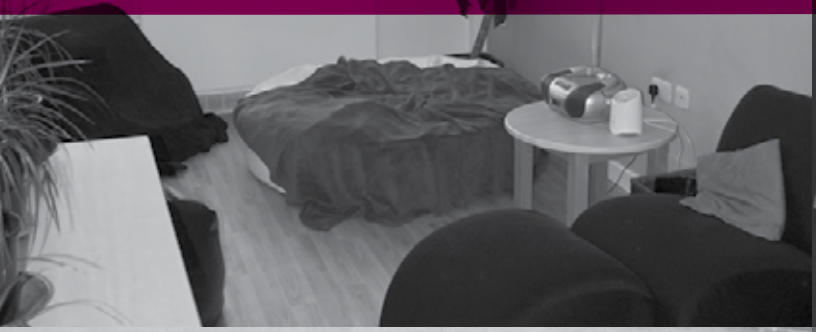
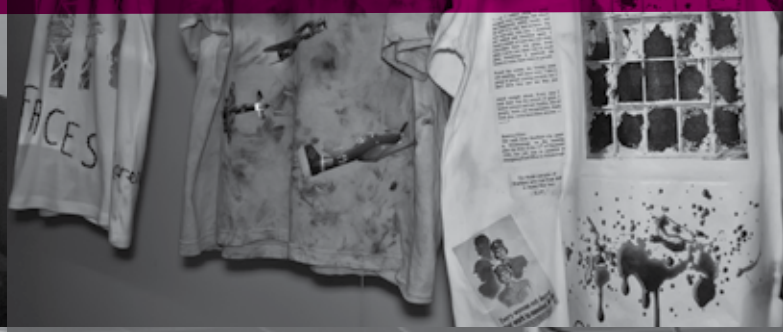



Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2011-2012


Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 20011/12

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

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1.0
About us

About us

This Annual Report outlines the developments and improvements in our services over the past 12 months. We also report on the key information used to monitor and measure our performance during the period.

Our statutory history and current status as a Foundation Trust

We were initially established in 2003 as Sheffield Care Trust. On 1st July 2008, we became authorised to operate as Sheffield Health and Social Care NHS Foundation Trust. As a membership-based organisation, our Board of Directors is accountable to the communities that we serve mainly through our Council of Governors, and directly to our members at our Annual Members' Meeting. Our Council of Governors includes people who use our services, their carers, representatives of members of the general public and our staff as well as other Sheffield-based organisations with whom we work in close partnership. The diversity of our Council's membership helps our Board of Directors to always ensure that the services that we provide are shaped by the people living in the communities that we serve.

The services that we provide

We provide mental health, learning disability, substance misuse, community rehabilitation, and a range of primary care and specialist services to the people of Sheffield. We also provide some of our specialist services to people living outside of Sheffield. Our integrated approach to service delivery enables us to meet people's mental, physical, psychological and social care needs. The wide range of our services includes:

- psychological therapies for people with mild and moderate mental health problems
- community-based mental health services for people with serious and enduring mental illness, including early intervention services
- services that support people with a learning disability and their families and carers
- inpatient mental health services for young people, adults and older people
- specialist services including: those for people with eating disorders; rehabilitation services for people with brain injuries or those living with the consequences of a long-term neurological condition; services for adults with drug and alcohol misuse problems; assertive outreach services for homeless people and members of the traveller community; maternal mental health services, and; gender dysphoria services
- primary care services for people of all ages which we deliver through our GP practices
- translation and interpretation services.

How we provide our services

We have more than 3000 members of staff (including our flexible workforce) who support us in delivering our services to the people who need them. They have enabled us to generate an annual income of £122.5 million.

Our community-based services aim to provide care and treatment to individuals and their families close to their homes and help them to maintain their independence and thereby continue with their day-to-day lives as much as possible. We also provide a range of inpatient and residential services for individuals who cannot be appropriately helped within their community. Through our learning disability services, we provide supported living to the people who use our services and we work closely with residential care homes and in partnership with housing associations.

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

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

Our close partnership with Sheffield City Council and other organisations

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 an integrated range of 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 as well. 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.

2.0
Directors' report

2.1 Foundation Trust Chair's statement

Welcome to Sheffield Health and Social Care NHS Foundation Trust's Annual Report and Accounts for 2011/12. The Trust (SHSC) has now completed four years as an NHS Foundation Trust (FT) and is well on the way to delivering the improved service user outcomes that were the main reason for seeking to become an FT.

This Annual Report is full of information about the services that SHSC provides and the improvements we are making. It summarises information on the Trust's performance as judged by external regulators and reference points. On all fronts, this Trust is doing well and we are committed to build progressively on what has been achieved so far.

Like the rest of the NHS, this Trust faces a hugely challenging financial context. The Government expects the NHS, nationally, to save some £20billion from its budget over the next 3 years. For SHSC, this means around £16million for 2012/2013 – 2014/15, or just over £5million per year. The Trust's total annual income for 2011/12 was £122.5million which means that this has to be reduced by approximately 13%. I hardly need to say that this is very difficult to do when most of that expenditure is on staff and these reductions come on top of more than a decade of annual efficiency savings targets. In addition, the demand for the Trust's services is increasing constantly, for example, because of population ageing and the survival of more babies with highly complex disabilities. Responding to these huge challenges takes a great deal of effort on the part of the Trust Board, Clinicians and Managers. The view taken by the Board of Directors is that this circle can only be squared by reconfiguring services, with the primary aim of improving recovery for service users while trying to save money at the same time.

Despite the scale of the challenge faced by the Trust, I am confident that it is possible to deliver improved services while reducing costs in some areas. This confidence is based, first, on the track record of this Trust. We have overcome previous obstacles because of strength of purpose, dedication to patients and service users and sheer quality of staff throughout this organisation. Secondly, our partnership with service users and carers gets stronger and stronger. It is this, above all else, that will guarantee the responsiveness and quality of the Trust's services. Third, I expect a close partnership to develop between SHSC and the new Clinical Commissioning Group (CCG) in Sheffield. Many staff in the Trust already work closely with primary care and we will seek to extend that as much as possible. Breaking down barriers between primary and secondary care, and between health and social care, is essential to maintain and strengthen SHSC services. Therefore, I am confident that this Trust can combine major service improvements with a sound financial balance, as it has done in the past.

From the start of this year, I was very pleased and proud to welcome to the Trust some of the services previously managed by NHS Sheffield. As part of a national policy called '*Transforming Community Services*', the PCT had to divest itself of its service provision activities to focus on commissioning. As a result, we welcomed new services including Long-Term Neurological Services, Brain Injury Rehabilitation Services, Sheffield Community Access and Interpreting Services and four GP practices known collectively as the 'Clover Group'.

In terms of the quality of the services the Trust provides, its finances and the viability of its governance arrangements SHSC are in a very healthy position. The Trust's *Financial Risk Rating* by Monitor, the independent FT regulator, is 4 and its *Governance Risk Rating* is Green. Both the service users and staff annual surveys place the Trust in the top 20 per cent nationally.

In terms of service quality, the Care Quality Commission (CQC) reviewed eleven of the Trust's sites in 2011/12 and found only minor issues of concern. There was no question about the Trust's continuing registration with the CQC. Those minor concerns were quickly rectified and all services are fully compliant. Also the CQC inspectors praised a number of the services and the work of Trust staff.

As a Foundation Trust, we are committed to a constant increase in membership and this now totals 12,299, excluding staff. It is essential for the Trust to be responsive to the needs of the community it serves and, therefore, a large membership is important. Equally important is the representation provided by the Council of Governors because it is the Governors who pass on intelligence from members and who speak for the membership when contributing to the development of the Trust's plans. One of the main opportunities for members to interact with Governors is the Annual Members' Meeting. Last year's was the biggest yet with over 200 participants.

This Trust has been very fortunate in having a tremendous set of Governors who, although from a wide variety of backgrounds, are all committed to SHSC and want to help it to achieve its goals. Governors have to hold the Board of Directors to account for the management of the Trust but they do so in a highly constructive and supportive way. I am proud of this partnership and will do what I can to sustain it.

During 2011/12, we said goodbye to 19 Governors whose terms of office had expired or who resigned for other reasons. The Trust is immensely grateful to all of them for their contributions to establishing the Council of Governors and to improving the quality of SHSC services.

Also during 2011/12, one of the Trust's longest serving directors, Pam Stirling, retired. I want to take this further opportunity to say thank you to Pam for her distinguished service to the NHS and for her major contributions to service development in the Trust. Many staff and Governors were able to say a fond farewell to Pam during a workshop on service innovations with which she had been associated. The centrepiece of the occasion was the presentation of a patchwork quilt consisting of squares made by staff (including the Chief Executive and me) and assembled by Julie Leeson. There is a picture of the quilt in the Spring 2012 Involve magazine and it is stunning. 2011/12 also saw the reappointment of two Non-Executive Directors, Mick Rooney and Martin Rosling, following external advertisement and a process led by Governors. Congratulations to both of them.

I have indicated that the next few years are going to be extremely difficult for this Trust, for its staff and for the service users and carers it serves. There will be less funding and increasing demand. We know that at times of economic downturn, the numbers of people with mental health and substance misuse problems increases. In partnership with primary care and the local authority, we will have to try hard to respond to this demand while also balancing our budget. We will do it but only with the hard work and dedication of staff and with the continued support of service users and carers. The ability to rise above adversity is the defining spirit of the NHS and this Trust in particular. It is this spirit that will prevail and ensure that the Trust is able to respond imaginatively to the challenges it faces.

Professor Alan Walker

Chair

2.2 The Chief Executive's statement

During the year 2011/12, our priority was to work closely with our partners to provide integrated services that met people's social, psychological and physical health and wellbeing needs.

We have also continued to provide strong support to our existing services. In addition, we wanted to extend our service provision – particularly to provide more integrated physical and psychological health and wellbeing services within both primary and secondary care. With the new services that we have been commissioned to provide, we wanted to explore our development towards becoming a provider of a broader range of community-based services beyond our 'core' mental health services.

Our priorities remained focused on ensuring that we continue to develop to:

- deliver high quality and safe services
- transform our services as a key means of delivering improvement
- deliver efficiency and effectiveness, and
- ensure that we have a sustainable and secure future

Overall, we have made good progress.

Our services perform well and are valued by the people who use them, and their carers. We are in the top 20% of mental health trusts in England for listening to the people who use our services, for treating them with respect and dignity and providing helpful talking therapies. We are also in the top 20% of mental health trusts in England whose staff would recommend us as a place to work, as a place to receive care and treatment, and where staff feel that they are able to contribute towards improvements at work. The Care Quality Commission has reviewed a number of our services and reached positive conclusions overall and we have achieved all national targets expected of us.

We have made important and positive progress in developing our approaches to improving the quality of the services that we provide. These are discussed in more detail in further sections of this report, but in summary some of the highlights are as follows:

- we have identified key areas where *Recovery* principles can underpin the way that we develop and provide opportunities for people to identify and access the support they need. Through this, we are developing our workforce training programmes, exploring the establishment of a *Recovery College* and from early April 2012, we intend to enter into a formal contract with *Recovery Enterprises* to provide different opportunities to support service users with their vocational and employment aspirations
- in partnership with MAAT Probe (a Sheffield-based men's self-help group of African Caribbean mental health service users) and other service users, we began the implementation of the RESPECT training programme which focuses on the prevention and management of violence and aggression. By working in partnership in this way, we have been able to effect significant positive practice changes in this challenging area. These initiatives follow on from an extensive review of our services that we carried out
- we have improved how we monitor what we do by building on the expertise of service user volunteers who already visit our wards to interview inpatients about their experience.

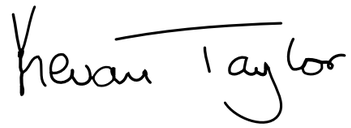
The year 2011/12 was a time of change and growth for the Trust, with us taking on new services that were previously provided by NHS Sheffield, our local Primary Care Trust. As Chief Executive, I have been delighted to welcome the *Clover Group* of General Practices, the Neuro-Enablement Services, the Homeless and Traveller Team and the Chronic Fatigue Syndrome/Myalgic Encephalopathy (CFS/ME) service. We have also been joined by the Sheffield Community Advocacy and Interpreting Service (SCAIS) and the Community Development Workers who bring, into the Trust, extra expertise in working with minority communities. These services have brought fresh ideas and examples of good practice to the Trust and they will allow us to explore new ways of delivering services in the future.

We have made good progress during the year 2011/12 in preparing for the changes that we want to make as part of our service development strategies. We have been doing a lot of planning and consulting on these proposed changes with members of the public, with the people who use our services and with our members of staff. We have also been actively engaged with other NHS Trusts, Sheffield City Council and our other strategic partners about how city-wide care pathways need to develop, improve and change in order to deliver real benefits that meet the needs of the people of Sheffield. All this work has been important in ensuring that we are focusing on the right changes and have the support of our key stakeholders as we go forward.

In 2011/12:

- we agreed new investment to go towards improving the support, care and treatment provided to people with dementia in general hospital settings. We will introduce new services in partnership with Sheffield Teaching Hospitals NHS Foundation Trust and the social care services to support and enhance the care and treatment they provide
- we agreed with NHS Sheffield that additional money currently spent on out-of-town inpatient care will be invested in the Trust to support the development of new services. We are now able to progress plans for new services such as the provision of Crisis Houses, admission avoidance services for older people and the improvement of the care provided to people on our wards
- we have agreed investment to support enhanced community services for people with complex learning disabilities with the intention of providing more local care in Sheffield
- we have identified a location and started the work to build and open a new specialist community centre for the *Intensive Support Service* that will provide care and support to people with learning disabilities in modern purpose-built facilities
- we were selected by the Department of Health to be one of the 15 pathfinder sites for the national IAPT (Improving Access to Psychological Therapies) team that will be working to address the needs of people with long term physical health conditions and medically unexplained symptoms in 2012/13. This means that our IAPT Service will be receiving funding for the provision of specialist training in these areas in order to improve the service that we deliver to the people who use our services by better linking physical and mental health care. It also brings Health and Medical Psychologists into primary care to work with us as part of the stepped care pathway
- we opened a new specialist day service for people with eating disorders. This new service is providing intensive support and treatment for people who would previously have needed hospital care, often in neighbouring cities.

While most of the progress I have described above is about decision-making and preparing for changes, it demonstrates that we can be really confident and optimistic about the prospects of success of the changes that we will be introducing in 2012/13.



Kevan Taylor
Chief Executive

2.3 The Board of Directors

The Board of Directors provides the experience and expertise that is essential to the effective governance of the Trust. Its members continue to demonstrate the visionary leadership and oversight that enables the organisation to fulfil its ambition.

At the end of 2011/12, the Board of Directors comprised 6 Non-Executive Directors, including the Chair, and 5 Executive Directors, including the Chief Executive.

2.3.1. Non-Executive Directors

The Non-Executive Directors of the Trust are:

- Professor Alan Walker, Chair
- Susan Rogers, MBE, Vice-Chair
- Councillor Mick Rooney, Senior Independent Director
- Martin Rosling
- Mervyn Thomas
- Anthony Clayton

2.3.2. Executive Directors

The Executive Directors of the Trust are:

- Kevan Taylor, Chief Executive
- Mick Rodgers, Deputy Chief Executive and Executive Director of Finance
- Clive Clarke, Executive Director of Operational Delivery and Social Care
- Professor Tim Kendall, Executive Medical Director
- Liz Lightbown, Executive Director of Nursing and Integrated Governance

Further details on the Board of Directors can be found in Section 7 of this report.

2.3.3. Directors' interests

Under the provisions of the Trust's Constitution and the Board of Directors' Standing Orders, we are required to have a register of interests to formally record declarations of interests made by members of the Board of Directors. In particular, the register will include details of all directorships and other relevant material interests which both Executive and Non-Executive Directors have declared.

Members of the Board of Directors must declare any interests which might create, or be seen to create a conflict or potential conflict between their personal or private interests and those of the organisation or their duties as members of the Board of Directors. They are also required to declare any conflicts of interest that arise in the course of conducting Trust business, specifically at each meeting of the Board.

The Register of Interests is maintained by the Foundation Trust Company Secretary and is available for inspection by members of the public on request.

The Company Secretary can be contacted by ringing **0114 271 6310** or emailing **chipo.kazoka@shsc.nhs.uk.**

2.3.4. Directors' statement as to disclosure to the auditors

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

2.3.5. Going concern

After making enquiries, the directors have a reasonable expectation that the 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.

2.3.6. Accounting policies statement

Accounting policies for pensions and other retirement benefits are set out in the Annual Accounts in Section 15 (note 1) of this report and details of senior employees' remuneration can be found in the Remuneration Report in Section 3 of this report.

2.4. Operating and Financial Review

2.4.1. An overview of our principal activities

We provide mental health, learning disability, substance misuse, community rehabilitation and primary care services to the people of Sheffield. We also provide some of our specialist services to the wider region. We are a provider of integrated services that meet peoples mental, physical, psychological and social care needs. An overview of our principle activities over the year is summarised in the sections below.

Restructuring of Our Services

We are constantly looking to provide our services in a more efficient and effective manner. Mindful of the fact that, prior to 1st November 2011, the structure of our clinical directorates had been in place for over 5 years and that, within that time, a number of significant events had taken place, namely:

- the Sheffield health community experienced the implementation of the "*Transforming Community Services*" scheme which saw the transfer of primary care services, previously provided by NHS Sheffield (our local Primary Care Trust), to the 3 NHS Foundation Trusts in Sheffield (which included us)
- the general economic downturn led to the reduction in the Government's health spend and thereby compelled us to take steps to reduce our back office and management capacity and associated costs

Taking into account these changes in our operating environment, as well as the need to ensure that our services were managed along care pathways, we undertook work to develop a new structure for our clinical directorates. The new service structure was designed to:

- work along care pathways
- accommodate the services transferred to us under the Transforming Community Services scheme, and
- significantly contribute to the savings that we needed to deliver on back office and management costs.

The new service structure, which took effect from 1st November 2011:

- brought together some of the clinical directorates that previously existed separately
- reduced the number of our clinical directorates from 6 (Acute, Community and Primary Care-Adult Mental Health; Recovery Rehabilitation and Specialist-Adult Mental Health; Dementia-Older Adults Mental Health; Functional Mental Illness-Older Adults Mental Health; Learning Disabilities, and; Substance Misuse) down to 4 (Acute; Community; Learning Disabilities and Specialist)
- reduced the number of directors and their assistants
- brought in the services that we acquired under the Transforming Community Services scheme. They report directly to the Executive Medical Director and the Executive Director of Operational Delivery and Social Care.

The new service structure is now embedded and, together, the clinical directorates are taking our strategic agenda forward.

2.4.1.1. Acute Directorate

Our Acute Directorate is made up of wards providing inpatient care and treatment to adults with acute mental health problems. All the wards in the Directorate provide 24-hour care for patients working towards their recovery. We deliver this inpatient care from:

- four adult acute inpatient wards that provide a total of 95 beds, including a small number of ring fenced specialist beds for substance misuse detoxification programmes
- the Psychiatric Intensive Care Unit ('PICU') based at the Longley Centre. This is a secure unit of 8 beds from which we provide care to people requiring a safe and controlled environment with high intensity and a multidisciplinary approach
- two wards for adults over 65 years of age providing 46 beds for older people requiring treatment and care
- 22 beds for forensic patients, which include provision for assessment and rehabilitation services supporting service users in making their transition into the community
- 62 beds to support the rehabilitation and recovery of service users with longer term mental health needs. These are provided at our inpatient ward at Forest Close and Pinecroft Ward based at the Longley Centre.

Additionally, the Acute Directorate is responsible for the management of the Mental Health Act throughout the Trust. The directorate also manages an Electro-Convulsive Therapy service which is available to service users from inpatient wards and the community. Electro-Convulsive Therapy involves the use of electrically-induced seizures in anaesthetised service users to treat severe mental health conditions (such as severe depression or prolonged or severe episodes of mania) that have not responded to other treatment.

In 2011/12, our key priorities for the delivery of inpatient care have been:

- ensuring a systematic approach to undertaking and recording risk assessments in line with the *Recovery Model*. This has been achieved through the introduction of risk management training and supporting systems
- the delivery of appropriate same sex accommodation for all service users. This has been achieved through changes to ward buildings and the establishment of Hawthorne Ward as a dedicated female ward
- taking a consistent approach to developing and recording care planning in partnership with service users and in line with best practice around the *Recovery Mode*l. The development of Insight (which is the Trust's organisation-wide information management system) this year has supported teams to develop their practice and to take a more collaborative approach to care planning
- the development of supervision for all staff in line with the Recovery Model. All staff receive supervision and the directorate is continuing to work towards improving the quality and consistency of this supervision.

The next year will see the Acute Directorate focusing its efforts on reconfiguring the delivery of inpatient services in order to improve the quality of care that we provide to service users whilst enabling us to achieve efficiency savings at the same time.

2.4.1.2. Community Services Directorate

The Community Services Directorate provides community-based services mainly to adults of working age. Most of these services are for secondary care which supports individuals with complex mental health problems. These services are mainly delivered through our *Community Mental Health Teams* (CMHTs) which are multi-disciplinary teams made up of health, social care and other allied professionals as well as support staff. They receive referrals from primary care and other sources, carry out assessments, provide interventions and care co-ordination for people with complex mental health problems.

The Directorate also provides social care services that help service users with practical support and developing day-to-day living skills, re-engaging with social and occupational activities, and planned and emergency respite. The way that these services are funded is changing significantly with the introduction of Self-Directed Support.

The Directorate also includes some primary care-based services such as IAPT *(Improving Access to Psychological Therapies)* which is aimed at providing time-limited, evidence-based psychological therapies for people with mild to moderate mental health problems.

The Directorate has undertaken significant work in 2011/12 in preparation for the reconfiguration of Community Mental Health Teams. These changes will take effect from June/July 2012. They are designed to enable the Community Mental Health Teams to work more effectively with primary care services and to meet our targets for delivering financial savings.

2011/12 has seen a number of other significant service developments within the Community Services Directorate which are set out below.

We established and successfully ran a pilot for the use of some beds at our Wainwright Crescent site for the provision of step down care from our acute wards. This was particularly aimed at meeting the needs of service users whose mental health has stabilised sufficiently for them to return home but whose accommodation is not yet ready for them to return to. The provision of the step-down beds has assisted in easing the pressure on our acute wards and in preventing service users from staying in acute beds for longer than is necessary. Service users were involved in the planning and reviewing of the pilot. As a result of its successful launch, NHS Sheffield has agreed to pay us to provide 4 of the step-down beds to service users who need them.

The Directorate developed an in-house Cognitive Behavioural Therapy training programme which was specifically designed for staff working with service users who suffer from psychosis. Cognitive Behavioural Therapy can be a very beneficial approach to providing support to people suffering from serious mental health problems. At times, however, the way in which it is delivered needs to be tailored to the circumstances of each individual service user. This training programme resulted in courses being provided to all our *Continuing Needs Teams, Assertive Outreach Teams, Early Intervention Teams* and to a number staff working in our long-stay inpatient services. Over 120 members of staff have now been trained on these courses.

The Directorate continued to implement *Self-Directed Support*, the process by which service users who are eligible for social care funding receive individual budgets to assist them in meeting their social care needs. The *Self-Directed Support* process can be quite complicated at times but it can also deliver significant benefits to service users, giving them more choice and control over the services that they receive and thereby enabling them to develop much more innovative ways of meeting their social care needs. There are now over 230 people who have an agreed support plan in place and many others who have an identified indicative budget and are developing their support plan.

The Directorate finalised, piloted and rolled out the *Scheduled Care Pathway* across all of our adult *Community Mental Health Teams*. It is designed to provide a consistent approach to the standards of care for non-crisis referrals to mental health services. It works in conjunction with the *Acute Care Pathway* which is designed for crisis mental health referrals.

2.4.1.3. Learning Disabilities Directorate

Our Learning Disabilities Directorate hosts the Joint Learning Disabilities Service. This is a single service through which we work in partnership with Sheffield City Council to support people with learning disabilities and their families in Sheffield. The main areas of service that we provide include:

- **Supported living and accommodation:** We provide care and support that enables people with a learning disability to live in their own home. Working in partnership with housing associations, we also provide 5 residential homes and 1 nursing home across Sheffield, as well as intensive support to people with a learning disability in supported living where they can be cared for in a way that enables them to maintain their independence and be treated with dignity and respect
- **Short break (respite) services:** We provide carers with the opportunity for planned breaks from their caring roles and emergency breaks which meet their family needs. We also provide service users with care in focused short breaks that helps to meet their needs. This service is provided from 3 sites across Sheffield
- **Community learning disability teams**: We provide community-based support from a multi-disciplinary team. This includes psychology, community nurses, physiotherapy, occupational therapy, and speech and language therapy alongside the local authority social workers. Working closely with primary and secondary care, this service provides direct care as well as working with the whole range of provider organisations across the city to improve the health and well being of people with learning disabilities and their families
- **Specialist mental health services:** Through our *Assessment and Treatment Unit*, we provide care and support to people with a learning disability who also have behavioural and/or mental health problems. We assess their needs and find the best way of helping them to live in their community with support. Our acute mental health service also provides inpatient care to people with learning disabilities who have also been diagnosed as having mental illness. Through our *Community Assessment and Intensive Support Service*, we provide a multidisciplinary approach to caring for people whose behaviour challenges their carers or the services that they use.

The delivery of services that support people with learning disabilities and their families in Sheffield requires a collaborative approach. In this regard, we work in close partnership with a range of other agencies and play an important role in helping to develop local, strategic priorities for service delivery.

Our key achievements in 2011/12 were:

- the development of a new model for the provision of specialist services that are community based and focused on meeting the needs of people with challenging behaviours who may also have mental health needs. Service delivery under this new model will be done from new premises that will replace our *Assessment and Treatment Unit*. These plans have been approved by the Board of Directors and our service commissioners. We are aiming for full implementation of the new service model at the new site by early 2013
- the service that we provide at our *Assessment and Treatment Unit* was inspected by the Care Quality Commission in November 2011 and we received a positive outcome from that inspection. This unannounced inspection formed part of the Care Quality Commission's national review of similar units following the disclosures of abuse at a privately run hospital in the south

of England. We have cause to be proud of the quality of service that we deliver to service users at the *Assessment and Treatment Unit*. It is one of a very small number of similar service units in England that were found to be fully compliant with the Care Quality Commission's assessments against its standards on *Safeguardin*g and *Care and Welfare* of people that use such services

- The development of care and support pathways to ensure that our *Community Learning Disability Teams* are structured to work in the most effective way to support the health and wellbeing of people with learning disabilities and their families. The restructuring of Community Teams is now under way.

Going forward, we continue to face the following significant challenges:

- the provision of accommodation, support and respite services is facing significant challenges across the city of Sheffield. We are working very closely with Sheffield City Council, NHS Sheffield and our housing association partners to look at service reconfiguration and future provision. The significance of the challenge for us lies in our ability to deliver affordable services that will be sought by customers purchasing accommodation and support services with individual budgets under the *Self-Directed Support* framework. The shape of our future service provision remains uncertain for now
- we are continuing to work with NHS Sheffield to secure further investment in our specialist mental health services. The main focus of this work is on returning, to Sheffield, residents whose care has had to be provided to them through placements with service providers based outside the city. We have not yet arrived at a final agreement. However, it remains as a key objective as it will increase our opportunities to meet the growing demand for people to be cared for closer to where their families live, and to manage future budgets
- aligned to the objective referred to immediately above is our involvement with the *Improving Health and Lives: Public Health Observatory* which aims to provide better and easier to understand information on the health and wellbeing of people with learning disabilities. This will help us to identify service quality improvements that will enable us to achieve the best possible health and life outcomes for people with learning disabilities

2.4.1.4. Specialist Services Directorate

Our Specialist Services Directorate hosts a range of specialist services that we provide. These include:

- community-based mental health and social care services for older people
- bed-based health and social care services for people with dementia
- services for people with problems associated with the misuse of drugs and alcohol
- specialist mental health services
- services for people with eating disorders
- relationship, sexual and gender identity services
- psychological services
- therapy services
- services for people with a neurological injury or disease that causes long-term impairments and restrictions in the scope and quality of their everyday life.

Some of our significant achievements of the year include the following:

- we retained our existing service contracts and expanded the range of services that we provide
- we have led the general growth in service provision across the whole spectrum of services that we deliver to the people of Sheffield and its surrounding districts
- we increased the level of care that we provide to people within the community
- we successfully reconfigured the way that we provide services through our Dementia Resource Centres, to older people. This has resulted in more people receiving increased alternatives of care and support within their communities
- we successfully relocated all service users from the *Kirkhill Resource Centre* which we closed
- we successfully reconfigured the way that we provide services through our Day Hospitals to older people with functional mental illness. This has resulted in our development of a proposal for a new Functional Intensive Community Service which provides more intensive support to service users to ensure that they stay out of hospital where this is appropriate
- following NHS Sheffield's decision to continue commissioning our provision of services to two nursing homes that faced the possibility of closure, we successfully negotiated new staffing and clinical service models that will enhance the high quality care that we already provide at these two homes
- we opened a new *Eating Disorders Day Service* with the aim of providing the people who use the service with a range of activities that offer them an alternative to hospital admission
- as a result of Sheffield's Transforming Community Services, we welcomed, into our Therapy Services, new professions and services which included, among others, physiotherapy, speech and language therapy and services for people with long-term neurological conditions. This was the first major change to therapy services in over 8 years and we have worked successfully to develop new thinking and increased awareness of the different professions and services that we have taken on
- the people who use our *Neurological Enablement Services* and their carers were involved in an event which actively engaged service users with degenerative neurological conditions and those with severe physical and communication difficulties in a collaborative evaluation programme
- the *Chronic Fatigue Service/Myalgic Encephalomyelitis (CFS/ME) Service* has been driving forward a number of innovative projects to elicit the voices of service users through a creative writing pilot project and collaboration with the University of Sheffield for the production of a DVD exploring patient stories
- the *Brain Injury Rehabilitation Research Partnership* has grown from strength to strength, with members involved in a range of diverse projects including the production of '*Head-lines*', an anthology of work presented as part of the Sheffield Literary Festival
- led by our *Therapy Services*, we progressed further with the implementation of our *Arts and Health Strategy* which resulted in: our active involvement in organising an event hosted by the Lord Mayor in April 2011 which was aimed at raising awareness of mental health issues and the value of the creative arts as an aid to recovery; our active involvement in organising a ground-breaking art exhibition at the Sheffield United Football Club Stadium at Bramall Lane which showcased artwork by people who use our services and other people from across the country dealing with mental health issues. This was the outcome of our close working with *Sheffield United Football Club, Breakthrough*, an organisation that promotes positive mental

health through the creative arts and its associated charity, *Reflections Art in Health*, and; the publication of the first arts and wellbeing newsletter in December 2011.

Our operating environment continues to present us with risks and uncertainties that challenge our provision of services in the future. These include:

- the continued increase in the level of competition that we face and the retendering, by our commissioners, of the core services that we provide
- the challenge to our capacity to maintain a viable level of demand for our services in the face of the advancement of *Self-Directed Support* and *Payment by Results* which are intended to provide the people who use our services with the choice of obtaining the services that they need from alternative providers
- the impact of the adverse economic climate and the resulting reduction in public sector expenditure. This has led to unprecedented reductions in the budgets of those who purchase our services on behalf of the people who use them.

Other trends and factors that are likely to affect the future development of our business include:

- the predicted rise in the number of older people within Sheffield. This is bound to result in an increase in demand for services to meet their needs
- the continuing need for us to work across primary and secondary care services and develop our expertise as a reputable provider of primary care solutions
- the need for us to increase the level of our partnership working with our local authority and other agencies in the not-for-profit sector in order to deliver high quality and affordable services to the people who need them
- the need for us to continue to build on our interface with our local acute hospital Trust in order to increase our service provision to people who are in need of our services in times of ill health or crisis
- the need for us to increase our income generation opportunities through the specialist services that we provide. To do this, we must ensure that we develop our level of understanding of the needs of the people who currently use our services and of those who could but are not yet using these services. This will enable us to take a proactive approach in marketing our service offerings to them.

2.4.1.5. The Clover Group

Services provided by the Clover Group

The *Clover Group* consists of the *Homeless and Traveller Team*, the *Sheffield Community Access and Interpreting Services (SCAIS)* and the four *Clover Group* GP Practices.

The *Homeless and Traveller Team* is a health visiting and nursing service for people in Sheffield who are homeless, travellers or resident in a women's refuge. The service provides an enhanced health visiting and nursing service for children and adults of all ages.

SCAIS provides interpreters in 80 languages for people whose first language is not English. Interpreters are provided to work within the health service but also for other organisations such as solicitors, housing providers and benefits agencies across South Yorkshire. The service organises approximately 30,000 interpreting sessions per annum.

The four *Clover Group* GP Practices are based in Darnall, Tinsley, Jordanthorpe and Mulberry (city centre). The populations served by the practices are some of the most vulnerable and socially-deprived patients in the city. These include asylum seekers, high levels of frail older people and those from black and minority ethnic (BME) backgrounds. There are over 15,000 patients registered with the practices.

Key strategic objectives

The *Clover Group's* priorities for the past year have been to:

- fully integrate into Sheffield Health and Social Care NHS Foundation Trust following their transfer from NHS Sheffield through the *Transforming Community Services* process
- develop a management and directorate structure within the Trust in order to support service development and maximise organisational integration
- develop a service delivery model for the *Clover Group* GP Practices under a 3-year *Alternative Medical Provider Service (APMS)* contract by working closely with the service commissioners. *APMS* contracts support the provision of a range of services tailored to local needs
- continue to develop the *Clover Group* GP Practices as a multi-site super-practice
- increase service user involvement through service user feedback and the establishment of a patient participation group
- develop an IT and telecoms strategy to support the development of the services and enhance the patient journey
- improve health services for homeless and traveller single adults and young people and develop robust assessment and referral systems
- review and achieve financial plans and agree achievement of cost improvements.

Key strategic achievements

The following are some of the highlights of the *Clover Group's* significant achievements for 2011/12:

- *SCAIS* has recently introduced some new key developments to ensure they remain in a strong position within the interpreting market. These include a new database, telephone system and online booking facility and telephone interpreting
- the *Clover Group* GP Practices have negotiated a fit for purpose *APMS* contract and will benefit from the security of a three-year term of the contract. The service is currently in the process of developing as a multi-site flagship that others can learn from
- the *Clover Group* GP Practices have established a *Patient Participation Group* which will enable us to engage with patients, increase awareness of their needs and improve health outcomes, particularly for hard to reach, *BME* and vulnerable groups
- the *Clover Group* continues to maximise income streams through achievement of *Quality Outcomes Framework* key performance indicators and enhanced service delivery. The service has taken on new, enhanced services during 2011/12 in order to increase its income generation.

Significant challenges, strategic risks and uncertainties

The following are some of the significant challenges, risks and uncertainties that the *Clover Group* faces:

- the risk of reduced staffing due to financial constraints has the potential to reduce access and patient satisfaction. There are potential adverse implications for recruitment and retention of senior clinical staff if their contracts are not permanent
- the ability to maintain excellent levels of performance and achieve key performance indicators in order to maintain income streams and the continuation of the *APMS* contract beyond the current 3-year term.

2.5 An overview of our arrangements for quality governance

The Trust has produced an *Annual Governance Statement* which describes our arrangements for quality governance. This is contained in Section 13 of this report.

2.6 How we use our Foundation Trust status to improve patient care

Foundation Trust status enables us to engage Governors and members, who represent the communities that we serve, in the development of our services and the improvement of patient care. The *Quality Report*, contained in Section 11 of this report, shows some of the ways in which our Governors and members have been involved shaping the way that we have delivered our services over the last 12 months.

2.7 How we involve patients and the public in improving services

The involvement of patients and the public in improving our services is also shown in more detail in the *Quality Report*. One example of an exciting development in this regard has been our introduction of a new *Service User Experience Monitoring Unit* which draws on the involvement of service users in helping us to continuously improve the quality of their experience of using our services. More details on the *Service User Experience Monitoring Unit* are contained in the *Quality Report.*

2.8 How we monitor improvements in service quality

We monitor improvements in service quality through our governance systems and the *Quality Accounts*. The Board and its *Quality Assurance Committee* receive regular reports on service quality and improvements.

The *Quality Improvement Group* provides an opportunity for clinical staff, managers, Board members, Governors and others to hear, in detail, about quality improvement projects, and share ideas for innovation and best practice.

We also report externally to our commissioners on: the quality of services that we provide; the service improvements that we make; our progress in achieving the various quality targets that are set for us annually in our contracts with our commissioners and; our performance in the additional arrangements that our commissioners use to incentivise us to make quality improvements in areas that they prioritise. These arrangements are known as *Commissioning for Quality and Innovation (CQuINS).*

Further information is available in the *Annual Governance Statement*, the *Quality Report* and our performance reports which are contained in further sections of this report.

