quality of the Annual Quality Account for 2009/10 was audited last year by the Audit Commission, who shared their findings with the Trust. A total of 14 recommendations for improvement were made by the auditors. Actions agreed following this audit have been implemented or are in progress, although some timescales have been delayed.

The Trust had access to sufficient sources of information to enable the production of these accounts and to cover the aspects of quality as required by the national guidance, including safety, clinical effectiveness and service user experience. It will continue to work on improvements to quality data reporting with the second phase of Inform and through comprehensive reports to the new Quality Assurance Committee.

Table 11: Aspects of Data Quality

1. NHS Number and General Medical Practice Code Validity
Sheffield Health & Social Care NHS Foundation Trust submitted the Admitted Patient Care (APC) Commissioning Data Set (CDS) and the Mental Health Minimum Dataset (MHMDS) to the required timetables to the Information Centre/Secondary Uses Service
The percentage of records in the CDS APC published data which included a valid NHS number was 99.8% (April-December 2010)
The percentage of records in the CDS APC published data which included a valid General Medical Practice Code was 100.0% (April-December 2010)
The percentage of records in the MHMDS published data which included a valid General Medical Practice Code was 99% (Quarter 1 2010-2011 figures)
Information Governance Toolkit
Sheffield Health & Social Care NHS Foundation Trust Information Governance Toolkit Assessment Report score overall score for 2010-2011 (version 8, March 2011 submission) was 59% and was graded red (not satisfactory).
Clinical Coding Audit
Sheffield Health & Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010-2011 by the Audit Commission

The Information Governance Toolkit Assessment changed significantly during 2010/11, setting a much higher standard than previously. The Trust made significant progress towards achievement of the new requirements during the year but was not able to reach the required standards on all items and reach a 'satisfactory' position by the end of the year. It has an action plan in place to deliver level 2 on all items and it has prioritised work on those items which have a direct bearing on the care and treatment of service users.

Part 3
3A Review of Quality Performance

This section provides evidence and an overview of the quality of care and treatment in the Trust. It considers all the components of good quality care:

1. Safety

The Trust prides itself on having a strong safety culture and it encourages staff to report incidents and 'near misses.' It does this to make sure that it can learn from looking at patterns and trends and make improvements to services to reduce the risk of harm to service users and others. In incident and serious incident reports, the Trust expects to see high number of incidents reported, but only a small proportion of these should be serious incidents, or ones that have resulted in harm to service users or others.

During the year there were 262 serious incidents reported by the Trust. The current Trust definition of a 'serious incident' means that this appears high in comparison with other NHS Trusts, including some other mental health trusts. The way in which the Trust assesses and defines a 'serious incident' has been reviewed in the year and will be changed in 2011/12 so that it more closely corresponds to the guidance from the National Patient Safety Agency (NPSA). We anticipate the number of incidents defined as 'serious' will decrease next year and we will be able to present more benchmarking data in future.

None of the serious incidents reported during the year were 'never events' i.e. incidents defined by the National Patient Safety Agency as ones which should have been prevented.

The NHS disseminates urgent patient safety alerts through the Central Alerting System. The Trust received 127 Central Alerting System (CAS) alerts during the year and 89% were concluded within the target timescale. This is an improvement from the previous year (71% within timescale) and we aim to have a 100% success rate on concluding the alerts in 2011/12.

Patient Safety Information
We have chosen to report on 4 specific types of incidents in particular in these accounts:

- The Trust reports a high number of slips, trips and falls. There was a reduction in the number of fractures resulting from falls during the year, down to 8 from a range of 17-26 per year over the previous 4 years (report from Falls NICE Guidelines Implementation group in February 2011). However there was no overall reduction in those falls resulting in injury of any kind. The Trust has an active programme of work in place to reduce the risk of falling and minimise the negative consequences which can result for service users following a fall.
- The risk of self harm or suicide is a concern for mental health and substance misuse services, and the Trust is implementing new clinical risk assessment and management training for staff.
- Violence, aggression and verbal abuse incidents are being scrutinised by the Trust as it plans to introduce the new Respect approach.
- Medication incidents are scrutinised regularly with lead Pharmacy involvement in the Incidents process. The overwhelming majority of these incidents do not result in harm to service users. Of the 18 that were rated as serious incidents, 1 person was admitted to hospital for observation and 1 was assessed by an Emergency Care Practitioner, but none resulted in actual harm (information from review of the 18 serious incident reports).

Table 12: Serious incidents, all incidents, specific incidents
Data from Ulysses Safeguard, supplemented by review of incident reports

Indicator	Number of Incidents		
	2010/11	2009/10	2008/09
All reported incidents	5914	6000	5921
All serious incidents	262	292	294
'Never events' Target =0	0	0	0
Suicide and self harm			
All reported self harm incidents	358	363	275
Suicide of inpatient or within 7 days of discharge	1*	1	0
Assault/verbal abuse			
All reported physical assaults where the instigator was a service user	758	1049	855
All reported physical assaults where the instigator was a service user and where the incident was graded as serious	12	12	12
All reported physical assaults where the instigator was a service user that resulted in injury	19	25	20
All physical assaults on staff by service users, carers, visitors, other staff and the public	526	708	612
Physical assaults on staff by service users, carers, visitors, other staff and the public where the incident was graded as serious	6	10	12
Physical assaults on staff resulting in injury	178	193	167
Slips, trips and falls			
All service user slips, trips or falls	1547	1524	1475
Slips, trips or falls resulting in service user injury	668	536	541
Medication			
All medication incidents	336	367	329

*Anticipated number: awaiting results of Coroners' Inquest for confirmation

Cleanliness and infection control information

The Trust has declared full compliance with the Hygiene Code and Infection Control regulations. It continues to report very low levels of healthcare acquired infections, methicillin-resistant Straphococcus aureus (MRSA) and clostridium difficile (c-diff.)

Table 13: Cleanliness and Infection Control indicators
Data from local Infection Control database - cases as defined by Health Protection Agency guidelines

Indicator	2010/11	2009/10	2008/09
MRSA cases	0	0	1
C-diff cases	1	1	Data not available
Outbreaks resulting in service closure	8	12	Data not available

This year the Trust is also reporting on outbreaks of infections (e.g. a cluster of people with the norovirus) which have resulted in services being closed. We have systems in place to deal with these emergencies, make sure people are safe and undertake rigorous cleaning, but hope to see further reductions in outbreaks in the year ahead.

We have also added information about the risks of infections faced by people using the Drugs and Alcohol Services this year:

Table 13: Infection Control and Substance Misuse. Data from Insight

BBV (Blood Born viruses) activity	2010/11 Target	As at end Q3
New presentations offered BBV vaccination	90%	100%
New presentations who accept an offer commence a BBV vaccination	90%	91%
New presentations (previous or current injectors) have a recorded HEPATITIS C vaccination status	90%	96%
New presentations (current or ever injectors) offered a HEPATITIS C test	90%	100%
Number of HIV screening tests completed since 1st April 2010	Not applicable	524

Information on patients' physical health and wellbeing

As a Trust that provides services for people with learning disabilities, mental health problems or drug and alcohol misuse, we recognise that many of the people using our services face challenges to their physical health and wellbeing too. Our commissioners NHS Sheffield are also keen to see good quality physical healthcare in our services, and have set CQUIN targets in this area. We therefore monitor some key indicators of physical well-being.

We monitor all people who are admitted to inpatient services to make sure their physical health is maintained or improved if necessary. We do this by screening for pressure ulcers, nutritional status and overall physical health. The work on screening for nutritional status is described in more detail earlier in these accounts.

Table 14: Physical health indicators. Data from CQUIN submissions - Insight data

Indicator	NHS Sheffield target	2010/11 Q4 figure	2009/10	2008/09
% of people screened for pressure ulcers (Grade II and above)	100%	100%	Data not collected	Data not collected
Physical health screening of older adults on admission	100%	100%	84%	81%
Nutrition (MUST) screening of older adults on admission	100%	100%	98.6%	Data not collected
Nutrition (MUST) screening of older adults on discharge	95%	97%	Data not collected	Data not collected

In previous Quality Accounts, data on physical health screening was presented from local records audits of a sample of cases: these new reports are derived from records of all older people admitted to inpatient areas and so are more comprehensive. For this reason, we have not presented the results from working age adults this year. Next year we intend to report more widely using the more comprehensive data.

The report on pressure ulcers is new this year. The pressure ulcer screening on the older adult inpatient areas showed that no service users were suffering from pressure ulcers of the Grade II or above level of severity.

A programme of work on pressure ulcers during the year saw a new protocol developed together with information for staff, service users and carers about pressure ulcers. Training for staff and Essence of Care benchmarking took place in older adults areas and the learning disabilities respite care service at Longley Meadows.

Single sex accommodation

The Trust declared compliance with the national standard for Eliminating Mixed Sex Accommodation during 2010/11. It has recently reviewed its Delivering Single Sex Accommodation Plan. In partnership with NHS Sheffield it holds regular visits across services to check continuing compliance and any issues identified as a result are included in the updated action plan.

The action plan is monitored through the new Quality Assurance Committee (formerly through Quality and Risk Group).

2. Effectiveness

The Trust assesses the effectiveness of the care and treatment it provides against both local and national standards. For example, it reviews if it is meeting the guidance from the National Institute for Health and Clinical Excellence (NICE) in the form of technology appraisals, standards and guidelines. Last year all NICE technology appraisals applying to the Trust were implemented within the 3 month target time and work was in progress to deliver all the NICE mental health guidelines.

Early intervention in psychosis
The Trust aims to diagnose and treat people with serious conditions quickly. Early identification and treatment of psychosis is known to improve the long term prognosis for people. The Trust therefore monitors the number of people seen by the Early Intervention Service (EIS). In 2010/11 129 new cases were seen by the EIS (data from Insight). This continues to outstrip the target set by NHS Sheffield

of 90 new cases per year, building on the 285 new cases seen in 2009/10 and 147 in 2008/09.

In 2010/11, the Early Intervention Service received 1 complaint and 13 compliments. One compliment was:

" *Thanks so much for being a brilliant social worker. You're fun to be around and seem to work really hard behind the scenes to make sure the people you're helping (to help themselves) get the best possible service* "

West Early Intervention Service

Adult mental health care and treatment
The Trust monitors some other critical aspects of mental health service delivery and reports on them to the regulator, Monitor:

Table 15: Mental Health Indicators. Data from Insight

Target Indicator	Threshold	2010/11 Q4 figure	2009/10	2008/09
100% CPA patients receiving follow-up contact within 7 days of discharge from hospital	95%	96.4%	97.2%	97%
Minimising delayed transfers of care	No more than 7.5% delayed	6.9%	6.4%	6.9%
Admissions to inpatient services who had access to crisis resolution and home treatment ('gate keeping')	90% of all admissions	97.3%	94.6%	93.1%
New home treatment episodes	1202 people	1361	1365	1249
Everyone on CPA should have an annual review with their care co-ordinator	95% of people on CPA	99.3%	Not measured	Not measured
Everyone on CPA should have a formal review of their care plan	90% of people on CPA	91 - 93%	89%	85%
Access to an assessment within 4 hours of referral when in crisis	80% of people to be assessed within 4 hours by Q3	83.1%	59%	Not measured
Access to support/treatment within 8 weeks of referral (routine referrals)	50% of people to be assessed within 8 weeks by Q3	62.9% (at quarter 3) 67.8% (at quarter 4)	42.2%	Not measured

Improving Access to Psychological Treatment (IAPT)

Improving Access to Psychological Treatment services aim to treat people with mild or moderate mental health problems quickly, using effective talking therapies. These new services were set up in 2008/09). The IAPT team measure the effectiveness and impact of what they do closely; for example, they collect systematic service user outcome measures to monitor the mental health and wellbeing of everyone they see for cognitive behaviour therapy or counselling.

The table below shows the difference they are making to people, who are helped to recover and to return to work from benefits. Last year over 400 people were able to return to work:

Table 16: IAPT indicators. Data from Insight (quarterly returns to Department of Health)

Indicator	NHS Sheffield target	2010/11	2009/10	2008/09
Number of new cases seen by IAPT	5364	9036	6728	1937 (started from Oct 08)
Number (percentage) of people moving to recovery	50%	41%	44%	40%(part year)
Number of people returning to work from benefits	89 people	419	304	17 (part year)

Other services across the Trust are collecting evidence of the effectiveness of their interventions, using clinical outcome measures and measures of impact such as whether people are in work or in settled accommodation.