2.9 How we are improving Patient/ Carer Information

Information is an important part of the service user journey and is central to the overall quality of each service user's experience of the NHS. Improving information for service users is a commitment in the *NHS Constitution.*

During 2011/12, we have been involved in a range of initiatives that have helped to improve the way we provide information to the people who use our services and their carers. These include:

- working in collaboration with a range of service users and carers, including people with learning disabilities. The *Partners in Improving Quality Group* has designed 'easy-read' pictorial versions of a range of different leaflets and reports about the *Care Quality Commission* – which is the body responsible for regulating all providers of care services in England. Their 'mock visits' to services are an important part of our quality assurance processes
- throughout 2011/12, service users and carers have been a part of reading panels. The members of these panels were asked to contribute their ideas and expertise on a wide variety of documents, including policies, ward leaflets and posters
- specific information for carers has been designed in the spirit of co-production, using carers' expertise and lived experiences. This has included the creation of another five digital stories from carers, in collaboration with *Pilgrim Projects*, and including some stories from carers within black and minority ethnic communities. These powerful mini movies offer an insight into carers' experiences and an opportunity for viewers to reflect on the quality of services that we provide. They can be seen on the Trust's website under *Patient and Carer Information* using the following link:
  www.patientvoices.org.uk

2.10 How we handle complaints and concerns

The Trust is committed to ensuring that complaints and concerns are dealt with promptly, thoroughly and fairly. Service users, carers or members of the public who make a complaint or raise a concern can be confident that their feedback will be taken seriously and that it will be fed back to services to enable improvements to be made.

During 2011/12, we received 110 formal complaints and 235 informal complaints.

We responded to an estimated 91% of the formal complaints and we are awaiting final resolution of some of these complaints at the time of writing. We responded to 100% of the informal complaints within the agreed timescales.

More information is provided in our comprehensive *Annual Complaints and Compliments Report* which is available on our website and can be accessed by using the following link:
www.shsc.nhs.uk/about-us/complaints

Patient Advice and Liaison Service (PALS)

We also received 79 *Patient Advice and Liaison Service (PALS)* queries during the year. These have included questions about our services from the general public, service users, carers and staff members. They can range from a service user asking for advice about treatment for a particular problem, to people inquiring about volunteering opportunities. The *PALS* service aims to answer all queries within 24 hours during the working week.

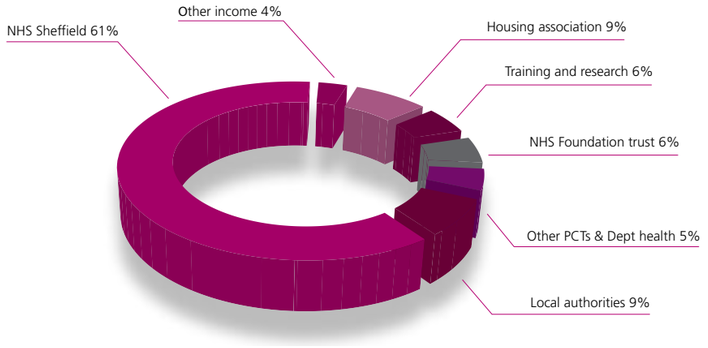
2.11 Who our main commissioners are

As an NHS Foundation Trust, we provide 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.

Our non-patient care services are commissioned by NHS Sheffield, other NHS 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 from us.

Housing Associations commission our residential care services.



2.12 Our performance against key healthcare targets

We have performed well and achieved all required healthcare targets. The information about how we did against different targets for our services is contained in our Quality Report in Section 11.

In summary we achieved:

- all targets for mental health services required of us by Monitor, the independent regulator of NHS Foundation Trusts, and by the Department of Health
- all targets to improve access to psychological therapies for common mental health problems within primary care
- national targets for the effectiveness of treatment for substance misuse services
- required standards of care in respect of the quality of food, privacy and dignity, and the environment in which we deliver our services.

2.13 How we monitor improvements towards meeting national and local targets

Our performance framework ensures we are able to effectively monitor progress against national and local targets. The framework is based upon:

- clear accountability throughout the organisation ensuring that we are aware of what is expected of us
- established performance measures and indicators that will enable us to assess our achievement in delivering high quality care and our overall strategic aims
- the provision of appropriate information to enable reviews of local and organisational performance and on-going decision making and support the above-mentioned framework.

The Board of Directors receives a range of performance data and information within a planned reporting framework to ensure monitoring and evaluation of progress and outcomes is undertaken and improvement interventions are directed when required.

2.14 Significant changes we have made to existing services and new services we are providing

Detailed information regarding the range and scope of the changes we have introduced to improve and develop our services is outlined in Section 2.4 of this report.

At an organisation-wide level, the more significant changes that we have made to our services is summarised as follows:

- we provided new services during the year following the transfer of established community services under the T*ransforming Community Services* programme. These services consisted of GP Practices, services for people with long term neurological conditions and services for vulnerable people
- in line with established city-wide strategies, we closed 2 residential centres that provided residential and respite care services for older people as we continue to deliver more services in more community-orientated ways
- we opened a specialist day centre for people with eating disorders in order to enable to us provide them with more intensive community based support as an alternative to hospital care and treatment
- we reduced our provision of social care respite services during the year in response to changing use by the people who had used our services and we developed new services in their place in order to allow people to leave hospital earlier and continue their recovery in more community-orientated settings.

2.15 How we work with our partners

We work in partnership with the organisations that commission our services, namely NHS Sheffield, the emerging Clinical Commissioning Group, and Sheffield City Council. This allows us to understand the health and social care needs of the wider population, to influence the commissioning approach taken and to develop new services for the benefit of the system as a whole and ultimately, for the people of Sheffield.

We work in partnership with a diverse group of interested parties across the public and third sectors and with voluntary and local community groups. This allows us to develop better relationships with other organisations that provide support to people in Sheffield and fosters better collaborative working between us. We use these opportunities to promote the needs and interests of the people that we serve and to reduce some of the barriers people can often experience in accessing the services that they need.

We also provide a number of services in partnership with other organisations.

Delivering integrated health and social care

We have a formal partnership agreement with Sheffield City Council to deliver integrated mental health services across health and social care for adults (people aged between 18-65 years of age). Under this partnership, Sheffield City Council has formally delegated to us its statutory responsibilities for the provision of services covered by the partnership agreement. This partnership has been in place for over 10 years and has been instrumental in allowing us to develop and provide the services that we deliver. The people who use our services have benefited from our ability to develop and deliver genuine integrated models of services that provide single care pathways across health and social care.

Through our partnership arrangements with Sheffield City Council, we also deliver integrated services for people with learning disabilities. We have established a single joint service model across health and social care services.

Intermediate care

We also work in partnership with Sheffield Teaching Hospitals NHS Foundation Trust to provide occupational therapy and mental health services into the services that they provide.

Improving service user experience

In partnership with *MAAT Probe* and other service users, we began the implementation of the *RESPECT* training following an extensive review of our services focussing on the prevention and management of violence and aggression. By working in partnership in this way, we have been able to effect significant positive practice changes in this challenging area.

Improving support for service user arts

We have also developed a number of partnerships around arts and health. Our close work with *Breakthrough*, a national organisation that promotes positive mental health through the creative arts, its associated charity, *Reflections Art in Health and Sheffield United Football Club (SUFC)* has resulted in service user artwork being displayed in the executive suite at *SUFC*'s football stadium at Bramall Lane and promoted through a series of events. SUFC has also devoted time to raising awareness of mental health and invited artists to make art at match days and we continue to build on this innovative partnership. Service user artists have also accessed unique opportunities through the University of Sheffield's '*Storying Sheffield*' project and working with Sheffield Museums to create a 2 year art exhibition themed '*Coming Home*' at Weston Park Museum.

Increasing access to vocational opportunities and employment for our service users

We are a key member of the *Employment Multi-Agency Group*, whose membership consists of health, social care, voluntary sector organisations and *Job Centre Plus*. Together, we and our partners are committed to working towards improving vocational and employment opportunities for service users on the *Care Programme Approach (CPA)*.

Successful bidding for regional funds and some additional resources from *Life-Long Learning and Skills* at Sheffield City Council has enabled us to employ a dedicated worker and three individuals with lived experiences of supporting people on their vocational journeys.

We have a formal contractual relationship with a social enterprise organisation called Broomby for the provision of catering services at one of our sites where it trades under the name Busters' Cafe. It offers additional vocational training and paid work to service users.

As an organisation that has signed up to the *Mindful Employer* initiative, we have also been supporting and advising other organisations in the city on the implementation of this initiative which is aimed at raising awareness of mental health at work and providing support for business in recruiting and retaining staff. We recently shared our expertise with other key city-wide stakeholders to ensure that mental health needs form part of the development of a city strategy to tackle unemployment.

From April 2012, we intend to enter into a formal contract with *Recovery Enterprises*, a not-for-profit organisation. This will provide employment opportunities for people who use our services as a means of promoting their recovery and rehabilitation.

Partnerships with the people who use our services

Most importantly, we work in partnership with the people who use our services, our members and Governors who represent them. We work together in monitoring and evaluating the current performance of our services and in planning their development in the future. Numerous examples that illustrate how we have benefited from this are outlined in the Quality Report in Section 11.

Relations with our other strategic partners

Alongside our formal Section 75 Partnership Agreement with Sheffield City Council, we continue to work with a range of other partners, from the statutory, independent and voluntary sectors across the city, in a number of key areas. Some of them are even represented in the membership of our Council of Governors.

2.16 Valuing our staff

Supporting staff through change

The process of change and dealing with the implications of such change has been and will continue to be a key element of the work of our Human Resources (HR) Directorate. As a Trust, we have a number of policies and procedures designed to support our staff who are engaged with this process. Despite the degree of change involved, we have, to date, been able to successfully redeploy affected employees.

Our Human Resources Directorate has continued to work with Staff Side (the trade unions) to assist directorates with meeting the challenges arising from a wide range of organisational change projects. For instance, over 200 staff were successfully transferred to us from NHS Sheffield as part of the Transforming Community Services process. This has substantially added to the depth and scope of the skills and competencies available to us and they will enable us to take forward our vision.

As part of the transfer of services which was at the heart of the Transforming Community Services process, we welcomed the four GP Practices previously housed within NHS Sheffield. We have now brought these together as the "*Clover Group*". The transfer itself occurred in April 2011, but the process of building understanding and sharing learning continues and has been a feature of the progressive integration of our new members of staff and services.

There have been other transfers of staff between us and the other Trusts within Sheffield, albeit on a smaller scale. The potential interchange of staff is likely to be a continuing feature in the coming year.

Our major change projects have included the restructuring of our Clinical Directorates which had two main phases involving the reduction in the number of directorates and the appointment of new management teams within the new directorate structure. This has enabled the interchange of senior personnel to help widen the experience available for decision-making and improve working between directorates. The new structure also offered us the opportunity to re-align our HR Directorate *Partner Teams* that provide HR expert support to our directorates in order to reflect the new arrangements and obtain similar benefits in terms of sharing approaches and the cross-fertilisation of ideas.

At the current time, our HR Directorate is actively involved in supporting the Community Mental Health Teams reconfiguration which involves around 250 members of our staff and 50 social workers employed by Sheffield City Council.

Service provision in relation to our social care establishments has also been under review at different points in the year.

We continue to have in place mechanisms to challenge and review vacancies to ensure the effective deployment of our staff. Monitoring of staff changes has occurred via the *Vacancy Control Panel* and we have undertaken a specific review around short-term temporary posts and agency staff in order to establish any roles that could be released in order to increase opportunities for employees. We have established a specially-constituted *Vacancy Control Panel* with the involvement of Staff Side to look at applications under our *Mutually Agreed Resignation Scheme (MARS)*. This scheme is based on a national model and enables members of staff to be released from the organisation with a prescribed payment where the release of the role would assist the Trust with its financial and workforce requirements. So far, 15 former members of staff have been released under the scheme and further consideration is being given to applications in April/May 2012.

For the next financial year, we are developing an *Accountability Framework* with our directorates in order to give them greater ownership of the financial implications of their staffing decisions and accountability for the impact of these decisions. This will remove the need for the *Vacancy Control Panel* to consider posts below the level of *Band 7*.

2011/12 also saw us commence the roll-out of the electronic rostering project which will assist with the effective scheduling of staff rotas and provide for more efficient attainment and transfer of information on payments and absences. This is a major exercise and a substantial commitment is required to ensure its successful implementation.

2.16.1. Equal opportunity statement

We believe in fairness and equality and aim to value diversity and promote inclusion in all that we do. This is demonstrated in our strategic vision, that people who use our services will achieve their full potential, living fulfilled lives in their community. Valuing the diversity of people who work in our services and prioritising equal opportunity is essential to meeting this aim.

We are committed to eliminating discrimination, promoting equal opportunity and doing all that we can to foster good relations in the communities in which we provide services and within our staff teams, taking account of gender, race, colour, ethnicity, ethnic or national origin, citizenship, religion, disability, mental health needs, age, domestic circumstances, social class, sexual orientation, marriage or civil partnership, beliefs and trade union membership. Everyone who comes into contact with our organisation can expect to be treated with respect and dignity and to have proper account taken of their personal, cultural and spiritual needs.

Within our teams, valuing difference is fundamental. It enables staff to create respectful work environments and to deliver high quality care and services whilst giving service users the opportunity to reach their full potential.

If unjustified discrimination occurs, it will be taken very seriously and may result in formal action being taken against individual members of staff, including disciplinary action.

2.16.2. Equality and diversity

In 2011/12, we have been preparing for changes in equality legislation which are found in the Equality Act, 2010. We have a *Single Equality Scheme* which sets out our *Equality Objectives* and the actions that we will take to meet these until April 2012. In April 2012, this scheme will be replaced by our new *Equality Objectives.*

To report on progress, we produce an Annual Equality and Human Rights Report which provides full details of our Equality and Human Rights work and other related, detailed information.

The new *NHS Equality Delivery System (EDS)* was introduced in 2011 and is available to all NHS organisations. We have started to focus our equality work around this new framework. The *EDS* has four goals for the NHS, as a whole, which are:

1. *Better health outcomes for all*
2. *Improved patient access and experience*
3. *Empowered, engaged and included staff*
4. *Inclusive leadership at all levels*

The *EDS* has a grading system and we have used this system to consider how we are progressing, as an NHS service provider and as an employer, towards meeting the goals enshrined in the *EDS*. We have shared our initial findings at a stakeholder workshop that was held in February 2012. We intend to continue framing our equality work around our *EDS* grading and have identified some actions that we will take in 2012/13 to support this.

The Equality Act, 2010 includes a new duty known as the *Public Sector Equality Duty* which applies to us as a Foundation Trust and to other public sector organisations. The nature of the duty is such that we should have 'due regard' to the following in all that we do:

- *the elimination of discrimination, harassment and victimisation*
- *the advancement of equality of opportunity between people protected by the Equality Act, 2010 and others*
- *the fostering of good relations between people protected by the Equality Act, 2010 and others.*

What we did in 2011/12 to eliminate discrimination, harassment and victimisation:

- we looked, in detail, at our staff recruitment data and our staff disciplinary data and have identified some actions we will take in 2012/13
- we worked with the *Yorkshire and Humber Regional Equality Leads* Group to develop a good practice protocol for use in inpatient hospital services to support people who are either undergoing gender reassignment or have already done so
- we undertook a second programme of training in cultural capability for senior managers
- we completed the '*Disability Standard*' assessment by the *Employers Forum* on *Disability* and the Stonewall '*Workplace Equality Index*'.

What we did in 2011/12 to advance equality of opportunity for protected groups:

- in March 2011, we were involved in an event with other NHS organisations in Sheffield at which the *Public Sector Equality Duty* and the *NHS Equality Delivery System* were introduced. We used the feedback from this event in 2011/12 to inform the development of our new *Equality Objectives*
- we were involved in the *NHS Employers Equality and Diversity Partner programme*. This demonstrates our continuing efforts to improve our performance and capacity around equality and diversity
- we started to review how we train staff in managing violence and aggression in our inpatient services. This was done in partnership with *MAAT PROB*E, a Sheffield-based group for African Caribbean mental health service users
- we supported the development of a DVD for people who are deaf and use mental health services
- as a result of the feedback that we received from a *Stonewall* staff survey that was undertaken in 2010, we held a *Lesbian, Gay and Bisexual Sharing Good Practice Seminar*. This was attended by over 55 people. We plan to develop some staff good practice guidelines in 2012/13 as a result of this event.

What we did in 2011/12 to foster good relations between people in protected groups and others:

- in June 2011, we attended the Sheffield *Lesbian, Gay, Bisexual and Transgender Pride* event. We: promoted *Stonewall* initiatives; were actively involved in the new stage of the *Time to Change* mental health anti-stigma campaign called '*Time to Talk*' and; sold '*Recovery*' bracelets which are part of our mental health recovery work
- we held our annual African Caribbean celebratory day. As usual, this was an excellent event
- we continued to develop our *Staff Network Groups* and in February 2012, we officially launched the Trust's *BME (Black and Minority Ethnic) Staff Network Group* with a celebratory event.

In January 2012, we updated the information we had published in our 2011 *Annual Equality and Human Rights Report* to include more information about the people who use our services. This helped us to meet our legal duties and to provide information to help us decide our new Equality Objectives which are due to be published in April 2012. All of our information and *Annual Equality and Human Rights Reports* can be found on our website using the following link: **www.shsc.nhs.uk/about-us/Equality-Diversity-Human-Rights**

2.16.3. Disability employment

As a sign of our commitment to providing equal opportunities for people with a disability, we renewed our '*two ticks*' status which is conferred by *Jobcentre Plus* to organisations that are able to provide tangible demonstration of their positive commitment to providing equal opportunities to people with a disability. We also maintained our action plan to uphold our commitment to the *Mindful Employer* initiative which aims to raise awareness of mental health at work.

As an *NHS Employers Equality and Diversity Partner,* we took part in piloting the new benchmarking process of the *Employers Forum on Disability (EFD)* and completed a full report for the Trust in October 2011. We have also undertaken a *Staff Carer Survey* aimed specifically at identifying our members of staff who care for a relative, friend or neighbour with a disability. We intend to produce an action plan in response to the survey results.

Currently, 4.23% of our members of staff report that they have a disability. In 2012/13, we hope to do some more detailed analysis to see the types of disability that they have reported in order to enable us to respond appropriately through our policies, procedures and practices.

2.16.4. Staff engagement and working with staff side (Trade Unions)

Engagement with staff

We have a workforce of over 3,000 staff (including our flexible workforce). As a Trust, we recognise that our staff are our "most valuable asset" and we are committed to working in partnership with them in order to ensure that they are properly informed and engaged.

We have a variety of mechanisms for engaging with our members of staff and we continue to abide by and support the NHS Constitution which applies to all NHS organisations and sets out the principles and values of the NHS, its pledges to the public, service users and staff as well as their rights and responsibilities.

The national *Annual Staff Survey* results which have been published recently indicate that we have maintained our position within the top 20% of mental health/learning disability Trusts within the country for overall staff engagement. Further details on this are contained in Section 8 of this report.

In 2011/12, we sought to extend our engagement with staff through events relating to equality and diversity and to their health and well-being. The latter is demonstrated by the success of our *"12 for 12 Campaign"* that we launched in September 2011. This initiative involves 12 sets of activities over 12 months, picking up the theme of the 2012 Olympic Games. This is part of our approach to supporting and improving the health and well-being of our staff. We have actively encouraged their participation in activities such as cycling, walking, stress reduction, eating well and dancing, among other things.

Engagement with staff side (Trade Unions)

On a continuing basis, we engage with Staff Side in a variety of ways. These include the maintenance of dialogue through the *Joint Consultative Forum*, the *Joint Policy Group* and the Bargaining Forum. Staff Side also have representation on our *HR and Workforce Group* as do Staff Governors. Matters relating specifically to our medical staff are considered by the *Joint Local Negotiating Committee*.

New initiatives arising from the work of these groups have included *Salary Sacrifice Schemes* to enable the purchase, by staff, of bicycles and, most recently, additional annual leave. The groups have also contributed to a number of key policies being reviewed and revised including the Disciplinary Policy, the *Career Break Scheme*, the *Managing Sickness Absence Policy* and the *Retirement Policy*.

Our commitment to continue engaging our staff

Engaging with our staff during this challenging period for the NHS, as a whole, is the focus of a targeted communications plan that we have developed. Our work in this regard will continue into the next financial year. An example of one of our recent initiatives is our establishment of the staff forum on cost savings. This forum provides our members of staff across the Trust with the opportunity to raise and discuss their views on this major challenge that we must address together. For the future, we intend to roll out initiatives such as staff roadshows, targeted presentations and newsletters in order to help ensure continued and effective engagement with staff and other key stakeholder groups.

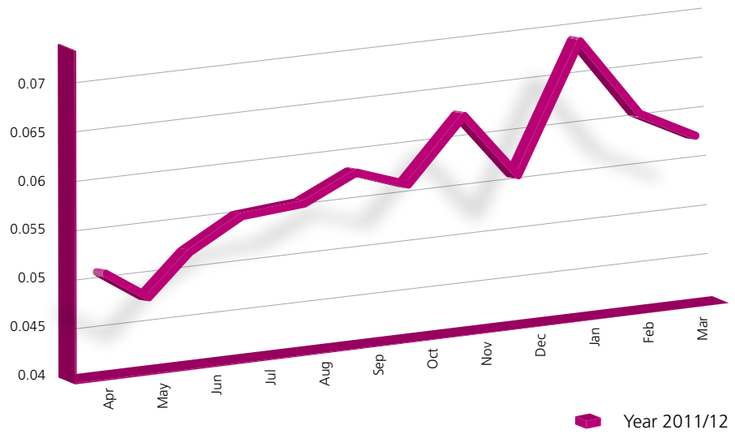
2.16.5. Sickness absence

The level of sickness absence within the Trust is broadly comparable to other Mental Health Trusts. Last year, we achieved our target of attaining a sickness absence level of less than 5.4%. However, the average, so far, for 2011/12 has been above the new target of 5.1%. The management of sickness absence continues to be a major area of work through which our HR Directorate provides support to line managers and staff.

We are revamping the manner in which we provide information on absence, in general, to the Board of Directors and directorates with a view to broadening their understanding of the available data. Similarly, we have moved to an electronic system of absence notification in order to improve recording. We intend to carry out further developments around the ongoing use of electronic data to measure and monitor absence management. We are also undertaking work with our Occupational Health providers to review the range and nature of services that they provide to us.

We are taking proactive steps to reduce levels of absence and this is evidenced by the *"12 for 12 Campaign"* referred to above. We have also improved the take-up of flu vaccinations within staff groups, with a significant increase in uptake in 2011/12 when compared with the previous year.

Sickness absence in 2011/12



2.16.6. Occupational health

We provide an Occupational Health service to our staff via a contract we have with the Sheffield Teaching Hospitals NHS Foundation Trust. We have regular meetings with our Occupational Health service provider to review performance and to identify the need for any new initiatives. 2011/12 has seen the following:

- the review of pre-employment screening in line with the recommendations of the Boorman Review on NHS staff wellbeing and the Equality Act, 2010
- the revision of guidance to staff on Occupational Health referrals
- the establishment of new measures to assist with the uptake of flu vaccinations by our members of staff
- the involvement of an Occupational Health consultant in the HR Governance Group and the *"12 for 12 Campaign" Working Group*

In addition to the Occupational Health service, we also provide our staff with our own *Workplace Well-Being (WWB) Service* which is a free and confidential counselling service for any member or group of our staff. *WWB* also provides training on issues such as stress awareness and dealing with conflict. *WWB* contributed to the *"Stress Reduction"* themed month of the *"12 for 12 Campaign"*.

We also provide a *Staff Health and Wellbeing* site on our website. It was created to support our strategic aim of creating a working environment which promotes healthy and active lifestyles amongst our members of staff and it provides access to local, regional and national resources and tools.

2.16.7. Volunteers

In recognition of the important contribution which volunteers make to our work, we set up a *Volunteer Development Group* in order to improve the participation of this valuable resource in what we do. As a result of the work undertaken by the *Volunteer Development Group*, we have issued a new *Volunteer Policy* and established a dedicated role within the Trust to support our volunteers.

2.17 Our financial performance and other disclosures in the public interest

We have now been established as Sheffield Health and Social Care NHS Foundation Trust for over three years. Through strong financial performance, we have successfully maintained a *Financial Risk Rating* of 4 with Monitor, our independent regulator.

In respect of the year 2011/12, we exceeded our planned forecast of a £1,742,000 surplus and achieved a surplus of £1,990,930 with *Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA)* of £6,529,027 (against a plan of £6,046,000).

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 and, where appropriate, enhance the quality of the 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.

We are pleased to report that the surplus has exceeded the target identified in the Annual Plan, and this has been achieved through rigorous expenditure control and tight management of our efficiency programmes. We have maintained our surplus to enable us to achieve the minimum *Financial Risk Rating* of 3 which provides Monitor with assurance that a Foundation Trust is in good financial health.

Our present *Financial Risk Rating* has come about due to the effective delivery of our *Annual Plan* objectives and focus on our *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 for 2011/12, some of this delivery (approximately, £1.5 million) has been through non-recurrent measures.

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

The following sections provide 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 commencing from 1st April 2011 to 31st March 2012 are included in full under Section 15 of this Annual Report.

2.17.1. Financial risk rating

Part of the NHS Foundation Trust governance framework requires NHS Foundation Trusts to submit, to Monitor, an *Annual Plan* as well as 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 and 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 2011/2012.

As a Trust, we have a rigorous performance monitoring system in place through the structure of our operational committees, committees of the Board of Directors, right through to the Board of Directors itself where performance reports are monitored and reviewed on a monthly basis.

2.17.2. Our income and expenditure position

In the 12 months covered by this report, the Trust generated an income totalling £122,547,000. A summary of the position is provided below:

	Total 1st Apr 11 – 31st Mar 12 (£'000)	Total 1st Apr 10 – 31st Mar 11 Restated (£'000)
Income from Activities	86,961	80,579
Other Operating Income	35,513	36,523
Total Income	**122,474**	**117,102**
Operating Expenses	(118,466)	(112,737)
Profit on disposal of property, plant and equipment	73	8
Interest received and other financial costs	101	72
Public dividend	(2,191)	(2,109)
Surplus for the year	**1,991**	**2,336**

2.17.3. Disclosure in relation to other income

The composition of other operating income is disclosed in note 3.1 to the Annual Accounts contained in Section 15 of this report.

2.17.4. Cash flow management

We continue to review our Treasury Management Policy and cash and working capital management. Our aim is to ensure that cash management continues to be in line with Foundation Trust requirements, which are based on commercial cash management arrangements.

Our cash balance at the end of March 2012 was £17.028 million and the Trust has a contracted working capital facility of £2.5 million. During the year, the Trust did not need to use its working capital facility.

2.17.5. Capital expenditure

The Trust's investment in capital expenditure for 2011/12 was £0.678 million. The spending of capital has been minimal this year as we continue to review our existing estates strategy. A major part of this review relates to the *Acute Care Reconfiguration* of mental health services.

The planning and development of the *Intensive Support Service Unit (ISSU)* within the Learning Disabilities Service commenced in 2011/12 although the majority of expenditure for this will occur in 2012/13. The site has been identified, plans drawn up and building work is due to be completed in Spring 2013.

With the exception of the ISSU, the majority of capital funds are being retained until the estate strategy review is complete.

2.17.6. 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. Our approved long-term borrowing limit for 2011/12 was set at £23.5 million. During the year, we have not borrowed against this limit.

2.17.7. Key financial risks and challenges for 2012/13 onwards

Price risk

As a Foundation Trust, we have relatively low exposure to price risk for a number of reasons:

i. salary costs are the single biggest component of our costs and our staff are on *Agenda for Change* terms and conditions of service. The majority of Trust staff will not receive an inflationary pay award for 2012/13 except those staff earning less than £21,000 who will receive a £250 pay increase

ii. a large proportion of our income is derived from NHS Commissioners and the income assumptions are set out each year in the *NHS Operating Framework*. For 2012/13, there is a national efficiency requirement of 4%, with pay and price inflation uplifts at 2.2%. The application of this formula gives a net reduction for NHS commissioned services of 1.8%. This level of reduction has been taken into account in our refreshed *Financial Plan* and going forward, the Trust's *Financial Risk Rating* will be a minimum of 3 but certainly not less

iii. robust contracting arrangements are in place with Commissioners and clauses for over-performance against contracted targets continue to be further clarified and refined to give the Trust added financial stability. The Trust's response to the *Care Pathways and Packages* initiative in respect of future contracting arrangements is being well co-ordinated with a clear project structure, and reporting arrangements are in place. The financial impact of costing on a cluster basis is neutral at present, as this will be in shadow form for 2012/13.

Credit risk

This is minimal as the majority of the Trust's income comes from contracts with other public sector organisations, namely NHS organisations and the Local Authority (See also note 20 to the Annual Accounts in Section 15).

Liquidity risk

Liquidity risks are felt to be relatively low due to the fact that the net operating costs are incurred under contracts with NHS and other Government bodies that are, in turn, financed from money received from Parliament. Assumptions regarding additional income in 2012/13 have been incorporated into our *Financial Plan* and this income mainly derives from NHS Commissioners (See also note 20 to the Annual Accounts in Section 15).

Cash flow risk

The main sources of income and expenditure are relatively predictable. The Trust currently has a sound cash position with a balance of £17m at 31st March 2012. The Trust is not expecting problems with its cash flow, and cash holdings will be maintained and maximised going forward. A 12-month rolling cash flow forecast is provided as part of the monthly Board financial reporting process.

Other financial risks/challenges

Along with all other NHS and public sector organisations operating in the current economic climate, the Trust will be facing a series of challenges for the coming year. Our main challenges are as follows:

- achieving a further *Cost Improvement Plan (CIP)* target of around £8.2 million in 2012/13
- 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*
- introducing *Service Line Reporting* within the organisation. *Service Line Reporting* will improve our strategic and clinical decision-making by providing a breakdown of the operational and financial performance of each service
- the Trust is required to work with its service commissioners to jointly develop and implement the proposed currency model from the Care Pathways and Packages Consortium to support and inform currency development as part of the national roll-out of its implementation. This will involve the development of shadow pricing to ensure that the implementation of the *National Payment by Results (PbR) Policy* for Mental Health is effectively managed locally
- the increasing choice and personalisation agenda may shift purchasing and budgets for certain types of care to the individual, and this does present some financial risks for the Trust over the next 2 years. Development programmes and structures are in place for *Self-Directed Support* packages and pathways and defined services have completed market assessment and customer care reviews. In order to mitigate against any income loss, additional service redesign plans are in place to focus on core business alternatives and specialist care re-enablement, or provision of high quality care and support for people with complex needs.

2.17.8. 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.

2.17.9. Additional pension liabilities incurred

It is considered best practice for NHS Foundation Trusts to disclose the number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.

These disclosures are made in note 5.3 in the Annual Accounts based on figures supplied by NHS Pensions.

2.17.10. Better payment practice code

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 88.92% in terms of the number of invoices paid and 87.98% in terms of the value of invoices paid.

2.17.11. Countering 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 of Directors' Audit and Assurance Committee meetings, 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 LCFS regularly provides group sessions at various locations across the Trust, with many attendees, including at staff induction sessions. This is seen by the Audit and Assurance Committee as a major deterrent and effective 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.

In February 2012, our *Local Counter Fraud Specialist* and the Trust received an assessment of *Level 3* from *Counter Fraud and Security Management's Quality Assurance Programme* signifying that the organisation is performing well, with no items for improvement noted in the assessment report.

2.17.12. Health and safety performance

We recognise our responsibilities for ensuring the health, safety and welfare of our employees, and that we have a responsibility to others who may be affected by our work activities. Our approach to health and safety is based on risk assessment, which aims to identify, assess and minimise the potential for injury and ill health.

In 2011/12, we adopted a new *Health and Safety Policy* supported by the introduction of a formal *Health and Safety Committee*. The Policy includes a *Statement of Intent*, jointly signed by our Chief Executive and Chairman, outlining the aims and objectives of the *Policy.*

The role of the Committee is to promote co-operation between the Trust and its employees by instigating, developing and carrying out measures to ensure the health, safety and welfare of all staff and other people in connection with the our activities. The Committee is chaired by the Executive Director with responsibility for Health and Safety, and includes representatives from Staff Side and all Trust services. This Committee complements the work of the *Patient Safety Group* which considers clinical risk issues. The Trust's *Health & Safety Advisor* attends the meetings of both groups and acts as the key link for both aspects of safety.

We employ a number of competent people to provide specialist advice in managing health and safety and related matters, including members of the *Risk Management and Clinical Governance Service*; a *Senior Infection Control Nurse* and a *Fire and Security Officer* (who also acts as the *Local Security Management Specialist*). The Trust's *Health & Safety Advisor* is managed via the Facilities Directorate but has an organisation-wide remit for instigating a proactive approach to health and safety. The Facilities Directorate also has specific responsibility for ensuring consideration of health and safety in all aspects of premises maintenance and design, and for compliance with a range of statutory requirements.

We attach great importance to achieving good practice in the management of fire safety and to ensuring that our staff are suitably trained so that the safety of all users of our premises and the protection of Trust property and assets are assured. In 2011/12, we revised our approach to the delivery of fire safety training using a risk-based methodology. Generic/ induction training is now delivered by the Trust's *Education, Training & Development* staff, whilst *site – or service specific* training is provided at agreed intervals by the *Fire and Security Team* at work bases and to staff who act as *Fire Marshalls* and *Wardens*. These face to face training interventions are supplemented by an e-based programme.

Managers are responsible for the provision of a safe working environment and for making assessments as to what actions are 'reasonably practicable' to carry out in order to mitigate risks. This requires them to make balanced and pragmatic decisions based on the level of risk, and the cost and practicality of actions required to reduce the risk.

2.17.13. Consultations we have completed

During 2011/12, we completed the following consultations on proposed service changes:

- the re-configuration of our *Community Mental Health Team* services aimed at bringing together a range of separate teams into a more integrated locality-based model
- the redesign and closure of day hospital services for older people and the establishment of new community teams to provide intensive support for older people when experiencing a crisis
- the closure of 2 residential centres in line with established, city-wide strategies as outlined earlier
- the proposed location of our new facilities to support the *Intensive Support Servic*e to provide *community – and residential – based* care for people with complex learning disabilities in new, modern, high-quality facilities.

2.17.14. Consultations we have in progress

There were no consultations in progress at the time that this Annual Report was approved.

2.17.15. Consultations we have planned for next year

In line with our Annual Plan for 2012/13, we expect to consult on the following proposed changes:

- the development of new acute care services across community and inpatient settings supported by an estate improvement and redesign programme

2.17.16. Significant research and development activities we have undertaken

Participation in clinical research

Research is a priority for us and is one of the means by which we seek to improve the quality of our services, increase productivity and initiate innovation. We recognise the key role of the NHS in promoting and conducting clinical research and the right of service users to be informed about opportunities to participate in ethically-approved clinical research trials. We work closely with the *East Midland and South Yorkshire Mental Health Research Network* and academic partners to maximise the research activity taking place in the Trust.

Our Research Development Unit provides the research governance for the Trust and for NHS Sheffield. The Unit meets all the standards set by the *National Institute for Health Research* and is monitored by the *South Yorkshire Comprehensive Local Research Network*.

Research that we are currently undertaking aims to improve the quality of our services, increase service user safety and promote our ability to meet the needs of NHS service commissioners. An example of this research is the *Understanding and Preventing Adverse Effects of Psychological Therapies* study. This work is funded by the *National Institute for Health Research* through its *Research for Patient Benefit* programme and is conducted by our clinicians in collaboration with academicians from the University of Sheffield.

This is important research as the NHS has invested more than £170 million to improve access to psychological therapies. Although most service users benefit from improved access to psychological therapies, some deteriorate after a course of such therapy and a significant proportion of clients do not complete their therapy course. This project aims to improve quality of care and patient safety by seeking to establish whether there are certain service users who have a greater risk of dropping out or experiencing deterioration after engaging in a course of psychological therapies. The findings of the study will enable services to target resources at limiting the occurrences of these risks.

2.17.17. Serious incidents involving data loss or breaches of confidentiality

The Trust had no serious incidents involving data loss or breaches of confidentiality during the period commencing 1st April 2011 to 31st March 2012.

2.17.18. Political or charitable donations we have made

The Trust has not made any political or charitable donations during the year 2011/12 as it is not lawful for an NHS Foundation Trust to make such donations.

2.17.19. Significant differences in market values of fixed assets

The Directors consider that the methodology used to determine the carrying value of the property, plant and equipment base as at 31 March 2012 is appropriate as it has been determined in accordance with the *Foundation Trust Annual Reporting Manual 2011/12* and through the application of approved *International Financial Reporting Standards (IFRS)* based accounting policies.

The Directors have also considered the possibility of impairment on the carrying value of the Trust's property as at 31 March 2012. They consider that the current valuation does not materially misrepresent a fair presentation of the accounts.

The Board of Directors ratified these statements at their meeting held on the 25th April 2012.

2.17.20. Significant events affecting us after the end of the financial year

These are disclosed in note 23 in the Annual Accounts contained in Section 15.

2.17.21. Future developments that are likely to affect us

The following are the significant developments likely to affect us in the future:

- agreements to take on responsibility for the NHS Sheffield's out-of-town funding which includes an *Intensive Psychiatric Treatment Facility, Acute Mental Health Beds and Locked Rehabilitation Beds*
- potential funding for transforming *Dementia Services* located within the Sheffield Teaching Hospitals NHS Foundation Trust to be transferred into the community settings run by us
- the reconfiguration of our acute psychiatric services and our older people's mental health services which will bring separate accommodations into a single site and the upgrading of the ward sites
- completion of the new building to house an Intensive Support Service facility for people with a learning disability

3.0 Remuneration report

Executive Directors' remuneration (information not subject to audit)

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 7 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. The table below provides details of Executive Directors' contracts:

Executive Director	Date of contract	Unexpired terms (Years to age 65)
Kevan Taylor	February 2003	14
Mick Rodgers	April 2003	4
Clive Clarke	April 2003	17
Liz Lightbown	April 2011	20
Prof Tim Kendall	April 2003	11

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 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.

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 (information not subject to audit)

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 Remuneration 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 5 of this report.

Details of the remuneration paid to all of the Directors during 2011/12 are shown in the table below. The Non-Executive Directors' duration of office is reported in Section 7 of this report.