Access to Equipment

The Trust provides equipment for people with physical disabilities and frail health from the Community Equipment Store. It aims to deliver the necessary equipment within 7 days of assessment in 95% of cases. In 2010/11, it met this target.

Table 17: Access to equipment. Data from local reporting systems

Indicator	NHS Sheffield target	2010/11	2009/10	2008/09
Community equipment to be delivered within 7 days of assessment	95% to be delivered within 7 days	95.7%	97.2%	94.3%

Learning Disability Services

The Assessment and Treatment Unit achieved 100% against all its quality standards for service users in 2010/11.

These were:
- Having a discharge plan with clear advice for families and carers
- Having a care plan centred around individual needs
- Offered referral where appropriate to an independent advocacy service
- Having a plan to address health needs
- Having a communication profile/passport
- Individual risk management plan re restrictions (locked doors)
- Individual plans record what physical interventions are prescribed
- Maximum length of stay (12 months)

The community learning disability teams have introduced routine clinical outcome measures including HONOS-LD (HONOS for people with learning disabilities). The results from these measures will be reported next year. The learning disability teams are also collecting feedback from service users and carers.

> **She listens to me. She took me on holiday and helped me get a ground floor flat. She is happy, kind and we have fun together.**
>
> Compliment from service user with learning disabilities

Dementia Services

Early identification of dementia means treatment and support can start early and is more effective. Dementia services were redesigned in 2008/09 to provide more community based services and earlier diagnosis in Memory Clinics. The table below shows the increase in provision in community services.

Table 18: Dementia indicators. Data from Insight

Indicator	NHS Sheffield target	2010/11	2009/10	2008/09
Discharges from acute care (G1)	78	38	53	12 (new service during year)
Number of assessments for memory problems by Memory Management Service	600	728	636	614
Rapid response and access to home treatment	300	336	288	183 (new service)
Waiting times to access an assessment of memory problems	Not applicable	16	28	20

The dementia services are responding to urgent referrals within 24 hours as described above, but the wait for a memory assessment remains long. It reduced from 28 weeks in 2009/10 to 16 weeks in 2010/11. We will continue work on this issue, with our partners in the city, as part of the Trust quality objective to implement the NICE standard for dementia.

The dementia services receive many more compliments than complaints:

Table 19: Dementia services Complaints and compliments

Number of complaints/ compliments received	2010/11	2009/10	2008/09
Total number of compliments	457	491	431
Number of informal complaints	1	11	6
Number of formal complaints	11	8	9
Total number of complaints	12	19	15

More information on complaints and compliments about all the services is available in the Annual Report on Complaints and Compliments, posted on the Trust website.

An example of a compliment about the dementia services:

> *Many thanks for helping with Mum and all her needs. All staff have had a great attitude and I don't know what I would have done without your service. The care you have shown has been second to none.*
>
> Dementia Rapid Response Team (North)

Drug and Alcohol Services

The Drug and Alcohol Services provided by the Trust measure the effectiveness and impact of their work against a number of quality indicators, which are set by the commissioners in contracts.

Table 20: Drug and Alcohol services - effectiveness and outcome measures. Data from Insight and the National Drug Treatment Monitoring System (NDTMS)

Drugs and Alcohol quality indicator	Target	2010/11	2009/10	Data From
(DRUGS) No client should wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	Insight
(DRUGS) No Drug Intervention Programme client should wait longer than 5 days from referral to medical appointment	100%	100%	100%	Insight
(DRUGS) No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	Insight
(DRUGS) No Prison release client should wait more than 24 hours from referral to medical appointment	100%	100%	100%	Insight
(ALCOHOL Single Entry and Access Point) No client will wait more than 1 week from referral to assessment	100%	100%	New target	Insight
(ALCOHOL TREATMENT SERVICE) No client should wait longer than 3 weeks from Single Entry and Access Point assessment to treatment start	100%	100%	New target	Insight
% Problematic Drug Users clients retained in treatment 12 weeks or more	Local DAAT target - 90%	89%	89%	NDTMS
Start/Initial Treatment Outcome Profile (TOP) completed	100%	96%	Not available	NDTMS
Review TOP completed	100%	59%	Not available	NDTMS
Discharge (Planned) TOP completed	100%	50%	Not available	NDTMS
Drugs and Alcohol quality indicator	**Target**	**10/11**	**09/10**	**Data from**
All clients new to treatment undergo physical health check as part of comprehensive assessment	100%	100%	New target	Insight
Number of service users & carers trained in overdose prevention and harm reduction	240	243	New target	Insight and audit
% of successful completions for the provision of treatment for injecting related wounds and infections	75%	92%	New target	Insight

Key (ratings as determined by Commissioners):
🟥 Target not met
🟧 Target partially/nearly met
🟩 Target fully met

The sampling method used by the Commissioners for the Treatment Outcome Profile (TOP) outcome measure is that initial TOPs were measured for people starting in treatment during July, August and September 2010 (49 people), review TOPs were measured for these people if they remained in treatment for 6 months or more (39 people). Discharge TOPs were taken for people who were discharged drug free during July, August and September 2010 (6 people fell into this group). The target is met (green rating) if 80% are completed and not met if the percentage is 59% or less.

The service is committed to using the TOP outcome measure with all its service users. Between 750 and 850 service users are in treatment at any one time, and TOPs are reviewed in a clinically appropriate way for over 80% of them.

The services monitor the effectiveness of the treatment they provide closely with individual service users, sharing this information with service users in a way that helps them see progress and understand their problems. The illustration below gives an anonymous example of the kind of data that is shared with service users in care and treatment; it shows how psychological health

has deteriorated with increased consumption of alcohol, even though the use of illegal substances has reduced. This kind of information can provide invaluable insights for both service users and staff.

Example of Service User Outcome reports used to aid care and treatment by Drug and Alcohol Services
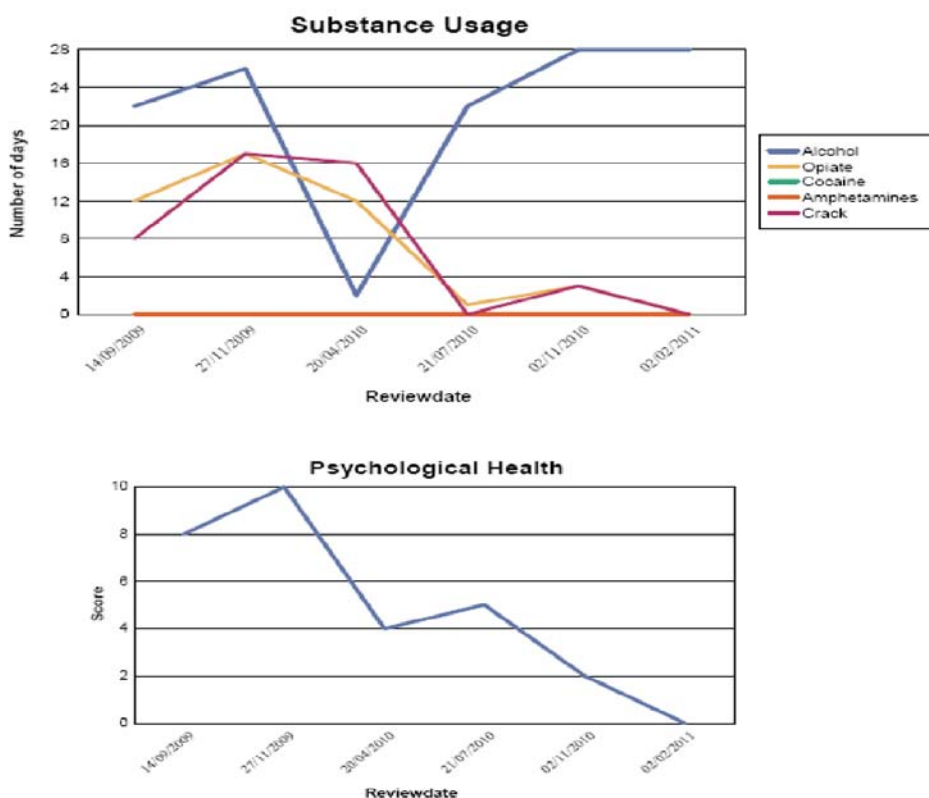
3. Service User and Carer Experience

The Trust collects service user and carer feedback about the quality of care and their experiences in many different ways. Among the most useful is the collection and analysis of the information from complaints and compliments:

Table 21: Complaints and compliments across the Trust. Data from Ulysses Safeguard

Indicator	2010/11	2009/10	2008/09
Number of formal complaints	86	79	68
Number of informal complaints	286	226	303
Number of compliments	1559	1440	1273

Compliments outnumbered complaints in 2010/11 by a proportion of 23 to one.

A full picture of the complaints and compliments received by the Trust is available on the Trust website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (people making complaints) about the experience of complaining.

Issues raised in complaints are reviewed:

Table 22: Issues raised/categories of complaints across the Trust. Data from Ulysses Safeguard

Category of Complaints	2010/11		2009/10		2008/09	
	Formal	Informal	Formal	Informal	Formal	Informal
Admission, transfer or discharge	11	7	9	12	4	14
All aspects of clinical care	34	52	35	44	32	62
Appointment delay or cancellation	3	10	6	10	0	8
Attitude of staff	16	57	19	39	19	61
Communication/ information to patients	2	12	3	4	0	16
Complaints Handling	1	0	0	0	0	0
Discrimination Age, Gender, Race	0	3	0	0	0	2
Failure to follow agreed policies	0	3	2	1	3	2
Hotel services including food	0	25	0	14	0	29
Other	2	12	1	25	1	16
PCT Commissioning	0	0	0	1	0	0
Policy & Commercial Decisions	4	15	0	12	1	13
Privacy and dignity	9	36	2	18	4	20
Patients' property and expenses	2	14	2	13	4	12
Personal records	0	6	0	0	0	0
Premises, aids and equipment	2	33	0	29	0	47
Transport	0	1	0	4	0	1

All complaints are investigated and, if they are upheld or partially upheld, actions plan will be put in place to address the problems.

During 2010/11, other sources of feedback included posts on the Patient Opinion website (a total of 5 posts were made about the Trust during the year) and on the Trust's own website (184 website enquiries were made and responded to during the year).

An idea of how the Trust is performing in comparison with other mental health trusts nationally can be obtained from the Care Quality Commission (CQC) Annual Patient Survey. In 2010 the Survey received responses from 303 service users (36% of all those surveyed.) The full results are available on the CQC website on www.cqc.org.uk

The Trust fell within the average range for the replies to the question 'Overall, how would you rate the care that you have received from Mental Health Services in the last 12 months?'

The table below shows results for CQC patient surveys over the last 3 years: it should be noted that the 2009 survey was of inpatients rather than community patients and so different questions were asked. This has made year on year comparisons more difficult. More detail on the 2009 results in available in last Year's Quality Accounts or on the CQC website.

Table 23: Care Quality Commission Patient Survey feedback. Data from CQC

Topic	Summary of question asked	Results 2010 Survey (Community)	Results 2009 Survey (Inpatients)	Results 2008 Survey (Community)
Health and social care workers	Listen to you	Amber	Amber Psychiatrist	Red Psychiatrist
			Green Nurse	Amber Nurse
	Treat you with respect	Amber	Amber Psychiatrist	Amber Psychiatrist
			Green Nurse	Amber Nurse
Medications	Your views taken into account	Green	Amber Involvement in decisions about care and treatment	Green
	Given information	Green	Green Explain purpose Side effects	Amber Explain purpose Side effects
Talking therapies	Meet your needs	Amber	Amber	Green
	Find helpful	Green	Too few numbers replied	Amber
Care Coordinator	Do you know who it is	Amber	Not asked	Amber
Care Plan	Given a copy	Amber	Not asked	Amber
	Views taken into account	Green	Not asked	Green
Care Plan Review	Find helpful	Green Highest score nationally	Not asked	Amber
Day to Day Living	Help with work	Amber	Not asked	Amber
	Help with accommodation	Amber	Not asked	Not asked
Crisis Care	Number to call out of hours	Red	Red	Red

Key
- ■ Top 20% of Trusts
- ■ Middle range
- ■ Bottom 20% of Trusts

Plans to improve the current arrangements to ensure service users can access support via a phone line out of hours have not progressed as intended. During 20010/11 the Trust had intended to strengthen access to telephone support for existing service users. Plans were outlined to provide improved out of hours support for adults with mental health problems in crisis through the Acute Care re-configuration developments. Good progress has been made in responding to the needs of people in crisis (as reported elsewhere). However, the Trust has not been able to make the hoped for progress on improving access to telephone support 24 hours per day. It continues to be a priority for the Trust's governors to make sure this issue is resolved, and a paper is going to Board on it in summer 2011. During 2011/12 the Trust will finalise its new service model for Acute Care services, and will ensure this need is effectively provided for.