Directors' Remuneration and Pension Entitlements (information subject to audit)

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.

A) Salaries and Allowances 2011/2012

Directors' remuneration and pension entitlements

	Period 1.4.11 to 31.3.12		
	Salary (bands £5000)	Other Remuneration (bands £5000)	Benefits in kind (rounded to the nearest £00)
	£000	£000	
Prof. A Walker, Chairman	25-30		
Cllr. M Rooney, Non-Executive Director	10-15		
M Rosling, Non-Executive Director	10-15		
A Clayton, Non-Executive Director	10-15		
M Thomas, Non-Executive Director	10-15		
S Rogers, Non-Executive Director	10-15		
K Taylor, Chief Executive	135-140		
M Rodgers, Executive Director of Finance and Deputy Chief Executive	105-110		
Dr T Kendall, Executive Medical Director	60-65	125-130	
C Clarke, Executive Director of Operational Delivery and Social Care	100-105		
L Lightbown, Executive Director of Nursing and Integrated Governance	100-105		
Band of Highest Paid Director's Total (Remuneration £000)	**185-190**		
Median Total Remuneration	**21,798**		
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	**8.6**		

In accordance with the Hutton Review of Fair Pay, reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.

The median remuneration is based on full time equivalent directly employed staff as at 31st March 2012, excluding the highest paid director (as per the guidance).

Total remuneration includes salary, non-consolidated, performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The highest paid Director is also the highest paid employee. The median is the middle number in a sorted list of numbers. The ratio is the number of times the median can be divided into the highest paid Director's total remuneration.

	Period 1.4.10 to 31.3.11		
	Salary (bands £5000)	Other Remuneration (bands £5000)	Benefits in kind (rounded to the nearest £00)
	£000	£000	
Prof. A Walker, Chairman	25-30		
Cllr. M Rooney, Non-Executive Director	10-15		
M Rosling, Non-Executive Director	10-15		
A Clayton, Non-Executive Director	10-15		
M Thomas, Non-Executive Director	10-15		
S Rogers, Non-Executive Director	10-15		
K Taylor, Chief Executive	130-135		
M Rodgers, Executive Director of Finance and Deputy Chief Executive	105-110		
Dr T Kendall, Executive Medical Director	60-65	125-130	
C Clarke, Executive Director of Operational Delivery and Social Care	100-105		
L Lightbown, Executive Director of Nursing and Integrated Governance	80-85		

Note:

L Lightbown was appointed from 1st April 2011 (during 2010/11 she was on secondment from Barnsley Primary Care Trust).

B) Pension Benefits for 2011/2012

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

	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total acccrued pension at age 60 at 31 March 2012 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2012 £000	Cash equivalent transfer value at 31 March 2011 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
K Taylor, Chief Executive	0-2.5	5.0-7.5	40-45	130-135	823	695	106	0
M Rodgers, Executive Director of Finance and Deputy Chief Executive	(2.5)-0	(2.5)-0	55-60	165-170	0	0	0	0
Dr T Kendall, Executive Medical Director	2.5-5.0	10-12.5	50-55	150-155	1,011	859	125	0
C Clarke, Executive Director of Operational Delivery and Social Care	0-2.5	0-2.5	15-20	45-50	266	214	45	0
L Lightbown, Executive Director of Nursing and Integrated Governance	2.5-5.0	10-12.5	20-25	70-75	370	256	106	0

Notes

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

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

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses Government Actuary Department ("GAD") factors to calculate the CETVs.

Please note that the GAD factors used to calculate the CETVS at 31 March 2012 were issued in December 2011. The new factors will have a different impact on transfer values depending on the age of the individuals involved. The approximate impact of the new factors on the CETV figures shown above is estimated as between a 0% and 10% increase in CETV.

Pension Liabilities

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

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

Kevan Taylor

Chief Executive

4.0
NHS Foundation Trust
Code of Governance

Our commitment to good Governance

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance followed by all those who play a part in the conduct of the Trust's business.

The Board 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 Annual Governance Statement
- 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 the Trust has complied with the requirements of the Code.

Disclosure of corporate governance arrangements

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

Statements on how the Board of Directors and the Council of Governors operate, including high level statements of which types of decisions are to be taken by each one of them and which are to be delegated to the management by the Board of Directors, are contained in Sections 5 and 7 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 5 and 7 of this report.

The number of meetings of the Board of Directors, its Committees and the attendance by individual Directors are shown in Section 7 of this report.

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

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 is employed by the Trust or has been in the last five years

ii. none of them has, or has 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 scheme is 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

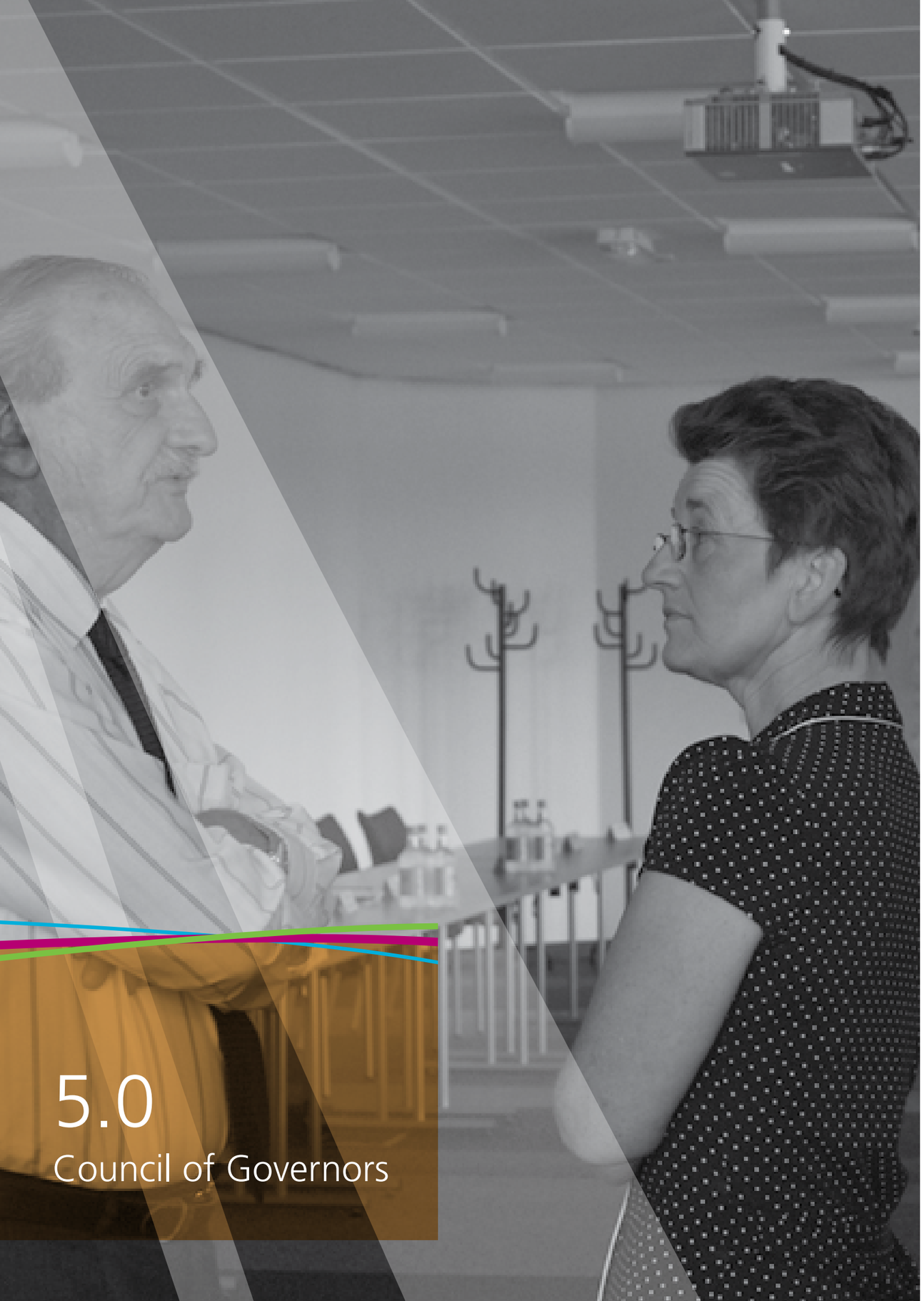
v. none of them holds cross-directorships or has significant links with other Directors through involvement (with those other Directors) in other companies or bodies

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 7 of this report
- a statement on the Board of Directors' balance, completeness and appropriateness is contained in Section 7 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 5 of this report
- the number of meetings of the Council of Governors and the individual attendance by Governors and Directors is contained in Section 5 of this report
- the Trust Chair's other significant commitments and any changes to them during the year are contained in the Directors' Register of Interests referred to in Section 2 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 5 of this report
- a statement on how the performance of the Board, its Committees and individual Directors was evaluated is contained in Section 7 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 2 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 2 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 or re-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 met on several occasions to share ideas on how the two groups could enhance their collaborative working relationship. Details of these are disclosed in Section 5 of this report. For instance, every formal Council of Governors' meeting is preceded by an informal meeting between Governors and the Non-Executive Directors. The topics of the meetings are open-ended allowing Non-Executive Directors and Governors to discuss as wide a range of concerns as possible. There is a Membership and 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



5.0
Council of Governors

The role of the Council of Governors

Governors play a vital role in the Trust's governance. They primarily carry out their role through the meetings of the Council of Governors, of whom there were five in 2011/12.

Table 5 below provides a detailed breakdown of the number of meetings attended by each Governor.

All meetings of the Council of Governors are open to members of the public, except in instances where there are confidential matters which need to be discussed. In these circumstances, members of the public are excluded when matters of a confidential nature are being discussed.

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

In 2011/12, the Council of Governors reappointed Councillor Mick Rooney and Martin Rosling as Non-Executive Directors and set their remuneration and terms and conditions of appointment. Further details on the process that was followed in these appointments are contained in a further part of this Section of this report.

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

- assisting the Board of Directors in setting the strategic direction of the Trust
- monitoring the activities of the Trust with a view to ensuring that they are being carried out in a manner that is consistent with the Trust's Constitution and its terms of authorisation
- receiving the Trust's Annual Report and Accounts and the auditor's report on the Annual Accounts
- representing the 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 by the Trust's key stakeholders who are drawn from the communities which the Trust serves.

Composition of the Council of Governors

The Council of Governors comprises 43 seats, 32 of which are elected from the membership. Governors are elected for a period of 3 years and can hold their position for a total of 9 years, if re-elected.

Eleven of the seats are for organisations with whom the Trust works, or partner organisations, as they are called. These positions also have a 3-year term.

The Council of Governors is chaired by Professor Alan Walker who is also the Chair of the Board of Directors. The Chair has the responsibility of ensuring that Governors' views are represented in the Board of Directors' deliberations and that information from the Board is fed back to the Council. He fulfils this responsibility through a monthly letter to Governors as well as by providing updates to them at each Council meeting.

In 2011, John Kay, a Service User Governor, was elected as the Lead Governor/Reserve Chair, thus fulfilling the requirements of the Trust's Constitution and those of Monitor, its independent regulator.

Table 1 below shows a breakdown of the seats on the Council of Governors and the names of the Governors who occupied them as at 31st March 2012.

Table 1

Seats	Name	Constituency	Date appointed from	Date term of office ends
8 Public seats (Elected)	Dorothy Cook	Public South East	01.07.2010	30.06.2013
	Jules Jones	Public South East	01.07.2011	30.06.2014
	Brandon Ashworth	Public South West	01.07.2010	30.06.2013
	Nicky Hindmarch	Public South West	01.07.2010	30.06.2013
	Dave Jones	Public North East	01.07.2011	30.06.2013
	Trudie Smallwood	Public North East	01.07.2011	30.06.2013
	Paul Harvey	Public North West	01.07.2011	30.06.2014
	Susan Wood	Public North West	01.07.2010	30.06.2013
10 Service user seats (Elected)	Dean Chambers	Service User	01.07.2010	30.06.2013
	Tyrone Colley	Service User	01.07.2011	30.06.2014
	Shamshad Hussain	Service User	01.07.2011	30.06.2014
	John Kay	Service User	01.07.2010	30.06.2013
	Annette Phillips	Service User	01.07.2011	30.06.2014
	Sue Sibbald	Service User	21.03.2012	20.03.2015
	Kate Steele	Service User	01.07.2011	30.06.2014
	Nev Wheeler OBE	Service User	01.07.2010	30.06.2013
	Myra Wilson	Service User	01.07.2011	30.06.2014
	Vacancy	Service User		
2 Young service user/ carer seats (Elected)	Gemma Wake	Young Service User/Carer	01.07.2010	30.06.2013
	Natasha Elliott	Young Service User/Carer	01.07.2011	30.06.2014
4 Carer seats (Elected)	Leon Ballin	Carer	01.07.2011	30.06.2014
	Ian Downing	Carer	01.07.2010	30.06.2013
	Lindsay Oldham	Carer	01.07.2010	30.06.2013
	Jean Nicholson	Carer	01.07.2011	30.06.2014
8 Staff seats (Elected)	Mia Bajin	Clinical Support Staff	15.12.2010	14.12.2013
	Jim Buck	Nursing Staff	01.07.2011	30.06.2014
	Elaine Hall	Allied Health Professionals	01.07.2011	30.06.2014
	Elliott Hall	Central Support Staff	01.07.2011	30.06.2014
	Ingrid King	Psychology Staff	01.07.2011	30.06.2014
	Geraldine Mountain	Social Work Staff	01.07.2011	30.06.2014
	Paul Miller	Medical & Clinical Staff	01.07.2011	30.06.2014
	Stephanie Pursehouse	Support Work Staff	01.07.2011	30.06.2014
11 Appointed Governors (Stakeholders)	Professor Peter Woodruff	University of Sheffield	24.08.2011	23.08.2014
	Joan Healey	Sheffield Hallam University	29.09.2011	28.09.2014
	Sue Highton	Staffside (Unions)	01.07.2011	30.06.2014
	Graham Harris	Age UK Sheffield	17.10.2011	31.08.2012
	Janet Sullivan	Sheffield MENCAP	01.07.2011	30.06.2014
	Dr Abdul Rob	Pakistan Muslim Centre	24.01.2011	23.01.2014
	Patrick Anyomi	SACMHA	01.07.2011	30.06.2014
	Cllr Ali Qadar	Sheffield City Council	19.05.2011	18.05.2014
	Cllr Ibrar Hussain	Sheffield City Council	07.12.2011	06.12.2014
	Cllr Jack Scott	Sheffield City Council	07.12.2011	06.12.2014
	Vacancy	NHS Sheffield		

Changes to the Council of Governors

As at 1st April 2011, there were 37 Governors in post. Since then, there have been a number of changes in the membership of the Council throughout the year and there were, as at 31st March 2012, 42 Governors in post.

Table 2 below shows the Governors who left the Council in 2011/12. In a majority of these cases, this was because their respective tenures of office had ended and they either chose not to stand again or, in the case of those who stood, were not re-elected.

Table 2

Name	Constituency
Alick Bush	Staff (Psychology)
Ashton Wynter	Appointed (SACMHA)
Audrey Croft	Public South East
Brendan Stone	Service User
Elizabeth Draper	Carer
Gillian Hancock	Staff (Support Work)
Helen Best	Appointed (Sheffield Hallam University)
Jim Monach	Public South West
Joanne Dobson	Service User
Julia Walsh	Staff (Social Work)
Julie Forrest	Staff (Nursing)
Julie Leeson	Staff (Allied Health Professionals)
Lewis Atkinson	Carer
Marie Harris	Service User
Matthew Flinders	Appointed (University of Sheffield)
Rosalind Eve	Appointed (Age UK Sheffield)
Ruth Mitchell	Public North East
Stephanie de la Haye	Service User
Tony Farrington	Staff (Medical & Clinical)
William Andrews	Service User

In addition to the Governors who left, Table 3 below shows the new Governors and how they came into office through the electoral process. Their respective terms of office are shown in Table 1 above.

Table 3

Name	Constituency	Method of appointment
Leon Ballin	Carer	Ballot
Jean Nicholson	Carer	Ballot
Tyrone Colley	Service User	Ballot
Marie Harris	Service User	Ballot
Shamshad Hussain	Service User	Ballot
Annette Phillips	Service User	Ballot
Katherine Steele	Service User	Ballot
Myra Wilson	Service User	Ballot
Sue Sibbald	Service User	Ballot
Nicola Hindmarch	Public South West	Ballot
David Jones	Public North East	Ballot
Trudie Smallwood	Public North East	Ballot
Paul Harvey	Public North West	Ballot
Natasha Elliott	Young Service User/Carer	Ballot
Jules Jones	Public South East	Unopposed
Elaine Hall	Staff – Allied Health Professionals	Unopposed
Elliott Hall	Staff – Central Support Staff	Unopposed
Geraldine Mountain	Staff – Social Work	Unopposed
Paul Miller	Staff – Medical & Clinical	Unopposed
Jim Buck	Staff – Nursing	Unopposed
Ingrid King	Staff – Psychology	Unopposed
Stephanie Pursehouse	Staff – Support Work	Unopposed

As mentioned earlier, the Trust has a number of Appointed Governors, and there were changes to these as well during 2011/12. These are shown in Table 4 below.

Table 4

Name	Organisation
Cllr Ali Qadar	Sheffield City Council (Liberal Democrats)
Cllr Ibrar Hussain	Sheffield City Council (Labour)
Cllr Jack Scott	Sheffield City Council (Labour)
Graham Harris	Age Concern UK (replaced Rosalind Eve for the remainder of her term)
Joan Healey	Sheffield Hallam University
Patrick Anyomi	Sheffield African Caribbean Mental Health Association (SACMHA)
Professor Peter Woodruff	University of Sheffield
Susan Highton	Staff Side (reappointed)

Governor Activities in 2011/12

The relationship between the Board of Directors and Council of Governors is an important one and its development was supported by the holding of joint development sessions and meetings between members of the two bodies. This was especially important in 2011 which saw a large number of new Governors coming into post.

Governors have also made contributions to the Trust's strategic objectives and Quality Accounts. Additional development sessions have been provided for Governors in order to enhance their knowledge of both the Trust and the NHS in general. These sessions have included:

- governance within the NHS
- understanding Performance Reports
- understand New Commissioning Arrangements.

In addition to their statutory duties, Governors are also actively involved in a number of other groups and activities which provide them with the opportunity to engage with various areas of work within the Trust. 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 those of the Trust's members whom they represent, are heard and taken into account. They exert a genuine positive influence on the Trust and its affairs.

Governors' attendance at council meetings

The number of meetings attended by each Governor in post during the period covered by this report are shown in Table 5 below.

Name	Governor category	Number of meetings eligible to attend	Number of meetings attended
Audrey Croft	Public South East	2	0
Dorothy Cook	Public South East	5	5
Jules Jones	Public South East	3	3
Jim Monach	Public South West	2	2
Brandon Ashworth	Public South West	5	4
Nicky Hindmarch	Public South West	3	1
Paul Harvey	Public North West	5	4
Susan Wood	Public North West	5	4
Ruth Mitchell	Public North East	2	2
Trudie Smallwood	Public North East	3	0
Dave Jones	Public North East	3	3
Bill Andrews	Service User	2	0
Brendan Stone	Service User	2	0
Dean Chambers	Service User	5	2
Jo Dobson	Service User	2	1
John Kay	Service User	5	5
Marie Harris	Service User	5	3
Myra Wilson	Service User	5	5
Nev Wheeler	Service User	5	4
Tyrone Colley	Service User	3	3
Kate Steele	Service User	3	2
Shamshad Hussain	Service User	3	1
Annette Phillips	Service User	3	3
Stephanie de-la-Haye	Service User	2	0
Gemma Wake	Young Service User/Carer	5	5
Natasha Elliott	Young Service User/Carer	3	0
Elizabeth Draper	Carer	2	2
Ian Downing	Carer	5	4
Lewis Atkinson	Carer	2	2
Lindsay Oldham	Carer	5	4
Leon Ballin	Carer	3	2
Jean Nicholson	Carer	3	3
Alick Bush	Staff	2	2
Elliott Hall	Staff	5	3
Gill Hancock	Staff	2	0
Julia Walsh	Staff	2	1
Julie Forrest	Staff	2	1
Julie Leeson	Staff	2	2
Tony Farrington	Staff	2	0
Mia Bajin	Staff	5	3
Elaine Hall	Staff	3	2
Stephanie Pursehouse	Staff	3	1
Ingrid King	Staff	3	1
Jim Buck	Staff	3	0
Paul Miller	Staff	3	3
Geraldine Mountain	Staff	3	3
Councillor Mary Lea	Sheffield City Council	1	1
Councillor Ali Qadar	Sheffield City Council	4	4
Councillor Ibrar Hussain	Sheffield City Council	2	0
Councillor Jack Scott	Sheffield City Council	2	1
Joan Healey	Sheffield Hallam University	3	2
Helen Best	Sheffield Hallam University	2	1
Peter Woodruff	University of Sheffield	3	3
Matt Flinders	University of Sheffield	2	1
Sheila Paul	NHS Sheffield	2	1
Sue Highton	Staff Side	5	3
Patrick Anyomi	SACMHA	3	1
Ashton Wynter	VCFS (SACMHA)	2	1
Janet Sullivan	VCFS (Mencap)	5	2
Graham Harris	VCFS (Age UK)	3	1
Rosalind Eve	VCFS (Age UK)	2	0
Dr Abdul Rob	VCFS (PMC)	5	2

Governors' Register of Interests

Governors are required to declare any material or financial interests in the Trust. For a copy of the register of interests, please contact Chipo Kazoka by emailing chipo.kazoka@shsc.nhs.uk or telephoning (0114) 2716710.

5.1 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. In addition, the 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.

In 2011/12, the Committee successfully selected two candidates for appointment as Non-Executive Directors of the Trust. These were recommended for appointment to the Council of Governors, and the Council accepted the Committee's recommendations. The posts for these two candidates were advertised by the Committee on the *NHS Jobs* website and the Trust's Human Resources Directorate conducted the recruitment process on behalf of the Committee. No external agency was used in this process. The Committee also started preparing to launch the process of recruiting three candidates for appointment as Non-Executive Directors as the terms of office of the current post holders are due to expire in the course of 2012.

During 2011/12 the following changes have taken place in the membership of the Committee:

- Jim Monach retired from the Committee as he was not re-elected as a Governor
- Julie Forrest retired from the membership of the Committee following the expiry of her term of office as a Governor
- Matthew Flinders retired from the membership of the Committee following the expiry of his term of office as a Governor
- Patrick Anyomi resigned from the membership of the Committee following his resignation from his post as Governor
- Geraldine Mountain joined the Committee following her appointment by members of the Council of Governors.

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	1/1
John Kay	Committee Member and Reserve Chair	1/1
Brandon Ashworth	Committee Member	0/1
Susan Wood	Committee Member	0/1
Lindsay Oldham	Committee Member	1/1
Geraldine Mountain	Committee Member	0/0
Patrick Anyomi	Committee Member	0/0
Matthew Flinders	Committee Member	0/0
Jim Monach	Committee Member (Retired)	0/0
Julie Forrest	Committee Member and Reserve Chair (Retired)	0/0

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

6.0 Membership

Foundation Trust status gives us the advantage of being closely influenced by the people who live in the communities that we serve. This is well reflected in the diversity of the constituencies into which our membership base is divided.

Constituencies, eligibility criteria and membership numbers

We have 3 elected membership constituencies, each of which is divided into a number of classes. Table 6 below shows the details of each constituency and class, their eligibility criteria and, where applicable, the number of members in the class.

Table 6

Constituency	Class	Number of members	Criteria
Public	South West	3069	Must live in the following electoral wards: Gleadless Valley, Dore & Totley, Fulwood, Graves Park, Nether Edge, Ecclesall, Beauchief & Greenhill, Crookes
	South East	2539	Must live in the following electoral wards: Darnall, Manor Castle, Arbourthorne, Richmond, Birley, Mosborough, Beighton, Woodhouse
	North West	2393	Must live in the following electoral wards: Stocksbridge & Upper Don, Stannington, Hillsborough, Walkley, Broomhill, Central
	North East	2293	Must live in the following electoral wards: West Ecclesfield, East Ecclesfield, Southey, Firth Park, Burngreave, Shiregreen & Brightside
Service user	Service User	980	Must have received a service or services from the Trust within the last 5 years
	Carer	591	Must have cared for someone who has received a service from the Trust in the last 5 years
	Young Service User or Carer	111	As service user and carer, but must be 35 years old or younger

Constituency	Class	Number of members	Criteria
Staff	Allied Health Professionals	181	Must have either worked for the Trust continuously for at least 12 months or have a contract of no fixed term
	Central Support Staff	334	
	Clinical Support Staff	659	
	Medical & Clinical	185	
	Nursing	571	
	Psychology	184	
	Social Work	82	
	Support Work	1031	
Appointed	Voluntary, Community & Faith Sector Organisations	Not applicable	Not applicable
	University of Sheffield		
	Sheffield Hallam University		
	Staff Side (unions)		
	Local Councillors		
	NHS Sheffield		

At the end of March 2012, we had a total of 12,299 members (excluding staff) compared to 11,694 at the same time last year. We had set for ourselves a 5% recruitment target for 2011/12 which is equivalent to an additional 585 members. The actual number of new members we recruited was 1,360. This equates to an increase in membership of 132% above target. However, the final membership number reflects the number of discontinued members, which totalled 854.

Developing a representative membership

As a successful Foundation Trust, it is our aim to maintain and further develop a membership that involves and widely represents the communities that we serve. We have set out how we intend to do this through our membership strategy. It is the responsibility of the Council of Governors, through the Membership and Communication Sub-Group, to implement and review this strategy on an annual basis.

This strategy outlines how we plan to:

- benefit from being a membership-based organisation
- communicate with and support the development of our members
- make sure that our membership base continues to reflect Sheffield's diversity
- provide opportunities for our members to become involved with the Trust in ways that suit their needs and wishes.

In order to achieve the aims of our membership strategy as set out above, we developed an action plan which identified the following as worthy of pursuit:

- publicising widely the opportunities and benefits of membership
- recruiting members from across the whole community
- targeting hard to reach groups specifically, supported by appropriate communication
- developing and supporting effective channels of communication and engagement between Governors and members
- ensuring membership is a worthwhile experience for individuals through engaging individuals in ways that they have said will suit them.

We are proud to say that we successfully fulfilled these actions during 2011/12. Further details on how we did this are outlined below.

Membership recruitment and engagement

In line with our membership strategy to both recruit and engage with members from across Sheffield, Governors and staff participated in 23 community events, specifically targeting areas of the city with a high population of people from minority ethnic groups. We also targeted specific groups such as people with a learning disability. Some of these events included:

- BME (Black and Minority Ethnic) Network Annual General Meeting
- Sharrow Festival
- Abbeyfield Festival
- Learning Disabilities Day
- African Caribbean Event
- Older People's Roadshows
- Well-being Festival (part of World Mental Health Day events)
- Sheffield Fayre.

16.9% of Sheffield's population is made up of people from minority ethnic backgrounds and11.2% of our members are drawn from these backgrounds. However, this increases to 13.88% when 'White Irish' and 'White Other' groups are taken into account. Our total membership profile is broken down as shown in Table 7 below:

Table 7

	Membership as at 31.3.2012	Sheffield Demographic
White (including White Irish and White Other)	85.8%	91.2%
Mixed	1.37%	1.6%
Asian or Asian British	4.25%	4.56%
Black or Black British	3.71%	1.78%
Other	1.87%	0.86%
Those who refused to disclose their ethnic background	3%	–

Of the new members recruited in 2011/12, 20.87% were from black and minority ethnic backgrounds.

As a Foundation Trust, we continued to respond to and engage with members on issues that matter to them by holding 3 membership events, namely, one on spirituality, one on personality disorders and another on dementia. These were very successful and well-attended events. Our programme of events throughout 2012/13 will continue to reflect the issues members have told us are important to them.

Apart from ensuring that we maintain a high public profile which helps us to draw in our members and the general public to engage with us, we use our membership magazine, *Involve*, as the primary means by which we provide focused communication to our members. Both Governors and members sit on the editorial group to make sure that the content of the magazine remains focused on those issues that are important to our members. The editorial group also makes sure that the magazine gives information on all aspects of our services.

Through our website, we also provide our members with updated information that helps to ensure that they can easily communicate with both the Trust staff and Governors if they want to.

Social Media

In order to open up new methods of communicating with our members and the wider members of the public, we entered the world of *Social Media* in 2011/12.

Social Media is a term covering the use of websites and other online tools which allow users to interact with each other. We now have accounts on Facebook and Twitter which are regularly updated with news, events and photos, and are gradually growing in popularity, and cultivating an online dialogue.

We intend to develop this further to include facilities for online service user interaction and support groups. We are also looking to build a video library, starting with the creation of our own *Youtube* channel.

In 2011/12, we produced a large amount of proactive publicity about our work and services. For the second year running, we have had the highest coverage rating and media impact out of all the NHS healthcare service provider Trusts in Sheffield and South Yorkshire.

This is the result of the hard work we have put into getting our positive public relations taken up by the media; the efforts we have made to minimise negative publicity, and building up good relationships with the local media.

We have written some excellent service user and carer case studies and we are confident that these have resulted in raising public awareness of what we do and have complemented our tireless efforts at fighting the stigma attached to those who suffer from mental illness.

We are also developing a communications toolkit to support all staff with delivering good communications on our behalf. It explains, among other things, how and when to engage with our communications function and also contains related policies and templates.

Website: **www.shsc.nhs.uk**

Facebook: **www.facebook.com/shscft**

Twitter: **www.twitter.com/shscft or @SHSCFT**

If you want to contact your Governor, you can telephone **(0114) 2718825**, email: **governors@shsc.nhs.uk** or write to

The Council of Governors
FREEPOST
SHSC NHS FOUNDATION TRUST

7.0
Board of Directors

The Role of the Board of Directorts

The Board is responsible for:

- promoting the success of the Trust by directing and supervising the organisation's affairs
- providing proactive 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.

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.

Composition of the Board of Directors

The Board comprises six Non-Executive Directors (including the Trust Chair) and five Executive Directors (including the Chief Executive). During 2011/12, the Board met every month (except August) in meetings which were open (in part) to members of the public and the press. 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 2011/12 (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 the Vice Chair. The Trust Chair presides over the meetings of the Board of Directors and the Council of Governors. The Chair is responsible for:

- providing leadership to the Board of Directors and the Council of Governors
- ensuring that the Board of Directors and the Council of Governors work effectively together
- enabling all Board members to make a full contribution to the Board's affairs and that the Board acts as an effective team
- leading the Non-Executive Directors through the Board of Directors' Remuneration and Nominations Committee in 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 were three Associate Directors and a Foundation Trust Company Secretary in place to support the effective functioning of the Board. The Associate Director of Strategic Development retired before the end of 2011/12. This support provided to the Board by these senior officers has helped to ensure strong progress on key items relating to:

- the Trust's strategic positioning
- managing its external relationships and strategic interfaces
- workforce development
- progressing the Trust's broader social responsibility agenda and commitments
- ongoing development of organisation-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 2011/12 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	11/12
Kevan Taylor	Chief Executive	12/12
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	12/12
Clive Clarke	Executive Director of Operational Delivery and Social Care	10/12
Liz Lightbown	Executive Director of Nursing and Quality	9/12
Professor Tim Kendall	Medical Director	8/12
Martin Rosling	Non-Executive Director and Senior Independent Director	11/12
Councillor Mick Rooney	Non-Executive Director and Vice Chair	10/12
Anthony Clayton	Non-Executive Director	12/12
Mervyn Thomas	Non-Executive Director	11/12
Susan Rogers	Non-Executive Director	12/12

7.1 Board Committees

The Board has several Committees to whom it delegates authority to carry out some of its detailed work. These are discussed further below.

7.1.1. 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 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 7 occasions during 2011/12 and details of members' attendance at its meetings are as shown in the table below:

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	5/7
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	4/7
Susan Rogers	Committee Member and Non-Executive Director	6/7

Also in attendance at the Committee's meetings are the Executive Director of Finance, the Executive Director of Nursing and Integrated Governance, the Foundation Trust Company Secretary, the Head of Integrated Governance and other Executive Directors (except for the Chief Executive) as and when necessary, along with representatives from internal and external audit and the Trust's Local Counter-Fraud Specialist.

7.1.2. 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.

This Committee started operating from April 2011. It is responsible for providing assurance to the Board on the effectiveness of the Trust's systems and processes for safeguarding and improving the quality of the Trust's 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 Integrated Governance, the Executive Director of Finance and the Executive Director of Operational Delivery and Social Care.

Also in attendance at the Committee's meetings are the Foundation Trust Company Secretary, who serves as the secretary to the Committee, the Director of Quality, the Head of Integrated Governance, the Director of Planning and Performance and a representative of NHS Sheffield, the main commissioners of the healthcare services which the Trust provides. Other people, including senior members of staff within the Trust attend as and when required to do so by the Committee.

The Committee met on 9 occasions in the course of 2011/12 and details of members' attendance at its meetings are shown in the table below:

Name	Position	Number of meetings attended out of total number of those that could possibly be attended by each Committee Member
Mervyn Thomas	Committee Chair and Non-Executive Director	9/9
Martin Rosling	Committee Member and Non-Executive Director	8/9
Anthony Clayton	Committee Member and Non-Executive Director	9/9
Councillor Mick Rooney	Committee Member and Non-Executive Director	7/9
Susan Rogers	Committee Member and Non-Executive Director	7/9
Professor Tim Kendall	Committee Member and Executive Medical Director	6/9
Liz Lightbown	Committee Member and Executive Director of Nursing and Integrated Governance	7/9
Clive Clarke	Executive Director of Operational Delivery and Social Care	6/9
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	7/9

7.1.3. 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 met on 10 occasions during 2011/12 and Committee members' attendance at its meetings are as shown in the table below:

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	10/10
Mervyn Thomas	Committee Member and Non-Executive Director	7/10
Susan Rogers	Committee Member and Non-Executive Director	9/10
Mick Rodgers	Committee Member and Deputy Chief Executive and Executive Director of Finance	10/10
Clive Clarke	Committee Member and Executive Director of Operational Delivery and Social Care	8/10
Liz Lightbown	Committee Member and Executive Director of Nursing and Integrated Governance	5/10

7.1.4 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 is responsible for determining the remuneration and terms and conditions of service of the Executive Directors (including the Chief Executive) in order to ensure that they are properly rewarded having regard to the Trust's circumstances.

The Chief Executive attends the Committee's meetings in an advisory capacity. The Associate Director of Human Resources and the Company Secretary attend the Committee's meetings to provide advice and professional support to its members.

Further details on the remuneration of members of the Board of Directors are provided within the Remuneration Report contained in Section 3 of this report.

The Committee did not meet in the course of 2011/12.

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 the Board and the Council.

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).

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.

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 22 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 UK, Sheffield.

Clive Clarke
Diploma in Social Work (CQSW)

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 27 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 Leadership Programme.

Professor Tim Kendall

MB ChB, B Med Sci, FRC Psych.

Executive Medical Director

Professor Tim 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 practised 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 chaired the first National Quality Standard (Dementia), and has carried out 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.

Liz Lightbown

MSc Health Planning and Financing, BSc Behavioural Sciences, Diploma in Public Health, Registered Mental Health Nurse

Executive Director of Nursing and Integrated Governance

Liz Lightbown joined the Trust on 21st April 2010, initially on secondment. She was subsequently appointed on a permanent basis in April 2011.

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.

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 Rogers was awarded an MBE for her services to the Trade Union movement. She currently serves as a member of the 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.

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. He was recently reappointed to serve for a further term of three years. 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 well-being 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.

His extensive experience in dealing with health and social care issues has given 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.

Prior to the expiry of his term of office, the Council of Governors extended Councillor Rooney's term of office for a maximum period of 6 months in order to enable the Nominations and Remuneration to carry out the process of recruiting candidates to the post he occupied. Following the advertisement of the post on the *NHS Jobs* website, the Nominations and Remunerations Committee formally interviewed Councillor Rooney for the post and recommended that he be appointed as a Non-Executive Director of the Trust. The Council accepted this recommendation and appointed Councillor Mick Rooney for a further term of three years with effect from 1st November 2011.

Tenure of office
1st November 2011 to 31st October 2014.

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 Foundation Trust with effect from 1st July 2008 up to 31st October 2010, which was extended for a further period of 12 months. Following the advertisement of the post on the *NHS Jobs* website, the Nominations and Remunerations Committee formally interviewed Martin Rosling for the post and recommended that he be appointed as a Non-Executive Director of the Trust. The Council of Governors accepted this recommendation and appointed Martin Rosling for a further term of three years with effect from 1st November 2011.

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 Accountancy (CPFA). Martin's financial expertise is invaluable to the Board where he currently serves as Chair of the Audit and Assurance Committee.

Tenure of office
1st November 2011 to 31st October 2014.

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. He 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 have added strength to the Board's ability to reap the commercial advantages which Foundation Trust status offers. Tony Clayton'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.

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 a Fellow of the Royal Society of the Arts.

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

Board evaluation

At two of their Board Development Sessions, members of the Board of Directors reflected on the quality of their interaction as a group and the manner in which they provide effective leadership in overseeing service user experience as an important aspect of the quality of the Trust's services.

These occasions enabled them to identify areas for improvement and increased their confidence in their existing strengths to effectively carry out their functions as a body.

Members of the Board's Audit and Assurance Committee, and its Finance and Investment Committee have completed questionnaires and their responses to these have helped to inform them on the degree of their effectiveness in discharging their respective functions.

The Quality Assurance Committee evaluated the effectiveness with which it carries out its role against the criteria set by Monitor's *Quality Governance Framework* and its members were confident that it is properly carrying out its functions. An evaluation of the Board's Remuneration and Nominations Committee was not carried out as this Committee did not meet in the year 2011/12.

The Trust Chair also carried out performance evaluations of each of the Non-Executive Directors with a view to reporting the outcome of his evaluations to the Council of Governors' Nominations and Remuneration Committee and then to the full Council of Governors.

The formal evaluation of the Chair's performance was commenced with Board members and Governors responding to a formal questionnaire on the Chair's performance in various aspects of his role. The responses to these questionnaires were considered by the Reserve Chair/Lead Governor and the Senior Independent Director who will present them to a formal meeting of the Council of Governors.

The evaluation of the performance of the Executive Directors is carried out by the Chief Executive during his monthly one-to-one meetings and annual reviews with them. As stated in Section 3, the evaluation of the Chief Executive's performance is carried out by the Trust Chair in his one-to-one meetings with the Chief Executive.

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

8.0
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, wellbeing 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 focusing on these, the Trust aims to enhance the high quality care it offers to the people who use its services.

Survey results 2011

The Trust was within the highest 20% of comparable Trusts in respect of overall staff engagement and specifically in respect of staff recommending the Trust as a place to work or receive treatment.

Other areas where the Trust scored within the highest 20% are given in the Top Four/Bottom Four Ranking Summary Table below, together with the extent of good communication between senior managers and staff.

In addition, the Trust is above average on indicators such as the Trust's commitment to work-life balance, and fewer staff consider leaving their jobs than the national average.

The areas where further positive action is required include appraisals and training in relation to health and safety and also equality and diversity. These areas need further attention although the indicators also show some positive elements. For example, the Trust scores better than average in respect of the percentage of staff who received job-relevant training, learning or development in the last 12 months.

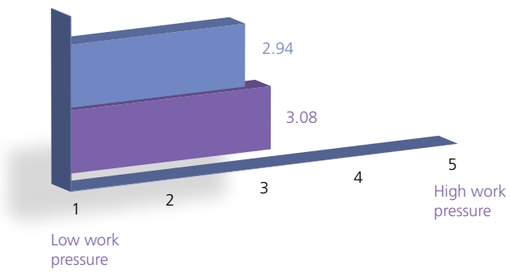
On appraisal, the Trust is still below the relevant average score but the percentage of staff appraised, nevertheless, increased compared with last year. This is the same situation with health and safety training.

In terms of health and safety, fewer staff in the Trust suffer a work-related injury than is the case on average. However, the figure for work-related stress has increased. This may be related to the increase in staff reporting harassment from patients, relatives or the public which is a cause for concern. Further consideration will be given to this area and the survey indicates that, where it occurs, the Trust is viewed as being better than average in taking effective action.

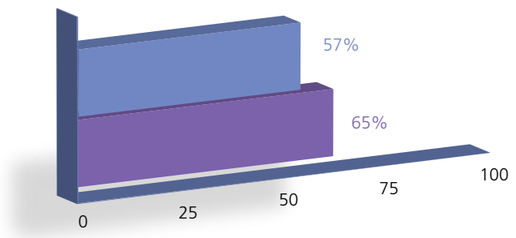
These results, together with other available information, will be used to determine an Action Plan for the key areas of focus for improvement.

Top four ranking scores

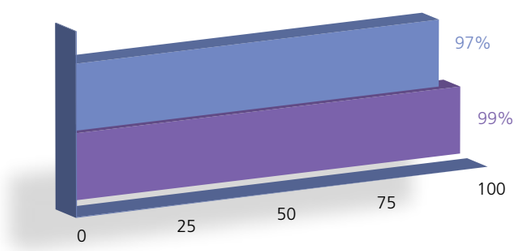
KF5. Work pressure felt by staff



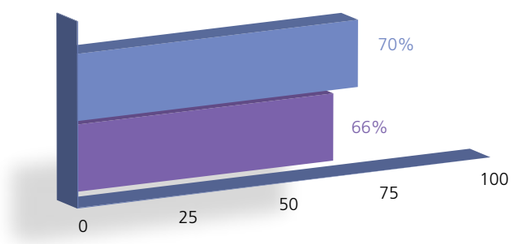
KF8. Percentage of staff working extra hours



KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



KF31. Percentage of staff able to contribute towards improvements at work

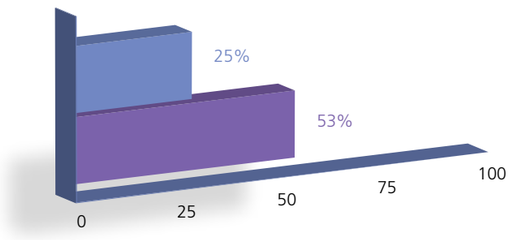


Trust score 2011

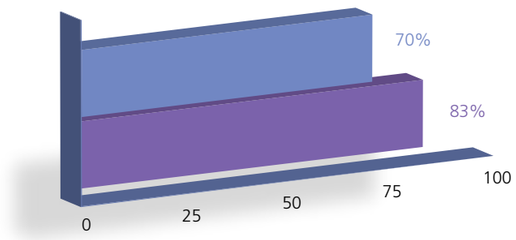
National 2011 average for mental health/learning disability trusts

Bottom four ranking scores

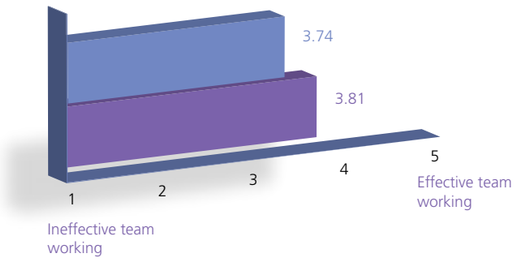
KF36. Percentage of staff having equality and diversity training in the last 12 months



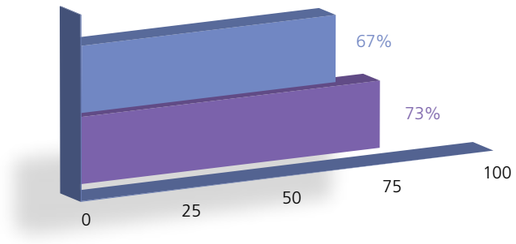
KF16. Percentage of staff receiving health and safety training in the last 12 months



KF6. Effective team working



KF14. Percentage of staff appraised with personal development plans in the last 12 months



Trust score 2011

National 2011 average for mental health/learning disability trusts

9.0
Regulatory ratings

Our performance against the regulatory requirements set for us by Monitor, the independent regulator of NHS Foundation Trusts, over the year 2011/12 is summarised as follows:

	Annual Plan 2011/12 assessment	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	4	4	4	4	4
Governance Risk Rating	Amber Red	Amber Red	Amber Red	Green	Green

The *Amber Red* risk rating reflected the additional actions required of us following a planned service review undertaken by the Care Quality Commission. A range of compliance actions was agreed following the review in January 2011. The Amber Red rating reflected the additional assurance required through the full completion of the development plan agreed with the Care Quality Commission.

We assessed this would be completed by the Quarter 3 period and successfully made the required progress.

Allowing for the above, we have achieved each of the *Quality and Governance* targets and standards for each quarter during the last year.

As a Trust, we remain fully compliant with the registration requirements of the Care Quality Commission for all of the health and social care services that we provide.

10.0
Sustainability report

Our approach to sustainability is embodied in our *Sustainable Development Policy*. The objectives of the policy are for the Trust to continually improve upon and manage the environmental impact of its activities wherever possible, while taking value for money into account.

This will include conservation of water, energy and other resources; appropriate waste disposal; monitoring discharges and emissions with the aim of reducing pollution and greenhouse gases; promoting recycling, training and educating staff and involving them in developing new ideas and initiatives.

The intended outcomes will be our increased ability to meet legislative and regulatory requirements; contribute to the NHS carbon reduction target; demonstrate our commitment to working with and supporting other organisations, and have better-engaged and informed staff who actively contribute to these outcomes.

We have achieved some specific changes during 2011/12. For instance, at our headquarters building at Fulwood House, we have introduced:

- improved paper recycling via segregation of confidential and non-confidential paper waste. This has saved us £5,000
- a *Voltage Optimisation Unit (VOU)*. This was a *'Spend to Save'* scheme. Combined with the completion of a new main server room which is mainly cooled via passive ventilation techniques (only using air conditioning as back-up), this has seen a drop in electricity consumption of at least 9.3%.

Our general waste contractor has continued to provide very good levels of recycling across all waste streams and currently, a minimum of 87% of this waste is recycled. This has also enabled us to generate savings of £7,000 during 2011/12.

We have continued our electricity contract with Scottish & Southern Energy which guarantees that a minimum of 25% of the electricity that we consume is provided from renewable sources. This contract will change in 2012/13 but we have retained our commitment to purchasing the same percentage of renewable energy.

We also have two properties (Brunswick House and St. George's Community Health Centre) where central heating/hot water is provided from Sheffield's 'energy from waste' city system (sometimes termed 'green heat').

We no longer support use of bottled water coolers and all such equipment has been removed from Trust premises and, where appropriate, replaced with 'mains plumbed in' equivalents.

We have continued rolling out a vehicle tracking system. This has supported more efficient route planning and elimination of wasteful practices such as excessive engine running.

Reporting Table/Metrics

Area	Type	Non Financial information	Financial information
Greenhouse Gas Emissions	Direct Greenhouse Gas Emissions	In 2011/12 the Trust consumed **11,516,730 kWh** of Gas which equates to **2,372.45 tonnes of CO2e***	In 2011/12 the Trust spent **£359,166** purchasing gas
	Indirect Energy Emissions	In 2011/12 the Trust consumed **3,223,609 kWh** of Electricity which equates to **1731.41 tonnes of CO2e**	In 2011/12 the Trust spent **£327,351** purchasing electricity
	Official Business Travel Emissions	**Grey Fleet (inc Lease Car Mileage)**** : In 2010/11*** mileage travelled by the grey fleet amounted to **1,868,111 miles** The figure for CO2e is not currently available"	**Grey Fleet (inc. Lease Cars):** In 2010/11 the Trust spent **£772,754** on mileage for the Grey Fleet
Waste Minimisation and Management	**Domestic Waste:** For 2011/12 the figures for domestic waste are as follows: Total Waste arising: 470,625 kg Waste to landfill: 67,385 kg Waste recycled: 403,240 kg Waste Incenerated: 0 kg	**Domestic Waste:** In 2011/12 the cost of disposing of domestic waste was **£65,584**	
	Healthcare Waste: For 2011/12 the figures for healthcare waste are as follows: Total Waste arising: 10,940 kg Waste Incinerated: 2672 kg"	**Healthcare Waste:** In 2011/12 the cost of disposing of healthcare waste was £25,304	
Finite Resources	In 2011/12 the Trust consumed **38,854 m3** of water and sent away **36,911 m3** in the form of sewage	In 2011.2012 the total water and sewage cost was **£98,357**	

*CO2e = Carbon Dioxide Equivalent which is a way of reporting all greenhouse gas emissions or reductions as one standard unit
**Grey Fleet = employmee-owned (or leased) vehicles used for Trust business purposes (home visits, meetings, conferences, etc.)
***The last year for which figures are available for this metric

Future priorities and targets

The Executive Directors Group (EDG) agreed to support implementation of a range of practical measures aimed at both reducing operational costs and improving sustainability. This will be implemented via a *Working Group*, led by the Facilities Directorate. Topics will include an energy saving campaign; improved management of water, waste, post, printing and; effectiveness of purchasing, among other things. The activities of the Working Group will be monitored by the *Executive Directors' Group* and an annual report will be produced on actions carried out and their impact on the Trust.

2012/13 will also see the building of a brand new unit from which we will provide care for people with learning disabilities who require health service assessment and treatment. This new building will be to full *BREEAM* standards, demonstrating our conformance to the world's foremost environmental assessment method and rating system for buildings. It will include the provision of a 'green roof'. This will be an exciting development for us and will significantly reduce the environmental impact of our activities when it is complete around Spring 2013.

Also in 2012/13, we plan to replace a number of boilers at some of our medium/small sized premises as well as replacing windows at one of our *Community Team* bases. This will have an impact on our energy consumption/greenhouse gas emissions.

Another important piece of work that we plan to undertake in 2012/13 is a review of our transport services. This may result in the downsizing of our in-house vehicle fleet, again with related consumption and emissions reductions.

11.0
Quality report

Part 1: A Statement on Quality from Kevan Taylor, the Chief Executive

This is our fourth Annual Quality Account and I hope you will enjoy reading it. It gives an overview of the quality of Sheffield Health and Social Care NHS Foundation Trust services and tells you what we have done to improve the quality and safety of care. It also sets 5 quality objectives for the year ahead; these are the five areas where we most want to make improvements in 2012 to 2013.

The Trust takes the dignity and respect of service users very seriously. Feedback from service users in the Care Quality Commission Annual Community Mental Health Patient Survey this year was positive about how people are treated by staff in the community mental health teams:

In the CQC Annual Community Mental Health Patient Survey for 2011, the Trust received the highest score nationally of people saying they were treated with dignity and respect by their health or social care worker.

Some service users have written to the Trust to express what it feels like to be treated with dignity and respect.

This has been a time of change and growth for the Trust, with new services joining us from the former NHS Sheffield PCT Provider Services. I have been delighted to welcome the *Clover Group* of General Practices, the Neuro-Enablement Services, the Homeless and Traveller team, the Chronic Fatigue Syndrome/Myalgic Encephalopathy (CFS/ME) service and a number of professionals such as Speech and Language Therapists and Physiotherapists in the Learning Disabilities Service. We have also been joined by the Sheffield Community Advocacy and Interpreting Service (SCAIS) and the Community Development Workers who bring extra expertise in working with minority communities into the Trust.

These services have brought fresh ideas and examples of good practice to Sheffield Health and Social Care NHS Foundation Trust. For example, the Brain Injury Research Rehabilitation Partnership:

"Thank you for understanding my situation and the pain I was going through. You are a kind and considerate and very caring nurse. You have been there for me and giving me support. One day I am fine, another day I am rubbish, so rubbish, so bad, I don't even know who I am and you still gave me support and were nice, very nice to me at my worst times… I find it difficult to talk about my problems with someone I do not know and you understand. Thank you for respecting my wishes and making me feel comfortable with you. I have taken your advice on board and I will continue working towards one day at a time toward recovery."

Service user from the Transcultural Team

The Brain Injury Research Rehabilitation Partnership

Hosted by the Sheffield Community Brain Injury Rehabilitation Team

The Brain Injury Rehabilitation Research Partnership (BIRRP) started in 2006. It is a group consisting of survivors of brain injury, carers who have experience of caring for someone with a brain injury and clinicians from the Sheffield Community Brain Injury Rehabilitation Team (SCBIRT). BIRRP was established to develop a collaborative body that recognises the expertise that everyone has in managing life after brain injury and aims to bring this together to work on projects that will improve services for people.

Following significant consultation with many stakeholders, it was decided to develop a service evaluation project based around examination of the experiences that clients have had about discharge from SCBIRT. Some service users had described discharge from community services as being 'sent into the wilderness'. Service users and the clinical team were keen to gather information and learn from it so the Trust could look at how people experience moving from rehabilitation to life afterwards. This information can then be fed into operational practice and changes made accordingly.

The project is now well under way…

BIRRP has had a significant impact on service delivery and at the individual level for group members. Service user involvement is now embedded in the culture of the team and there is a genuine sense that service user voices are part of the conversation of operational delivery. This includes service user recruitment panels for all professional appointments, service user-led training workshops in health and social care forums, participation on a plethora of health and social care advisory bodies, health champions, to name but a few of the pathways that members have taken.

BIRRP will continue to grow and develop and initiate other service evaluation plans. It is a model that continues to attract much attention from other services and we are about to embark on a collaboration with the Social Policy Research Unit at the University of York.

Mark Parker, Service Manager

The Trust has been able to share its areas of strength with the new services. In the field of quality, the Trust is sharing its passion and experience about local team governance approaches, where quality improvement comes from, and is led by the clinical team. All teams review the quality of care they provide in a team governance report, and set goals for improvements with their directors.

The Trust has invested in improving staff expertise in a number of areas:

- new risk assessment and management tools, the BRAM and DRAM, have been developed and introduced on a rolling programme throughout the Trust. All staff responsible for the care and treatment of service users are receiving training in clinical risk assessment and management: during the year 879 staff were trained. The number of staff being trained was increased and the time to complete the roll-out to all staff was extended during the year
- training in equality and diversity has been reviewed and improved
- the Respect Approach to preventing and managing violence and aggression is being introduced to all areas, with intensive staff training in the new, more person-centred approach. At the end of the year, 157 staff from the Trust's inpatient areas had received the training. Staff who have trained are very positive about the new approach.

"This is what I've been crying out for! A person centred approach which keeps people safe whilst maintaining their dignity. Respect is about challenging attitudes and behaviour and putting service users at the heart of what we do as mental health workers"

Staff member, Maple Ward

I would most like to highlight the areas where we have been working in partnership with service users and carers to improve services.

We held a brilliant event for the Recovery model in the Trust, addressed by Rachel Perkins, a service user, Clinical Psychologist and NHS manager from London, and by Trust champions for the model.

What is Recovery?

"Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems."

Shepherd, Boardman and Slade 2008
From Rethink website www.rethink.org.uk on 29.3.12

Staff were challenged and invigorated by the idea of working in 'co-production' with service users to bring about positive change. As a result, the Trust is setting up a Recovery College to provide education, training, consultation, support and advice to service users and staff and Recovery Enterprises, an umbrella organisation reflecting the principles of social enterprise, to develop creative work opportunities for service users.

Following the publication of the NICE (National Institute for Health and Clinical Excellence) Quality Standard for Service User involvement, the Trust is launching a Service User Experience Monitoring team. Service users from across the Trust, including people of all ages, from different races and cultural backgrounds and including people with learning disabilities, will be working together on 2 big ideas:

- short, rapid surveys of service user feedback on care
- service user-led interviews and longer surveys to find out about the experiences of service users in more detail.

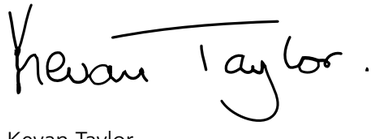
The Service User Experience Monitoring team is building on the expertise of service user volunteers who already visit the wards to interview inpatients about their experience of care in the Quality and Dignity surveys, or who visit alongside staff to give their perspective on care and whether it meets the requirements of the Care Quality Commission (CQC) or the Patient Environment Action Team (PEAT).

I would like to take this opportunity to thank all those service users and carers who give up their time to work with the Trust to help improve the quality of care.

I would also like to pass on the thanks of myself and the Trust Board to all those staff who have worked hard during the year to maintain and improve the quality and safety of services. It was positive to see in the CQC Staff Survey results this year that the Trust again fell into the top 20% nationally for those staff who responded that they would recommend it as a place to work or receive treatment.

To the best of my knowledge the information in this document is accurate.

Signed



Kevan Taylor

Chief Executive

Part 2: Priorities for improvement in 2012/13

The Trust has chosen 5 quality improvement priorities for the year ahead, to cover each of the following 4 areas:

1. Safety

2. Clinical effectiveness

3. Positive Service User Experience

4. Access, Equality and Inclusion

Trust Quality Objectives for 2012/13

There will be 2 safety objectives this year:

- To reduce the number of falls that cause harm to service users
- To reduce the incidence of violence and aggression and the subsequent appropriate use of restraint and seclusion

The clinical effectiveness objective is:

- To improve the identification and assessment of physical health problems in at-risk groups

The positive service user experience objective is:

- To improve the experience of first contact with the Trust

The objective for access, equality and inclusion is:

- To improve access to dementia care

Objective 1: To reduce the number of falls that cause harm to service users

We are intending to work on this issue as a priority for the next 2 years.

Executive/Director Lead:
Liz Lightbown

Operational Lead:
Elaine Hall

We chose this priority because:

- falls cause direct harm to service users because of injury, pain, restrictions on mobility and community participation, impacting on quality of life and well-being
- the Trust reports high number of slips, trips and falls in comparison with other mental health trusts. Information from the National Patient Safety Agency showed that 49% of all the patient safety incidents reported in Sheffield Health and Social Care Trust were patient accidents in comparison with 25% as a national average for mental health trusts. (Information from the NPSA Organisation Patient Safety Incident Report for 1 April 2011 to 30 September 2011)
- the National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust older people inpatient areas than the national average rates of falls. There were 13.5 falls per 1000 bed nights compared with 8.4 falls nationally
- there is guidance and support available on how to reduce the severity, frequency and impact of falls from NICE, Harm-free NHS and the Energise for Excellence national NHS campaign
- recent audits for the Falls NICE guideline group have shown little reduction in falls so far.

The current situation is:

- during 2011/12 **1599** incidents of slips, trips and falls for service users were reported by the Trust
- **514** slips, trips or falls **(32.1%)** resulted in harm or injury to the service user concerned
- this compares with **36.3%** resulting in injury in 2010/11, **33.8%** in 2009/10 and **35.6%** in 2008/09
- the diagram below shows the slips, trips and falls reported over the last 4 years
- it is evident that falls are a significant service user safety issue.

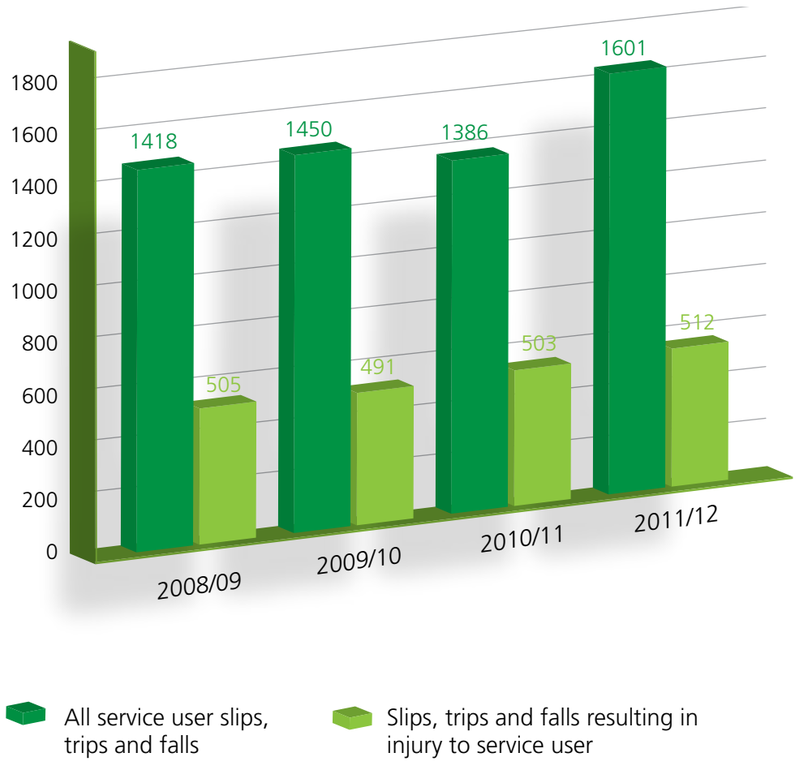


Diagram 1: Slips, trips and falls reported over the last 4 years (Data from Ulysses Safeguard)

N.B. Data has changed from previous Quality Accounts, because in previous years the Trust had included staff falls as well as service user falls. The above data represents recalculations of previous years' figures, excluding staff incidents. Changes also result from additional incidents being reported after the initial data capture date.

The intended outcomes are:

- to reduce the number of falls resulting in serious harm to service users by 5% by the end of the year and by 10% in the following year
- to reduce the level of harm experienced by service users from falls, as measured by reduction in number of falls resulting in A&E or hospital admission
- 100% of older people admitted to inpatient areas will be screened for falls using a standardised screening tool, the MFRA, by the end of the year
- environmental falls risk assessments will be completed for all inpatient and residential areas.

This is what we will do:	Lead	Timescale
• Implement MFRA (Multi-factorial Risk Assessment) screening tool for falls for all older people admitted to inpatient areas	Elaine Hall	By September 2012
• Monitor the use of the MFRA	Elaine Hall, ward managers and Trust Falls Group	Minimum quarterly
• Carry out environmental falls risk assessments in all inpatient and residential areas	Elaine Hall, ward/team managers and Trust Falls Group	By December 2012
• Identify appropriate training packages for staff	Elaine Hall. Training Dept	By September 2012
• Deliver falls training to staff	Training Dept	December 2012

Cost of implementation:

- Amendment of Insight care record system to enable recording of MFRA
- Release of staff time to train
- Release of staff time to attend training.

Objective 2: To reduce the incidence of violence and aggression, and the subsequent appropriate use of restraint and seclusion

The introduction of the new approach to the management of violence and aggression, the Respect Approach, and the associated staff training, began in 2011/12 as part of a previous quality objective.

We intend to continue work on this objective into 2013/14.

Executive/Director Lead:
Clive Clarke

Operational Leads:
Richard Bulmer and Kim Parker

We chose this priority because:

- the Trust has started re-training all staff working on the inpatient wards in a new, more person-centred approach to the prevention and management of violence and aggression, the Respect Approach
- the prevention and management of violence and aggression is as an area of concern for service users, with critical feedback about the negative impact on them.

"The Maat Probe Group, who are service users, came together and did a survey about how people had encountered control and restraint in hospital wards. We the group put (a presentation) to Sheffield Care Trust, and we approached Grimsby Care Trust who lead on Respect de-escalation for distressed people. Respect is now being introduced to all nursing staff on all mental health wards.

We are all pleased that the Respect is taking place in Sheffield"

Members of Maat Probe African Caribbean service user group

- The Trust reports relatively low rates of violence and aggression overall towards service users from service users, according to the latest benchmarking information from the National Patient Safety Agency. This showed that 15.5% of patient safety incidents reported by the Trust in the first 6 months of 2011/12 were related to disruptive, aggressive behaviour, in comparison with 19% of incidents reported by mental health trusts nationally. The incidence is higher in some ward areas than others.
- The CQC Staff Survey for 2011 shows the Trust fell into the highest (worst) 20% of staff from all areas of the Trust who reported that they had experienced physical violence from patients, relatives or the public in the last 12 months. The proportion of staff who said they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months was also above the national average and had got worse since the previous year's survey.

- Sheffield City Council and NHS Sheffield have issued a new framework for Good Practice in the Prevention and Management of the Use of Restraint during 2011.
- There is good practice in the learning disabilities service on alternatives to restraint, that could be adapted and rolled out to other areas of the Trust.

The current situation is:

- there were a total of **392** incidents reported in the year, where service users had been the victim of physical assault or attempted assault. The overwhelming majority of the assailants (386 or 98%) were other service users
- **15.4%** of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average for mental health trusts of 19%. (NPSA benchmarking data for first 6 months of the year.)
- **155** staff working in inpatient areas had completed the intensive 4 day level 3 Respect training by the end of 2011/12
- **17** staff had received the level 1 (introductory) Respect training: this programme was just beginning towards the end of the year.

The intended outcomes are:

- to train all inpatient nursing and support worker staff in the Respect Approach by the end of the year
- to reduce the number of incidents of violence and aggression, after staff on ward areas have completed the Respect training, and sustain the reduction over the next 2 years
- to reduce the use of seclusion over the next 2 years
- to reduce the use of restraint over the next 2 years
- to increase the percentage of service users in acute wards who report experiencing a safe environment in local Quality and Dignity surveys
- to increase the number of staff on acute wards who report a safe environment in local Productive Ward surveys
- to reduce the number of staff reporting that they have experienced physical violence from service users, relatives or the public in the CQC Staff Survey over the next 2 years
- to reduce the number of staff reporting that they have experienced harassment, bullying or abuse from patients, relatives or the public in the CQC staff survey over the next 2 years.

This is what we will do:	Lead	Timescale
• Continue to deliver the Respect training to all inpatient staff	Kim Parker, Training team	All staff to be trained by the end of the year
• Continue to monitor the incidents of violence and aggression at ward and team level, and analyse trends over time and between teams	Kim Parker, ward and team managers, risk management team	Minimum quarterly reporting
• Establish reliable and consistent methods for the recording of restraint and seclusion on all inpatient areas	Kim Parker, ward and team managers, risk management team	
• Establish a baseline for the rates of restraint and seclusion in all inpatient areas	Kim Parker, ward and team managers, risk management team	
• Set local targets and agree actions for the reduction of the use of restraint and seclusion in all inpatient targets	Clinical and service directors, Kim Parker, ward and team managers	
• Establish reliable and consistent reporting on the use of restraint in SHSC community settings with vulnerable adults	Kim Parker, Zara Clarke, team managers, risk management team	
• Establish a baseline for the rates of restraint in SHSC community settings with vulnerable adults	Kim Parker, Zara Clarke, team managers, risk management team	
• Set local targets and agree actions for the reduction of the use of restraint in SHSC community settings with vulnerable adults	Kim Parker, Zara Clarke, team managers, risk management team	

Cost of implementation:

- Purchase of Respect Approach training materials (already purchased)
- Release of staff time to train
- Release of staff time to attend training

Objective 3: To improve the identification and assessment of physical health problems in at-risk groups

Executive/Director Lead:
Liz Lightbown/Tim Kendall

Operational Leads:
Rose Hogan/Tony Flatley

We chose this priority because:

- physical health is a priority for governors and service users, as many SHSC service users are at higher risk of developing physical health problems
- evidence shows people with severe mental illness and people with learning disabilities have reduced life expectancy and greater morbidity: so do people who are homeless and people who misuse drugs and alcohol
- physical health is a national priority in the Mental Health Strategy, NHS Outcomes Framework, Public Health Outcomes Framework
- we are already working on a number of programmes to make improvements e.g. physical health checks on wards, use of early warning signs toolkit, link nurses for illnesses such as diabetes, smoking cessation, health facilitators and health action plans, staff training in 'healthy chats'
- the expertise of the *Clover Group*, now part of the Trust, can be built on
- the introduction of physical reviews for people with long-term mental health problems in primary care could be linked to CPA reviews – information such as body mass index, blood pressure etc could be added to communication between SHSC staff and GPs
- people with learning disabilities are supported by SHSC Health Facilitators to have their annual GP health check and develop a health action plan – this good practice could be spread to other areas
- the introduction of Energise for Excellence is planned
- the new Every Contact Counts e-learning tool, that supports staff to offer health promotion advice, is now available
- the regional 'health chats' approach is being adopted by the Trust. This gives frontline staff the confidence to talk to service users about potentially sensitive areas of their physical health such as obesity. It helps staff give clear and simple messages about improving physical health.

The current situation is:

- audits of Insight care records in November 2011 showed overall in 78% of service users' records their physical health status was checked and documented
- there was variability in performance between the 4 directorates.

Table 1: % service users whose physical health status had been checked, by directorate Data from Care Records Audit, November 2011. 579 Records were audited

Directorate	% service users with physical health check/status recorded
Acute mental health/inpatients	81
Community mental health	65
Learning disabilities	91
Specialist services	90

- 25 staff have trained as 'health chat' key trainers
- 2 staff have trained as level 2 smoking cessation experts
- 60 staff attended Learning Beyond Registration (LBR) funded physical health courses during 2011/12: these included additional training in care for diabetes, kidney failure and heart failure
- *Clover Group* practice recorded physical health checks for people newly diagnosed with dementia in 50% of cases (this was an underperformance on the QOF clinical indicator)
- *Clover Group* practice met the mental health QOF indicators including lithium checks, alcohol consumption, blood pressure, cholesterol levels, blood glucose and cervical screening of people with psychosis
- *Clover Group* recorded BMI in 85% people with psychosis: this was below the QOF target
- the *Clover group* could not meet the learning disability QOF indicator of thyroid checks for people with Downs' syndrome because the relevant patients were exempt.

The intended outcomes are:

- health chat' key trainers to cascade training into clinical settings and become 'champions' for these settings
- 90% of people to have physical health checks recorded in all relevant service areas
- diabetes link nurses in all inpatient areas
- measure of better communication between SHSC and primary care on physical health key information e.g. blood pressure
- *Clover Group* to improve performance and achieve the QOF targets on physical health checks for dementia and BMI for people with psychosis.

This is what we will do:	Lead	Timescale
Implement the electronic Medical Examination on Admission and Lifestyle Assessment across all relevant services	Rose Hogan	Sept 2012
Train additional 30 staff to become 'healthy chat' key trainers	Rose Hogan	March 2013
Key trainers to cascade training to 6 team members each	Rose Hogan	March 2013
Develop and rollout obesity care pathway	Rose Hogan	March 2013
Produce patient information leaflet	Rose Hogan	Dec 2012
Improve menu labelling and create healthy updates to menus	Rose Hogan	Sept 2012
Ensure smoking status of all inpatients is recorded in patient record	Rose Hogan	March 2013
Increase number of referrals to Sheffield Stop Smoking Service to 25 per quarter	Rose Hogan	March 2013
Train 2 staff in each inpatient area to be level 2 smoking cessation experts	Rose Hogan	March 2013
Clover Group to achieve QOF target in recording BMI in people with psychosis	Rachel Pickering	March 2013
Clover Group to achieve QOF target in physical health checks for people newly diagnosed with dementia	Rachel Pickering	March 2013

Cost of implementation:

- release of staff time to train
- release of staff time to attend training.

Objective 4: To improve the experience of first contact with the Trust

Executive/Director Lead:
Clive Clarke

Operational Leads:
John Burton, Kim Parker, Mia Bajin

We chose this priority because:

- it is a governor and service user priority, as part of a positive service user and carer experience
- although the CQC Community Mental Health service user survey indicates that service users feel they are treated with dignity and respect in most instances, complaints about staff attitude are still received
- the Respect training which is being implemented for all staff (see objective 2) includes key elements about treating service users with dignity and respect. Initial feedback indicates a positive impact on staff attitude
- first contact is relevant for Clover Group and Neuro-Enablement Services as well as 'old' SHSC services
- following low scores on the CQC Annual Community Mental Health for questions about a 24-hours phone line, the Trust is piloting an out-of-hours phone line to give advice and help to service users and carers, in partnership with Rethink
- a new '15 Steps Challenge' is available as part of the Productive Series of service improvement tools and techniques. This assesses service user experience by literally walking through and obtaining the first impressions of a service.

The current situation is:

- all new staff are trained at their induction in working respectfully with service users and carers
- 172 staff have received Respect training
- top 20% (highest score) nationally in CQC Annual Community Mental Health Survey for service users responding they were treated with dignity and respect by their health or social care worker
- middle 60% nationally in CQC Annual Community Mental Health Survey for service users responding that they had the phone number of someone from their local mental health services that they could ring out of hours
- 60% of service users, on the 4 acute mental health wards surveyed, reported that they had received a ward information pack or handbook in the last Quality and Dignity survey. The range was from 38% to 77% on the different wards.

The intended outcomes are:

- greater staff awareness and focus on the importance of first contact for service users
- delivery of an out-of-hours phone number for service users and carers
- more staff trained in customer care as part of the roll-out of Respect training
- review and revisions where needed, in partnership with service users, to standard communications e.g. initial appointment letters and information leaflets.
- new standards to be agreed and implemented for the provision of information leaflets for new service users/new referrals
- all service users on wards who want one will receive a ward 'welcome pack'
- to remain in top 20% of mental health trusts in CQC Annual Community Mental Health Survey for being treated with dignity and respect
- to improve score in CQC survey on 24 hour phone line.

This is what we will do:	Lead	Timescale
• Pilot an out-of-hours telephone helpline	John Burton	March - April 2012
• Following the pilot, develop a plan for a sustainable out of hours phone line	John Burton	End April 2012
• Deliver Respect training	Kim Parker and Training team	See objective 2 above
• Implement 15 Steps Challenge with NEDS, staff and service users in inpatient areas and 1 community team	Kim Parker	Awaiting national release of 15 Steps
• Audit use of ward welcome packs and make any improvements needed following audit	Kim Parker	
• Review and revise standard communications relating to first contact including initial appointment letters and information leaflets sent out with initial appointments	Mia Bajin, Kim Parker	
• Set and monitor standards for the provision of information leaflets at first contact	Mia Bajin, Kim Parker	

Resources needed:

- funding to support out-of-hours phone line (currently being piloted)
- costs of production and printing of information leaflets and welcome packs
- release of staff time to train
- release of staff time to attend training
- release of staff time and expenses for service users to implement 15 steps challenge.

Objective 5: To improve access to dementia care

Executive/Director Lead:
Clive Clarke

Operational Leads:
Michele Fearon/Peter Bowie

We chose this priority because:

- IImproving dementia care is a priority for the Trust, governors, the City Council and LINks
- Tthe incidence of dementia is predicted to rise with Sheffield's ageing population
- early identification and rapid access to services can delay the impact of dementia and lead to a better quality of care and better support for carers
- we wish to build on the delivery of the NICE Quality Standard for Dementia
- it builds on work to reduce the waiting times for memory clinics
- learning disability services are implementing a dementia care pathway because of the increased risk of early dementia in people with Down,s syndrome
- there is partnership work with Sheffield Teaching Hospitals NHS Foundation Trust and NHS Sheffield and the voluntary sector to improve access to dementia care
- it links to Sheffield City Council Prevention work.