Service user feedback at team level
Teams in the Trust are also collecting feedback from service users and using it to improve the quality of care, as described in the report on the quality objectives for 2010/11. There are 61 teams, wards or services in the Trust that provide health and social care for service users and carers.

Here are just a few examples of the kind of results that have come from this work:

![Sheffield City Council logo] **Sheffield Health and Social Care** NHS
NHS Foundation Trust

Eating Disorders – Service User Questionnaire

Background

The aim of this survey was to ensure that patients were satisfied with their care from the Eating Disorders service in 2010 following discharge.

Results	% Yes
1. Were you satisfied with the waiting time?	100%
2. Were decisions about your care clearly communicated?	89%
3. Were you given useful information that helped you understand your difficulties?	78%
4. Was the service sensitive to the patients culture and background?	78%
5. Did the treatment you received help you deal with your difficulties?	78%
6. Did the treatment you received meet your need?	78%
7. Were you satisfied with the plans that were made following discharge?	67%
8. Overall, were you satisfied with the service?	78%

"Friendly and relaxed. Able to talk easily and openly, didn't feel judged or pressured"

"Learned to accept my difficulties and not be in denial"

"Referred me to in-patient care which was needed"

Conclusions / Next steps

Service users expressed overall satisfaction with their care from the Eating Disorders service. The only recommendation was to perhaps have more flexibility with appointments. The service is considering administering this regularly throughout treatment to obtain more feedback.

Sheffield Health & Social Care NHS
Foundation Trust

Sheffield Health and Social Care NHS

NHS Foundation Trust

Hawthorn & Daleside
Inpatient Exit Questionnaire

Aim

The aim of this project was to ask patients that stayed on Hawthorn and Daleside whether they were satisfied with their stay on the above wards in 2010.

Results	Daleside % yes	Hawthorn % yes
Was your privacy and dignity respected?	100%	100%
How safe did you feel in your surroundings?	100%	100%
Did you receive enough information about the ward?	100%	100%
Did you meet with your named nurse to discuss your care?	83%	100%
Were you offered a copy of your care plan?	50%	66%
Did you see your doctor regularly?	66%	100%
Did you get the necessary information about your medication?	100%	83%
Were you able to participate in activities on the ward?	100%	100%
Were you offered occupational therapy regularly?	100%	100%
Did you know about arrangements for your follow up care?	100%	100%
Did you have confidence in the staff that worked with you?	100%	100%

Conclusions

Patients were "on the whole" satisfied with their care on Hawthorn and Daleside. It appeared that more patients need copies of their care plans.

"The staff were kind, they were always willing to help and put me at ease. They were very patient even when things got difficult"

Sheffield Health & Social Care NHS Foundation Trust

LIMBRICK SATISFACTION SURVEY RESULTS 2010 – KEY FINDINGS
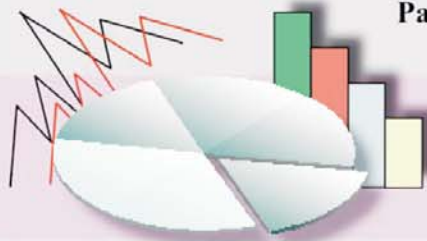
Patients Experience in Clinic, with Dr Mullins and with the Limbrick Staff

Demographics

Average Age	Female	Male	White British	Black/ Black British Caribbean	Black/ Black British African	Other
43	9	14	19	1	1	2

Background and Methodology

- Survey carried out to rate service users experience of outpatient appts at the Limbrick centre
- 23 service users gave feedback out of a possible 25 respondents.
- Responses scored on 1 to 5 scale (0 = worst, 5 = best) and service users comments
- Feedback carried out by volunteer service user at Limbrick Centre

Satisfaction with the Limbrick Centre building and appointment system

KEY AREA: THE LIMBRICK CENTRE EXPERIENCE

- 'Friendly and welcoming staff. Very understanding, talkative, competent and give opinions'
- 'Calm environment. Comforting and reassuring'
- 'Friendly/professional place'

Satisfaction with reception staff at Limbrick

KEY AREA: THE LIMBRICK STAFF

- 'Very friendly, reassuring, efficient and trust them. Everyone is nice'
- 'Discreet, polite, professional, informative and accommodating'
- 'Cheery and welcoming'

KEY AREA: DR MULLINS

- 'Nicest Dr I have seen. Give him 10 out of 10'
- 'Compassionate, very good listener. Reassuring, sympathetic and forthright'
- 'Brings himself down to my level. Talks in normal terms not medical terminology'
- 'Helpful, understanding. Good at his job'
- 'Puts my families mind at ease'

OVERALL PERCEPTIONS:

- 'Limbrick Centre very warm and welcoming. Staff friendly and compassionate'
- 'Sympathetic, intelligent and compassionate psychiatrist. Easy to talk to and puts mind at rest'
- 'Staff cheery and welcoming'

4. Equality and inclusion

The Trust wants to make sure that it is treating its service users fairly and without discrimination and that it is responsive to the diverse needs of individuals and communities. It meets all its Equality duties and has a Single Equality Scheme and related action plan.

It has been carrying out a number of projects to improve the experience of people from Black and minority ethnic groups. This was a Trust quality objective for 2010/11 and the results are reported in detail above.

It has been working with other partners in the city to try to support people with mental health problems, drug or alcohol problems or learning disabilities into employment, training, volunteering. It has set a good example by becoming a Mindful Employer and supporting the employment of people with mental health problems within its services. In May 2010 it led a city-wide launch of the Mindful Employer Scheme and encouraged all local NHS providers, NHS Sheffield and the City Council to sign up to the scheme.

Table 24: Inclusion indicators for people with severe mental health problems.
Data from Insight and audit - Quarter 4 figures for the 2 years.

Indicator	Local Area Agreement target (where applicable)	2010/11	2009/10
People with severe mental health problems in employment (on Care Programme Approach) - number of people		102 people	98 people
People with severe mental health problems in employment (on Care Programme Approach) - % of people on CPA	8.02% of people on CPA in employment by Q4	6.3%	6.9%
% of Carers of people on CPA offered a carer's assessment		83.9%	85.6%
People accessing direct payments to purchase their own social care packages		115 people receiving direct payments by quarter 4	Not measured

The figures for people supported by IAPT who have returned to work off benefits have been described above.

Although the figures for people on CPA in employment are below the target set by the Local Area Agreement, there has been a small rise in the numbers of people in work despite the economic challenges. The Trust has a focus on supporting people into work and volunteering, for example:
- Buster's café opened at the Grenoside site, staffed by services users and providing fair-trade teas and coffees;

- 'The Works', an interactive tool designed by service users with support from staff in the User Support and Employment team helps service users find ways into employment;
- the launch of a DVD 'It could work for you' this year, supporting service users into volunteering.

5. Staff views and experience of quality

The Trust believes that having sufficient, well trained and experienced staff is critical to providing the best quality care. Staff also have an important role in improving quality and in making sure that services are safe and the quality of care is good. Every year, the Care Quality Commission (CQC) commissions a review of staff in the NHS, including staff in SHSC.

During 2010/11, the CQC staff survey results showed that 68% of SHSC staff would recommend the Trust as a place to work, in comparison with 54% of NHS staff nationally. 63% of SHSC staff said that if a relative needed treatment they would be happy with the standard of care the Trust provides, compared with 59% of staff nationally. 81% of staff said they felt satisfied with the quality of work and patient care they were able to deliver, falling within the top 20% of mental health trusts nationally.

The Trust results fell within the top 20% nationally for the percentage of staff receiving job-relevant training, learning or development in the last 12 months.   The numbers of staff reporting that they had received appraisals and personal development plans had risen significantly since the previous year from 48% to 66%, although the Trust remained in the lowest 20% nationally on this item. All teams have been asked to report on staff appraisals in their team governance reports.

6. Regulators' views

The Trust is regulated by the Care Quality Commission, which focuses on quality and service user experience, and Monitor, which focuses on finance and governance. It is also assessed by the NHS Litigation Authority (NHSLA) for risk management standards and the Patient Environment Assessment Team (PEAT).

A summary of the Trust's compliance with these regulators is presented to the Board each month as part of a regulation dashboard

Table 24: Compliance with regulation
Data from Trust regulation dashboard, derived from regulator reports

Regulator		Status				Date last reviewed
Care Quality Commission	Healthcare locations	Fully registered - no conditions				Planned review winter 2010/11
	Social care locations	Fully registered - no conditions				
	Primary care locations from 1.4.11	Registration application in process - continued registration through NHS Sheffield until registration approved				
Monitor	Governance	Amber/green and Amber/red during year				March 2011
	Finance	4				March 2011
NHS Litigation Authority	Risk management standards	Level 1				March 2011
Patient Environment Access Team (PEAT) Good or above in 1) Cleanliness & environment 2) Food 3) Privacy and dignity		1.	2.	3.		
	Michael Carlisle	Good	Good	Excellent		March 2010
	Longley	Good	Good	Excellent		March 2010
	Forest Lodge	Good	Good	Excellent		March 2010
	Forest Close	Good	Self Catering	Excellent		March 2010
	Grenoside	Good	Good	Excellent		March 2010

3B Development of the Quality Accounts

These are the third set of Quality Accounts produced by the Trust, and it has tried to make improvements to the development process each year. Last year's accounts were commended by both the Audit Commission and the Yorkshire and Humber Quality Observatory review for their balanced view and for their involvement and engagement with service users, carers and governors.

The Trust's governors asked to be involved at an earlier stage this year and for the quality accounts to be developed in tandem with the Annual Plan. This was done in a series of meetings during the year.

The Governors were particularly interested in shaping the choice of quality objectives for the year ahead. The Sheffield Local Involvement Network (LINk) and the City Council Health and Wellbeing Scrutiny Committee were also consulted during the winter of 2010/11.

A long list of potential quality objectives was developed from the following:

- the 2010/11 quality objectives were all included, as work was progressing on all of them, and the staff involved were keen to see further progress made;
- the information the Trust holds about the quality of its services and feedback from service users and carers was reviewed and areas where improvements were needed were found;
- senior leadership teams in the service directorates, and professional heads, were asked for their views about the priorities for improvement.

The long list was presented to the Board and the Board of Governors as part of the annual planning process. A new item - support for carers - was added at this point and the long list was cut down to 8 possible objectives. A further round of consultation with senior staff, the local LINk, the local Scrutiny Committee and Board resulted in the final 4 quality objectives for 2011/12.

The LINk suggested some areas they would wish to see reported in the accounts, including Central Alert System (CAS) alerts and feedback from the Care Quality Commission. Ideas for good indicators to use were sought from colleagues in the Trust in clinical as well as corporate roles and the author attended some directorate senior management teams to discuss ideas. All clinical directorates have been approached to contribute to the construction of the accounts.

National reviews and reports on Quality Accounts from Monitor, the Audit Commission and the King's Fund were reviewed as well as the Audit Commission assurance report on last year's Sheffield Health and Social Care NHS Foundation Trust quality accounts. Other trust's quality accounts have been considered. This has led to the addition of more data, especially on service user and carer experience. More service specific information has been included.

3C Statements from Partners and Stakeholders

A draft version of the Quality Account (or Quality Report) was circulated to key partners and stakeholders in the city for their comments. All have responded and their comments are presented below, together with a response from the Trust.