The current situation is:

- Sheffield performs well in comparison with other areas in the identification of people with dementia, enabling them to access care and treatment. This is measured by people with a diagnosis on the Quality Outcomes Framework dementia register in primary care. The Alzheimers' Society prevalence and diagnosis map for 2011 showed 57% of those predicted to have dementia had been diagnosed, putting Sheffield in the top 3 areas nationally. See **www.alzheimers.org.uk/dementiamap**
- **862** people were diagnosed with dementia by the Memory Management Service in 2011/12
- the average waiting time for a first appointment with the Memory Management Service over the year was **14.7 weeks**, down from 21.3 weeks in 2010/11 and 28 weeks in 2009/10
- approximately **40** people with learning disabilities were assessed for dementia
- people from Black and Minority Ethnic Groups are less likely than others to be diagnosed and treated with dementia
- the *Clover Group* practice recorded physical health checks for people newly diagnosed with dementia in 50% of cases (this was an underperformance on the QOF clinical indicator).

The intended outcomes are:

- to maintain the reduction in waiting time for memory service achieved over last 2-3 years and aim to reduce it further
- more than 900 people will be seen for assessment in Memory Management service. (The new target set by Commissioners is up from 800 to 900 new assessments and diagnoses)
- to evaluate the service user and carer experience and establish a reliable baseline for the number of people with learning disability receiving memory assessments
- to evaluate experience through service user and carer experience surveys for people receiving dementia services from the Memory Management Service
- to establish reliable baseline figures for people from different Black and Minority Ethnic Groups accessing dementia services.

This is what we will do:	Lead	Timescale
• Meet the new target for more memory assessments in the Memory Management Service	Peter Bowie, Tony Bainbridge	To report quarterly
• To maintain the reduction in the waiting times for first assessments and aim to reduce it further	Peter Bowie, Tony Bainbridge	To report quarterly
• Implement and evaluate the dementia pathway for adults with a learning disability	Debbie Albrow	From 1 April 2012
• Develop and implement a plan to improve access to memory services by people from Black and Minority Ethnic Groups	Elaine Hall	December 2012
• Survey service users and carers of dementia services about their experience of care and respond to any issues raised	Jane McKeown	October 2012

Resources needed:

- staff time for quality improvement work
- costs of surveys – production, administration, analysis – to be managed within Trust
- evaluation of learning disability dementia care pathway to be completed by Psychologist in clinical training as part of course requirements.

How the Trust is developing quality improvement capacity and capability to deliver these improvements

When the Trust was developing its quality objectives for 2012/13, a number of possible objectives were put forward that concerned improving the Trust as an organisation, its systems and processes, to build capacity for quality improvement. Although these things are important, the Trust decided to focus on objectives that would have a direct, measurable impact for service users and carers. The Trust took the decision to remove them from the shortlist for quality objectives, but is still committed to developing a number of these projects. They include:

- setting up the Service User Experience Monitoring Unit and making sure all teams in the Trust are using its service user survey, and all inpatient areas are visited by service user volunteers to interview people about their experience of care
- creating a strong Recovery culture in the Trust, implementing the Recovery College and Recovery Enterprises
- standardising team governance reports to enable benchmarking and compliance with CQC essential standards, while retaining team and directorate ownership and making sure there is joining up from team to Board with quality assessment, improvement and assurance
- reviewing and improving quality measures and quality indicators in the light of the national outcomes framework, NHS Sheffield expectations, national development in the Quality Outcomes Framework (QOF) and mental health indicators
- continuing to make improvements to how the Trust learns from serious incidents or complaints – when things have gone wrong – including being open with service users and families, and giving feedback to staff
- continuing to develop support for carers, building on last year's quality objective and action plan
- making sure all staff are trained in clinical risk assessment and management, and that effective, systematic risk tools including the Brief Risk Assessment and Management (BRAM) and the Detailed Risk Assessment and Management (DRAM) are in place throughout the Trust
- implementing the NHS Equality Delivery Scheme
- implementing the new Volunteer Policy and developing support for volunteers
- continuing the work on food and improving nutrition that was a quality objective for 2011/12, through the Nutrition Group
- supporting the Black and Minority Ethnic (BME) Strategy group to continue its work to improve the experience of care by service users from BME groups
- delivering Energise for Excellence, a new national quality framework:

Energise for Excellence (E4E)

Energise for Excellence in Care (E4E) is a quality framework for nursing and midwifery that aims to support the delivery of safe and effective care, creating positive patient and staff experiences that build in momentum and sustainability; this is underpinned by 'Social movement thinking' principles.

Aims:

- patients reporting a positive experience when accessing Healthcare
- nurses driving the delivery of high quality and job satisfaction
- commissioners using quality indicators to drive improvements in safe, efficient effective care
- inform Boards in their decision making about nursing and patient care.

Overarching approach

Trust services were redesigned during the year to move from 6 to 4 directorates from October 2011 and reduce management costs where feasible. In addition to the *Clover Group*, the directorates are:

- acute mental health (all adults)
- community mental health (all adults)
- specialist services
- learning disabilities.

The corporate services and systems that support frontline care have been redesigned to reflect these changes and give energy, leadership and resources into the new directorates. The senior nurses, for example, are now managed within the directorates rather than by the centre.

A number of directorates are committed to quality improvement projects within their service areas, for example:

- the *Clover Group* is taking steps to improve the quality of service user experience and is setting up new ways of involving service users in the practices.

The *Clover Group* Practice – patient participation

A new Patient Group has been set up with 69 members from all the practice sites. Ages range from 16 to 86 years, and there is a good representation from all the communities the practices serve. The group began in November 2011 and has met twice so far: it also has its own website.

The Patient Group has set its own priorities which include:

- an appointments survey – carried out in several languages, on paper and online
- improvements to Patient Information
- the development of Patient Group Advocates
- patient involvement in protocols and procedures.

- The Homeless and Traveller Service is working to improve health outcomes, especially of young people
- the Learning Disability Service is developing a new Integrated Support Service which will include a much improved inpatient environment for those service users with severely challenging behaviour or mental health problems, who currently use the Assessment and Treatment Unit.

During the year, the Trust implemented changes to its governance and performance management arrangements in the light of the Francis Report recommendations and its self review. A new Board sub committee, the Quality Assurance Committee, began in April 2011. The Committee has received regular updates on delivery of the Trust's quality objectives, and reports on different aspects of quality including safety, clinical effectiveness, service user experience, equality and inclusion.

It enables Board members to track progress on quality measures, audits and indicators, and also to have in depth discussion and review of quality issues. The governance committee structure overall has been reviewed and streamlined. The Trust's Quality Framework is being revised and a new Governance Handbook is being developed.

The Board has deepened its understanding of service user experience, with service user and carer presentations at every Board, and visits to services by Board members, including Non-Executive Directors. A Board development session was held in March 2012 to build on these approaches.

Progress on last year's quality objectives

The Trust chose 4 quality objectives for 2011/12. They were:

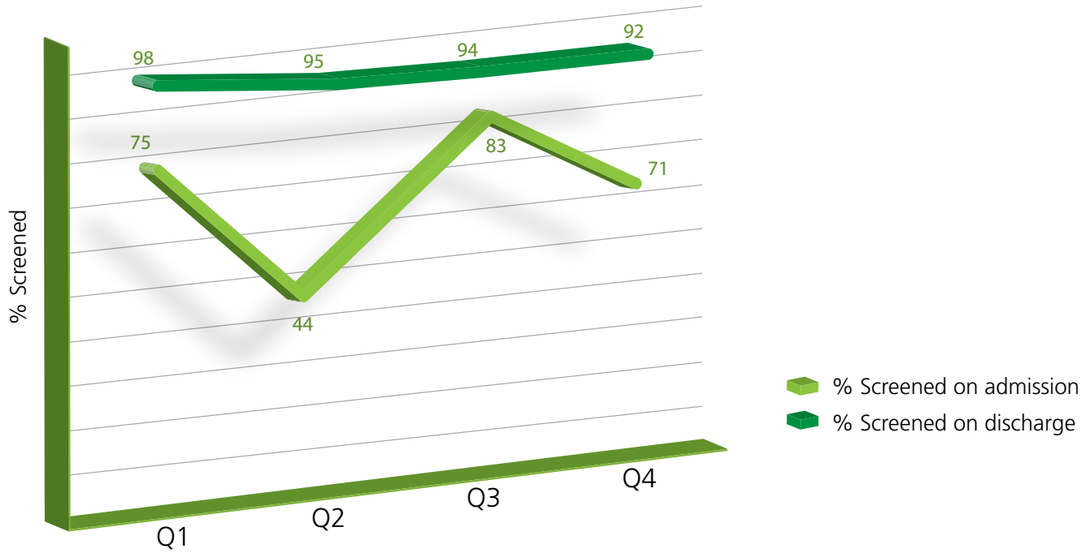
1.To improve nutritional support for service users, develop a Nutrition Strategy, reduce the risk of malnutrition and obesity and improve the quality and experience of meals provided by the Trust.

By the end of the year:

- the Nutrition Strategy was completed in draft form and being implemented during 2012
- all directorates in the Trust had action plans for improving nutrition in their areas, and had set targets for improvement. This work will be continuing in the year ahead
- a new Dietician post had been created and a part-time Dietician appointed to provide expert advice on food and nutrition
- all older people admitted to older adults' inpatient wards were being screened for malnutrition or obesity on admission and discharge using the Malnutrition Universal Screening Tool (MUST). If problems were found, action was being taken. The same programme was being extended to younger people admitted to inpatient wards
- the percentage of service users screened on admission during 2011/12 was 95%. The percentage screened on discharge was 71%. The table below shows performance varied over the year.

Diagram 2: Screening using the MUST (Malnutrition Universal Screening Tool) on admission and on discharge from wards, for each quarter of 2011/12.

Data from insight.



- 14 staff including nurses, OTs, catering and housekeeping staff working with people with mental health problems, received specialist weight management training
- An obesity care pathway is being developed by the dietician and there are plans to train more staff in weight management
- Patient Environment Action Team (PEAT) assessment visits in February 2012 found 4 out of 5 sites were 'good' against a target of food in all areas being 'good' or 'excellent.' The other site was assessed on the food PEAT standard for the first time this year: because of the timing of the inspection visit the food could not be tasted and so a score of 'acceptable' was deemed the maximum possible
- New standards had been developed for nutritional assessment of meals and these were adopted in all areas of the Trust. Improvements were made in any areas where menus were found not to meet the standards
- A survey of 122 service users in February found:
  - 78% said the food looked nice when it arrived
  - 76% said the food tasted nice
  - 75% said they had a choice of what to eat
  - 72% said there was the right amount of food on the plate
  - 88% said they received enough to drink
  - 77% said they were usually able to eat the food provided
- Plans have been put in place in the different ward areas to improve the meals, based on the service user feedback

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.

By the end of the year:

- the Trust's dementia services were working with partners across the city to implement the NICE Quality Standard
- a review of the Trust services against the standards showed a gap in support for advanced directives. By December, everyone using the Memory Service was receiving advice or support in advanced directives at the post-diagnostic review
- 134 more people received a memory assessment than in the previous year (up from 728 to 862 people)
- waiting times for memory assessments were down from 21.3 weeks last year to 14.7 weeks over the year.

"I need to tell you that our appointments rescued us from a horrible and miserable situation in which we felt very frightened and helpless and lonely. I was drowning. You were the lifeboat. This came after months of terrible anxiety and waiting, intimidating tests and then the expected but overwhelming misery of the diagnosis. The change in our lives is massive, beyond description, and the losses are devastating. Really the only things that matter now are kindness, cheerful sympathy and practical help. These are what are helping us get used to things and hopefully mean we can find little joys and pleasures still."

Letter to Memory Service North, Dementia Services

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

Progress on this objective was delayed by changes to staffing, but by the end of the year:

- carers were involved in many ways in shaping and planning services

Examples of carers' involvement in dementia services

- 2 carers who have been members of the 'Caring and Coping with Loss in Dementia' group (a 6-8 week course providing information and support for carers) have now been trained and are able to deliver the course alongside staff
- in the Memory Service, carers' feedback on follow-up appointments was addressed as part of the continuing Carers Experience Project
- carers' feedback on the dementia cafes means that the cafes now offer education/training on topics service users and carers have chosen, rather than what the service thinks they might want

- Family carers of people using Trust services were asked in a survey about their needs and experiences. Only 25 were returned out of 240 sent out so the results must be treated with caution. The findings were generally positive. 59% felt that their needs were being met, 9% felt that their needs were not being met and 39% said they did not know. 87% said their knowledge as a carer was respected by staff. 75% said they knew who to contact in a crisis but 25% either did not know or were unsure. 72% said they had received help or information: this was usually advice from staff or an information leaflet.
- Surveys were also completed by over 100 Trust staff with caring responsibilities:

Results of survey of staff carers (2012)

An email was sent to all staff encouraging those with caring responsibilities to complete an online questionnaire. Out of approximately 2,800 staff, 111 completed the survey.

- 80% of the staff who replied said that their line manager was aware of their caring responsibilities. 74% said their colleagues were also aware
- Staff had a good understanding of the Trust's Carers' Leave Policy. 80% were aware of it and 92% of those who had asked for carers' leave had received it
- They had less knowledge of the Trust's Flexible Working Policy and how it could help carers. 11% had applied to work flexibly and 53% of these had been successful in their application.

Staff comments on the questionnaire have been analysed and a number of ideas will be taken forward. Key points include:

- more information is needed for staff who are carers about what kind of help and support they are entitled to from the Trust, and more general help and advice e.g. about local carers' groups. A staff carers' webpage was suggested
- managers need to be knowledgeable and consistent in supporting staff carers. They may need some extra training in this area. A number of staff commented very positively on the support they received from their managers, but others said their manager seemed unsure how to help and there seemed to be some inconsistencies in the application of the Carer Leave Policy

- a Trust action plan, based on the surveys, is being completed and further work is planned for 2012/13
- 523 carers (79.4% of carers of people on the Care Programme Approach) were offered a carers' assessment and 67.4% of those who wanted an assessment received one.

4. To continue work on improving the experience of people from Black and Minority Ethnic groups who receive care and treatment from the Trust

By the end of the year:

- following critical feedback from Black service users, the Trust reviewed its ways of managing the risk of violence and aggression on the wards and has begun training all staff in a new approach, the Respect approach. By the end of January, 12 trainers had been identified and 48 staff had been trained, with overwhelmingly positive feedback; by the end of the year 172 staff had been trained. The delivery of the Respect training will be continuing as a key part of the objective to reduce the incidence of violence and aggression in 2012/13
- equality and diversity training for staff was also revised and by the end of the year 449 staff had received the new equality and diversity training. In the CQC Staff Survey for 2011 32% staff reported they had received training in this area. Although this was an improvement on the previous year, the Trust still performs poorly in comparison with other mental health trusts, falling in the lowest 20% nationally
- specialist Race Equality Cultural Capability training was delivered to 23 senior practitioners and other key clinical staff. This equips the staff to become an expert resource for their teams.

Statements related to the quality of services provided

Review of services

During 2011/12 SHSC contracted with/provided and/or sub-contracted 139 NHS services.

SHSC has reviewed all the data available on the quality of care in all 139 of these NHS services. The Trust reviews data on the quality of care with NHS Sheffield, other PCTs, Sheffield City Council and the specialist commissioners in regular contract and performance meetings. However; 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 2011/12 represents 100% of the total income generated from the provision of NHS services by SHSC for 2011/12.

The data reviewed included safety, clinical effectiveness and a positive service user experience, and also access, equality and inclusion. The amount of data available for review has not impeded this objective.

These figures are derived from specific service headings in the contracts with the Trusts 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.

Participation in clinical audits

During 2011/12, 11 national clinical audits and 1 national confidential inquiry covered NHS services that Sheffield Health and Social Care NHS Foundation Trust provides.

During that time Sheffield Health and Social Care NHS Foundation Trust participated in all 11 (100%) of the national clinical audits and all 3 elements of the 1 (100%) national confidential inquiry of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that Sheffield Health and Social Care NHS Foundation Trust was eligible to participate in during 2011/12 are as follows:

Table 2: National audits and Sheffield Health and Social Care Trust participation

Name of National Audit	SHSC participation	Number of cases submitted	Number of cases submitted as a percentage of those asked for
National Audit of Schizophrenia	Yes	150	100%
National Audit of Psychological Treatments	Yes (IAPT)	1607	100%
National Parkinson's Audit	Yes (Neuro-Enablement Services)	20	100%
POMH-UK Topic 2 – Metabolic side effects of antipsychotics	Yes	122	100%
POMH-UK Topic 8 – Medicines reconciliation	Yes	80	100%
POMH-UK Topic 9 – Antipsychotic use in learning disabilities	Yes	20	100%
POMH-UK Topic 11 – Dementia and antipsychotic prescribing	Yes	110	100%
National Diabetes Audit	Yes (Clover Group)	914	100%
NHS Litigation Authority – Records Audit	Yes	850+	Not applicable
National Suicide Audit	Yes	10	Not applicable
National Study of Suicide in England and Wales	Yes	5	45%
Name of national confidential inquiry			
National Confidential Inquiry into Suicides and Homicides by People with Mental Illness	Yes	20	45%
National Confidential Inquiry into Suicides and Homicides by People with Mental Illness – Out of District deaths	Yes	1	50%
National Confidential Inquiry into Suicides and Homicides by People with Mental Illness – homicides	Yes	1	7%

(POMH-UK is the Prescribing Observatory for Mental Health in the United Kingdom, a national organisation that monitors the use of medication in mental health, provides trusts with benchmarking data and guidance on best practice.)

The reports of 7 out of 11 of national clinical audits were reviewed by the Trust in 2011/12 (all those where the results were published during the year) and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

Table 3: Result and actions from national clinical audits and confidential inquiries

National audit	Results		Actions	
	Positive findings – compliance with standards	Under performance or non-compliance with standards	Actions already taken	Actions to be completed
National Audit of Schizophrenia	The audit identified that SHSC were performing in the top 10% of Trusts with regard to Polypharmacy.	When compared with other Trusts, our performance was below average on the following : - service users report of experience of care - monitoring of physical health - prescribing of clozapine for treatment-resistant patients. The performance in relation to monitoring of weight was in the bottom 10%.	The consultants and psychologists that collected the data have initial ideas about how the Trust can improve. They include clearer guidance on what screening/ monitoring should be done and an updated physical health form to be used at CPA reviews.	A session is planned for doctors in a few months time that covers a case study, discussion of various issues then leads on to new guidance on physical health screening, monitoring and intervention. The results will also be fed back at QIG and at the Trustwide Audit Meeting.
National Audit of Psychological Treatments	- The audit found that most service users were waiting not longer than 18 weeks - All therapists had completed formal training - Service routinely collects outcome data to determine effectiveness of therapy - Service users staying in therapy	When compared with other Trusts - Service users reported a less positive relationship with their therapist - Service users reported lower level of satisfaction with treatment - Clinical outcomes less favourable than other services benchmarked	- A series of away days and workshops looked at the whole system -More shared responsibility and integration with GPs was introduced - Bureaucracy was removed from the referral process -10% fewer DNA rates - 5% improvement in recovery rates -Significant improvement in PHQ (depression) scores	- To continue to improve the access, outcomes and efficiency of service - To look at interaction between IAPT and Community Mental Health Teams
National Parkinson's Audit	Data was submitted in November 2011 for 20 service users. Report due June 2012			
POMH-UK Topic 2 – Metabolic side effects of antipsychotics.	- Compliance with the standards was below 50%.	The audit showed: - low recording of obesity - low recording of glucose levels - low recording of lipids - low recording of smoking cessation.	- Action Group set up to improve the recording of metabolic side effects - Insight modified to record physical health data - New Physical Health Screening tool has been added to Insight (care record) - Staff advised to use the screening tool.	- To re-audit recording of the metabolic side effects using Insight.

National audit	Results		Actions	
	Positive findings – compliance with standards	Under performance or non-compliance with standards	Actions already taken	Actions to be completed
POMH-UK Topic 8 – Medicines reconciliation.	The audit showed positive compliance: - the names and dosage of all the medications were recorded - the proportion of service users where 2 or more sources of information were checked, and the proportion where discrepancies were identified.	The recording of details of adherence to medication was less good.	- Audit results presented locally, by pharmacists to individual teams, and trust-wide at Audit and Quality Improvement Group meetings - Clinical teams include audit results and actions in team governance reports.	- To improve recording of adherence to medication.
POMH-UK Topic 9 – Antipsychotic use in learning disabilities	Positive results were found: - the need for anti-psychotic medication had been reviewed in last year - evidence of general assessment in last year - evidence of assessment of EPS.	- Lower compliance found with recording of blood pressure.	- Target set to increase documentation of blood pressure from 82% to 100%.	-to re-audit against target.
POMH-UK Topic 11 – Dementia and antipsychotic prescribing	The audit revealed good compliance with standards with: - proportion of service users with the indication for antipsychotic prescribing clearly documented - potential underlying causes of BPSD considered.	The audit showed lower compliance with: - evidence that a risk benefit analysis had been carried out before starting antipsychotics - evidence that service users and/ or carers were consulted about.	- Dementia services have plan to improve documentation of risk benefit analysis before prescribing.	- Re-audit recording of risk benefit analysis.
National Diabetes Audit	Data submitted in November 2011 for 914 patients. Report due mid 2012			
NHS Litigation Authority – Records Audit	A total of 579 patients had their records audited, compared to 318 last year. There have been significant improvements in the documentation of: - employment/ education status - accommodation status - diagnosis - HoNOS - previous history in mental health - mental state examination in last 6 months - risk of sexual vulnerability - suicide risk - self harm risk - child/adult protection risks - up-to-date risk management plans - risk plans containing non compliance advice - service users being sent copies of their correspondence.	Since last year, there has been significant reductions in the documentation of: - potential for predatory behaviour - individual names being assigned to action plans The following standards are still scoring below 50% in the audit: - advance directives/ statements - evidence of relapse prevention plans - risk plan advising GP.	Following the previous audit the results were fed back to the senior management teams and down to the clinical teams. All teams were sent a web version of their results and a laminated card. The results were also presented at numerous forums. In addition to this, there have been some major developments to the Insight system including the introduction of DRAM risk assessment and the continued development of Form C. More teams are now using Insight instead of a paper record.	The latest results will be fed back to the senior management teams and clinical teams as before. Directorates will develop action plans to address the underperforming standards. Clinical teams will use their records audits as evidence for their team reports. A further audit will be scheduled.
National Suicide Audit	- Compliance good with 7 out of 8 standards.	The initial audit found that not all staff trained in risk assessment.	- All staff now trained in risk assessment.	To extend audit to all wards at Michael Carlisle Centre.

Local clinical audits are conducted by staff and teams evaluating aspects of the care they themselves have selected as being important to their teams. The commissioner, NHS Sheffield, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities.

The reports of 53 local clinical audits were reviewed by the Trust in 2011/12 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided, based on a selection of these projects:

Table 4: Results and actions from local clinical audits

Local audit	Results		Actions	
	Positive findings – compliance with standards	Under performance or non-compliance with standards	Actions already taken	Actions to be completed
Use of DRAM on wards (risk assessment and management tool)	- DRAM in place and being used routinely onwards	- Doctors not inputting to DRAM - DRAM not used as multi-disciplinary tool.	- Additional training provided for doctors - Staff attendance at risk training monitored by directorate.	- Re-audit of use of DRAM is under way to check progress.
NICE Quality Standard for Depression	- Good compliance with standards: - diagnosis recorded - risk assessment before prescribing	- Evidence that service user had received an appropriate information leaflet	- New checklist/ template developed covering compliance with NICE Quality Standard for Depression	- To implement checklist - To re-audit
NICE Guidelines or Falls Prevention	- Rate of falls down on G1.	Rate of falls increased on Daleside, Hawthorn and West Wing.	- Findings presented to Quality Improvement Group.	- To improve feedback of data on falls to wards - To review and improve actions to reduce falls.
Referrals from GPs to Community Mental Health Teams (CMHTs)	- Referrals record: medical history, current medical status, ongoing problems and changes that have precipitated referral.	- Referrals do not record as well: alcohol dependence, contact assessment form, adjustment/ bereavement problems, ethnicity, carer and next of kin details, support systems/agencies, urgency.	- Results reported to GP group.	- Considering future use of assessment criteria by CMHT referral screening staff when new referrals are received by CMHTs.
Nutrition	Positive findings: - nutritional screening (using MUST) on admission for on older adults wards.	Negative findings: - nutritional screening (using MUST) on discharge for on older adults wards - nutritional screening for other wards not yet in place.	- MUST results monitored by Nutrition Group and fed back to wards - dietician visiting wards and training staff - rates improving (up 39% on discharge).	- MUST to be rolled out to all acute wards with Dietician's support.
Safeguarding adults	Majority of staff knew content of policy and who to contact when an adult had been abused. 85% staff had attended safeguarding adults training.	9 staff found not to be CRB-checked. Doctors less well informed about safeguarding adults.	All staff now CRB checked. Doctors are being trained in safeguarding.	
Safeguarding children	Majority of staff have some understanding of child abuse and know who to contact.	Only 1/3 staff knew who the Trust's safeguarding lead doctor and nurse were.	Audit results presented to safeguarding Steering Group, and an action plan to improve training is being developed.	To complete plan and implement improved training for staff in collaboration with other agencies.

Local audit	Results		Actions	
	Positive findings – compliance with standards	Under performance or non-compliance with standards	Actions already taken	Actions already taken
Accelerated Dementia Discharge Services (ADDS) – collaboration with Sheffield Teaching Hospitals Trust (STHFT).	STHFT staff aware of ADDS and the service they provided.	STHFT staff had less awareness of follow-up care provided by ADDS post-discharge.	After consultation, it was agreed to introduce an information leaflet about ADDS, with contact details, and to offer brief information sessions about ADDS to STHFT staff.	To implement the leaflet and information sessions and then re-audit.
Caring and coping course, for carers of people with dementia.	Audit found better results from 6-week than from 8-week course. 6-week course showed significant benefits on GHQ (general health) outcomes for carers.	8 weeks course benefited carers on measures of insomnia and anxiety.	Findings are being reviewed by service and will be used to improve support for carers.	
Quality of A&E mental health referrals.		Problems found in quality of mental health referrals made by medical staff in A&E.	Education and training provided for junior doctors in A&E.	
Recording of capacity to consent on inpatient ward		Capacity to consent was not being recorded on Hawthorn ward.	Capacity to consent forms introduced on Hawthorn ward and are being used by ward staff.	

Local audit	Results		Actions	
	Positive findings – compliance with standards	Under performance or non-compliance with standards	Actions already taken	Actions to be completed
Prescription of exercise for people with long-term neurological conditions.		Audit found a need for regular exercise for people with long-term neurological conditions.	Funding secured for targeted exercise group at Sheffield International Venues. Services signpost service users with long-term conditions to this facility.	Training planned for Sheffield International Venues staff so they can support people with long-term neurological conditions to exercise regularly.

Research

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research on the National Portfolio of the National Institute for Health Research was 375 and the number recruited to studies approved by a research ethics committee was over 500.

Sheffield Health and Social Care NHS Foundation Trust was involved in conducting 17 clinical research projects which aimed to improve quality of services, increase service user safety and promote the ability of the Trust to meet the needs of NHS commissioners.

Research is a priority for Sheffield Health and Social Care NHS Foundation Trust and is one of the means by which the Trust seeks to improve quality, increase productivity and initiate innovation. The Trust recognises the key role of the NHS in promoting and conducting clinical research and the right of service users to be informed about opportunities to participate in ethically-approved clinical research trials. The Trust works closely with the East Midland and South Yorkshire Mental Health Research Network and academic partners to maximise the research activity taking place in the Trust.

Together with Bradford Care Trust and the Universities of Sheffield and Oxford, the Trust is taking part in a national pilot study, funded by the Department of Health. The study is investigating how to use service user reported outcome measures to assess the effectiveness of treatment for depression by community mental health teams, including the teams working with older adults. It is hoped that this work will help develop a method for measuring the effectiveness of the care provided by mental health services in future.

Understanding and preventing adverse effects of psychological therapies

An example of the research currently underway in the Trust is the study *Understanding and Preventing Adverse Effects of Psychological Therapies.* This work is funded by the National Institute for Health Research through their Research for Patient Benefit stream and conducted by collaboration between Trust clinicians and academics from the University of Sheffield. This is important research as the NHS has invested more than £170 million to improve access to psychological therapies. Although most service users benefit, some deteriorate after a course of psychological therapy and a significant proportion of service users do not complete the therapy. This project aims to improve quality of care and service user safety by establishing whether there are certain service users that have a greater risk of dropping out or experiencing deterioration after engaging in a course of psychological therapy.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Sheffield Health and Social Care NHS Foundation Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between Sheffield Health and Social Care NHS Foundation 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.

Table 5: Contracts with CQUINs 2011/12 CQUIN Value and Payment achieved: data from Trust records

Contract Name	CQUIN Value 11/12	CQUIN Value Achieved 11/12
Sheffield Block Contract	£907,370	£606,804
Barnsley Block PCT Contract	£1,816	£1,217
Specialist Commissioning Grp (Hosted by Barnsley PCT)	£49,645	£49,645
Rotherham PCT Block Contract	£2,127	£1,425
Derbyshire County PCT Block Contract	£2,435	£1,631
Doncaster PCT Block Contract	£975	£653
TOTAL	**£964,367**	**£661,375**

Further details of the achieved goals for 2011/12 and for the following 12 month period are available electronically on the Trust website www.shsc.nhs.uk

What others say about Sheffield Health and Social Care NHS Foundation Trust

1. Statements from the Care Quality Commission (CQC)

Sheffield Health and Social Care 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. Full registration in all areas (and full compliance) has been maintained throughout the year. The Care Quality Commission (CQC) has not taken enforcement action against the Trust in the year ending 31st March 2012.

Sheffield Health and Social Care Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC visited the Michael Carlisle and Longley Centres to monitor the delivery of the action plan agreed following its planned review visit to the wards in January 2011, which had resulted in 8 compliance actions and 1 improvement action. On its return visit, the assessors commentated favourably on the progress that had been made. All compliance actions were lifted and 1 improvement action remained. This was related to care records during the transition from paper to electronic records.

The CQC also issued 1 compliance action for Grenoside Grange following the planned review in January 2011: this was related to staffing and the use of flexi staff, the permanent staff numbers and the skill mix. They visited Grenoside Grange in September 2011 and lifted the compliance action, as new staffing arrangements had been agreed and posts were under recruitment.

The CQC visited Bole Hill View in December 2011 as a planned review of social care provision and found one improvement action, relating to records. An action plan is being implemented to address this issue.

Following the exposure by BBC Panorama of abuse at Winterbourne View, the CQC undertook a programme of visits to learning disability services nationwide. The Trust's Assessment and Treatment Unit was visited in November 2011 as part of this targeted inspection programme.

The CQC found the Assessment and Treatment Unit fully compliant and commended good practice in the care and welfare of service users in its feedback to the Trust, in particular the quality of the person-centred plans and health action plans, and the relationships between staff and service users. An improvement action was made to improve the quality of the building, pending the move to new, purpose-designed premises in 2013. Remedial work to the building has begun.

The CQC has not produced an annual report on the implementation of the Mental Health Act by the Trust in 2011/12.

2. Monitor

At the end of 2011/12, the Trust had a 'green' rating for Governance from Monitor, the Foundation Trust regulator.

The Trust has assessed itself against the Monitor Quality Governance Framework and reviews this self assessment quarterly at the Quality Assurance committee.

Table 6: Monitor quality governance framework – rag rated summary (self assessment)

Strategy	Capabilities and culture	Processes and structure	Measurement
1A. Does quality drive the Trust's strategy?	2A. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	3A. Are there clear roles and accountabilities with regard to quality governance?	4A. Is appropriate quality information being analysed and challenged?
1B. Is the Board sufficiently aware of potential risks to quality?	2B. Does the Board promote a quality-focused culture throughout the Trust?	3B. Are there clearly-defined, well-understood processes for escalating and resolving issues and managing quality performance?	4B. Is the Board assured of the robustness of quality information?
		3C. Does the Board actively engage patients, staff and other key stakeholders on quality?	4C. Is quality information used effectively?

Key – item rated as amber if any actions still to complete – green if fully meets all Monitor guidance.

- Item 3B is rated amber because of the continuing work on improving the management of serious incidents
- Item 4B is rated amber because of the Trust's underperformance on the Information Governance toolkit. There is an action plan to improve this score

3. NHS Litigation Authority Risk Management Standards

The Trust has currently attained Level 1 of the NHSLA risk management standards.

It plans to be re-assessed at Level 1 by the end of March 2013 and progress to Level 2 by November 2014.

4. Health and Safety Executive

There have been no visits by the Health and Safety Executive to Trust premises this year.

5. Fire Authority

Following the recommendations arising from a serious fire in a care home in Scotland, the Fire Service set up a proactive series of visits to health and social care premises.

A Fire Authority inspection of Wainwright Crescent in September 2011 led to an Enforcement Notice, which was rapidly addressed. On a follow-up visit in November 2011, the Fire Service found all necessary actions had been taken, and the Enforcement Notice was withdrawn.

6. Patient Environment Action Team

The Patient Environment Action Team (PEAT) assessment team this year included a service user and an external assessor from Bradford District Care Trust, who provided very valuable perspectives on the quality of the environment in in-patient areas.

Results for the 2010/11 Patient Environment Action Team (PEAT) assessment were published in August 2011.

Table 7: 2011 PEAT results

Site Name	Environment Score	Food Score	Privacy & Dignity Score
Longley Centre	Good	Good	Good
Michael Carlisle Centre	Good	Good	Good
Forest Close	Good	Acceptable*	Good
Forest Lodge	Good	Good	Excellent
Grenoside Grange	Excellent	Good	Excellent

* Following review, it was agreed that Forest Close could no longer be assessed as 'self-catering' and the quality of its food should be assessed. However, because the assessors were unable to visit at mealtime on the day of assessment and taste the food, the highest possible score was 'acceptable'. Comparisons with the previous 2 years show:

Table 8: PEAT results for last 3 years – Environment

Site Name	Environment Score		
	2010/11	2009/10	2008/09
Longley Centre	Good	Good	Good
Michael Carlisle Centre	Good	Good	Good
Forest Close	Good	Good	Good
Forest Lodge	Good	Good	Good
Grenoside Grange	Excellent	Good	Good

Table 9: PEAT results for last 3 years - Food

Site Name	Food Score		
	2010/11	2009/10	2008/09
Longley Centre	Good	Good	Excellent
Michael Carlisle Centre	Good	Good	Good
Forest Close	Acceptable*	Self-catering	Self-catering
Forest Lodge	Good	Good	Excellent
Grenoside Grange	Excellent	Good	Excellent

* Following review, it was agreed that Forest Close should be assessed for the quality of food this year. However, because the assessors were not able to visit at mealtime on the day of the inspection and taste the food, the highest possible score was 'acceptable.' Comparison with the PEAT environment scores over the last 3 years show a consistent picture, with the exception that the rating for Grenoside Grange, a dementia inpatient unit, increased form 'good' to 'excellent.'

"Generally a very pleasant environment that has benefited from a lot of thought and work to create this working and caring environment. The practice of colour-coding toilets with red door frames was an imaginative and very practical piece of work: this has been followed through by coding toilet seats red as well. There have been significant improvements since the last inspection."

Comment from PEAT submission on Grenoside Grange

A review of the PEAT scores for privacy and dignity over the last 3 years shows a lower score in 3 areas this year. This followed changes to how the team assessed single sex accommodation and their interpretation of the national and regional guidance.

There was no change to the layout or physical environment of the wards, but the Trust is assessing itself more rigorously against these standards in comparison to previous years.

Table 10: PEAT scores over last 3 years – Privacy and Dignity

Site Name	Privacy and Dignity Score		
	2010/11	2009/10	2008/09
Longley Centre	Good	Excellent	Excellent
Michael Carlisle Centre	Good	Excellent	Excellent
Forest Close	Good	Excellent	Excellent
Forest Lodge	Excellent	Excellent	Excellent
Grenoside Grange	Excellent	Excellent	Good

Data quality

Statement on relevance of data and actions taken to improve data quality.

Data quality is important because it enables information to be shared that is accurate, timely and appropriate.

The Trust endeavours to triangulate information about quality and safety i.e. to check for a consistent picture across several different data sources. An example of this would be the work carried out to find out more about the risk of violence and aggression on the acute inpatient wards and how staff can best respond to it. Records of incidents of violence and aggression, staff survey results and the results of service user interviews have been brought together in the work that has led to the implementation of the new Respect training for staff.

Sheffield Health and Social Care NHS Foundation Trust will be taking the following actions to improve data quality:

- They 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
  - the Trust Information Management and Technology (IMT) team 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
- there are clear and consistent definitions for indicators in the Trust's new Inform system, a web-based datastore for quality and performance information
- inform is designed to enable staff such as team managers or directors to assess the accuracy of data held about their service quickly and address any anomalies identified as a result of this feedback loop
- new key performance indicators relevant to data quality are being built into Inform as it develops
- the Insight (Patient Information) system has built-in routines to validate data as it is entered
- the Trust Commercial Relations department checks details before submitting their returns to GP practices
- we make regular submissions to the Demographics Batch Service to identify and verify NHS numbers, which helps to prevent the creation of duplicate service user records and identify and remove existing duplicates
- staff have access to the Summary Care Record/ Personal Demographics Service so that they can check NHS number, registered GP and address details. We are working to automate checking of registered GPs for Insight service users
- we use the Enhanced Reporting Service to identify deaths of service users and keep the Insight system up-to-date.

The Trust is rolling out electronic service user records to all parts of the Trust and the majority of teams are now running electronic records. Because Insight is a bespoke service user record and information system, it can be flexible and has been adapted to meet the specific needs of different service areas. New developments have included 'front pages' for staff in acute wards with key data visible at a glance. An Electronic Records Clinical Summit held in the summer attracted a large number of clinical staff who were able to contribute to further system improvements to meet the needs of staff and service users.