1. Sheffield LINk

These comments refer to the Draft Quality Account 2010/11 Version 5 dated 6.4.11. The work you have undertaken to collect the views of your service users and carers is admirable; your use of volunteers rather than staff is an example of good practice that should be shared with the other Trusts in Sheffield and elsewhere. Extracts from the surveys would have been a helpful aid as part of the report especially as they were shared at an event in March.

The productive programme is another area of good practice that deserves more local and national recognition as this fits better with patients being the focus rather than the administrative tasks.

Sheffield LINk agrees that the 4 priorities chosen are areas needing quality assurance. However the document could usefully refer to how this will be bench marked by this Trust compared to similar ones regionally and nationally. For example for access to the memory assessment services we are told there will be a 25% increase but not what the current figures are therefore how will we know that there has been the aimed for increase? Data reporting on the previous QA is not presented as performance over time and therefore it is difficult to be able to make comparison and evaluation of year on year performance.

Within the report page 11 there is mention of reporting to a new board Quality Assurance Committee, LINk suggests that these progress reports are made publically available on the Trust's web site as part of the "ongoing dialogue" that should take place throughout the year as part of the QA process.

In respect of last years priorities 1 the statement is To achieve a target of 4 hours from referrals for service users in adult and older adult mental health care including dementia services, the table of results does not cover those in the title of the priority only that for working age adults. The obvious areas missing in this QA are the need for both positive and negative aspects of performance to be identified. The first paragraph on page 13 is not a positive result against the 4 hour response but this is not made clear and we need to know what is going to be done about this.

Staff feedback, the views of staff are an important marker of an organisation's managerial competence, workforce well-being and hence its ability to deliver high-quality care. Staff views should be shown in the quality accounts. The annual national surveys of NHS staff provide a readily available source of data on the views of NHS staff. Your only mention of staff is in respect of one area of training.

The report is in the main a dialogue, this dialogue is clear and understandable to the public however LINk would recommend the use of visual aids to show readily where results are good, bad and indifferent. Emoticons could be used as a simple way of indicating this.

LINk commends the Trust in their inclusion of Patient Safety Alert data (page 33) which we requested were included in the report.

We are pleased to note that you will produce an easy read version of the QA report.

We are also pleased that one of the priorities for the year 2010/2011 is one we recommended last year "The quality of care for people with dementia".

Finally we state that Sheffield LINk accepts this QA as an honest account of the services provided by this Trust.

Mike Smith

Mike Smith
Chair, Sheffield LINk
6th May 2011

Response from Sheffield Health and Social Care NHS Foundation Trust:

We would like to thank Sheffield LINk for their engagement in the development of the accounts and for their comments on the draft Quality Accounts. We are glad that they have noted our efforts to engage service users and carers in the development of the accounts, and that they recognise the accounts are an honest view of the services provided by the Trust.

We accept the comments about the need to improve the use of benchmarking data and to report more on trends over time, where this data is available. We take on board the comments about visual and graphic indicators to show where results are good, bad or indifferent. We will be working to make improvements in these areas over the year ahead and will hope to share this with the LINk in routine reporting.

In the final version of the accounts, we have added more in the commentary about the challenges of a 4 hour waiting time for a urgent dementia referrals. We have also added more on staff views on quality and made more use of the CQC staff survey in this respect.

2. Sheffield Health and Community Care Scrutiny Committee, Sheffield City Council

The draft Quality Accounts were presented to the Committee on 18 April 2011 and the following commentary was received as a result:

Response to the Sheffield Health and Social Care NHS Foundation Trust Quality Account April 2011

This year we engaged with the Trust early on in the Quality Account process, enabling us to contribute to the consultation on which quality objectives should be included in the Quality Account.

We are pleased that our views were taken on board, and feel that the chosen objectives are appropriate and reflect what is important to Sheffield people. We are particularly pleased to see the inclusion of dementia care. The needs of people suffering from dementia and their carers have been a key focus of

the Committee this year and we are pleased to see a commitment to improve care and reduce assessment waiting times.

We are pleased to see that the Quality Account presents a balanced picture of performance within the Trust, and includes staff and service user feedback, which we found particularly useful. We feel that the Quality Account contains some good examples of innovative working that has been effective in improving the quality of care provided to patients - particularly around service user feedback and the Productive Programme. We'd like to see the learning from these programmes shared with other Trusts in the City and beyond as an example of best practice.

We look forward to monitoring progress on the quality objectives over the course of the year.

Response from Sheffield Health and Social Care NHS Foundation Trust

We welcomed the involvement of the Committee in the development of the accounts this year and we would like to thank them for their positive comments.

We will be very pleased to share the progress on the quality objectives over the year ahead.

3. NHS Sheffield

STATEMENT FROM NHS SHEFFIELD

Received from Tim Furness, Deputy Director of Strategy on 12 May 2011

We have reviewed the information provided by Sheffield Health and Social Care NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and gives a fair picture of the Trust's performance.

Our view is that the Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities. The Trust achieves good results against national standards and the quality accounts demonstrate improvements against its objectives for last year. In addition it has met most of the quality objectives set in our contract for 2010/11, reducing waiting times for access to care, reducing the length of stay on wards and reducing, through joint action with NHS Sheffield, the numbers of people who need to be placed in services outside Sheffield.

However, the Trust needs to improve the timeliness of its investigation and reporting of serious untoward incidents and we would have expected this account to describe current performance and the plans in place to improve it. We would also have expected the account to set out plans to respond to those areas of the staff survey where the Trust does not perform as well as most mental health and learning disability providers.

Sheffield Health and Social Care NHS FT provides a wide range of services, and it is right that all of these services should aspire to make year-on-year improvements in the standards of care they can achieve. We support the specific priorities identified for the Trust in 2011/12, and welcome the ongoing priority given to the experience of users from BME groups, but would note that there is also a continued need for focus on a number of areas from the 2010/11 plan:

- Waiting times for a response to crises, including response to patients presenting in A&E
- Waiting times for non-urgent referrals
- Satisfaction of all service users
- Reducing and if possible eliminating inpatient placements outside Sheffield

In addition, and in support of the focus on nutritional support, we would like to see more consideration of the ways in which a mental health provider can support improvement in the physical health of all its patients, including support to stop smoking and promotion of healthy lifestyles.

Response from Sheffield Health and Social Care NHS Foundation Trust

We would like to thank NHS Sheffield for their comments and for their overview that 'the Trust provides, overall, high-quality care for patients, with dedicated, well-trained, specialist staff and good facilities.'

We have made some changes and additions as a result of the NHS Sheffield feedback:

We have added more in the final version of the Quality Accounts on the timeliness and quality of our serious incidents reporting, in the context of the work we have described on improving our serious incidents systems and processes. We have also added more reference to the staff survey and in particular those areas where we performed less well in comparison with other trusts, and what we are doing to address these areas (e.g. the numbers of staff reporting that they have received training in equality and diversity in the last 12 months).

We have made more reference in the final version of the accounts to the continuing work on the areas covered by the 2009/10 quality objectives and the physical health agenda.

We note that the other areas of quality proposed for inclusion by NHS Sheffield are already covered in the CQUIN and routine quality reporting to NHS Sheffield. Detailed information on the CQUIN indicators is available on the Trust website, as referenced in the accounts. NHS Sheffield priorities for quality improvement and those of our other commissioners were taken into consideration in the development of the quality accounts, alongside the views of other key stakeholders. However, we have chosen not to add all of them to the main text of the final version of the accounts at this point.

4. Trust Governors

The Quality Accounts and in particular the choice of quality objectives were presented to governors at a meeting in April 2011, together with the Trust's Annual Plan objectives for the year ahead. Governors were supportive of the choice of objectives and asked for more detail on the physical health policy and staff training. The Governors asked about the Patient Survey results and the issue of the lack of a 24 hour phone line.

Subsequently Governors were invited to respond via email with more detail on their views of the Quality Accounts. Two emails were received, both wanting to see more progress on the delivery of a 24 hour phone line.

"*'My particular concern, and has been for some time, is the provision of an out of hours contact telephone number. We are one of very few trusts who don't have such a facility and service users want this to be a priority...*

...As a service user governor I continue to push for progress on this on behalf of our service users. Please listen to your service users and ensure that this is given the priority it deserves.

I look forward to hearing regular updates on this subject.'"

Extract from email from service user governor

Response from Sheffield Health and Social Care NHS Foundation Trust

We would like to thank the Governors and Members for their contribution over the year to the development of the Quality Accounts, as well as their feedback on the final version.

More detail has been added to the commentary in the Quality Accounts about the 24 hour phone line issue raised by the CQC Patient Survey results. Reports of progress on the issue during the year will be presented to Governors, alongside the regular feedback on progress on the quality objectives.

3D Annex: Statement of Directors' Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health and Monitor have issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts present a balanced picture of the Trust's performance over the period covered:

- the performance information reported in the Quality Account is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review: and the Quality Account has been prepared in accordance with Department of Health guidance and Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Accounts (available at www.monitor-nhsft.gov.uk/ annualreportingmanual).

- the content of the Quality Account is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the Commissioners dated 12 May 2011
  - Feedback from the Governors dated 7 April 2011
  - Feedback from the LINk dated 6 May 11
  - The Trust's quarterly complaints reports and previous Annual Complaints Reports, noting that the Annual Complaints Report for 2010/11 (to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009) was not available at the time of Quality Account preparation
  - The latest CQC national patient survey dated 14 September 2010
  - The latest CQC national staff survey dated 22 March 2011
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 3.6.11
  - Care Quality Commission quality and risk profiles dated September 2010, October 2010, November 2010, December 2010, February 2011, March 2011, April 2011
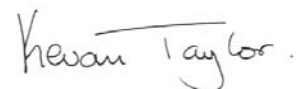
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chairman
Date: 3rd June 2011

Chief Executive
Date: 3rd June 2011

Independent Assurance Report to the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Sheffield Health and Social Care NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

Scope and subject matter
I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

Respective responsibilities of the Directors and auditor
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011
- Papers relating to Quality reported to the Board over the period April 2010 to May 2011
- Feedback from the Commissioners dated 12 May 2011
- Feedback from Governors dated 7 April 2011

- Feedback from LINKS dated 6 May 2011
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, was not available at the time of Quality Account preparation. We reviewed information on complaints from the Trust's Ulysses Safeguard risk management system
- The national Survey of people who use community mental health services 2010 and Mental health acute inpatient service users survey 2009
- The 2010 National NHS staff survey
- The Head of Internal Audit's annual opinion over the trust's control environment dated 3 June 2011;
- Care Quality Commission quality and risk profiles dated September 2010, October 2010, November 2010, December 2010, February 2011, March 2011, April 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sheffield Health and Social Care NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Health and Social Care NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

• Making enquiries of management;
• Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
• Reading the documents listed previously.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

6 June 2011

12 Statement of Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Sheffield Health and Social Care NHS Foundation Trust.

The NHS 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 NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS 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; and

- prepare the financial statements on a going concern basis

The accounting officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is 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

Kevan Taylor
Chief Executive
Date: 3rd June 2011

13 Statement on Internal Control

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 communities. As the Accounting Officer I work closely with NHS Sheffield, which is the main commissioner of our mental health, substance misuse 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 the Joint Performance Group, and quarterly via a Partnership Board. Part of the agreement includes an accountability framework. We also have a Non-Executive Director on our board of Directors who is also elected member of the Council. Positive relationships with the 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 ongoing 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, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2011 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 Integrated Governance Team (including risk management and clinical governance functions) within the Service Development Directorate. The Directorate is led by the Executive Director of Nursing and Quality/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 revised and ratified in March 2011. Responsibilities include:

- All directors are operationally responsible for safety and the effective management of risk within their areas of responsibility;

- 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 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.

Staff Training and Development

Staff training and development needs with regard to risk management and safety are described in the Trust's Mandatory Training Policy and are contained within the appended Training Needs Analysis. This policy was revised and approved by the Executive Director's Group (in accordance with the Policy on Policies) in January 2011.

Development for the Board and senior managers in 2010-11 has included various workshops 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 Welcome - An introduction to the organisation;
- Core Training - An intense 3/4 day training package for all new starters, which includes risk management, health and safety, equality and human rights, infection control etc. Training is tailored, dependent upon their job role;
- Incident Reporting and Investigation;
- Mental Health Act;
- Mental Capacity Act;
- Health, Safety and Security, including Fire Safety;
- Equality & Human Rights;
- Managing Violence and Aggression;
- First Aid and Resuscitation;
- Root Cause Analysis;
- Clinical Risk Assessment and Management;
- Medicines Management;
- Safeguarding Children and Vulnerable Adults;
- Infection Control;
- Care Programme Approach.

The 6 service directorates and the professional groups also provided a range of regular training up-dates for their staff during the year.

National Institute for Health and Clinical Excellence (NICE) guidance and evidence-based practice continue to be incorporated into clinical practice.
NICE guideline implementation groups are established for all mental health guidelines, progress is reported into quarterly joint Operational Management Group/ NICE Implementation Group meetings and monitored by the Medical Director. All NICE Technical Appraisals have been implemented within timescales.

The Trust employs a range of suitably qualified and experienced persons who are accessible to all staff to advise on risk issues, eg 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 reports
- staff and patient surveys and the dissemination of results
- reports of compliments received and the learning from complaints and incidents
- Improving Quality events
- Quality Check meetings
- team and directorate governance reports and events
- Acute Care Forum
- Community Care Forum
- sharing good practice events
- making contributions at conferences
- Safety subgroup
- risk register leads meetings

One of the key learning points from incidents reported in the period has been around strengthening the recording of service user information on the Trust's electronic patient record system, together with improving areas where incomplete documentation has been reported. Both of which could assist onward care planning processes.

Learning is also shared through newsletters, for example Quality Sheet, Litigation News and Sheffield Health and Social Care NHS 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.

The Trust's annual Quality Accounts provides a balanced view of the Trust's performance on quality issues.

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, considered and managed effectively as part of improvements.

The Trust's Safety and Risk Strategy, which was revised and ratified by in March 2011, is shared with new staff at induction, handed out at training courses and is available on the Trust's intranet and internet, together with other policies and procedures to inform practice. The Trust also has a Risk Management Policy Manual (revised and ratified in March 2011) 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 Registers,
  - Incident and Serious Incident Reporting,
  - Learning from incidents and complaints;
- 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;
- Integrated governance structure.

Other policies related to the effective assessment and management of risk are available to all staff via the Trust intranet and internet and are 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 agencies and team governance in all clinical teams. The Trust reviewed its committee and governance structure in 2009 and again during 2011. 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, which is linked to the broader Trust (Corporate) Risk Register. All moderate or high risks are entered onto the Trust Risk Register, together with all risks that are categorised as cross-Trust risks, e.g. information risks. This is a single electronic database with sub sections for each directorate. Within directorates, individual teams or departments also have their own sub-sections.

Directorate Risk Registers are reviewed as part of the service review process to ensure that they are 'live' and being managed effectively and efficiently. Each directorate has a risk register lead that is responsible for reviewing and maintaining 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 moderate or high 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 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 feedback 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 National Confidential Enquiries Policy.

Information Governance and Data Security

The Trust has an Information Governance Policy which provides a framework that incorporates a range of policies relating to the creation, use, safe handling and storage of all records and information. Policies included within this framework are Information Security Policy, Remote Working and Mobile Devices Policy, E-mail Policy, Internet Acceptable Use Policy, Information Quality Assurance Policy Records Management Policy, Confidentiality Code of Conduct (including Safe Haven Procedures), Starter and Leavers

Procedures, Subject Access Procedures and Incident Reporting Procedures. The management and monitoring of information risks is the responsibility of the Trust's Senior Information Risk Owner (the Director of Finance) 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 (up to 31 March 2011). The Information Governance Steering Group has a number of sub-groups including Confidentiality and Consent Group.

The Trust continues to adhere to the Information Governance Toolkit. The Trust submitted the Information Governance Toolkit in March 2011 and has not met the required level on all key items. Its score of 59% is graded as not-satisfactory. An action plan is being developed to improve this 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 training is included as part of the core training for new starters and other training sessions have been provided for managers. Information Governance is also covered in the Trust's local induction checklist for all new staff. Reminders are sent out to all staff via 'pop-up' messages with regards to access to information.

There were no linked serious incidents of severity 3-5 reported in the Trust between 1 April 2010 and 31st March 2011.

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

Incident Number	Incident Date	Incident Type	Details Of Incident	Outcome Type	Guide
76525	4/5/2010	Patient Confidentiality	Email containing assessment information sent to recipients in error.	Closed	1
78825	24/9/2010	Organisation Confidentiality	List containing door codes found on floor	Closed	0

Board Assurance Framework

The Board has an approved Board Assurance Framework for the period 1st April 2010 to 31st March 2011, which was last approved by the Board in February 2011. The Assurance Framework is based on the Trust's strategic aims, as described in the Annual Business Plan, and the corporate objectives derived from these strategic aims. The Board Assurance Framework was further developed this year using an improved, more simplified layout. Key high level and corporate risks identified through risk registers were incorporated during the development of the Framework.

Implementation of the actions in the Board Assurance Framework is monitored monthly through the Executive Directors' Group. The Framework is updated and reviewed quarterly by the Executive Directors Group and the Audit and Assurance Committee.

As at 1st April 2011, there were 2 high level risks with outstanding actions to address gaps in their controls and assurances in the Assurance Framework. Both of these risks relate to Transforming Community Services and the impact that this may have on our efficiency requirements over the coming year(s). 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 2011-2012 Board Assurance Framework and will be entered onto the Trust Risk Register.

Internal Audit has undertaken a review during 2010/11 of the organisation's Assurance Framework and related assurance processes to ensure that they are embedded and effective and thus provide evidence to support the Statement of Internal Control. This review has concluded that the Trust's Assurance Framework is consistent with Department of Health guidance, is fit for purpose and acts as a key evidence source for the Trust in its preparation of the annual 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). Governors played a large role in the development of the Trust's Quality Accounts and LINk members also consulted.

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 receives 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 Care Quality Commission's Essential Standards of Quality and Safety in January 2011 and has been and continues to be fully registered with the Care Quality Commission for all its healthcare activities from 1st April 2011 and from 1st October 2011 for all its social care activities.

The Care Quality Commission (CQC) carried out a Planned Review of SHSC's 11 healthcare locations in January 2011. The Trust was found to be fully compliant across all Essential Standards of Quality and Safety at 8 locations. Fulwood House received a recommendation in relation to outcome 14 (supporting staff). Grenoside Grange received 1 Compliance Action for moderate concerns in relation to outcome 13 (staffing). The Longley Centre and Michael Carlisle Centre received 1 Compliance Action for moderate concerns in relation to outcome 4 (care and welfare of people who use services) and 2 Compliance Actions for minor concerns in relation to outcomes 2 (consent to care and treatment) and outcome 21 (records). Additionally, the Longley centre received Compliance Actions for minor concerns in relation to outcome 8 (cleanliness and infection control) and 10 (safety and suitability of premises) and 1 Improvement Notice in relation to outcome 13 (staffing).

Action plans are in place following this Planned Review and progress is monitored through the Trust's governance committee structure to the Board of Directors. It is anticipated that the Care Quality Commission will revisit the Longley Centre, Michael Carlisle Centre and Grenoside Grange during 2011 to gain assurance that all necessary actions to achieve and maintain compliance with the Essential Standards of Quality and Safety have been completed. I am confident that once all plans have been fully implemented, we will be compliant with all the Care Quality Commission's Essential Standards of Quality and Safety.

The Trust has been assessed against the NHS Litigation Authority's (NHSLA) Risk Management Standards for Mental Health and Learning Disability 2010/11 and has achieved level 1 in March 2011. The Trust is aiming to be assessed at level 2 in 2013 and work is underway to achieve this.

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 all employer obligations contained within the Scheme regulations are complied with. 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 timescales detailed in the Regulations.

Equality, Diversity and Human Rights
Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has a lead manager responsible for maintaining and reviewing compliance and good practice. Assurance and performance in terms of equality and human rights is reviewed through the Trust's Human Resources and Workforce and Quality and Risk governance groups, these groups have considered the following areas in terms of assurance.

The Equality Act 2010 led to changes in the statutory requirements that the Trust is obliged to meet and the Trust has taken these changes into account in reviewing its existing systems and processes including processes for 'Equality Impact Analysis' across the range of the organisation's policy development and review systems. Those aspects of the Act which came in to force in 2010 have been reviewed and responded to. The Trust continues to review and respond to ongoing changes in statutory requirements as they are enacted.

The Trust met statutory requirements in 2010 including publication of an annual report and relevant data on the organisation's website. The Trust has reviewed and taken account of statutory and non-statutory guidance issued by the Equality and Human Rights Commission and related guidance from other bodies. The Trust also maintains compliance through attention to relevant aspects of contract compliance. The Trust has been considering and taking forward action relevant to the development of the NHS Equality Delivery System and in particular to a transition plan from its Single Equality Scheme to setting equality objectives from 2012.

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 this 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 following the review of the implications of the Francis Report are the Board of Directors have approved the suggested amendments. This new structure is being established from 1st April 2011 and includes the establishment of a new Board committee, the Quality Assurance Committee, with the first meeting being held on 12th April 2011.

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 sub-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. 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 CIPs to be achieved. As a result of this continued review on high spending areas, our reference cost metric has reduced to 97.

Specific benchmarking for corporate services has also enabled the Trust to focus on those high cost areas and targeted additional cost savings over and above the QIPP efficiencies.

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 Central or 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 which will be 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 Information Management and Technology (IM&T) Service provision; value for money studies on the Trust Housekeeping Services and as a result of a previous review on training facilities we are now

moving to a new purpose built training facility at Fulwood. This has allowed us to expand and save on external venues and also rent the space at the previous facility to increase income.

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 the 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. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their 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 by the National Health Service Litigation Authority;
- External assessment by the Care Quality Commission, including Mental Health Act Commissioners;
- Full registration with the Care Quality Commission across all locations;
- The quarterly Performance Review is held with all Service Directorates to review their progress and performance against targets;
- The similar 6 monthly Performance review is held with all support/corporate directorates;
- Information Governance Toolkit assessment.

I have been advised on the implications of the result of my review of the effectiveness of the system of

internal control by the Board, the Audit and Assurance Committee, the Finance and Investment Committee, the Quality and Risk Group, the Performance and Information Group, the Human Resources and Workforce Group, Service Business and Development Group, Operational Management Group and the Executive Directors' Group.

These Committees/Groups 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 is 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 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:

• 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 black and minority ethnic 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.

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 taken from the Trust's systems for patient records (Insight) and risk management (Ulysses Safeguard) and public website (Care Quality Commission). Service user feedback and information collected through team governance has also been used in the production of the report.

National reviews and reports on Quality Accounts from Monitor, the Audit Commission and the King's Fund were reviewed as well as the Audit Commission's assurance report on Sheffield Health and Social Care NHS Foundation Trust's quality accounts from last year.

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 Group.

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 of Non-Executive Directors

and is chaired by the Chair of the Trust. The Chief Executive also attends the Committee meetings in an advisory capacity except in those instances where he has an interest in matters to be discussed by the Committee. 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.

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 1st April 2010 to 31st March 2011.

Signed

Kevan Taylor
Chief Executive
Date: 3rd June 2011

14 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 31st March 2011 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 in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes; and
- the table of pension benefits of senior managers and related narrative notes.

This report is made solely to the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Council of Governors those matters I am required to state to it in an auditor's report and for no other purpose. 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 this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

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's affairs as at 31st March 2011 and of its income and expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:
- 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

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with Monitor's requirements.

Certificate

I certify that I have completed the audit of the accounts of Sheffield Health and Social Care NHS Foundation Trust 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

6 June 2011

15 Annual Accounts 2010/11

For us, 2010/2011 was a year of embedding the Trust's financial regime as we entered the second full year of our Foundation Trust status. We successfully maintained a Level 4 financial risk rating with our regulator, Monitor, for all four quarters. This is indicative of the Trust's position as a strong and financially sound organisation. This positive risk rating could only have been achieved through the robust budgetary and accounting systems that we have in place and, more importantly, the hard work of all our staff. Our managers were able to efficiently direct the funding allocated to them towards their proper purposes whilst ensuring, at the same time, that we safeguarded the quality of our services for the benefit of the people who use them.