The data quality of the annual Quality Accounts for 2010/11 was audited last year by the Audit Commission on behalf of Monitor. They shared their findings with the Trust. A total of 5 recommendations for improvement were made by the auditors. (In the previous year there were 14 recommendations for improvement.) Actions were agreed and have been implemented.

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 data quality with the extension of Inform. It has implemented regular data quality reporting to the Information Governance Steering Group, covering submissions of the Mental Health Minimum Dataset.

National Dataset key performance indicators

Sheffield Health and Social Care NHS Foundation Trust submitted records during 2011/12 to the SUS (Secondary Uses Service) for inclusion in the HES (Hospital Episodes Statistics) which are included in the latest published data. The latest published data from the SUS data quality dashboard is for April 2011 - February 2012. The percentage of records in the published data that included the Patient's valid NHS number was 100%, and the percentage with a valid GP Registration Code was also 100%. (The data source is the SUS Data Quality Dashboard for Sheffield Health and Social Care Trust, published by the NHS Information Centre as of 16.5.12.)

Data was submitted from the Admitted Patient Care (APC) Commissioning Dataset and the Mental Health Minimum Dataset (MHMDS) to the required timetables to the Information Centre/Secondary Uses Service.

For the December 2012 APC submissions, 82% of inpatient records were reported to be comprehensively coded.

Table 11: Data quality - APC and MHMDS submissions for last 3 years. Data from relevant published data for APC or MHMDS

Indicator	2011/12	2010/11	2009/10
% Records in CDS APC with valid NHS number		99.8%	
% Records in CDS APC with valid General Medical Practice Code		100%	
% Records in MHMDS with valid NHS number	99.9%		
% Records in MHMDS with valid General Medical Practice Code	99.5%	99%	
% Records in MHMDS with valid postcode	99.7%		
% Records in MHMDS with valid ethnic group	94.1%		
% Records with valid marital status recorded	92.7%		

By the end of 2011/12, the *Clover Group* had a total of 15,329 registered patients. 41 (0.3%) had no NHS number yet. (Data proved by *Clover Group* records as of 13.4.12.) It should be noted that the *Clover Group* includes the Mulberry Practice which works with asylum seekers and refugees. People new to the country may not yet have an NHS number allocated.

Clinical coding error rate

Sheffield Health and Social Care NHS Foundation Trust was not subject to Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

A clinical coding audit was completed in line with the requirements of the Information Governance Toolkit in March 2011. The report received in July 2011 concluded that coding of primary diagnoses met the requirements of Level 3 of the Information Governance Toolkit, but that there was a shortfall in the recording of secondary diagnoses.

Information governance toolkit

In March 2011, Sheffield Health and Social Care Trust Information Governance Toolkit assessment report overall score was 60%, which was graded not satisfactory. This is because the Trust did not meet level 2 on all items. The Trust prioritised action on those areas of the Toolkit which would have the most impact or benefit for service users.

The Trust has a programme of work to improve performance on those items where Level 2 has not been achieved. Further information is available from the Information Manager.

Part 3: Review of quality performance

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

1. Safety

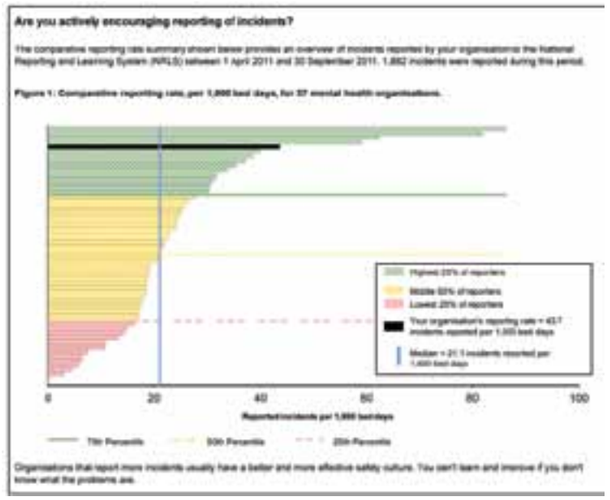
The Trust prides itself on having a strong safety culture and it encourages staff to report incidents and near misses. It does this to make sure it can learn from looking at patterns and trends and make improvements to services to reduce the harm to service users, carers, staff and others. In reports of incidents and serious incidents, the Trust expects to see a 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.

In the annual National NHS Staff Survey, Sheffield Health and Social Care Trust fell into the top 20% of Trusts for the percentage of staff reporting errors, near misses or incidents witnessed in the last month.

Like all NHS Trusts, Sheffield Health and Social Care Trust reports all patient safety incidents to the National Patient Safety Agency (NPSA). The NPSA is then able to produce benchmarking information, to show how this Trust compares with others. The latest information from the NPSA shows the Trust is in the highest 25% (ranked 5th) of mental health trusts nationally when it comes to reporting patient safety incidents, reporting 43.7 patient safety incidents per 1,000 bed days in comparison with a median figure nationally of 21.1.

Table 12: Number of incidents reported: benchmarking data for all mental health Trusts from NPSA for the period April - September 2011

This Table represents the most recent NPSA benchmarking data available and is extracted from the NPSA website.



During the year there were 101 serious incidents reported. 262 serious incidents were reported in the 2010/11 Quality Accounts. This reduction in numbers in part reflects a change in the Trust's definition of a serious incident to reflect the guidance from the National Patient Safety Agency.

6343 incidents were reported overall (including near misses and incidents where no harm occurred). The proportion of all incidents reported that were graded as serious during 2011/12 was therefore 1.6 %.

Of all the patient safety incidents that were reported between April and September 2011, 0.4 % (8 incidents) resulted in severe harm or death, in comparison with 0.8% of all incidents reported by mental health trusts nationally (NPSA information for the first 6 months of 2011/12.)

These figures indicate a positive patient safety culture in the Trust, because they indicate that staff are willing to report when things have gone wrong, and to learn from incidents.

Table 13: Findings on 'Errors and Incidents' from national nhs staff survey 2011 for shsc information from report on picker institute website

Question	Change since 2010 survey	Ranking, compared with other mental health trusts
% witnessing potentially harmful errors, near misses or incidents in the last month	No change	Above (worse than) average
% reporting errors, near misses or incidents in the last month	No change	Highest (best) 20%
Fairness and effectiveness of incident reporting procedures	No change	Average

None of the serious incidents reported during the year was a 'Never Events' i.e. incidents defined by the National Patient Safety Agency as ones that should have been prevented.

The Trust is performance monitored by NHS Sheffield on its management of serious incidents. NHS Sheffield set targets for improving the timeliness of reporting and the quality of the incident reports. During 2011/12, the Trust reported 81.6% of its serious incidents within the 48 hour timescale, against a target of 60%; it submitted 60% of its investigation reports within a 12 week timescale, against a target of 70%. NHS Sheffield graded the quality of the investigation reports and found 65.8% were good or excellent, 34.2% were fair and none was poor. The target was that 70% were excellent and only 10.5% reached this standard.

The Trust has improved the quality and timeliness of its investigation reports over the last 12 months and aims to make further improvements in the year ahead.

Patient safety alerts

The NHS disseminates patient safety alerts through the Central Alerting System. The Trust received 112 Central Alerting System (CAS) alerts during the year and 97.3% were concluded within the target timescale. In the previous year there were 127 alerts and 89% were concluded within the timescale: in 2009/10 the percentage meeting the timescale was 71%.

All emergency alerts from other sources (including MHRA Drug alerts, MHRA Dear Doctor Letter and Chief Medical Officer messaging) are cascaded within the set timescales.

Patient safety Information on types of incidents

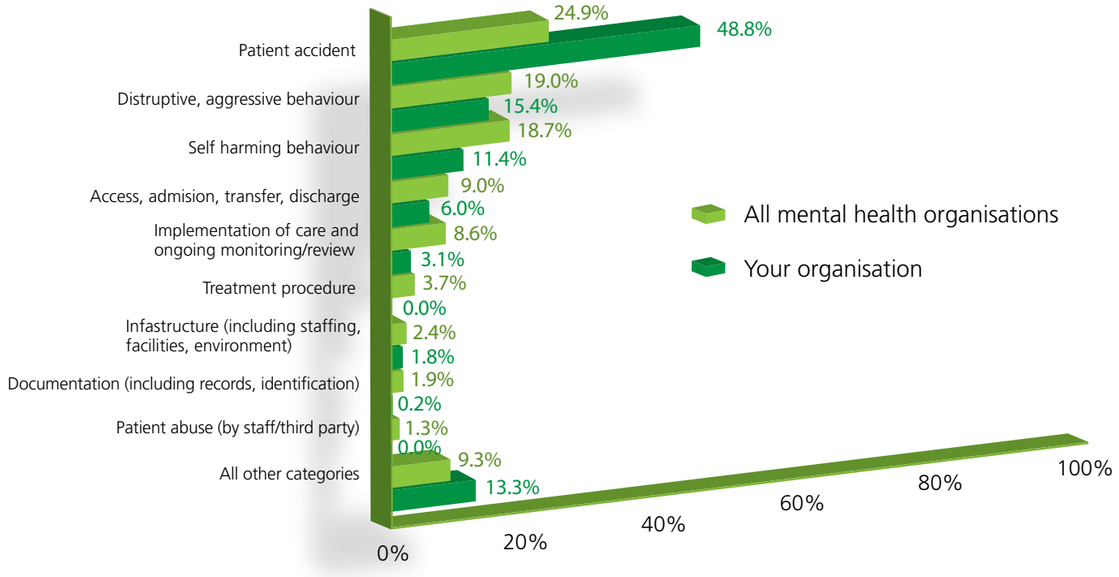
Like all NHS Trusts, Sheffield Health and Social Care Trust reports all patient safety incidents to the National Patient Safety Agency (NPSA). The incidents are grouped into different categories. The NPSA is then able to produce benchmarking information, to show how this Trust compares with others. The NPSA benchmarking information, although useful, has certain limitations:

- no two NHS Trusts are the same in terms of the services they provide or the populations they serve. Sheffield Health and Social Care Services, for example, provides service for substance misuse and the *Clover Group* general practices, but it does not provide child mental health services; other trusts in the 'mental health trust' group nationally will provide a different set of services
- at present, a relatively high proportion of the patient safety incidents reported by Sheffield Health and Social Care Trust fall into the 'other' category - 13.3% in comparison with 9.3% nationally. Work is underway to look at how the Trust categorises types of incidents in future.

Table 14: Types of incidents reported by the Trust in comparison with other mental health trusts nationally. Data extracted from NPSA website April 2012 and based on most recent available data (April-September2011)

This Table represents the most recent NPSA benchmarking data available for April-September 2011.

What type of incidents are reported in your organisation?



This year the Trust has chosen to report on the four specific areas of:

- falls
- self harm and suicide
- violence and Aggression
- medication.

Falls

The Trust reports a high number of slips, trips and falls in comparison with other mental health trusts. Information from the National Patient Safety Agency showed that 49% of all the patient safety incidents reported in Sheffield Health and Social Care Trust were patient accidents in comparison with 25% as a national average for mental health trusts. (Information from the NPSA Organisation Patient Safety Incident Report for 1 April 2011 to 30 September 2011) This area has been chosen as a priority area for improvement in 2012/13 and is a Trust quality objective for the year ahead.

More information about the Trust and falls has therefore been provided in part 2 above, in the section on the quality objectives for 2012/13.

Table 15: Self harm incidents over last 4 years

Indicator	Number of incidents			
	2011/12	2010/11	2009/10	2008/09
All reported self harm incidents (Trust incident data from Ulysses Safeguard)	366	358	363	275
Suicide of inpatient or within 7 days of discharge (information from Coroner's Inquest findings)	3	1	1	0

Self harm and suicide

The risk of self harm or suicide is always a serious concern for mental health and substance misuse services. The NPSA figures show 11.4% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 18.7% for mental health trusts nationally.

During 2011/12 clinical risk training was provided for SHSC staff and new clinical risk assessment and management tools are being introduced throughout the Trust. 879 staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. Within the new acute and scheduled care pathways for people with mental health problems, standards have been set for risk screening, risk assessment and risk management plans, as part of each person's care and treatment.

An audit of care records in November 2011 showed a significant improvement in the recording of clinical risk, with risk assessments and risk management plans in place.

Violence, aggression and verbal abuse

The risk of violence or aggression for service users, family carers and staff remains a focus for the Trust, because of the impact it can have on people's lives and sense of safety and well-being. Some conditions such as dementia may sometimes increase the risk of violence or aggression for some of the people who experience them.

Overall the Trust reports relatively low incidents of violence and aggression from service users towards service users (NPSA benchmarking data for first 6 months of the year.) 15.4% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 19%.

Table 16: Disruptive/aggressive behaviour incidents benchmarking data from NPSA (data from April – Sept 2010 and 2011 respectively) comparisons with other local mental health trusts. Number and % of all patient safety incidents reported in this category

Trust	Disruptive/aggressive behaviour incidents reported	
	2011/12	2010/11
Trust A, Yorkshire and Humber	637 (24.6%)	528 (20.6%)
Trust B, Yorkshire and Humber	779 (23.5%)	390 (29.95%)
Trust C, Yorkshire and Humber	197 (18%)	128 (21.05%)
Sheffield Health and Social Care NHS Foundation Trust	290 (15.4%)	294 (17.2%)
Trust D, Yorkshire and Humber	455 (14.8%)	538 (22.3%)
Trust E, Yorkshire and Humber	296 (11.9%)	323 (18.1%)
Nationally (Mental Health Trusts)	18,402 (19.1%)	19,699 (22.6%)

The above data shows Sheffield Health and Social Care Trust remains well below the national average for mental health trusts.

The annual National NHS Staff Survey, carried out by the Picker Institute (previously done via the CQC), on behalf of the Department of Health, asks a random sample of Trust staff about their experience of violence and aggression at work. The survey for 2011 was published in March 2012 and the results showed:

Table 17: The Picker Institute staff survey results 2011 – findings on violence and aggression

Question on violence and aggression	Change since 2010	Ranking, compared with all mental health trusts in 2011
% experiencing physical violence for patients, relatives or the public in last 12 months	No change	Above (worse than) average
% experiencing physical violence from staff in last 12 months	No change	Average
% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Increase (deterioration)	Above (worse than) average
% experiencing harassment, bullying or abuse from staff in last 12 months	No change	Above (worse than) average
Perceptions of effective action from employer towards violence and aggression	No change	Above (better than) average

As described above, in the section on this year's quality objectives, a new programme of training for staff in how to prevent and manage the risk of violence, using the 'Respect' approach has begun during the year. Its aim is to improve how staff respond in situations where service users may become violent or aggressive, to minimise the risk of violence happening and reduce any potentially harmful consequences.

Medication

Medication errors and near misses are another focus of Trust attention. Staff are encouraged to report near misses and errors that do not result in harm to make sure that they are able to learn to make the use and prescribing of medication as safe and effective as possible. 3.4% of patient safety incidents reported by the Trust related to medication, compared with 8.6% in mental health trusts nationally. There has been little change in the number of medication incidents reported by the Trust over the last 4 years.

Table 18: All medication incidents including 'near misses' for the last 4 years. Data from Ulysses Safeguard.

Indicator	Number of incidents			
	2011/12	2010/11	2009/10	2008/09
All medication incidents	354	346*	367	329

* Slight discrepancy between 2010/11 figure in this table and those reported in last year's Quality Accounts is due to additional incidents being added to the database after the Quality Accounts were completed.

Sheffield Health and Social Care Trust service users surveyed by the Care Quality Commission in the 2011 Community Mental Health Survey reported a generally positive experience with medication.

Table 19: CQC Patient Survey results 2010 and 2011 – questions on medication data from CQC website

Question	2011 results	2010 results
Do you think your views were taken into account in deciding which medicines to take?	Average (Middle 60% of trusts)	Above average (Top 20% of trusts)
Were the purposes of the medication explained to you?	Above average (Top 20% of trusts)	Average (Middle 60% of trusts)
Were you told about possible side effects of medications?	Above average (Top 20% of trusts)	Above average (Top 20% of trusts)
Were you given information about the medication in a way that was easy to understand?	Above average (Top 20% of trusts)	Above average (Top 20% of trusts)
Has a mental health or social care worker checked with you how you are getting on with your medication?	Above average (Top 20% of trusts)	Average (Middle 60% of trusts)

Cleanliness and infection control

The Trust has declared full compliance with the Code of Practice and Infection Control regulations again in 2011/12. It continues to have very low levels of the healthcare-associated infections methicillin-resistant straphococcus aureus (MRSA) and clostridium difficile (c-diff).

The Trust has also chosen to report on outbreaks of infections (e.g. a cluster of people with the norovirus) which have resulted in services being closed. There are systems in place to deal with these emergencies, making sure people are safe and premises are rigorously clean. The Trust also carries out routine infection control audits in all areas.

Staff receive training in cleanliness and infection control throughout the Trust. Trust teams and services, including the Clover Group, will contribute to in-depth investigations of c-diff cases (using Root Cause Analysis) when required.

Table 20: Infection Control indicators: Data from local Infection Control database – cases as defined by Health Protection Agency guidelines

Indicator	Number		
	2011/12	2010/11	2009/10
MRSA cases	1	0	0
C-diff cases	1	1	1
Outbreaks resulting in service closure	6	8	12

People using the Substance Misuse services face particular risks of infection from blood-born viruses. The teams provide tests and vaccinations to help reduce these risks and prevent infections.

Table 21: Infection Control in Substance Misuse Services: measures to reduce the risk of blood-born viruses (BBV). Data from Insight

Indicator	Target	2011/12 figures	2010/11 figures
New presentations offered BBV vaccination	90%	100%	100%
New presentations who accept an offer to commence a BBV vaccination	90%	98%	91%
New presentations (previous or current injectors) who have a recorded Hepatitis C vaccination status	90%	95%	96%
New presentations (current or ever injectors) offered a Hepatitis C test	90%	100%	100%
Number of HIV screening tests completed	Not applicable	311	422

Single sex accommodation

The Trust has declared compliance with single sex accommodation in 2011/12. There has been 1 breach of the Eliminating Mixed Sex Accommodation (EMSA) regulations during the year. This was investigated and remedied.

A programme of building work is in place to improve compliance. Guidance on the EMSA standards is available for managers and there is an information leaflet for service users. Service users' views on sharing ward spaces are elicited regularly, at admission in the acute wards, and every month in the recovery wards.

Safeguarding

Sheffield Health and Social Care Foundation Trust continues to work in partnership with statutory and voluntary services to ensure a consistent and structured approach is taken in Safeguarding Adults and Children. There is regular training for staff on safeguarding adults and children and the Trust has completed training audits to check all staff receive the necessary training. Any gaps in coverage found were addressed.

A number of complex reviews began during the year within the Trust Safeguarding Adults and Children's processes, linked to national reviews and changes. The policies and procedures for safeguarding adults, children and domestic abuse are being fully reviewed and updated with a date for completion set for May 2012. The Trust's Insight recording and data collection systems were reviewed and the safeguarding team is working in collaboration with the IT department to implement changes to the electronic system following the review.

The Safeguarding Adults team is working in partnership with the Local Authority to implement the Vulnerable Adults Risk Management Model (VARMM) for the care of those at high risk of self neglect.

The Executive lead for Safeguarding Adults and Children is Liz Lightbown. The Non-executive lead for Safeguarding Adults and Children is Councillor Mick Rooney. The Professional lead for Safeguarding Adults and Children is Dr Nusrat Mir.

2. Clinical effectiveness

The Trust assesses the effectiveness of the care and treatment it provides against local and national standards and targets. For example, it reviews its care against the standards and guidance laid down by the National Institute for Health and Clinical Excellence (NICE).

Because the Trust covers a wide range of diverse services, this section of the Quality Accounts is divided up into different service areas.

Mental health services

The year has seen some important changes in the delivery of adult mental health services with the embedding of the Acute Care Pathway and the delivery of new Scheduled Care Pathway. Quality standards are fundamental to both these pathways, which have been designed to make sure service users get the right care at the right time. The electronic care record, Insight, enables team and directorate managers to get rapid feedback on whether the quality standards are being met, such as how long people have to wait for an assessment or whether they have received a care plan or a risk assessment. At the same time, mental health clustering has been introduced, a new way of grouping service users by need, which has been developed nationally to help facilitate the introduction of Payment by Results (PbR) in Mental Health. Staff who are introducing the clusters in their everyday work are gaining new insights into how to provide the right care in the right team.

Table 22: Mental Health indicators. Data from Insight

Indicator or standard	Target/threshold (set by NHS Sheffield)	2011/12	2010/11	2009/10
Service users on CPA receiving follow-up within 7 days of discharge from hospital	95%	96.8%	96.4%	97.2%
Minimising delayed transfers of care	No more than 7.5% delayed	4.2%	6.9%	6.4%
Admissions to inpatient services who had access to crisis resolution and home treatment (gatekeeping)	90% of all admissions	99.4%	97.3%	94.6%
New home treatment episodes	1202	1443	1361	1365
Everyone on CPA should have an annual review with their care co-ordinator	95% of people on CPA	98.7%	99.3%	Not measured
Everyone on CPA should have a formal review of their care plan	90% of people on CPA	89.5%	91.8%	89%
Access to assessment within 4 hours of referral when in crisis	80% of people to be assessed within 4 hours	92%	83.1%	59%
Access to support/treatment within 8 weeks of referral (routine referrals)	50% of people to be treated within 8 weeks	77%	67.8%	42.2%

Early Intervention in Psychosis

Early identification and treatment of psychosis is known to improve the long-term likelihood of recovery. The Trust therefore monitors the number of people seen by the Early Intervention Service.

Table 23: Early intervention in Psychosis – new cases seen each year Data from Insight

Indicator	Target (set by NHS Sheffield)	New cases 2011/12	New cases 2010/11	New cases 2009/10
Number of people seen by Early Intervention Service	90 new cases per year	136	129	285

Improving Access to Psychological Therapies

Improving Access to Psychological Therapies (IAPT) Services aims to treat people with mild or moderate mental health problems, using effective talking therapies. They aim to help people stay in work or get back to work quickly. The IAPT team monitors the effectiveness and impact of what they do closely: for example, they collect systematic outcome measures from the people who use their service for cognitive behaviour therapy or counselling.

Table 24: Effectiveness of IAPT services
Data from Insight

Indicator	Target (set by NHS Sheffield)	2011/12	2010/11	2009/10
Number of new cases seen	5364	10,661	9,036	6,728
Percentage of people moving to recovery	50%	49.5%	41%	44%
Number of people returning to work from benefits	89 people	396	419	304

Although Sheffield IAPT fell just below the local target for percentage of people moving to recovery, its performance remains strong in comparison with other parts of the country.

Dementia services

During the year, the dementia services audited themselves against the standards in the NICE Quality Standard for dementia and have made improvements, such as making sure people newly diagnosed with dementia have access to advice about advanced directives. They have also seen more people and reduced waiting times for a memory assessment.

Table 25: Effectiveness of Dementia Service
Data from insight

Indicator	Target (set by NHS Sheffield)	2011/12	2010/11	2009/10
Discharges from acute care (G1)	78	34	38	53
Number of assessments for memory problems by memory management services	600	862	728	636
Rapid response and access to home treatment	300	267	336	288
Waiting times for memory assessment	N/A	14.7 weeks	21.3 weeks	28 weeks

Substance Misuse

The Drug and Alcohol Services provided by the Trust measure the effectiveness and impact of what they do against a number of indicators, set by their commissioners.

Table 26: Drug and Alcohol Services quality indicators – performance over last 3 years
Data from Insight and NDTMS

Indicator	Target (set by commissioner)	2011/12	2010/11	2009/10
(Drugs) No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	100%
(Drugs) No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	100%
(Drugs) No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100%
(Drugs) No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100%
(Alcohol Single Entry and Access Point) No client to wait longer than 1 week from referral to assessment	100%	100%	100%	N/A
(Alcohol Treatment Service) No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100%	N/A
% problematic drug users retained in treatment for 12 weeks or more	90%	94%	89%	89%
Start/Initial Treatment Outcome Profile (TOP) completed	100%	96%	96%	N/A
Review TOP completed	100%	80%	59%	N/A
Discharge (planned) TOP completed	100%	100%	50%	N/A
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	N/A
Number of service users and carers trained in overdose prevention and harm reduction	240	292	243	N/A
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	85%	92%	N/A

Learning disabilities

There were no people in campus provision in Sheffield Health and Social Care NHS Foundation Trust last year. We always aim to provide person-centred care that meets individuals' needs.

In Learning Disability Services, the annual Sheffield WILD (working in Learning Disabilities) awards ceremony for staff saw a number of teams and individuals win recognition for their excellence, creativity and innovation. For example the Assessment and Treatment Unit staff team won an award for their work to improve the health of service users. The same team was commended by the Care Quality Commission on an inspection visit for the quality of their person-centred care plans and health action plans.

Clinicians in the learning disability services have been involved in developing quality standards which can be used by commissioners and contractors to assess the quality of specialist care for people with challenging behaviour and autism in care homes and other services. This work developed as part of the city's response to the Winterbourne report, following the BBC Panorama report on maltreatment of vulnerable people with learning disabilities in care.

Learning disability staff have also been working in partnership with Sheffield Teaching Hospitals NHS Foundation Trust colleagues to improve access to healthcare by people with learning disabilities:

Hospital Passport for people with a learning disability

The Hospital Passport has been updated by Mencap and the Joint Learning Disability Services. It is designed to be taken to hospital when the person attends outpatients or is admitted to a ward.

The Passport gives hospital staff important information about the person. It uses a traffic light system of colours:

Red = Things you MUST know about me

Amber = Things that are important to me

Green = My likes and dislikes

The Hospital Passport is available to download from www.signpostsheffield.org.uk

Anne Hutchinson, Health Facilitation Coordinator

Clover Group

QOF overview

General practices are assessed against the national Quality and Outcomes Framework.

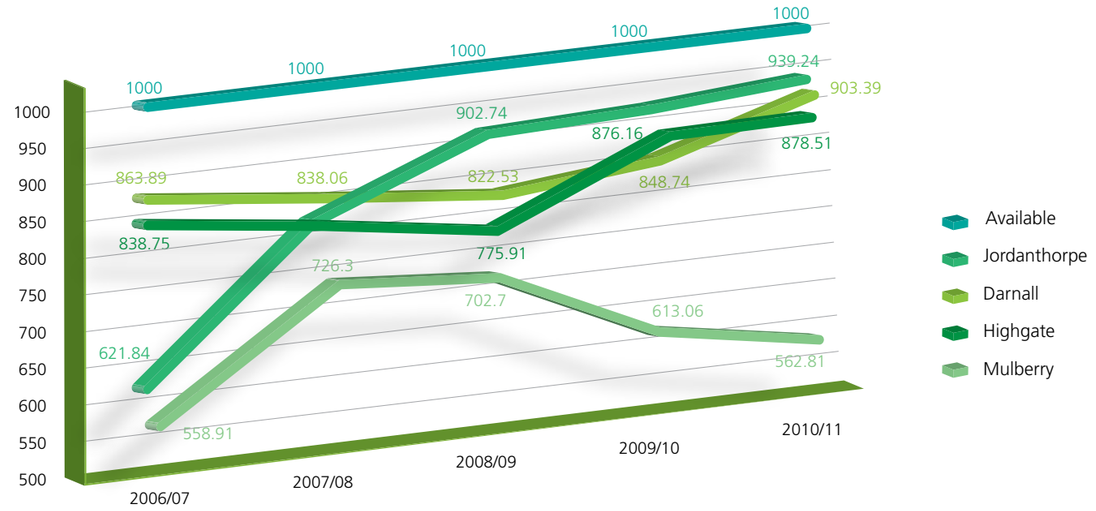
The Quality and Outcomes Framework consists of 143 indicators totalling 1000 points across 4 domains, these being clinical, organisational, additional services and patient experience. 88 indicators are clinical and they carry 661 points: the 1 patient experience indicator carries 33 points.

Attached to the Clover Group Practices (APMS) contract is a series of key performance indicators, and the practice is required through one of these KPIs to achieve 95% of the available QOF points. QOF performance is assessed annually and achievement based on our position on 31 March forms a significant funding stream for the service. The Clover Group Practice's target for 2012/13 is to achieve 100%.

Historical position

As individual practices, 3 of our 4 sites made significant progress over the preceding 5 years. The Mulberry Practice, which provides health services for asylum seekers and refugees, was unable to meet many QOF targets as the demographic of the site means that it is atypical with very low levels of chronic disease and extremely high levels of depression and mental health.

Table 27: QOF Performance over last 5 years, broken down by site
Data from Clover Group records



Achievement 2011/12

The Clover Group Practice's achievement in 2011/12, our 1st year as one practice, has seen significant improvement in our QOF performance. This increase is attributable to:

- The specific issues at Mulberry being nullified by the merge
- Sharing of best practice across the sites
- Improved performance management in year

Table 28: Clover Group QOF performance for 2011/12
Data from Clover Group records

Achievement 2011/12	Maximum Indicators	Achieved Indicators	Maximum Points	Achieved Points 31st March 2012*	Achieved Points Final position May 2012 (expected)*
Clinical	88	77	661	653.04	653.04
Organisational	45	44	262	244.24	259.24
Additional Services	9	9	44	44	44
Patient Experience	1	1	33	33	33
Total	143	131	1000	974.29	989.28

The indicators that the practice did not meet in 2011/12 were:

- Patient review within 6 months of confirmed diagnosis for cancer patients
- Physical health checks for people with a new diagnosis of dementia
- Assessment of depression in people with diabetes and coronary heart disease
- Follow-up assessment of people with a new diagnosis of depression
- Body-mass index checks of people with psychosis
- Recording of smoking status in people aged 15 years and above

A protected learning event will be held early in 2012/13 for clinical staff across the sites to discuss how to address these areas. It is important to note that the practice was not significantly away from target in any area.

3. Positive Service User Experience

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

Table 29: Complaints and compliments across the Trust over the last 3 years
Data from Ulysses Safeguard

Indicator	2011/12	2010/11	2009/10
Number of formal complaints	97	86	79
Number of informal complaints	215	286	226
Number of compliments	1401	1559	1440

Compliments again outnumbered complaints by a high margin in 2011/12, although there was a reduction in the overall number of compliments recorded.

89% of the formal complaints were responded to within 25 working days, down from 97% in the previous year. 100% of the informal complaints were responded to within 5 working days, the same as last year.

A full picture of the complaints and compliments received by the Trust in the year is available on the Trust website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (people making complaints) about their experience of the complaints process.

All complaints are investigated and, if they are upheld or partially upheld, an action plan will be put in place to address the problems found. The types of complaints made are reviewed to see if there are any consistent themes or trends.

Analysis of complaints themes shows that the categories 'all aspects of clinical' care and 'staff attitude' are consistently the most common causes of complaints overall, both formal and informal. They are broad categories which cover many different areas.

During 2011/12, other sources of information and feedback about the service user experience included:

- **Patient Advice and Liaison Service (PALS) queries.** There were 79 PALS queries in the year about the Trust services. Examples included a request from a service user about how to access help for anxiety, and requests from potential volunteers seeking opportunities in the Trust
- **Posts on the Patient Opinion website.** There was one post made about the Trust on this website during the year: it was positive
- **Posts on the Trust's own website.** There were 230 of these during the year. The most frequent type of query was related to work experience or jobs, but there were also requests for information about services and how to get help. 7 posts were dealt with as Complaints and are included in the information on Complaints above.

Quality and dignity survey

A third Quality and Dignity survey was completed during the year. In this work, a service user volunteer interviews service users on the wards and asks them about the quality of care they have received. There is a focus on feeling safe and being treated with dignity and respect. Service users on the wards have welcomed this opportunity to express their views to a fellow service user. The Quality and Dignity Survey has now been completed 3 times, in 3 phases:

Phase 1: November 2009 – March 2010

Phase 2: April 2010 – November 2010

Phase 3: January 2011 to July 2011

The results are fed back to ward staff and discussed at the Acute Care Forum. They are used to inform team governance and make improvements to the quality of care.

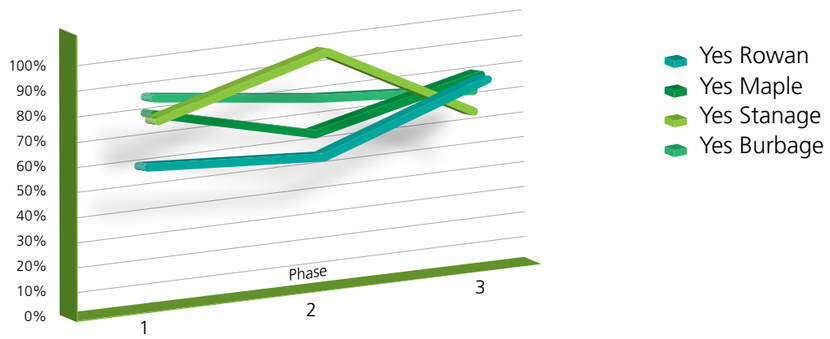
Examples of quality and dignity survey responses on safety, dignity and privacy

All the diagrams below are extracted from the Quality and Dignity Survey themes and trends report

1. Safety

Results over the 3 time periods and over the 4 wards are fairly consistent for the question 'Do you feel safe on the ward?' With around 75% of service users saying they did feel safe.

Do you feel safe on the ward?



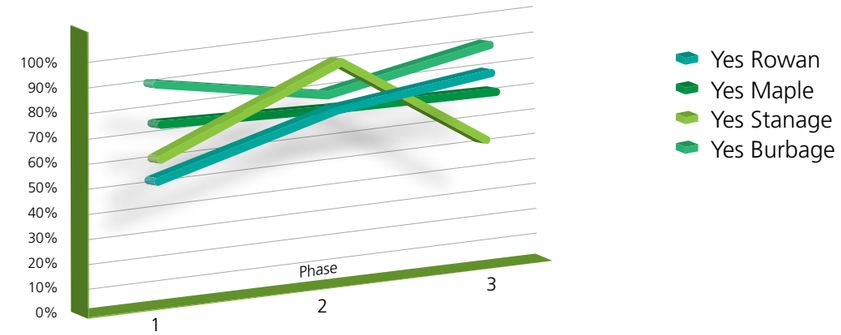
The narrative responses show why. The reasons were mostly a perceived threat from other service users, for example:

- 'Not when a particular patient kicks off, I always lock my door at night'
- 'Sometimes a bit nervous, because of other patients, especially at staff handover times'
- 'Some of the louder, unpredictable patients can be worrying'

2. Dignity

For the question 'Do you feel your dignity is respected?' There is an upward trend in 3 out of the 4 wards. At Phase 1, 69% said yes; at Phase 2 it was 77% and at Phase 3 it was 72%.

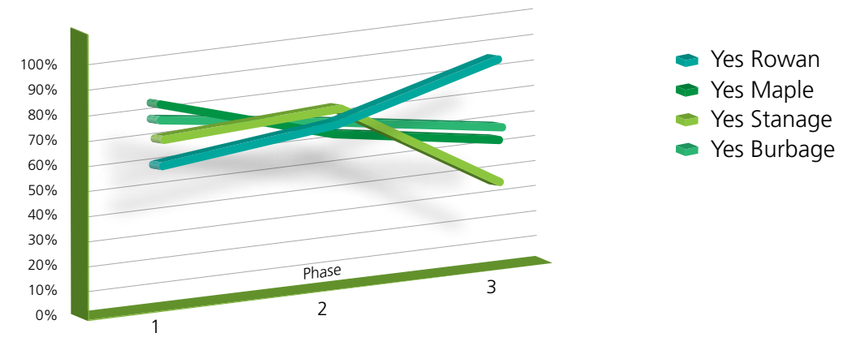
Do you feel your dignity is respected?



3. Privacy

There is a downward trend in responses to the question 'Do you feel you have enough privacy?' in 3 out of 4 wards and the results on this area were disappointing.

Do you feel you have enough privacy?



The wards receive detailed feedback from the survey including the service users' comments. This enables them to address any areas identified as problematic, such as people feeling they do not have enough privacy, or some service users feeling less safe when staff are in handover meetings.

Staff can see which wards are getting more positive feedback and learn from each other's best practice. Managers address the variation between wards with a range of proactive measures including leadership and team development work.

Service user satisfaction surveys

The majority of teams in the Trust are carrying out service user satisfaction surveys as part of their team governance procedures.

There are many examples where service user feedback has led to changes and improvements in services:

Service users from Sheffield Outreach Team (SORT) gave qualitative feedback about Occupational Therapy Services. This led to activities being more focussed on service user needs, specifically social groups, exercise classes and allotment sessions.

The Chronic Fatigue Service has involved service users from the start in giving regular feedback. This has led to an 'Introduction to Pacing' information session, for example. Feedback that people struggle to attend the clinic, which can make their symptoms worse, led to a range of access methods being offered. The service saw a rise from 38% saying that appointments were 'very convenient' in 2010 to 51% in 2011.

GP patient survey

Clover Group service users are asked to complete GP Patient Surveys. The results have shown both positive and negative feedback during the year.

The GP services have introduced their own surveys and started new ways of involving and engaging service users.

CQC Community Mental Health service user survey

Each year, the CQC surveys a random sample of community mental health survey users, enabling the Trust to compare its results with other mental health trusts. In 2011 replies were received from 294 people: this was 35% of those surveyed in comparison with a national response rate of 33%.

The full results are published on the Care Quality Commission website **www.cqc.org.uk**

The key result from this year's survey was that the Trust was in the top 20% of trusts nationally when service users were asked to rate their care overall in the last 12 months. It was also in the top 20% for the responses to the question 'Have mental health services involved a member of your family or someone close to you, as much as you would like?' For all questions it was either in the top 20% or the middle range: none fell into the bottom 20%.

The results on medication have been reported in the safety section above.

Results can be compared with previous years, but this presents some difficulty with the 2009 survey, where inpatients were surveyed rather than community mental health patients and different questions were asked. There were also fewer people surveyed and fewer responses, making some of the responses insufficient for data analysis.

Table 30: Results from CQC Service User Survey over last 3 years. Data from CQC website

Theme	Question	2011	2010	2009
Health and social care workers	Did this person listen carefully to you?	Top 20%	Middle 60%	Middle 60% (Psychiatrist) Top 20% (Nurse)
	Did they take your views into account?	Top 20%	Middle 60%	Not asked
	Did they treat you with respect and dignity?	Top 20%	Middle 60%	Middle 60% (Psychiatrist) Top 20% (Nurse)
Talking therapies	Did you find talking therapy you received in the last 12 months helpful?	Top 20%	Top 20%	Insufficient replies
Care co-ordinator	Do you know who our care co-ordinator is?	Top 20%	Middle 60%	Not asked
	Can you contact your care Coordinator if you have a problem?	Middle 60%	Top 20%	Not asked
	How well does your care coordinator organise the care and services you need?	Top 20%	Middle 60%	Not asked
Care plan	Do you understand what is in your care plan?	Middle 60%	Top 20%	Not asked
	Do you think your views were taken into account?	Top 20%	Top 20%	Not asked
	Does your care plan set out your goals?	Middle 60%	Middle 60%	Not asked
	Have mental health services helped you start achieving your goals?	Middle 60%	Top 20%	Not asked
	Does your care plan cover what you should do if you have a crisis?	Top 20%	Middle 60%	Not asked
	Have you been given (or offered) a copy of your care plan?	Middle 60%	Middle 60%	Not asked

Theme	Question	2011	2010	2009
Care plan review	In the last 12 months, have you had a care plan review meeting?	Middle 60%	Middle 60%	Not asked
	Were you told you could bring a friend, relative or advocate?	Top 20%	Middle 60%	Not asked
	Were you given a chance to express your views?	Top 20%	Top 20%	Not asked
	Did you find the care review helpful?	Top 20%	Top 20%	Not asked
Crisis care	Do you have the number of someone from local mental health services you can ring out of hours?	Middle 60%	Bottom 20%	Bottom 20%
Day-to-day living	Over the last 12 months, have you received support in getting help for your physical health needs?	Top 20%	Middle 60%	Not asked
	..help with care responsibilities	Middle 60%	Middle 60%	Not asked
	..help with finding or keeping work?	Top 20%	Bottom 20%	Not asked
	..support with finding or keeping accommodation?	Middle 60%	Middle 60%	Not asked
	..help with financial advice or benefits?	Middle 60%	Middle 60%	Not asked

Actions planned which it is hoped may impact on the CQC service user survey results in future include:

- The new Scheduled Care Pathway has been designed to set standards for activities like care plan reviews and assessments related to work and accommodation
- The pilot of an out-of-hours phone line to provide a contact number for service users and carers has begun and will be evaluated, to see if it brings the anticipated benefits.

Staff experience

2011 National NHS Staff Survey results

The quality of services delivered by the Trust depends on the quality of staff. It is essential that we have the staff with the right skills, knowledge, experience and attitude. One important way of knowing how staff feel about their work is through the annual NHS staff survey.

The results from the 2011/12 survey, which was completed by staff in autumn 2011, were positive overall for staff engagement in their work. They show that Sheffield Health and Social Care Trust staff would recommend it as a place to work or receive treatment, as they did last year.

The following tables show the overview picture of staff engagement, and then give the 4 best and 4 worst results for the Trust.

Table 31: Overall staff engagement
Extract from National NHS Staff Survey 2011, published by the Picker Institute

Key factor	Change since 2010 survey	Ranking, compared with other mental health trusts
Overall staff engagement	No change	Highest (best) 20%
Staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work)	No change	Highest (best) 20%
Staff recommendation of the trust as a place to work or receive treatment (the extent to which staff think care of service users is the trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment)	No change	Highest (best) 20%
Staff motivation at work (the extent to which they look forward to going to work and they are enthusiastic about and absorbed in their jobs)	No change	Average

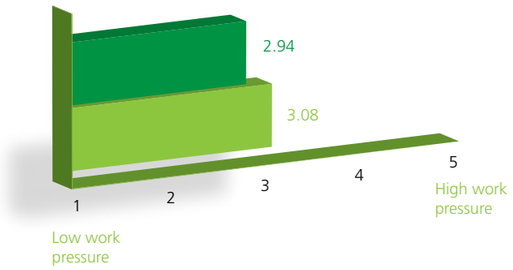
The following tables show the areas where the Trust performed best and worst in 2011 staff survey, which was published in March 2012.

The top ranking scores show areas where the Trust staff are reporting a very positive experience of work. There are actions in place to improve the areas where Trust staff are indicating a less positive experience than colleagues elsewhere.

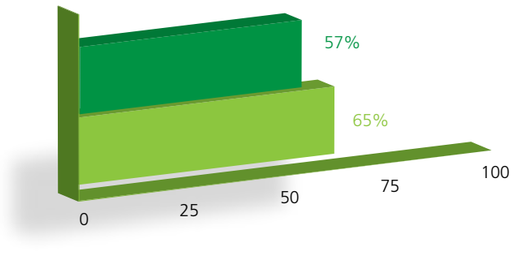
Table 32: Top and Bottom 4 ranking scores in 2011 staff survey
Extract from National NHS Staff Survey 2011, published by Picker Institute.

Top four ranking scores

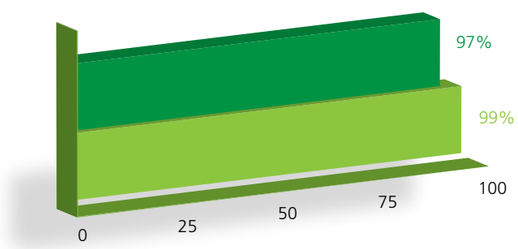
KF5. Work pressure felt by staff



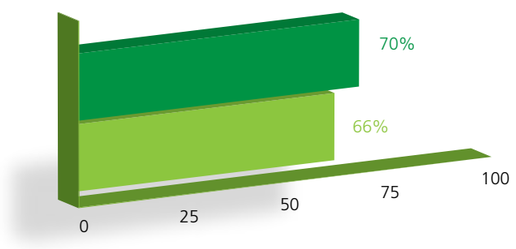
KF8. Percentage of staff working extra hours



KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month



KF31. Percentage of staff able to contribute towards improvements at work

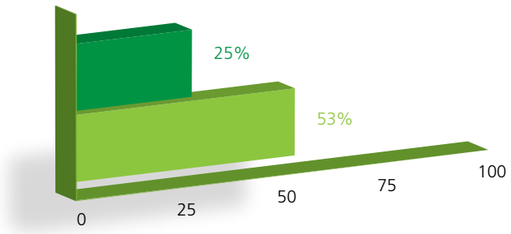


Trust score 2011

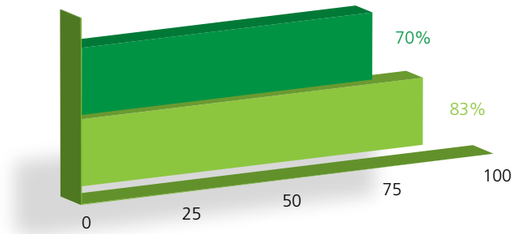
National 2011 average for mental health/learning disability trusts

Bottom four ranking scores

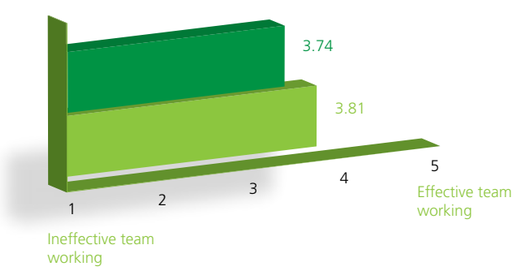
KF36. Percentage of staff having equality and diversity training in the last 12 months



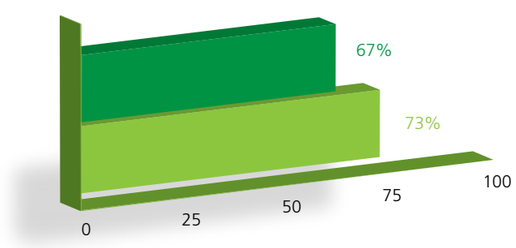
KF16. Percentage of staff receiving health and safety training in the last 12 months



KF6. Effective team working



KF14. Percentage of staff appraised with personal development plans in the last 12 months



Trust score 2011

National 2011 average for mental health/learning disability trusts

The improvements to equality training have been reported above in the section on last year's quality objectives.

There has also been a trust-wide focus on improving the provision and uptake of personal development plans, with teams and managers monitoring this issue, but the staff responses on this question in the survey have indicated that this work must continue and strengthen in 2012/13.

A newly re-established Health and Safety Committee is highlighting health and safety training issues.

Support is offered to teams where there are issues or concerns about effective team working by the Organisational Psychology staff. This may take the form of support for a one-off team development event or a more intensive period of support.

Equality, diversity and human rights

Sheffield Health and Social Care NHS Foundation Trust provides services to a wide range of communities in Sheffield and is committed to eliminating unlawful discrimination and promoting equality of opportunity. We believe that the public, service users and staff should have equal access to services and job opportunities offered by the Trust.

Equality and Human Rights are for everyone. This means people who use services or members of staff. Everyone has a right to be treated with dignity and respect; this means to have their Human Rights respected. Equality is relevant to everyone; people should not face discrimination and should have equal opportunities irrespective of characteristics that they may have.

More information on the Trust's performance on equality, diversity and human rights is available on the Trust website **www.shsc.nhs.uk**

Development and monitoring of the quality accounts

This is the fourth year of Sheffield Health and Social Care NHS Foundation Trust Quality Accounts, so many of the quality indicators chosen to give an overview of quality in the Trust have been retained so that readers can see changes and developments over the years. However, new services have joined the Trust and are included in this year's accounts for the first time. The format is similar to previous years and follows the Department of Health and Monitor guidance.

The process of developing this year's quality accounts began in the Autumn of 2011:

- the quality data, reports and survey results which are presented regularly to the Quality Assurance Committee were reviewed
- benchmarking data was sought from the NPSA results and CQC surveys
- Yorkshire and Humber Quality Observatory were consulted for their ideas on the development of regional and national mental health quality indicators
- clinical and service directors, lead professionals and senior managers were asked for their ideas for quality improvement
- at a meeting of the Board of Directors and Council of Governors, feedback was given on the delivery of the 2011/12 quality objectives and ideas for next year's objectives were elicited.

From this process, a long list of potential quality objectives was created, which went for further consultation with governors, LINKs, senior clinicians and managers. From the long list, a final shortlist of 7 resulted from the consultation, and the Trust Board selected a final 5 quality objectives for 2012/13.

The first draft of the Quality Accounts was presented to February Board and then, with minor amendments to create version 2, sent out for consultation with Sheffield City Council Health and Well-being Scrutiny Committee, LINks, NHS Sheffield and colleagues in the Trust.

Progress on the quality objectives is monitored quarterly by the Quality Assurance Committee. Quality data is reviewed at the Quality Assurance Committee and at Board (through dashboard and exception reports). The Committee and Board also review regular reports on the key aspects of quality – service user safety, clinical effectiveness and a positive service user experience.

Statements from local involvement networks, overview and scrutiny committees and Primary Care Trusts

Because of the prescribed consultation timetable, commissioners and partner organisations had to comment on an early draft of the quality accounts. Many of the issues raised below have been addressed in the later versions, as year end figures became available and the text could be expanded and clarified, in the light of feedback and further information.

1. Sheffield local involvement network

Sheffield LINk have been able to meet with the author of this report on one occasion; this has enabled a better understanding of the expectations of a report that is understandable to the public and yet meets the format and content requirements placed upon the Trust from Monitor.

We hope that the Trust will produce an easy-read version of the QA report.

Sheffield LINk provide the commentary for this years Quality Account without seeing the final document and therefore this has to be borne in mind as further information contained in the final document could have made a difference to our commentary.

Last year Sheffield LINk commented:

"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."

Unfortunately you have not included in this year's Quality Account details of the extensive work the Trust has been undertaking to develop the Service User Monitoring Unit; we believe this should have been included as an excellent example of user engagement.

Page 7 refers to staff training in the "Respect Approach" - for this to be meaningful there needs to be an explanation of what the "Respect Approach" is.

Pages 9/10 the objectives have lost their numbering. We find it difficult to give constructive commentary in respect of "This is what we will do" as apart from the objective on page 9, there is nothing listed for what you will do, therefore we don't know if it will be effective or not at this stage.

There is a lot of use of acronyms e.g. page 15 DAAT, page 19 DRAM; either an explanation of them within the text or a glossary to them within the document is needed to meet the needs of the wider audience for this document.

Part 3 of the document (Safety); we find it extremely difficult to judge if these results are good, bad or indifferent - the use of traffic lights or emoticons would help the lay reader with this information.

Page 35 if you are not going to provide the information of who the other Trusts are then just give us Sheffield against the national average; also is "second lowest regional reporter" the best way of saying this as it could mean you don't report them all!

In respect of Patient Safety Alerts, we request that greater detail is provided, the actions taken and did they meet the required timescale.

Page 39 Dementia services, Sheffield LINk receive a great deal of service-user input about these services and from this information we believe that although your Trust exceeds the performance of other regional Trusts, the people of Sheffield should not have to wait 8.5 weeks to be seen at a memory clinic. Early diagnosis enables better management of the condition which is more cost effective all round. Therefore we urge this to remain very much a priority to reduce this wait to no more than 4 weeks.

Throughout the document there is frequent use of % figures where no indication of what the % represents which makes it difficult to understand the rationale of including them.

Sheffield LINk agrees that the 5 priorities chosen are areas needing a quality assurance focus. We suggest that the reporting on them will include being bench-marked against similar Trusts both regionally and nationally.

We are also pleased that one of the priorities focuses on dementia as this is an area we receive very frequent contact about; we also expect to see Woodland View reported upon in next year's Quality Account.

We are pleased that your Trust has included all the service areas that were new to you from April 2011 under the PCT's Transforming Community Services policy.

Mike Smith

Chair, on behalf of Sheffield LINk

Sheffield Health and Social Care Trust response

Thank you very much for your feedback. We regret that the timing of the consultation period means that you had to comment on an earlier version of the accounts, and we hope you will be able to see that many of the points you raised have been addressed in this later version. For example, we have included more explanation and definition of acronyms and we have been able to add the final percentage figures to tables. There is a description of the Service Use Experience Monitoring Unit, which we agree is one of the highlights of last year in the Trust.

We have tried to add more commentary to explain the significance of the safety data, and to put it in context with benchmarked data. We are always trying to find more data to enable benchmarking, but this remains a challenge for mental health trusts nationally.

We will be producing a service-user-friendly version of the quality accounts as part of our review of the year, to be published later in 2012. We will make sure you get a copy.

We note your comments on the waiting times for dementia assessments and share your concerns, which is why access to dementia care has been set as one of our quality objectives for the year ahead. However, we are not able to commit to a 4 week wait at present, when we are simultaneously investing energy to increase the number of people who access these services.

2. Sheffield City Council Healthier Communities and Adult Social Care Scrutiny committee

Response to the Sheffield Health and Social Care Foundation Trust's Quality Account 2012

As in previous years, the Committee welcomes the opportunity to comment on the Health and Social Care Foundation Trust's draft Quality Accounts, and commends the Trust for presenting an honest and balanced picture of performance. We feel it is very important that the Quality Account is easy to understand for members of the public, and that content is relevant, succinct and clear.

The Committee considers that the quality priorities selected by the Trust reflect the needs of the City, and are particularly pleased to see improving access to dementia care as an objective this year. This has long been a priority for us, and we look forward to seeing significant improvement in this area over the coming year.

The Committee recognises that the quality priorities represent only a small part of the work that the Trust carries out, and welcomes the Trust setting up a Service User Experience Monitoring Unit. The Committee believes strongly that involving service users is a key factor in successful service development and quality improvement.

The Committee is pleased to see that the Trust's quality of care, and involvement of members of service users' families is rated highly by service users, as demonstrated by the 2011 Care Quality Commission Mental Health service user survey, which put the Trust in the top 20% of trusts nationally. The Committee congratulates the Trust on this achievement.

Emily Standbrook

Policy Officer (Scrutiny)

31st March 2012

Sheffield Health and Social Care Trust response

We would like to thank the Committee for their response and for the discussions held at their meeting.

We are glad that you have chosen to comment on the development of the Service User Experience Monitoring Unit and we intend to report more on this initiative in next year's Quality Accounts.

3. NHS Sheffield

Statement from NHS Sheffield

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 2011/12, reducing waiting times for access to care, taking actions to improve the physical health of their patients and to support people into employment.

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. We support the Trust's drive to improve the quality of care and recognise the particular challenge to do so whilst making significant changes in services to improve efficiency, and have constructed the quality indicators and the CQUIN scheme in our contract for 20112/13 to this end.

Sheffield Health and Social Care Trust response

Thank you for your comments, and for your earlier informal feedback which we were able to use to make improvements to the first drafts of the quality accounts.

We welcome the regular opportunity to meet with the Primary Care Trust to review the quality of care we provide, during the course of the year. We welcome too your support for our choice of quality objectives for the year ahead.

Governors' views

The Trust's governors received an in-year progress report on the quality accounts, with an emphasis on the delivery of the quality objectives, and they were involved in the development of this year's accounts.

Following discussions at a Council of Governors meeting, the governors suggested new topics for quality objectives this year which were included in a 20 item 'long list'. They were asked to vote on the long list in an electronic survey. 19 Governors responded: their rank order of priority was:

1. Improve access to services for homeless people
2. Deliver training for all staff in customer care with a 'recovery' focus (valuing service users and their contribution)
3. Improve access in crisis services
4. Improve the experience of first contact with the Trust
5. Improve the quality of support proved by the Trust for carers
6. Make sure the Trust recognises and assesses unmet need in people already receiving services (e.g. physical health problems)
7. Implement service user surveys and questionnaires consistently throughout the Trust
8. Improve nutritional support for service users
9. Deliver the new 'Respect' training for staff to help them prevent and manage violence and aggression
10. Expand and develop the 'recovery' work in the Trust

The Trust will be working on all of these in the year ahead, even though not all of them were included in the final choice of quality objectives by the Board of Directors.

The Board of Directors took the view that it wanted to select objectives that would have a real and evident impact for service users and were not primarily about improving internal Trust systems and processes. It also chose some new areas this year rather than areas where work was already underway and well established, such as the work on nutrition.

We note that the quality objective on 'improving first contact' was first proposed by governors and adopted by the Board as one of the 5 quality objectives for 2012/13. We very much welcome the extra perspective on quality which our governors bring to these accounts.

Annex: Statement of Directors' responsibilities in respect of the 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 the annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

The Quality Report presents a balance picture of the foundation trust's performance over the period covered;

The performance information reported in the Quality Report is reliable and accurate;

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

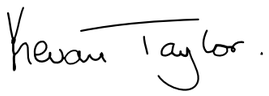
The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review:

And the Quality Report has been prepared in accordance with 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 Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board

Date: 30th May 2012
Chairman



Date: 30th May 2012
Chief Executive

Independent assurance on the quality accounts

These Quality Accounts have been independently audited by the Audit Commission against the standards set out in the Detailed Guidance for External Assurance on the Quality Accounts available on the Monitor website. **www.monitor-nhsft.gov.uk**

The Audit Commission have found that the Quality Accounts for 2011/12 meet the standards set by Monitor.

How to give feedback on these accounts

Your comments and feedback are welcome and will help us improve the Quality Accounts next year.

Please send your feedback to:

Tina Ball, Director of Quality

Email: **tina.ball@shsc.nhs.uk**

Tel: **0114 271 6393**

Or

Tony Flatley, Lead Nurse

Email: **tony.flatley@shsc.nhs.uk**

Tel: **0114 271 6713**

12.0
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 officers, 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
- 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 Memorandum.

Kevan Taylor

Kevan Taylor
Chief Executive
Date: 30th May 2012

13.0 Annual governance statement

Scope of responsibility

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

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, who is the main commissioner of the Trust's 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 an elected member of the Council. Positive relationships with NHS North of England, (formed in October 2011 from three Strategic Health Authorities – Yorkshire and the Humber, North East, and North West), have been maintained.

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 2012 and up to the date of approval of the Annual Report and Accounts.

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 Integrated Governance/Chief Nurse who has the Executive Director lead role for risk management and governance. The Executive Director of Nursing and Integrated Governance provides assurance on the Trust's capacity to handle risk through the various reports that are provided to the Quality Assurance Committee, the Audit and Assurance Committee and the Board of Directors itself.

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. This policy was revised and approved by the Executive Directors' Group (in accordance with the Trust's Policy on Policies) in January 2011.

Development for the Board and senior managers in 2011/12 has included various workshops on annual planning, including service and financial planning, financial challenges, the changing commissioning landscape, partnership working and the delivery of the Trust's vision.

Training provided by the Trust for its staff includes:-

- Corporate Welcome - An introduction to the organisation
- Core Training – An intensive 4-day training package for all new starters, which includes risk management, health and safety, equality and human rights, information governance, infection control etc. Training is tailored, dependent upon the individual's job role
- Incident Reporting and Investigation
- Mental Health Act
- Mental Capacity Act
- Health, Safety and Security, including Fire Safety
- Equality & Human Rights
- Respect (Managing Violence and Aggression)
- First Aid and Life Support (including Resuscitation)
- Root Cause Analysis
- Clinical Risk Assessment and Management
- Medicines Management
- Safeguarding Children and Vulnerable Adults
- Infection Control
- Care Programme Approach

The service directorates and the professional groups also provided a range of regular training updates 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 through the Quality Improvement Group and quarterly to the Quality Assurance Committee of the Board of Directors. Performance on implementation is monitored by the Medical Director and also by NHS Sheffield. All relevant 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, such as clinical risk, infection control, risk assessment, health and safety, litigation, liability, fire and security, environmental, estate management, medicines management, psychological therapies governance, safeguarding children and vulnerable adults, human resources and finance among others.

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
- quality Improvement Group
- staff and service user surveys and the dissemination of results
- reports of compliments received and the learning from complaints, incidents and claims
- improving Quality events
- quality Check meetings
- Team and directorate governance reports and events
- inpatient Forum (formerly Acute Care Forum)
- community Care Forum
- service User Safety Group
- sharing Good Practice events
- making contributions at conferences
- risk Register Leads meetings.

A key learning point from incidents reported in the period has been around strengthening communications with service users' families and carers to ensure they are involved in care planning. The Trust is continuing to embed the clinical risk assessment and management documentation introduced throughout 2011/12 and to improve recording the rationale for decision making in care records. A learning point that has arisen following the roll-out of electronic care records is to ensure key documents are appropriately tagged to enable easy retrieval and assist onward care planning.

Learning is also shared through the Service User Safety Group, as well as through a variety of communications, for example Risk Management Update, 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 provide a balanced view of the Trust's performance on quality issues.

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 seen 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 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 sites, 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, namely:
  - Board assurance framework
  - risk registers
  - incident and serious incident reporting
  - learning from incidents, complaints and claims

- 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 sites 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. Each team produces a report at least annually, for directorate review. All directorates are reviewed through a regular 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 risks are assessed using a stepped approach which identifies and analyses the risk, identifies the control measures in place and how effective these are, and the actions that need to be taken to reduce/mitigate/remove the risk. Risks are graded according to their severity and likelihood of recurrence, using a 5 x 5 risk grading matrix based upon guidance produced by the National Patient Safety Agency. All risks that are categorised as moderate or high (scoring 12 or above) are entered onto the Corporate Risk Register, together with all risks that are categorised as cross-Trust risks, for example, information risks which affect more than one directorate. Risks are recorded on the Ulysses Safeguard system which is an electronic database with sub sections for each directorate. Within directorates, individual teams or departments also have their own sub-sections. All recorded risks have an accountable individual and are reviewed and monitored by the appropriate operational governance group.

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 who is responsible for reviewing and maintaining their risk register. The Corporate Risk Register is administered by the Risk Register Co-ordinator, who also provides advice, support and guidance for the directorate risk register leads.

The Executive Directors' Group is responsible for reviewing all moderate and high risks when they are first identified, and allocating responsibility to the appropriate member of the Group and the appropriate governance group. All high level risks are reported to the Board monthly using a Board Risk Profile. The Corporate Risk Register is reviewed and reported to the Executive Directors' Group and the Audit and Assurance Committee quarterly.

Risks are also highlighted via feedback from incidents, including serious incidents, complaints, claims and Patient Advice Liaison Service (PALS) queries. The Executive Directors' Group, Clinical, Service and Support Directors receive a monthly overview of all ongoing serious incidents. Directorates also receive regular reports on their own incidents. The Quality Assurance Committee of the Board of Directors and directorates receive quarterly reports on incidents and complaints which analyse the data from these sources for any trends and issues identified. National benchmarking information from the National Patient Safety Agency is used to understand and interpret the Trust's incident reporting patterns. The findings of external inquiries and national reports are also shared and acted upon as described in the Trust's National Confidential Enquiries Policy.

Board assurance framework

The Board has an approved Board Assurance Framework for the period 1st April 2011 to 31st March 2012, which was last approved by the Board in March 2012. 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 through the Executive Directors' Group. The Framework is up-dated and reviewed quarterly by the Executive Directors' Group and the Audit and Assurance Committee and bi-annually by the Board.

As at 1st April 2012, there were 2 high-level risks with outstanding actions to address gaps in their controls and assurances in the Assurance Framework. One of these risks relates to Transforming Community Services and the impact that this may have on our efficiency requirements over the coming year(s). The other risk relates to the potential impact on the Trust's income in relation to the implementation of Self-Directed Support. I am confident that neither risk represents a significant nor serious risk to the effectiveness of the systems of internal control, and effective controls have been identified to manage the risks. Both risks have a lead Executive Director assigned to them and progress/assurance is reported on a regular basis through the appropriate operational governance group. All residual risks and actions will carry forward into the 2012/2013 Board Assurance Framework and will be entered onto the Trust's Corporate Risk Register.

Internal Audit has undertaken a review 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 Annual Governance Statement. The overall conclusion drawn from this review is that the Trust has maintained an Assurance Framework throughout 2011/12 that is consistent with Department of Health guidance and acts as a key evidence source for the Trust in its preparation of the Annual Governance Statement.

Public stakeholder involvement in managing risks

Service users and carers are members of the service governance structures at Trust, directorate and team level and contribute to planning and service improvement groups such as the Inpatient Forum and Service User 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 were also consulted.

Service users and carers, who are part of the Partners in Improving Quality Group, have undertaken various site visits across the Trust in relation to checking compliance against the Care Quality Commission's (CQC) Essential Standards of Safety and Quality, as well as being involved in the Patient Environment Action Team (PEAT) assessments.

As a Foundation Trust, Sheffield Health and Social Care 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 helps plan and steer the Trust and assists in setting priorities for improvements and changes. Governors are also members of key governance meetings where they can represent the interests of the local community, service users and carers and make sure that the Trust does what it says it will do.

Quality governance arrangements

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Care Quality Commission (CQC) carried out a Review of Compliance at Grenoside Grange, Michael Carlisle Centre and the Longley Centre in September 2011, as a result of the compliance actions previously issued in January 2011. From these inspections, all compliance actions were removed. Grenoside Grange received an improvement action in relation to outcome 13 (Staffing), this was due to ongoing recruitment processes.

A further Review of Compliance was also undertaken by the Care Quality Commission (CQC) at Bole Hill View Resource Centre in January 2012. One improvement action in relation to outcome 21 (Records) was received. This action asked the Trust to review care documentation to make it more streamlined, prior to the full roll-out of electronic care records.

Ongoing compliance with the CQC's Essential Standards of Quality and Safety is assessed throughout the year by individual teams within their internal governance processes. Any areas of concern are escalated through directorates and to the Head of Integrated Governance. The Trust also holds Quality Check meetings throughout the year, which includes stakeholders and members of the Partners in Improving Quality Group, which provides assurance to the Trust on ongoing compliance, and shares the learning from any inspection reviews. The Trust has devised a template that senior managers and volunteers use, to assess compliance against the standards, when carrying out site visits at registered locations.

The Trust assesses itself against Monitor's Quality Governance Framework on a quarterly basis and this is reported to the Board of Directors.

Sheffield Health and Social Care reports progress on the Trust's Quality Objectives to the Quality Assurance Committee of the Board of Directors quarterly and also regularly monitors progress against the quality indicators contained within the Quality Schedule that is agreed with our commissioners, NHS Sheffield.

The Trust has maintained Level 1 of the NHS Litigation Authority's Risk Management Standards for Mental Health and Learning Disability and is aiming to be assessed at Level 2 in 2014.

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 Leaver 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 Audit and Assurance Committee. The Information Governance Steering Group has a sub-group, the Care Records Group, reporting to it.

The Trust continues to adhere to the Information Governance Toolkit. The Trust submitted the Information Governance Toolkit in March 2012 and has not met the required level on 8 key items. Its score of 60% is graded as not-satisfactory. Documenting procedures, audits and training are the areas where the Trust did not meet the required level. An action plan has been developed to respond to the identified areas of need, which will ensure necessary and adequate progress is made over the following year.

The IT department has ensured all laptops have been encrypted locally and has rolled out a nationally-procured encryption solution, 'Safeboot', for portable computers and storage devices. The Trust has been reviewing a number of email encryption systems, in order to identify the best solution to procure in the near future.

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 regard to access to information.

Information governance and data security incidents and risks are recorded and reported through the Trust's risk management processes, as described above. There were no serious incidents of severity 3-5 (as classified by the Department of Health Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents, Gateway Ref. 13177) reported in the Trust between 1st April 2011 and 31st March 2012.

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 updated 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 is committed to eliminating discrimination, promoting equal opportunity and to fostering good relations in relation to the diverse community it serves and its staff, taking account of all protected characteristics.

The Trust has a lead Director responsible for Equality and Human Rights who reports to the Trust's Executive Directors' Group.

Over the past year, the Trust has focused its work to meet the statutory requirements of the 2010 Equality Act, ensuring ongoing regulatory compliance with the Equality and Human Rights Commission and the Care Quality Commission. It has adopted the NHS Equality Delivery System as a framework to develop its Equality Objectives.

An Equality and Human Rights Annual Report is published on the Trust's website.

Carbon reduction plans

The Foundation 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.

Review of economy, efficiency and effectiveness of the use of resources

The Board of Directors established a revised governance structure from 1st April 2011, which included the establishment of a new Board committee called the Quality Assurance Committee which held its first meeting on 12th April 2011.

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

The Trust has continued to review a number of operational efficiency metrics throughout the year, including the results of benchmarking exercises. Alongside this, the roll-out and implementation of service line reporting of income and expenditure has been developed to further focus on areas of overspending or inefficiency. This has enabled the Trust to focus on service elements that can be considered in terms of the delivery of the Trust's Cost Improvement Programme (CIP) targets. In addition, the Trust has put in place a Mutually Agreed Resignation Scheme (MARS) that has been utilised to facilitate enabling schemes and service transformations in order to deliver efficiency savings and a more effective use of resources.

The Trust has continued to take a Quality, Innovation, Prevention and Productivity (QIPP) approach to the delivery of Cost Improvement and Cash Releasing Efficiency (CIP/CRES) targets. Detailed plans have been presented to the Board of Directors and regular reports are provided to the Board regarding delivery against these targets.

In addition, the Trust continues to submit national Reference Cost data, although the submission for 2011/2012 may be the last submission before the data is refocused to a Care Pathways and Packages approach. The Trust's current Reference Cost Index is currently 96, which indicates an efficient use of resources.

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 has had budget training and is responsible for ensuring that the resources they manage are done so effectively and efficiently and are economic. Budget managers are provided with 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 is performance-managed by the respective Executive Directors.

During 2011/12, internal audit has, as part of the Trust's annual internal audit plan, conducted operational/value for money reviews in human resources, in respect of sickness absence recording and Performance Development Reviews (PDRs) and within IT, the implementation of electronic forms. The areas reviewed by internal audit link to the efficient and effective operation of the Trust.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 has 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 potential quality indicators to ensure that there was ownership of the process. The output from these sessions was consulted upon with the Council of Governors, LINk, senior clinicians and managers. From an eventual shortlist of seven potential objectives, the Trust Board selected five for the coming year. These are:

- to reduce the number of falls that cause harm to service users
- to reduce the incidence of violence and aggression and the subsequent appropriate use of restraint and seclusion
- to improve the identification and assessment of physical health problems in at risk groups
- to improve the experience of first contact with the Trust
- to improve access to dementia care.

These objectives, together with performance against last year's objectives, form a significant element of the Quality Report and will feature in the Trust's Annual Report.

In preparing the Quality Report, directors satisfied themselves that the 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 websites, eg the 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 Quality Report has been consulted upon with Sheffield City Council's Health and Well-being Scrutiny Committee, LINk, NHS Sheffield and colleagues in the Trust. It has also been received and considered by the Board of Directors' Audit and Assurance Committee, the Quality Assurance Committee and by the Board of Directors itself. Monitoring of the Quality Accounts and delivery of the Trust's quality objectives is through the Quality Assurance Committee of the Board of Directors.

The view of the Trust's External Auditors, the Audit Commission, of the Quality Report for 2011/12 is that it is balanced and meets the requirements of Monitor, and the Department of Health.

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, clinical audit and the executive managers and clinical leads within the 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. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit and Assurance Committee, the Quality Assurance Committee, the Finance and Investment Committee, the Information Governance Steering Group, the Human Resources and Workforce Group, the Business Planning Group, the Operational Delivery Group, the Strategic Leadership Group, the Quality Improvement Group and the Executive Directors' Group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

These Committees/Groups and their accountability and reporting relationships are described more fully below and in the Trust's Business Plan. I believe that they form an effective and robust system of governance for the Trust.

The Head of Internal Audit provides me with an opinion based on an assessment of the design and operation of the underpinning Assurance Framework and supporting processes, and an assessment of the individual opinions arising from risk-based audit assignments contained within the internal audit risk based plan that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses. The overall opinion of the Head of Internal Audit is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently.

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
- reports from Internal Audit
- external assessments by the National Health Service Litigation Authority
- external assessments by the Care Quality Commission, including Mental Health Act Commissioners
- full registration with the Care Quality Commission across all locations
- the bi-annual Performance Review held with all Service Directorates to review their progress and performance against targets
- the similar 6 monthly Performance Review held with all support/corporate directorates
- Clinical Audit Programme
- Patient Environment Action Team (PEAT) assessment
- Service User Surveys
- Information Governance Toolkit assessment
- stage two external review by Monitor.

Board of Directors

The Board of Directors is responsible for ensuring that the organisation has robust clinical, corporate and financial governance systems in place. This includes the development of systems and processes for financial control, organisational control and risk management.

Audit and assurance committee

The Audit and Assurance Committee is a committee of the Board of Directors and is chaired by a Non-Executive Director. It provides assurance to the Board through objective review and monitoring of the Trust's internal control mechanisms, such as financial systems, financial information, compliance with the law, and governance processes, among others. It monitors the effectiveness of the systems in place for the management of risk and governance, and delivery of the Board Assurance Framework.

Quality assurance committee

The Quality Assurance Committee is a committee of the Board of Directors and is chaired by a Non-Executive Director. It provides assurance to the Board on the quality of care and treatment provided across the Trust by ensuring there are efficient and effective systems for quality assessment, improvement and assurance and that service user and carer perspectives are at the centre of the Trust's quality assurance framework. A number of committees/groups report to the Quality Assurance Committee such as the Medicines Management Committee, Infection Control Committee, Safeguarding Adults and Children and Psychological Therapies Governance Committee, among others. These groups regularly meet to discuss risks in their specific areas. The Service User Safety Group has a particular role in reviewing risks to the safety of service users, staff and the public.

Finance and investment committee

The Finance and Investment Committee is a committee of the Board of Directors which provides assurance on the management of the Trust's finances and financial risks. This Committee is also chaired by a Non-Executive Director.

Remuneration and nominations committee

The Remuneration and Nominations Committee is a committee of the Board of Directors and is chaired by the Chair of the Trust and comprises Non-Executive Directors. The Chief Executive attends the meetings in an advisory capacity, except where he has an interest in matters to be discussed by the Committee. The Committee makes recommendations to the Board on the composition, balance, skill mix and succession planning of the Board, as well as advising on appropriate remuneration and terms and conditions of service of the Chief Executive, Executive and Associate Directors.

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 Executive Director of Nursing and Integrated Governance has executive responsibility for risk and governance.

Operational governance groups

12 operational governance groups report to the Executive Directors' Group:

- Business Planning Group
- Quality Improvement Group
- HR and Workforce Group
- Operational Delivery Group
- Strategic Development Forum
- Health and Safety Committee
- Service User Safety Group
- BME Strategy Group
- Mental Health Act Group
- Policy Governance Group
- Information Governance Steering Group
- Research and Development Group.

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

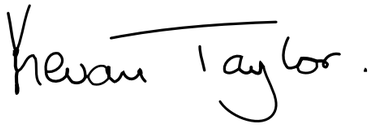
The HR and Workforce Group, Business Planning Group, Health and Safety Committee, Service User Safety Group, Operational Delivery Group and the Information Governance Steering Group cover relevant aspects of risk. For example, the HR and Workforce Group considers staff-related risks such as the Trust's response to staff sickness rates; information security risks are monitored through 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.

From the reports and information provided across the organisation to the various governance groups, I am satisfied that the system of internal control is effective and supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets.

Conclusion

In my opinion, no significant control issues have been identified for the period 1st April 2011 to 31st March 2012.