The Trust delivered its Cost Improvement Plan in full, albeit that a small element of the target was achieved on a non-recurrent basis. However, opportunities did arrive for the Trust as we took on the responsibility for the PCT commissioning funds for the Intensive Treatment Services for out of town placements. This unique partnership arrangement allowed both organisations to share in any savings made. As a result, we will be considering the extension of the arrangement to other similar budgets in the coming year.

The main elements of our financial performance are as follows:-

• We achieved our planned financial surplus
• We delivered our EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation) margin.
• We maintained a Level 4 financial risk rating with Monitor, our regulator

The Trust is expected to pay its non-NHS creditors within 30 days of receipt of their invoices, or by the due date of such invoices. The Trust achieved a compliance of 88.1 per cent by value and 86.7 per cent by number of invoices paid. As we have stated in previous years, it is incumbent upon public bodies, like ourselves, to support the businesses in the general economy with whom we trade by paying what we owe them in good time. The case for ensuring that we meet our targets has become even more compelling in the current adverse economic climate which is expected to continue for the next few years.

As we are planning to reconfigure the provision of our acute services, the first element of this strategy will be the need for us to look at options for a single inpatient facility. Consequently, our capital spending has been, and will continue to be limited for essential items only as we work towards the realisation of these plans.

We have commissioned architects to look at our estate in order to ensure that we have an estates strategy that is driven by our commitment to maintain and continue to improve the quality of our services in a manner that is financially sustainable. In order to ensure that we have the buildings that will support the delivery of our reconfigured acute services, an essential part of our financial plan will require us to maintain a pool of funds that will enable us to minimise any recourse to borrowing and, thereby, avoid the significant costs that this might entail. It is for this reason that we have maintained high cash reserves which will be augmented by our financial surpluses.

Work for the provision of a new Assessment and Treatment Unit for our Learning Disability Service is still ongoing. We expect the costs of this project to be in the order of £3m over the next two years.

Last year, the Trust successfully introduced the International Financial Reporting Standards (IFRS) regime and continues to apply these standards in this year's annual accounts.

Following the market testing that we carried out for the provision of our external audit service, our Governors appointed the Audit Commission as the Trust's external auditors. This decision was taken at a meeting of the Council of Governors that was held on 15th April 2010.

Our strategic planning and decision-making continues to take into account the dynamics at work in the environment in which we operate. This includes the general economic climate in the country; the wider political direction that the country is taking; the impact of both the economic and political forces on the public and private sectors of the economy and on the provision of public services in particular; and our position in

relation to our competitors. This strategic thinking is embedded in our Annual Plan which sets out our intentions for the coming year. The plan is scrutinised and approved by Monitor who rigorously review it and our performance against it on a quarterly basis. The Board of Directors maintains the first line of scrutiny on the Trust's performance via the finance and performance reports that are presented to it at its monthly meetings.

As part of its stewardship responsibilities, the Board of Directors is required to state that it is confident that the organisation will continue to operate as a going concern in the foreseeable future and to point to the evidence that validates the Board's belief. In expressing its confidence in the organisation's continued future operational existence, the Board is mindful of the current political debate on the future of the NHS which might lead to an increase in the level of competition in the provision of NHS healthcare services, should the market be fully opened up to "any willing provider". Such a significant alteration to the NHS' competitive environment could bring about potential adverse effects on our income streams. However, we remain confident in the Trust's ability to meet these challenges and we are working with the commissioners of our services as well as our strategic partners within the NHS and beyond to ensure that we put in place robust plans that will enable us to mitigate the impact of any potential loss of income that we can reasonably anticipate.

Being mindful of the future challenges facing the NHS as a whole, and our organisation in particular, we are introducing stringent cost reduction targets across the organisation using the principles embedded within the Quality Innovation Prevention and Productivity (QIPP) framework. The implementation of these principles will enable us to achieve the National Efficiency Savings required of us by the Government. As part of the process of developing our savings plan, we have spent a good part of this year reviewing major elements of our services with a view to strengthening our capacity to achieve our cost saving targets. The implementation of our savings plan will significantly alter the way we continue to deliver high quality services, albeit with significant cost reductions.

The coming years will see unprecedented financial demands placed on public services including the NHS. As an organisation, we must ensure that we deliver the financial targets expected of us, whilst at the same time continuing to safeguard and improve the quality services that we provide to the people of Sheffield.

M. J. Rodgers
Executive Director of Finance
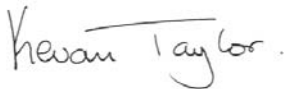
June 2011

Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts for the year ended 31 March 2011 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: 3rd June 2011

Statement of comprehensive income for the year ended 31 march 2011

	NOTE	**2010/11** **£000**	2009/10 £000
Operating income	3	**117,147**	116,149
Operating expenses	4	**(112,737)**	(111,720)
Operating surplus		**4,410**	4,429
Finance costs:			
Finance income	6	**72**	35
Public dividend capital dividends payable		**(2,109)**	(2,337)
Net finance costs		**(2,037)**	(2,302)
SURPLUS FOR THE YEAR		**2,373**	2,127
Other comprehensive income			
Impairments (losses)		**(76)**	(21,278)
Revaluation gains / (losses)		**(94)**	7,566
Actuarial gains/(losses) on defined benefit pension schemes		**(399)**	(64)
Other reserve movements		**(22)**	(22)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**1,782**	(11,671)

The notes on pages 128 to 157 form part of these accounts.

All revenue and expenses are derived from continuing operations.

Statement of Financial Position as at 31 March 2011

	NOTE	**31 March 2011** **£'000**	31 March 2010 £'000
Non-current assets			
Intangible assets	8	-	-
Property, plant and equipment	9	**56,500**	58,097
Investment property	10	**200**	200
Trade and other receivables	**12**	**2,186**	3,647
Total non-current assets		**58,886**	61,944
Current assets			
Inventories	11	**199**	182
Trade and other receivables	12	**3,054**	4,325
Non-current assets held for sale	14	**174**	-
Cash and cash equivalents	13	**14,689**	10,981
Total current assets		**18,116**	15,488
Total assets		**77,002**	77,432
Current liabilities			
Trade and other payables	15	**(5,199)**	(6,165)
Provisions	18	**(379)**	(226)
Taxes payable	15	**(1,894)**	(1,910)
Other liabilities	16	**(367)**	(497)
Total current liabilities		**(7,839)**	(8,798)
Non current assets plus net current assets		**69,163**	68,634
Non-current liabilities			
Provisions	18	**(425)**	(470)
Other liabilities	16	**(2,363)**	(3,571)
Total non-current liabilities		**(2,788)**	(4,041)
Assets less liabilities		**66,375**	64,593
Financed by taxpayers' equity:			
Public dividend capital		**33,572**	33,572
Revaluation reserve		**18,100**	18,552
Donated asset reserve		**604**	626
Income and expenditure reserve		**14,099**	11,843
Total taxpayers' equity		**66,375**	64,593

The financial statements on pages 123 to 157 were approved by the Board on 3rd June 2011 and signed on its behalf by:

Kevan Taylor.

Chief Executive
Date: 3rd June 2011

Statement Of Changes In Taxpayers' Equity

Changes in taxpayers' equity for 2010-11	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income & Expenditure Reserve £000	Total £000
Taxpayers' equity at 1 April 2010	33,572	18,552	626	11,843	**64,593**
Surplus for the year	-	-	-	2,373	**2,373**
Impairments on Property, Plant and Equipment	-	(76)	-	-	**(76)**
Revaluations on Property, Plant and Equipment	-	(94)	-	-	**(94)**
Actuarial gains / (losses) on defined benefits pension scheme	-	-	-	(399)	**(399)**
Other reserve movements	-	(282)	(22)	282	**(22)**
Taxpayers' equity 31 March 2011	**33,572**	**18,100**	**604**	**14,099**	**66,375**

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**
Surplus for the period	-	-	-	2,127	**2,127**
Impairments on Property, Plant and Equipment	-	(21,202)	(76)	-	**(21,278)**
Revaluations on Property, Plant and Equipment	-	7,566	-	-	**7,566**
Actuarial gains / (losses) on defined benefits pension scheme	-	0	-	(64)	**(64)**
Other reserve movements	-	(2,451)	(21)	2,451	**(21)**
Taxpayers' equity at 31 March 2010	**33,572**	**18,552**	**626**	**11,843**	**64,593**

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011

	NOTE	2010/11 £000	2009/10 £000 Restated
Cash flows from operating activities			
Operating surplus		**4,410**	4,429
Depreciation and amortisation		**2,043**	2,058
Impairments and reversals		**0**	286
Transfer from donated asset reserve		**(22)**	(22)
Amortisation of government grants		**(15)**	(8)
(Increase)/decrease in trade and other receivables		**2,732**	(510)
(Increase)/decrease in other assets		**(174)**	0
(Increase)/decrease in inventories		**(17)**	246
Increase/(decrease) in trade and other payables		**(966)**	(664)
Increase/(decrease) in other liabilities		**(1,338)**	2,030
Increase/(decrease) in provisions		**108**	(418)
Increase/(decrease) Tax payable		**(16)**	101
Other movements in operating cash flows		**(293)**	(293)
Net cash generated from operations		**6,452**	7,235
Cash flows from investing activities			
Interest received		**67**	34
Payments for intangible assets		**0**	0
Purchase of property, plant and equipment		**(701)**	(1,174)
Proceeds from disposal of property, plant and equipment		**7**	5,167
Net cash generated from / (used in) investing activities		**(627)**	4,027
Cash flows from financing activities			
PDC dividends paid		**(2,117)**	(2,384)
Net cash generated (used in) financing activities		**(2,117)**	(2,384)
Net increase in cash and cash equivalents		**3,708**	8,878
Cash and cash equivalents at 1 April 2010 / 1 April 2009		**10,981**	2,103
Cash and cash equivalents at 31 March	13	**14,689**	10,981

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 2010/11 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.

Accounting Convention
These accounts have been prepared under historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

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 ww.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.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

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 31st March 2004 and covered the period from 1st 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 per cent of pensionable pay and most employees had up to April 2008 paid 6 per cent, with manual staff paying 5 per cent.

Following the full actuarial review by the Government Actuary undertaken as at 31st March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1st April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14 per cent of pensionable pay, from 1st April 2008, following the introduction of employee contributions on a tiered scale from 5 per cent up to 8.5 per cent 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 31st March 2011, is based on detailed membership data as at 31st March 2008 (the latest midpoint) updated to 31 March 2011 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 31st March 2011, the deficit on the scheme was £1,911,000 (31st March 2010 - £3,120,000), which is offset by a non-current receivable of £1,624,000 (31st March 2010 - £3,051,000). 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 (a "grouped asset"); or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, (treated as a "grouped asset").

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where a service could be provided in any part of the City, 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 was utilised within this revaluation, which was performed as at 1 April 2009.

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.

The carrying value of plant and equipment is 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
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving

from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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 gains and losses
Increases in asset values arising from revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses 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.

Impairments
As required by the 2011 FT Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the assets are charged to operating expenses. As the Trust has no current or prior year impairments of this type, no adjustment is required. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

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. 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. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income 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 Income and Expenditure Reserve.

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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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.

As at 31st March 2011 the Trust has two extensions which were funded from Government grants; at Eastglade and at Grenoside Hospital.

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 cash flows 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'.

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

The Trust has no finance leases.

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 recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the

resources 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 per cent in real terms, except for early retirement provision and injury benefit provisions which both use the HM Treasury's discount rate of 2.9 per cent 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 but is not recognised in the Trust's accounts.

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 per cent) 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 (GBS) excluding cash balances held in GBS accounts that relate to a short-term working capital facility 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.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.19 Accounting Standards issued but not yet adopted

IFRIC 19 "Extinguishing financial liabilities with equity instruments" is effective from 1 July 2010. Neither the Treasury FREM nor the Department of Health's Manual for Accounts require this standard to be applied in 2010-11. The application of the IFRIC would not have a material impact on the Trust accounts in 2010-11, were it applied in that year.

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:

	2010/11	2009/10
	£000	£000
Income from patient care activities		
Block contract income	**73,835**	70,855
Clinical partnerships providing mandatory services (including Section 31 agreements)	**6,105**	5,207
Clinical income for the secondary commissioning of mandatory services	**11**	11
Other clinical income from mandatory services	**628**	1,067
	80,579	77,140
Other operating income		
Research and development	**740**	464
Education and training	**6,456**	6,554
Charitable and other contributions to expenditure	**291**	301
Transfers from donated asset reserve in respect of depreciation on donated assets	**22**	22
Non-patient care services to other bodies	**28,155**	30,667
Other income	**896**	708
Profit on disposal of other tangible fixed assets	**8**	7
Gain on disposal of assets held for sale		286
	36,568	39,009
Total operating income	**117,147**	116,149

Income is almost totally from the supply of services. Income from the sale of goods is immaterial.

3.2 Private patient income

The Trust has no private patient income.

3.3 Operating lease income

Rental income from operating leases:	2010/11	2009/10
	£000	£000
Rents recognised as income in period	**33**	33

Future minimum lease payments due:	2010/11	2009/10
	£000	£000
Receivable:		
Not later than one year	**13**	12
Later than one year and not later than five years	**50**	51
Later than five years	**-**	-
	63	63

3.4 Operating income by type comprises:

	2010/11 £000	2009/10 £000
Income from patient care activities		
NHS foundation trusts	8	6
NHS trusts	-	-
Primary care trusts	74,463	71,926
Local authorities	6,105	5,207
Non-NHS: Other	3	1
	80,579	77,140
Other operating income		
Research and development	740	464
Education and training	6,456	6,554
Charitable and other contributions to expenditure	291	301
Transfers from donated asset reserve in respect of depreciation	22	22
Non-patient care services to other bodies	28,155	30,667
Other income	896	708
	36,560	38,716
Total operating income	117,139	115,856
Profit on disposal of plant and equipment	8	7
Gain on disposal of assets held for sale	-	286
Total income	117,147	116,149

4 Operating expenses

4.1 Operating expenses comprise:

	2010/11 £000	2009/10 £000
Services from NHS Foundation trusts	750	692
Services from NHS Trusts	2	-
Services from other NHS bodies	83	25
Purchase of healthcare from non-NHS bodies	370	92
Employee expenses - Executive directors	759	678
Employee expenses - Non-executive directors	98	83
Employee expenses - Staff	93,977	92,561
Drug costs	1,704	1,622
Supplies and services - clinical (excluding drug costs)	1,312	1,622
Supplies and services - general	1,015	996
Establishment	2,407	2,758
Research and development	283	209
Transport	619	583
Premises	4,774	4,806
Increase / (decrease) in provision for impairment of receivables	(3)	(11)
Depreciation on property, plant and equipment	2,043	2,058
Impairments of property, plant and equipment and investment property	-	286
Audit fees: statutory audit *	63	58
Other auditors remuneration: Other services	16	7
Clinical negligence	245	188
Losses on disposal of property, plant & equipment	1	-
Legal fees	234	149
Consultancy costs	441	585
Training, courses and conferences	657	579
Patient travel	151	112
Car parking and security	5	5
Hospitality	1	-
Redundancy	57	-
Insurance	82	128
Losses and ex gratia payments	40	142
Other	551	707
	112,737	111,720

*There is no limit on Auditors liability.

4.2   Operating leases
4.2.1 Payments recognised as an expense

	2010/11	2009/10
	£000	£000
Minimum lease payments	710	729

4.2.2 Future minimum lease payments

	2010/11	2009/10
	£000	£000
Payable:		
Not later than one year	711	647
Later than one year and not later than five years	1,805	1,651
Later than five years	12,232	15,323
	14,748	17,621

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 NHS FT (STH) is based on the capital charges for the buildings. There has been a rent reduction in 2010/11 from £144,300 to £112,000 per annum following revaluation of the buildings by STH NHS FT, resulting in a significant reduction to total future lease payments of £3,091,000.

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 learning disabilities service users.

5   Employee expenses and numbers

5.1   Employee expenses

	2010/11	2009/10
	£000	£000
Salaries and wages	77,823	76,539
Social security costs	6,110	5,932
Employer contributions to NHS pension scheme	8,809	8,719
Employer contributions to other pension schemes	-	-
Termination benefits	57	-
Agency / contract staff	1,994	2,049
	94,793	93,239

No other employee benefits were provided to staff other than those disclosed above in 2010/11 (the year ended 31 March 2010 - £nil).

5.2 Average number of people employed

	2010/11 Number	2009/10 Number
Medical and dental	135	143
Administration and estates	500	495
Healthcare assistants and other support staff	190	189
Nursing, midwifery and health visiting staff	1,256	1,268
Scientific, therapeutic and technical staff	348	356
Social care staff	143	158
Bank and agency staff	58	56
Other	6	6
	2,636	2,671

5.3 Early retirements due to ill health

During 2010/11 there were 2 (year ended 31 March 2010 - 4) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £124,000 (year ended 31 March 2010 - £305,000). 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 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.

	Period 1.4.10 to 31.3.11				Period 1.4.09 to 31.3.10			
	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 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	-	25 - 30	-	3	-
A Barney, Non-Executive Director	-	-	-	-	0 - 5	-	-	-
E Jones, Non-Executive Director	-	-	-	-	0 - 5	-	-	-
Cllr. M Rooney, Non-Executive Director	10 - 15	-	1	-	10 - 15	-	1	-
M Rosling, Non-Executive Director	10 - 15	-	1	-	10 - 15	-	1	-
A Clayton, Non-Executive Director	10 - 15	-	1	-	5 - 10	-	1	-
M Thomas, - Non Executive Director	10 - 15	-	1	-	5 - 10	-	1	-
S Rogers, - Non-Executive Director	10 - 15	-	1	-	5 - 10	-	1	-
K Taylor, Chief Executive	130 - 135	-	15	18	130 - 135	-	15	18
M Rodgers, Deputy Chief Executive/Executive Director of Finance	105 - 110	-	12	15	105 - 110	-	11	15
Dr T Kendall, Executive Medical Director	60 - 65	125 - 130	22	21	60 - 65	115 - 120	20	19
C Clarke, Executive Director of Operations and Social Care	100 - 105	-	11	15	95 - 100	-	11	14
K Tomlinson, Executive Director of Governance, Performance and Nursing	0	-	-	0	95 - 100	-	11	14
L Lightbown, Executive Director of Governance, Performance and Nursing	80 - 85	-	8	12	-	-	-	-

K Tomlinson left the Trust on 31st March 2010. L Lightbown was on secondment from Barnsley Primary Care Trust from 24.04.10. to 31.3.11. and has now been appointed permanently into the post.

A Barney left the Trust in June 2009 but remains on the schedule to highlight the previous years figures as does E Jones who left the Trust in August 2009.

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

	2010/11 £000	2009/10 £000
Interest income:		
Bank accounts	72	29
Other loans and receivables	-	6
Total	72	35

7 Finance costs

The Trust did not incur any interest expense in 2010/11 (year ended 31 March 2010 - £nil).

In addition, no payments were made during 2010/11 under The Late Payment of Commercial Debts (Interest) Act 1998 (year ended 31 March 2010 - £nil).

8 Intangible assets

Computer Software - Purchased	2010/11 £000	2009/10 £000
Gross cost at 1 April 2010 / 1 April 2009	8	18
Disposals	-	(10)
Gross cost at 31 March	8	8
Amortisation at 1 April 2010 / 1 April 2009	8	18
Disposals	-	(10)
Amortisation at 31 March	8	8
Net book value - opening At 1 April 2010 / 1 April 2009	-	-
Net book value - closing At 31 March	-	-

9. Property, plant and equipment

2010/11:	Land £'000	Buildings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2010	9,184	48,764	625	843	427	1,619	140	61,602
Additions purchased	-	-	666	63	61	-	-	790
Impairments charged to revaluation reserve	-	-	(76)	-	-	-	-	(76)
Reclassifications	-	406	(684)	43	-	235	-	-
Revaluation loss	-	(94)	-	-	-	-	-	(94)
Reclassified as held for sale	(150)	(31)	-	-	-	-	-	(181)
Disposals	-	-	-	-	(41)	(22)	-	(63)
At 31 March 2011	**9,034**	**49,045**	**531**	**949**	**447**	**1,832**	**140**	**61,978**
Depreciation at 1 April 2010	-	1,682	-	352	232	1,141	98	3,505
Provided during year	-	1,689	-	96	58	188	12	2,043
Reclassified as held for sale	-	(7)	-	-	-	-	-	(7)
Disposals	-	-	-	-	(41)	(22)	-	(63)
Depreciation at 31 March 2011	**-**	**3,364**	**-**	**448**	**249**	**1,307**	**110**	**5,478**
Net book value								
Purchased	9,184	46,456	625	491	195	478	42	57,471
Donated	-	626	-	-	-	-	-	626
Total at 1 April 2010	**9,184**	**47,082**	**625**	**491**	**195**	**478**	**42**	**58,097**
Net book value								
Purchased	9,034	45,077	531	501	198	525	30	55,896
Donated	-	604	-	-	-	-	-	604
Total at 31 March 2011	**9,034**	**45,681**	**531**	**501**	**198**	**525**	**30**	**56,500**
Analysis of property, plant and equipment - net book value								
Protected	4,526	34,570	-	-	-	-	-	39,096
Unprotected	4,508	11,111	531	501	198	525	30	17,404
Total at 31 March 2011	**9,034**	**45,681**	**531**	**501**	**198**	**525**	**30**	**56,500**

No assets were held under finance leases or hire purchase contracts as at 31 March 2011.

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Prior year: 2009/10								
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 period	-	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
31 March 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 2011

10 Investment Property

10.1 Investment Property - Carrying Value

	31 March 2011	31 March 2010
	£000	£000
As at 1 April 2010 / 1 April 2009	200	-
Acquisitions in year	-	230
Impairments recognised in expenses	-	(30)
As at 31 March	200	200

10.2 Investment property expenses

	2010/11	2009/10
	£000	£000
Direct operating expense arising from investment property generating rental income in the year	18	27

10.3 Investment property income

	2010/11	2009/10
	£000	£000
Investment property income	33	33

11 Inventories

11.1 Inventories

	31 March 2011	31 March 2010
	£000	£000
Consumables	199	182

11.2 Inventories recognised in expenses

	2010/11	2009/10
	£000	£000
Inventories recognised as an expense in the period	2,126	2,307
Write-down of inventories (including losses)	6	7
	2,132	2,314

12 Trade and other receivables

12.1 Trade and other receivables

	Current		Non-current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
		Restated		
NHS receivables	**1,192**	1,333	**305**	338
Other receivables with related parties	**588**	1,297	**1,624**	3,051
Provision for impaired receivables	**(19)**	(22)	-	-
Prepayments	**313**	300	**257**	258
Accrued income	**701**	1,051	-	-
PDC receivable	**55**	47	-	-
Other receivables	**224**	319	-	-
	3,054	4,325	**2,186**	3,647

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 2011	31 March 2010
	£'000	£'000
Over six months	**19**	22
	19	22

12.3 Receivables past their due date but not impaired

	31 March 2011	31 March 2010
	£'000	£'000
By up to three months	**495**	708
By three to six months	**9**	30
By more than six months	**91**	419
Total	**595**	1,157

12.4 Provision for impairment of receivables

	31 March 2011 £'000	31 March 2010 £'000
Balance at 1 April 2010 / 1 April 2009	22	33
Increase in provision	-	-
Unused amounts reversed	(3)	(11)
Balance at 31 March	19	22

13 Cash and cash equivalents

	31 March 2011 £'000	31 March 2010 £'000
Balance at 1 April 2010 / 1 April 2009	10,981	2,103
Net change in year	3,708	8,878
Balance at 31 March	14,689	10,981
Made up of		
Cash at commercial banks and in hand	61	346
Cash with the Government Banking Service	5,130	4,031
Other current investments	9,498	6,604
Cash and cash equivalents as in statement of financial position	14,689	10,981

14 Non-current assets held for sale

Current year: 2010/11	Property, plant and equipment £000	Other assets £000	Total £000
As at 1 April 2010	-	-	-
Assets classified as available for sale in the year	174	-	174
Assets sold in year	-	-	-
Impairment of assets held for sale	-	-	-
As at 31 March 2011	174	-	174

Prior year: 2009/10	Property, plant and equipment £000	Other assets £000	Total £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)
Impairment of assets held for sale	-	-	-
As at 31 March 2010	-	-	-

Details of the non current assets held for sale are:

At 31 March 2011 the Trust held one property which had been declared surplus to operational requirements. This property (Coalbrook House) was used as offices. It is anticipated that the property will be sold at auction early in 2011/12.

15 Trade and other payables

	Current	
	31 March 2011	31 March 2010
	£000	£000
		Restated
NHS payables	**305**	346
Amounts due to other related parties	**1,107**	1,470
Trade payables - capital	**165**	75
Other trade payables	**779**	969
Accruals	**2,843**	3,305
	5,199	6,165
Taxes payable	**1,894**	1,910
	7,093	8,075

16 Other liabilities

	Current		Non-current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Deferred Income	**350**	489	**-**	-
Deferred Government Grant	**17**	8	**452**	451
Net Pension Scheme Liability	**-**	-	**1,911**	3,120
	367	497	**2,363**	3,571

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:

	31 March 2011	31 March 2010
	£'000	£'000
Total long term borrowing limit set by Monitor	**21,600**	22,700
Working capital facility agreed by Monitor	**2,500**	8,100
Total Prudential Borrowing Limit	**24,100**	30,800

Neither of the above facilities were utilised by the Trust in 2010/11 or in the year to 31 March 2010.

The financial ratios for 2010/11 and 2009/10 as published in the Prudential Borrowing Code are shown below, together with the actual level of achievement by the Trust.

Financial ratio	Actual ratios 2010/11	Approved PBL ratios 2010/11	Actual ratios 2009/10	Approved PBL ratios 2009/10
Minimum Dividend Cover	3.1	>1	2.8	>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 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Legal claims	**100**	112	-	-
Injury Benefits	**45**	45	**425**	470
Clinical Excellence	-	69	-	-
Specialist Registrars	**234**	-	-	-
Total	**379**	226	**425**	470

	Legal claims £'000	Injury Benefits £'000	Clinical Excellence £'000	Specialist Registrars £'000	Total £'000
At 1 April 2010	112	515	69	-	696
Arising during the year	79	-	-	234	313
Used during the year	(42)	(45)	(69)	-	(156)
Reversed unused	(49)	-	-	-	(49)
At 31 March 2011	**100**	**470**	**-**	**234**	**804**
Expected timing of cash flows:					
Not later than one year	100	45	-	234	379
Later than one year and not later than five years	-	156	-	-	156
Later than five years	-	269	-	-	269

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.

A provision of £470,000 relates 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 2010 - £515,000).

There are no **Clinical Excellence Awards** for Consultants outstanding as at 31 March 2011 (31 March 2010 - £69,000).

A provision of £234,000 relates to a regrading for **Specialist Registrars.** Negotiations are ongoing regarding the banding for the upgrade.

Of the total provision of £804,000 (31 March 2010 - £696,000), £338,000 (31 March 2010 - £370,000) has been covered by 'back-to-back' income arrangements with the Trust's major customers.

£1,356,000 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (31 March 2010 - £957,000).

19 Contingent liabilities

	2010/11 £000	2009/10 £000
Gross value	(127)	(90)

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 2011 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 obtained within its prudential borrowing limit. The Trust is therefore not exposed to significant liquidity risks.

20.1 Financial assets

	31 March 2011	31 March 2010
	£'000	£'000
Denominated in £ Sterling - Floating interest rate	14,689	10,917

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 2011	31 March 2010
	£000	£000
		Restated
Loans and Receivables		
NHS receivables	1,497	1,671
Other receivables with related parties	2,031	4,154
Provision for irrecoverable debts	(19)	(22)
Accrued income	701	1,051
Other receivables	224	319
Cash at bank and in hand	14,689	10,981
	19,123	18,154

20.4 Financial liabilities by category

	31 March 2011	31 March 2010
	£000	£000
		Restated
Other financial liabilities		
NHS payables	305	346
Other payables with related parties	1,107	1,470
Trade payables - capital	165	75
Other trade payables	779	969
Accruals	2,843	3,305
Provisions under contract	234	69
Total at 31 March	5,433	6,234

20.5 Fair values

The fair value of the Trust's financial assets and financial liabilities at 31 March 2011 equates to the book value.

21 Third Party Assets

The Trust held cash of £525,966 at bank and in hand at 31 March 2011 (31 March 2010 - £467,954) 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 45 cases (the year ended 31 March 2010 - 53 cases) of losses and special payments totalling £40,000 (the year ended 31 March 2010 - £153,000) approved during the year ended 31 March 2011.

23 Events after the reporting period

In response to the national Transforming Community Services (TCS) policy direction, a range of services will transfer from NHS Sheffield PCT Provider Services to the Trust on 1st April 2011. The services will transfer through a legal Business Transfer Agreement (BTA). Under this BTA 214 employees (165.5 whole time equivalents) working in the PCT Provider Services operation will move to the Trust under TUPE regulations governing the transfer of services. In line with Department of Health policy on the divestment of PCT provider services operations there will be no transfers of land or buildings to the Trust under the BTA. Where the former provider services continue to use premises as part of their operations they will be used under licence as defined in the BTA.

The range of services to transfer fall in to the broad categories of Long Term Conditions and Primary Care Services (including a group of salaried GP practices). The total value of the services to be transferred is £7,710,000 and in parallel with agreeing the BTA the Trust will enter into appropriate contracts with the PCT for the provision of these services.

TCS transactions represent a 'machinery of government change' as they involve a combination with the Trust of another entity within the Whole of Government Accounts boundary. NHS foundation trusts are required to merger account for these transactions as set out in the NHS Foundation Trust Annual Reporting Manual (paragraphs 3.44A & 3.44B).

24 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements are:

	31 March 2011	31 March 2010
	£'000	£'000
Property, plant and equipment	226	126

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 £
Sheffield Teaching Hospitals NHS FT	1,409,000	931,000	575,000	484,000
University of Sheffield	616,642	80,827	80,384	8,948
Royal College of Psychiatrists	6,075	93,557	2,820	13,016
Turning Point	26,582	1,800	-	1,800

The relationships are:
- The wife of one of the Trust's non executive directors is a non executive director at Sheffield Teaching Hospitals NHS Foundation Trust
- 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.
- One of the non executive directors receives a pension from Turning Point

One of the non exective directors serves as a councillor at Sheffield City Council.

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 the Trust's transactions with related parties during the year is given below:

	2010/11 Income £000	Expenditure £000	2009/10 Income £000	Expenditure £000
Department of Health	5	1,218	255	-
Other NHS bodies	92,429	2,903	92,653	12,499
Charitable funds	40	-	25	1
Other bodies (including WGA)	12,459	16,091	11,020	8,035
	104,933	20,212	103,953	20,535

The value of transactions with board members and key staff members in 2010/11 is £nil (2009/10 - £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 2011 | | 31 March 2010 | |
| | Receivables | Payables | Receivables | Payables |
	£000	£000	£000	£000
Department of Health	-	-	103	-
Other NHS bodies	2,233	967	2,074	2,359
Charitable funds	10	-	3	-
Other bodies (including WGA)	2,373	3,292	4,507	2,902
	4,616	4,259	6,687	5,261

Value of balances (other than salary) with board members and key staff members at 31 March 2011 is £nil (31 March 2010- £nil).

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2011 is £nil (31 March 2010 - £nil). In addition, the value of balances (other than salary) with related parties in relation to the writing off of receivables during 2010/11 is £nil (2009/10 - £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 gain for 2010/11 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £282,000 (the year ended 31 March 2010 a cost of £410,000). A pension deficit of £1,911,000 is included in the statement of financial position as at 31 March 2011 (31 March 2010 - £3,120,000 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 2011, the deficit on the scheme was £1,911,000 (31 March 2010 - £3,120,000 deficit), the majority of which is offset by a non-current receivable of £1,624,000 (31 March 2010 - £3,051,000).

Estimation of the net liability to pay pensions depends on a number of complex judgements. A firm of consulting actuaries is engaged by South Yorkshire Pensions Authority to provide expert advice about the assumptions made, such as mortality rates and expected returns on pension fund assets.

With effect from 2011, the UK Government announced that pension increases or revaluations for public sector schemes should be based on the Consumer Prices Index ("CPI") measure of price inflation, rather than the Retail Prices Index ("RPI") measure of price inflation.

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 2011	31 March 2010
	%	%
Rate of inflation	3.4	3.5
Rate of increase in salaries	4.65	5.0
Rate of increase in pensions and deferred pensions	2.9	3.5
Discount rate	5.5	5.8
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 2011	31 March 2010
	Years	Years
Non retired member - Male (aged 65 in 20 years time)	22.8	21.3
Non retired member - Female (aged 65 in 20 years time)	25.7	24.1
Retired member - Male	21.4	20.4
Retired member - Female	24.1	23.2

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	Scheme assets %	31 March 2011 £'000	Scheme assets %	31 March 2010 £'000
Equities	67.4	7,638	64.6	6,649
Government Bonds	14.6	1,654	15.4	1,585
Other Bonds	7.2	816	7.9	813
Property	9.8	1,111	9.1	937
Cash / Liquidity	1.0	113	3.0	309
Total fair value of assets	100.0	11,332	100.0	10,293
Present value of defined benefit obligation		(13,243)		(13,413)
Net retirement benefit deficit		**(1,911)**		(3,120)

Movements in the present value of the defined benefit obligations are:

	2010/11 £'000	2009/10 £'000
At 1 April 2010 / 1 April 2009	**(13,413)**	(9,070)
Current service cost	**(437)**	(239)
Interest on pension liabilities	**(786)**	(645)
Member contributions	**(155)**	(132)
Actuarial (losses) / gains on liabilities	**404**	(3,657)
Benefits paid	**300**	330
Past service costs	**844**	-
At 31 March	**(13,243)**	(13,413)

Movements in the fair value of the scheme's assets were:

	2010/11 £'000	2009/10 £'000
At 1 April 2010 / 1 April 2009	**10,293**	7,704
Expected return on plan assets	**661**	474
Actuarial gains / (losses) on assets - current year	**188**	2,013
Employer contributions	**335**	300
Member contributions	**155**	132
Benefits Paid	**(300)**	(330)
At 31 March	**11,332**	10,293

The net pension expense recognised in operating expenses in respect of the scheme is:

	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Current service cost	(437)	(239)
Past service costs	844	-
Pension expense gain / (charge) to operating surplus	407	(239)
Expected return on plan assets	661	474
Interest on pension liabilities	(786)	(645)
Pension expense credited	(125)	(171)
Net pension gain / (charge)	282	(410)

The reconciliation of the opening and closing statement of financial position is as follows:

	2010/11 £'000	2009/10 £'000
At 1 April 2010 / 1 April 2009	(3,120)	(1,366)
Gains / (Expenses) recognised in the statement of comprehensive income	874	(410)
Contributions paid	335	300
Actuarial gains / (losses) - current year	-	(1,644)
At 31 March	(1,911)	(3,120)

Actuarial gains and losses are recognised directly in the Income and Expenditure reserve. At 31 March 2011, a cumulative amount of £468,000, was recorded in the Income and Expenditure Reserve (31 March 2010 £69,000).

The history of the scheme for the current and prior year is:

	Year ended 31 March 2011 £'000	Year ended 31 March 2010 £'000
Present value of defined benefit obligation	13,243	(13,413)
Fair value of scheme assets	(11,332)	10,293
Net retirement obligation	1,911	(3,120)

Experience gains on scheme liabilities for 2010/11 are £15 (the year ended 31 March 2010 - £nil) and experience gains (or loss) on scheme assets are £188 (year ended 31 March 2010 - gain of £2,013,000).

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 per cent 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
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 that are no longer used by the Trust and declared surplus by the Board, which are available for sale.

Non-current asset or liability
An asset or liability which the Trust 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 Sheffield Health
and Social Care NHS Foundation Trust, visit the website:
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.