Kevan Taylor

Chief Executive

Date: 30 May 2012

14.0 Auditor's report

Independent auditor's report to the 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 2012 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:

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes; and
- the disclosure of the median remuneration of the reporting entity's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director.

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. In addition, I read all the financial and non-financial 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 31 March 2012 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 report to you if, in my opinion, the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

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.

Damian Murray

Officer of the Audit Commission
3 City Leeds Office Park
Holbeck, Leeds, LS11 5BD

30 May 2012

15.0
Annual accounts

Annual accounts

Director of Finance's Introduction to the Accounts

2011/2012 was the final year in the first three full years of being a Foundation Trust and the financial plan agreed by Monitor (the Independent Regulator) which was part of the Foundation Trust application process. I am pleased to say that the effort and work which went into both developing and delivering this three year plan by all staff has been excellent, with only one significant deviation from our intended aims and objectives.

We have had some difficulties in achieving our recurrent savings programme and this has left a legacy of around £1m not achieved. This will need to be carried over into the 2012/2013 plan. In order to meet the savings non-recurrently we have needed to keep a tight rein on vacancies as they arise, however, the result has not materially affected our contracted targets with Commissioners and staff have worked within these constraints to deliver the required savings. This has allowed the Trust to achieve a further surplus which can be used over the next year or so to fund major and fundamental service changes which we have embarked upon, including amongst others Adult Services, Community Mental Health Teams and the Acute Care Reconfiguration.

The financial problems facing the NHS and the world economy in general will become increasingly more challenging and it is especially pleasing to see that we have achieved our targets for this year and as stated above this is due to the hard work of all budget managers and their staff, supported by the Finance Team and other Corporate Services.

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

- achievement of planned surplus of £1,990,930
- delivery of EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation)
- delivery of planned financial rating with the Independent Regulator, Monitor of Level 4
- an expectation that the Trust will pay its non-NHS creditors within 30 days.

We have been accumulating our annualised capital funding (cash) and maintaining the interest receipts on deposits of cash where possible from the money we have received from the sale of properties. This has been a deliberate intention until we review our estate and produce a new Estate Strategy which will take account of the Acute Care Reconfiguration previously mentioned. We have, however, committed funding for a replacement building for the Learning Disability Intensive Support Service (formerly Assessment Treatment Unit). The new build is planned for completion in 2012/2013 at a cost of approximately £3m and will be the first new build for the Trust in over 15 years.

Capital funding has also been used to ensure we maintain our IT infrastructure as the investment in this area over the coming years is vital as we endeavour to achieve further savings imposed by Government.

In order for the Trust to ensure targets are met in accordance with our plans, there are a number of mechanisms used. These include the following high level processes:

- monthly finance and activity performance reports to the Board of Directors
- quarterly report to Monitor on the Trust's performance
- external and Internal Audits of our systems and processes as well as a detailed audit of the Annual Accounts to ensure they represent a trust and fair view of our finances
- risk Register review by Audit & Assurance Committee to ensure we are managing key risks
- regular budget manager meetings to ensure variances to budgets are understood and managed.

Each year becomes increasingly more difficult to achieve the level of savings and efficiencies required by the Government. This is further complicated when the local Commissioners (including the Local Authority) are also facing significant funding reductions. In order to ensure we are able to maintain our financial ratings and still maintain quality of services, will require significant planning and changes to what we all do and how we do it. This is no easy feat.

In order to deliver what is required of us, we will need to have robust future plans in order to assure the Commissioner and the public that we are doing our best. This is not going to be easy – the coming years will see unprecedented financial demands and will still be expected to deliver agreed targets, which will be negotiated with Commissioners. What is vitally important is to continue to deliver the quality of service expected by the public we serve.

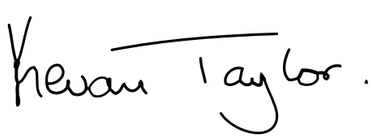
M. J. Rodgers

Executive Director of Finance/Deputy Chief Executive

Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts for the year ended 31 March 2012 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.



Kevan Taylor

Chief Executive (as Accounting Officer)

Date: 30th May 2012

Statement of comprehensive income for the year ended 31 March 2012

	NOTE	2011/12 £'000	2010/11 £'000 Restated
Operating income	3	**122,547**	117,110
Operating expenses	4	**(118,466)**	(112,737)
Operating surplus		**4,081**	4,373
Finance costs:			
Finance income	6	**101**	72
Public dividend capital dividends payable		**(2,191)**	(2,109)
Net finance costs		**(2,090)**	(2,037)
SURPLUS FOR THE YEAR		**1,991**	2,336
Other comprehensive income			
Impairments (losses)		**(19)**	(76)
Revaluation gains / (losses)		**258**	(94)
Actuarial (losses) on defined benefit pension schemes		**(41)**	(399)
Other reserve movements		**0**	25
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**2,189**	1,792

The notes on pages 193 to 230 form part of these accounts.
All revenue and expenses are derived from continuing operations.

Statement of financial position as at 31 March 2012

	NOTE	31 March 2012 £'000	31 March 2011 £'000 Restated
Non-current assets			
Intangible assets	8	**15**	-
Property, plant and equipment	9	**55,342**	56,500
Investment property	10	**200**	200
Trade and other receivables	12	**2,921**	2,186
Total non-current assets		**58,478**	58,886
Current assets			
Inventories	11	**163**	199
Trade and other receivables	12	**3,798**	3,054
Non-current assets held for sale	14	**-**	174
Cash and cash equivalents	13	**17,028**	14,689
Total current assets		**20,989**	18,116
Total assets		**79,467**	77,002
Current liabilities			
Trade and other payables	15	**(4,910)**	(5,199)
Taxes payable	15	**(2,013)**	(1,894)
Provisions	18	**(201)**	(379)
Other liabilities	16	**(204)**	(350)
Total current liabilities		**(7,328)**	(7,822)
Non current assets plus net current assets		**72,139**	69,180
Non-current liabilities			
Provisions	18	**(392)**	(425)
Other liabilities	16	**(2,714)**	(1,911)
Total non-current liabilities		**(3,106)**	(2,336)
Assets less liabilities		**69,033**	66,844
Financed by taxpayers' equity:			
Public dividend capital		**33,572**	33,572
Revaluation reserve		**18,523**	18,600
Donated asset reserve		**-**	-
Income and expenditure reserve		**16,938**	14,672
Total taxpayers' equity		**69,033**	66,844

The financial statements on pages 188 to 230 were approved by the Board on 30th May 2012 and signed on its behalf by:

Signed: Kevan Taylor . **(Chief Executive)** **Date: 30th May2012**

Statement of changes in taxpayers' equity

Changes in taxpayers' equity for 2011-12	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income & expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2011	33,572	18,600	-	14,672	**66,844**
Surplus for the year	-	-	-	1,991	**1,991**
Impairments on Property, Plant and Equipment	-	(19)	-	-	**(19)**
Revaluations on Property, Plant and Equipment	-	258	-	-	**258**
Actuarial gains/(losses) on defined benefits pension scheme	-	-	-	(41)	**(41)**
Other reserve movements	-	(316)	-	316	**-**
Taxpayers' equity 31 March 2012	33,572	18,523	-	16,938	**69,033**

Changes in taxpayers' equity for 2010-11	Public dividend capital £000	Revaluation reserve £000	Donated asset reserve £000	Income & expenditure reserve £000	Total £000 Restated
Taxpayers' equity at 1 April 2010	33,572	18,552	626	11,843	**64,593**
Prior year adjustment	-	500	(626)	585	**459**
Surplus for the period	-	-	-	2,336	**2,336**
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)	-	307	**25**
Taxpayers' equity at 31 March 2011	33,572	18,600	-	14,672	**66,844**

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

Statement of cash flows for the year ended 31 March 2012

	NOTE	2011/12 £000	2010/11 £000 Restated
Cash flows from operating activities			
Operating surplus		**4,081**	4,373
Depreciation and amortisation		**2,075**	2,043
(Increase)/decrease in trade and other receivables		**(1,479)**	2,732
(Increase)/decrease in other assets		**174**	(174)
(Increase)/decrease in inventories		**36**	(17)
Increase/(decrease) in trade and other payables		**(170)**	(982)
Increase/(decrease) in other liabilities		**657**	(1,338)
Increase/(decrease) in provisions		**(211)**	108
Other movements in operating cash flows		**(166)**	(293)
Net cash generated from operations		**4,997**	6,452
Cash flows from investing activities			
Interest received		**94**	67
Payments for intangible assets		**(15)**	0
Purchase of property, plant and equipment		**(678)**	(701)
Profit from disposal of property, plant and equipment		**73**	7
Net cash generated from/(used in) investing activities		**(526)**	(627)
Cash flows from financing activities			
PDC dividends paid		**(2,132)**	(2,117)
Net cash generated (used in) financing activities		**(2,132)**	(2,117)
Net increase in cash and cash equivalents		**2,339**	3,708
Cash and cash equivalents at 1 April 2011/1 April 2010		**14,689**	10,981
Cash and cash equivalents at 31 March	13	**17,028**	14,689

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *2011/12 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 the 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 www.nhsba.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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 31 March 2004 and covered the period from 1 April 1999 to that date. The notional deficit of the scheme at the 2004 valuation was £3.3 billion. However, the conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

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

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

b) Accounting valuation

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

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary.

At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2012 with summary global member and accounting data.

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

Local government pension scheme

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

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

The terms of the current partnership agreement with Sheffield City Council ('the Council') provide that any long-term pension liability arising from the scheme will be funded by the Council, with the exception of any pension changes which relate to salary increases in excess of any local government grading agreements. The impact on current and prior year Statement of Comprehensive Income and Statement of Changes in Taxpayers' Equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is mostly negated by the inclusion of a corresponding non-current receivable with the Council. As at 31 March 2012, the deficit on the scheme was **£2,714,000** (31 March 2011 - £1,911,000), which is offset by a non-current receivable of **£2,388,000** (31 March 2011 - £1,624,000). 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

In accordance with the *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. 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. As the Trust has no current or prior year impairments of this type, no adjustment is required.

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, government grant and other grant-funded assets

Donated and grant-funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant-funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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
- 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 and other grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a Government grant is used to fund expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

During 2011/12 no government grants or other grants were received.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First in First Out (FIFO) method.

1.9 Financial instruments, financial assets and financial liabilities

Recognition

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

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

De-recognition

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

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other Financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the next carrying amount of the financial asset.

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 cashflows of the asset.

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

The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.10 Leases

Finance leases

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% in real terms, except for early retirement provision and injury benefit provisions which both use the HM Treasury's discount rate of 2.8% (2.9% 2010/11) in real terms. The Trust does not discount any provisions.

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. As at 31st March 2012 the Trust has no contingent assets.

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 Trust's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust, being Sheffield Care Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded 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, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks.

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 that have been issued but have not yet been adopted

A number of standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted. We have considered each of these and have concluded that none will have a material impact on the Trust.

1.20 Critical judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts

of assets and liabilities that are not readily apparent from other sources. The Trust confirms that it has not used any key assumptions concerning the future or had any key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year that need to be disclosed under IAS1.

The main area of estimation uncertainty within the Trust is the carrying value of the property portfolio and the assumptions used in the determination of fair value at the Statement of Financial Position date. In accordance with Trust policy, a property valuation is commissioned every five years with interim valuations every third year. The revaluations are undertaken by professional valuers and significantly reduce the risk of material misstatement. The last revaluation took place on 1st April 2009, and an interim revaluation is due 1st April 2012.

Provisions have been calculated having recognised an obligating event during the year and include estimates and assumptions relating to the carrying amounts and timing of the anticipated payments. The litigation provisions are based on estimates from the NHS Litigation Authority and the injury benefit provisions on figures from NHS Pensions.

A further area where estimation is required relates to the net liability to pay pensions in respect of the staff who transferred to the Trust from Sheffield City Council. This estimation depends on a number of complex judgements relating to the discount rate used, the rate at which salaries are projected to increase, changes in the retirement ages, mortality rates and expected returns on pension fund assets. A firm of consulting actuaries is engaged by the South Yorkshire Pensions Authority to provide the Trust with expert advice about the assumptions to be applied.

1.21 Prior period adjustments

In line with Treasury-wide changes in accounting policy and the FT Annual Reporting Manual the Trust made prior year adjustments in respect of donated assets and government grants. The adjustments reflect a change in the interpretation of IAS20 and the new policy was applied retrospectively to 2010/11, in accordance with IAS8.

The donated asset reserve has been analysed between amounts representing the remaining historic cost of the original donated asset and the amounts representing the cumulative net revaluation gains. The net revaluation gains were transferred to the revaluation reserve and the historic cost balance to the income and expenditure reserve.

The government grant balances were transferred to the income and expenditure reserve in accordance with the FT Annual Reporting Manual.

1.22 Merger accounting and transforming community services

On 1st April 2011 a range of services transferred from Sheffield Primary Care Trust under the 'Transforming Community Services' initiative. The Department of Health obtained a one year departure from the application of full merger accounting. The departure relates only to the comparatives for 2010/11 and means that the comparatives do not have to be completed on a merger accounting basis. We have followed this agreed guidance in 2011/12.

Opening balances were not restated, as the net difference was £14,000 which was not considered material. No land or buildings were transferred to the Trust as it was agreed in the 'Business Transfer Agreement' that the transfer of property is planned to take place in 2012/13, subject to Department of Health direction. Our accounting treatment is consistent with the Sheffield Primary Care Trust, as the PCT has retained the closing balances for the TCS functions in its opening PCT balance sheet.

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:

	2011/12 £000	2010/11 £000
Income from patient care activities		
Cost & volume income	**2,986**	0
Block contract income	**76,026**	73,837
Clinical partnerships providing mandatory services (including Section 31 agreements)	**5,520**	6,105
Clinical income for the secondary commissioning of mandatory services	**11**	11
Other clinical income from mandatory services	**2,418**	626
	86,961	80,579
Other operating income		
Research and development	**540**	740
Education and training	**6,216**	6,456
Charitable and other contributions to expenditure	**-**	-
Non-patient care services to other bodies	**27,149**	28,446
Other income	**592**	501
Profit on disposal of other tangible fixed assets	**2**	8
Gain on disposal of assets held for sale	**71**	-
Income in respect of staff costs where accounted for on a gross basis	**1,016**	380
	35,586	36,531
Total operating income	**122,547**	117,110

Income is almost totally from the supply of services. Income from the sale of goods is immaterial.

On 1st April 2011 a range of services transferred to the Trust from NHS Sheffield PCT under the national Transforming Community Services (TCS) policy direction. This transfer increased the Trust's operating income by £8.1m. Other changes in income have however reduced the net increase in operating income to £5.4m.

3.2 Private patient income

The Trust has no private patient income.

3.3 Operating lease income

Rental income from operating leases:	**2011/12 £000**	2010/11 £000
Rents recognised as income in period	**33**	33

Future minimum lease payments due:	**2011/12 £000**	2010/11 £000
Receivable on leases of buildings expiring:		
Not later than one year	**13**	13
Later than one year and not later than five years	**50**	50
Later than five years	**-**	-

3.4 Operating income by type comprises:

	2011/12 £000	2010/11 £000
Income from patient care activities		
NHS foundation trusts	**47**	8
NHS trusts	**1**	-
Primary care trusts	**80,500**	74,463
Local authorities	**5,520**	6,105
Non-NHS: Other	**893**	3
	86,961	80,579
Other operating income		
Research and development	**540**	740
Education and training	**6,216**	6,456
Charitable and other contributions to expenditure	**-**	-
Non-patient care services to other bodies	**27,149**	28,446
Income in respect of staff costs where accounted for on a gross basis	**1,016**	380
Other income	**592**	501
	35,513	36,523
Total operating income	**122,474**	117,102
Profit on disposal of plant and equipment	**2**	8
Gain on disposal of assets held for sale	**71**	-
Total income	**122,547**	117,110

4. Operating expenses

4.1 Operating expenses comprise:

	2011/12 £000	2010/11 £000
Services from NHS foundation trusts	**1,216**	750
Services from NHS Trusts	**-**	2
Services from PCTs	**864**	58
Services from other NHS bodies	**-**	25
Purchase of healthcare from non-NHS bodies	**98**	370
Employee expenses - Executive directors	**796**	759
Employee expenses - Non-executive directors	**99**	98
Employee expenses - staff	**99,444**	93,977
Drug costs	**1,390**	1,704
Supplies and services - clinical (excluding drug costs)	**1,357**	1,312
Supplies and services - general	**1,090**	1,015
Establishment	**2,478**	2,407
Research and development	**66**	283
Transport	**539**	619
Premises	**4,615**	4,774
Increase / (decrease) in provision for impairment of receivables	**(1)**	(3)
Depreciation on property, plant and equipment	**2,075**	2,043
Audit fees: statutory audit *	**65**	63
Other auditors remuneration: Other services	**-**	16
Clinical negligence	**261**	245
Losses on disposal of property, plant & equipment	**-**	1
Legal fees	**121**	234
Consultancy costs	**286**	441
Training, courses and conferences	**507**	657
Patient travel	**106**	151
Car parking and security	**71**	5
Hospitality	**-**	1
Redundancy	**-**	57
Insurance	**121**	82
Losses and ex gratia payments	**47**	40
Other	**755**	551
	118,466	112,737

* There is no limit on Auditors' liability.

On 1st April 2011 a range of services transferred to the Trust from NHS Sheffield PCT under the national Transforming Community Services (TCS) policy direction. This transfer increased the Trust's operating expenses by £7.8m. This increase is offset by other expenditure reductions due to income losses and efficiency savings.

4.2 Operating leases

4.2.1 Payments recognised as an expense

	2011/12 £000	2010/11 £000
Minimum lease payments	**707**	710

4.2.2 Future minimum lease payments

	2011/12 £000	2010/11 £000
Payable:		
Not later than one year	**597**	711
Later than one year and not later than five years	**1,348**	1,805
Later than five years	**8,432**	12,232
	10,377	14,748

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 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

	2011/12 £000	2010/11 £000 Restated
Salaries and wages	**81,725**	78,111
Social security costs	**6,081**	5,822
Employer contributions to NHS pension scheme	**9,279**	8,809
Termination benefits	**446**	57
Agency / contract staff	**2,746**	1,994
	100,277	94,793

The above figure of £100,277 is net of the amount of £37K in respect of capitalised salary costs included in fixed asset additions. No other employee benefits were provided to staff other than those disclosed above in 2011/12 (the year ended 31 March 2010 - £nil).

5.2 Average number of people employed

	2011/12 Number	2010/11 Number
Medical and dental	**151**	135
Administration and estates	**542**	500
Healthcare assistants and other support staff	**176**	190
Nursing, midwifery and health visiting staff	**1,296**	1,256
Scientific, therapeutic and technical staff	**377**	348
Social care staff	**134**	143
Bank and agency staff	**64**	58
Other	**6**	6
	2,746	2,636

On 1st April 2011 a range of services transferred to the Trust from NHS Sheffield PCT under the Transforming Community Services (TCS) policy direction. The figures for 2011/12 include a total of 188 people relating to this transfer.

5.3 Early retirements due to ill-health

During 2011/12 there was 1 (year ended 31 March 2011 - 2) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £33,000 (year ended 31 March 2011 - £124,000). 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.

5.4 Exit packages

The table below summarises the total number of exit packages agreed during 2011/12. Included within these are compulsory redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications.

Exit package cost band	**Number of Compulsary redundancies**	**Number of Other departures agreed**	**Toal number of exit packages by cost band**
<£10,000	0 (0)	2 (0)	**2(0)**
£10,000 - £25,000	0 (0)	4 (0)	**4 (0)**
£25,001 - £50,000	0 (0)	8 (0)	**8 (0)**
£50,001 - £100,000	0 (1)	1 (0)	**1 (1)**
£100,000 -150,000	0 (0)	0 (0)	**0 (0)**
Total number of exit packages by type	**0 (1)**	**15 (0)**	**15 (1)**
Total resource cost	**0 (57,187)**	**446,188 (0)**	**446,188 (57,187)**

Figures in brackets relate to last year

5.5 Directors' remuneration

Name and title	Period 1.4.11 to 31.3.12				Period 1.4.10 to 31.3.11			
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Employer National Insurance Contributions (rounded to the nearest £000)	Employer Superannuation Contributions (rounded to the nearest £000)	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Employer National Insurance Contributions (rounded to the nearest £000)	Employer Superannuation Contributions (rounded to the nearest £000)
Prof. A Walker, Chairman	25 - 30	-	3	-	25 - 30	-	3	-
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	-	10 - 15	-	1	-
M Thomas - Non Executive Director	10 - 15	-	1	-	10 - 15	-	1	-
S Rogers - Non-Executive Director	10 - 15	-	1	-	10 - 15	-	1	-
K Taylor, Chief Executive	135 - 140	-	17	19	130 - 135	-	15	18
M Rodgers, Deputy Chief Executive / Executive Director of Finance	105 - 110	-	13	15	105 - 110	-	12	15
Dr T Kendall, Executive Medical Director	60 - 65	125-130	23	21	60 - 65	125-130	22	21
C Clarke, Executive Director of Operations and Social Care	100 - 105	-	12	14	100 - 105	-	11	15
L Lightbown, Executive Director of Governance, Performance and Nursing	100 - 105	-	12	14	80 - 85	-	8	12

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. The aggregate of remuneration received by executive directors is £635,000. There are 5 executive directors who benefit from the NHS defined benefit pension scheme. The total employer contributions paid to the NHS pension scheme in respect of these directors is £84,000

6. Finance income

	2011/12 £000	2010/11 £000
Interest income:		
Bank accounts	**101**	72
Other loans and receivables	**-**	-
Total	**101**	72

7. Finance costs

The Trust did not incur any interest expense in 2011/12 (year ended 31 March 2011 - £nil).

In addition, no payments were made during 2011/12 under The Late Payment of Commercial Debts (Interest) Act 1998 (year ended 31 March 2010 - £nil).

8. Intangible assets

	Computer software - purchased	
	2011/12 £000	2010/11 £000
Gross cost at 1 April 2011/1 April 2010	**8**	8
Additions	**15**	-
Disposals	**-**	-
Gross cost at 31 March	**23**	8
Amortisation at 1 April 2011/1 April 2010	**8**	8
Disposals	**-**	-
Amortisation at 31 March	**8**	8
Net book value - opening		
At 1 April 2011/1 April 2010	**-**	-
Net book value - closing		
At 31 March	**15**	-

9. Property, plant and equipment

2011/12:	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Cost or valuation at 1 April 2011	9,034	49,045	531	949	447	1,832	140	61,978
Additions purchased	-	-	589	17	63	-	9	678
Impairments charged to revaluation reserve	-	(19)	-	-	-	-	-	(19)
Reclassifications	-	335	(742)	-	-	407	-	-
Revaluation surpluses	-	222	-	-	-	-	-	222
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28)	(183)	-	(211)
At 31 March 2012	**9,034**	**49,583**	**378**	**966**	**482**	**2,056**	**149**	**62,648**
Depreciation at 1 April 2011	-	3,364	-	448	249	1,307	110	5,478
Provided during year	-	1,708	-	103	60	191	13	2,075
Reversal of Impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	-	-	-	-	-	-	-	-
Revaluation surpluses	-	(36)	-	-	-	-	-	(36)
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28)	(183)	-	(211)
Depreciation at 31 March 2012	**-**	**5,036**	**-**	**551**	**281**	**1,315**	**123**	**7,306**
Net book value								
Purchased	9,034	45,077	531	501	198	525	30	55,896
Donated	-	604	-	-	-	-	-	604
Total at 1 April 2011	**9,034**	**45,681**	**531**	**501**	**198**	**525**	**30**	**56,500**
Net book value								
Purchased	9,034	43,964	378	415	201	741	26	54,759
Donated	-	583	-	-	-	-	-	583
Total at 31 March 2012	**9,034**	**44,547**	**378**	**415**	**201**	**741**	**26**	**55,342**
Analysis of property, plant and equipment - net book value			-	-				
Protected	4,525	33,335			-	-	-	37,860
Unprotected	4,509	11,212	378	415	201	741	26	17,482
Total at 31 March 2012	**9,034**	**44,547**	**378**	**415**	**201**	**741**	**26**	**55,342**

No assets were held under finance leases or hire purchase contracts as at 31 March 2012

Prior year:

2010/11:	Land £000	Buildings £000	Assets under construction £000	Plant and machiner £000	Transport equipment £000	Information technology £000	Furniture and 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 period	-	1,689	-	96	58	188	12	2,043
Impairments charged to revaluation reserve	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-
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	198	198	525	30	55,896
Donated	-	604	-	-	-	-	-	604
Total at 31 March 2011	**9,034**	**45,681**	**531**	**198**	**198**	**525**	**30**	**56,500**
Analysis of property, plant and equipment - net book value							-	39,096
Protected	4,526	34,570	-	-	-	-	30	17,404
Unprotected	4,508	11,111	531	198	198	525	**30**	**56,500**
Total at 31 March 2011	**9,034**	**45,681**	**531**	**198**	**198**	**525**	**30**	**56,500**

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 2012 £000	31 March 2011 £000
As at 1 April 2011 / 1 April 2010	**200**	200
Acquisitions in year	-	-
Impairments recognised in expenses	-	-
	-	-
As at 31 March	**200**	200

10.2 Investment property expenses

	2011/12 £000	2010/2011 £000
Direct operating expense arising from investment property generating rental income in the year	**13**	18

10.3 Investment property income

	2011/12 £000	2010/11 £000
Investment property income	**33**	33

11. Inventories

11.1 Inventories

	31 March 2012 £000	31 March 2011 £000
Consumables	**163**	199

11.2 Inventories recognised in expenses

	2011/12 £000	2010/11 £000
Inventories recognised as an expense in the period	**1,794**	2,126
Write-down of inventories (including losses)	**7**	6
	1,801	2,132

12. Trade and other receivables

12.1 Trade and other receivables

	Current		**Non-current**	
	31 March 2012 £000	31 March 2011 £000 Restated	**31 March 2012 £000**	31 March 2011 £000
NHS receivables	**1,362**	1,192	**281**	305
Other receivables with related parties	**248**	429	**2,388**	1,624
Provision for impaired receivables	**(18)**	(19)	**-**	-
Prepayments	**468**	313	**252**	257
Accrued income	**1,357**	697	**-**	-
Interest receivable	**11**	4		
PDC receivable	**-**	55	**-**	-
VAT receivable	**65**	159	**-**	-
Other receivables	**305**	224	**-**	-
	3,798	3,054	**2,921**	2,186

The figure at 31 March 2012 includes trade and other receivables in respect of TCS balances, amounting to just under £0.3 million.

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 2012 £000	31 March 2011 £000
Over six months	**18**	19
	18	19

12.3 Receivables past their due date but not impaired

	31 March 2012 £000	31 March 2011 £000
By 0 - 30 days	**174**	346
By 30 - 60 days	**82**	132
By 60 - 90 days	**58**	17
By 90 - 180 days	**20**	9
Over 180 days	**50**	91

12.4 Provision for impairment of receivables

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April 2011/1 April 2010	**19**	22
Increase in provision	**-**	-
Unused amounts reversed	**(1)**	(3)
Balance at 31 March	**18**	19

13. Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April 2011/1 April 2010	**14,689**	10,981
Net change in year	**2,339**	3,708
Balance at 31 March	**17,028**	14,689
Made up of		
Cash at commercial banks and in hand	**106**	61
Cash with the Government Banking Service	**4,285**	5,130
Other current investments	**12,637**	9,498
Cash and cash equivalents as in statement of financial position	**17,028**	14,689

14. Non-current assets held for sale

Current year: 2011/12	Property, plant and equipment £000	Other assets £000	Total £000
As at 1 April 2011	174	-	**174**
Assets classified as available for sale in the year	-	-	**-**
Assets sold in year	(174)	-	**(174)**
Impairment of assets held for sale	-	-	**-**
As at 31 March 2012	-	-	**-**

Prior 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**

At 31 March 2012 there were no properties declared surplus to operational requirements.

15. Trade and other payables

	Current	
	31 March 2012 £000	31 March 2011 £000
NHS payables	**135**	305
Amounts due to other related parties	**1,250**	1,107
Trade payables - capital	**52**	165
Other trade payables	**778**	779
Other payables	**-**	-
Accruals	**2,691**	2,843
PDC dividend payable	**4**	-
Total excluding taxes	**4,910**	5,199
Taxes payable	**2,013**	1,894
	6,923	7,093

The figure (excluding taxes) at 31st March 2012 uncludes trade and other payables in respect of TCS balances, amounting to just over £0.3 million.

The taxes at least 31st March 2012 includes £0.1 million in respect of TCS balances.

16. Other liabilities

	Current		Non-current	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Deferredincome	**204**	350	**-**	-
Net pension scheme liability	**-**	-	**2,714**	1,911
	204	350	**2,714**	1,911

17. Prudential borrowing limit

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

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

Further information on the *NHS Foundation Trust Prudential Borrowing Code* and *Compliance Framework* can be found on the website of Monitor, the independent Regulator of Foundation Trusts.

The Trust's prudential borrowing limit is:

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Total long-term borrowing limit set by Monitor	**23,500**	21,600
Working capital facility aproved by Monitor	**8,100**	8,100
Total prudential borrowing limit	**31,600**	29,700

Neither of the above facilities was utilised by the Trust in 2011/12 or in the year to 31 March 2011.

The financial ratios for 2011/12 and 2010/11 as published in the Prudential Borrowing Code are shown below, together with the actual level of achievement by the Trust.

Financial ratio	**Actual ratios 2011/12**	**Approved PBL ratios 2011/12**	**Actual ratios 2010/11**	**Approved PBL ratios 2010/11**
Minimum Dividend Cover	3.0	>1x	3.1	>1x
Minimum Interest Cover	-	>3x	-	>3x
Minimum Debt Service Cover	-	>2x	-	>2x
Maximum Debt Service to Revenue	-	<2.5%	-	<2.5%

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 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Legal claims	**95**	100	**-**	-
Injury Benefits	**46**	45	**392**	425
Compromise Agreement	**60**	-	**-**	-
Specialist Registrars		234	**-**	-
Total	**201**	379	**392**	425

	Legal claims	**Injury Benefits**	**Compromise Agreement**	**Specialist Registrars**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2011	100	470	-	234	**804**
Arising during the year	85	14	60		**159**
Used during the year	(74)	(46)		(234)	**(354)**
Reversed unused	(16)	-	-	-	**(16)**
At 31 March 2012	**95**	**438**	**60**	**-**	**593**
Expected timing of cash flows:					
Not later than one year	95	46	60	-	201
Later than one year and not later than five years	-	148	-	-	148
Later than five years	-	244	-	-	244

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 £438,000 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 2011 - £470,000).

There is a Compromise Agreement provision of £60,000 as at 31 March 2012 (31 March 2011 - nil).

Of the total provision of £593,000 (31 March 2011 - £804,000), £314,000 (31 March 2011 - £338,000) has been covered by 'back-to-back' income arrangements with Sheffield Primary Care Trust.

£1,743,000 is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the Trust (31 March 2011 - £1,356,000).

19. Contingent liabilities

	31 March 2012 £000	31 March 2011 £000
Gross value	**(58)**	(127)

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

20 Financial instruments

IFRS 7, 'Financial Instruments: Disclosures', requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the international financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department within the parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling-based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has low exposure to interest rate fluctuations as it has no borrowings and any excess funds are invested on a short-term basis with low risk institutions.

Credit risk

As the majority of the Trust's income comes from contracts with public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2012 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 finances 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 2012 £000	31 March 2011 £000
Denominated in £ sterling - floating interest rate	**17,028**	14,689

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 2012 £000	31 March 2011 £000 Restated
Loans and receivables		
NHS receivables	**1,643**	1,497
Other receivables with related parties	**2,604**	2,031
Provision for irrecoverable debts	**(18)**	(19)
Accrued income	**1,368**	701
Other receivables	**305**	224
Cash at bank and in hand	**17,028**	14,689
	22,930	19,123

20.4 Financial liabilities by category

	31 March 2012 £000	31 March 2011 £000 Restated
Other financial liabilities		
NHS payables	**135**	305
Other payables with related parties	**1,250**	1,107
Trade payables - capital	**52**	165
Other trade payables	**778**	779
Accruals	**2,691**	2,843
Provisions under contract	**60**	234
Total at 31 March	**4,966**	5,433

20.5 Fair values

The fair value of the Trust's financial assets and financial liabilities at 31 March 2012 equates to the book value.

21. Third party assets

The Trust held cash of £3,960,418 at bank and in hand at 31 March 2012 (31 March 2011 - £3,775,994) 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 72 cases (the year ended 31 March 2011 - 45 cases) of losses and special payments totalling £216,000 (the year ended 31 March 2011 - £40,000) approved during the year ended 31 March 2012.

23. Events after the reporting period

At present NHS Sheffield directly commission and pay for mental health individual funding requests with out-of-area and private sector providers for services including mental health beds, locked rehabilitation beds and beds in intensive psychiatric facilities. From 2012/13 this responsibility will transfer to the Trust and the income the Trust receives from NHS Sheffield will increase by just over £3.5m. Expenditure will also increase as the Trust plans to increase the number of beds within the Psychiatric Intensive Care Unit (PICU) to minimise the out-of-town placements for this particular service area. The Trust will also be responsible for the purchase of mental health out-of-town placements for relevant services that cannot be accommodated within the city.

24. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements are:

	31 March 2012 £000	31 March 2011 £000
Property, plant and equipment	**34**	226

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 of organisations with which key employees/directors of the Trust have some form of relationship. These are detailed below:

	Payments to Related Party £000	**Receipts from Related Party £000**	**Amounts owed to Related Party £000**	**Amounts due from Related Party £000**
Sheffield Teaching Hospitals NHS FT	1,539	3,293	498	870
University of Sheffield	571	92	44	6
Royal College of Psychiatrists	16	95	3	4
Turning Point	36	4	-	4
Recovery Enterprises	17	-	-	-

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 Trust Directors is a Trustee of Recovery Enterprises
- One of the non executive 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 organisations concerned and not to the individual officers.

Amounts owed to related parties are unsecured, interest-free and have no fixed terms of repayment. The balances will be settled in cash. No guarantees have been given or received. No provisions for doubtful debts have been raised against amounts outstanding and no expense has been recognised during the period in respect of bad or doubtful debts due from related parties.

The value of the Trust's transactions with related parties during the year is given below:

	2011/12		2010/11	
	Income	**Expenditure**	Income	Expenditure
	£000	**£000**	£000	£000
Department of Health	**106**	**-**	5	1,218
Other NHS bodies	**97,189**	**4,242**	92,429	2,903
Charitable funds	**-**	**-**	40	-
Other bodies (including WGA)	**12,515**	**16,667**	12,459	16,091
	109,810	**20,909**	104,933	20,212

The value of transactions with board members and key staff members in 2011/12 is £nil (2010/11 - £nil). Details of Directors' remuneration and pensions can be found at note 1.2 of the accounts. Disclosures relating to salaries of board members are given in Note 5.5 and details of exit packages in note 5.4. Further details of executive and non executive directors salaries and pensions can be found in the Remuneration Report in the Annual Report.

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 2012		31 March 2011	
	Receivables	**Payables**	Receivables	Payables
	£000	**£000**	£000	£000
Department of Health	**-**	**18**	-	-
Other NHS bodies	**2,743**	**840**	2,233	967
Charitable funds	**-**	**-**	10	-
Other bodies (including WGA)	**3,201**	**3,557**	2,373	3,292

Value of balances (other than salary) with board members and key staff members at 31 March 2012 is £nil (31 March 2011- £nil).

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2012 is £nil (31 March 2011 - £nil). In addition, the value of balances (other than salary) with related parties in relation to the writing off of receivables during 2011/12 is £nil (2010/11 - £nil).

The Department of Health is the Trust's parent body and 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 Healthcare NHS Foundation 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 Business Services Authority

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 loss for 2011/12 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £369,000 (the year ended 31 March 2011 a gain of £282,000). A pension deficit of £2,714,000 is included in the statement of financial position as at 31 March 2012 (31 March 2011 - £1,911,000 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 2012, the deficit on the scheme was £2,714,000 (31 March 2011 - £1,911,000 deficit), the majority of which is offset by a non-current receivable of £2,388,000 (31 March 2011 - £1,624,000).

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 2012	31 March 2011
	%	%
Rate of inflation	**2.5**	3.4
Rate of increase in salaries	**4.25**	4.65
Rate of increase in pensions and deferred pensions	**2.5**	2.9
Discount rate	**4.9**	5.5
Expected rate of return on assets	**0.5 - 7.0**	0.5 - 7.5

The current life expectancies at age 65 underlying the accrued liabilities for the scheme are:

	31 March 2012	31 March 2011
	Years	Years
Non retired member - Male (aged 65 in 20 years time)	**22.8**	22.8
Non retired member - Female (aged 65 in 20 years time)	**25.8**	25.7
Retired member - Male	**21.5**	21.4
Retired member - Female	**24.2**	24.1

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	31 March 2012	**31 March 2012**	Scheme assets	31 March 2011
	%	**£000**	%	£000
Equities	**62.3**	**7,547**	67.4	7,638
Government Bonds	**17.0**	**2,059**	14.6	1,654
Other Bonds	**7.7**	**933**	7.2	816
Property	**9.9**	**1,199**	9.8	1,111
Cash / Liquidity	**3.1**	**376**	1.0	113
Total fair value of assets	**100.0**	**12,114**	100.0	11,332
Present value of defined benefit obligation		**(14,828)**		(13,243)
Net retirement benefit deficit		**(2,714)**		(1,911)

Movements in the present value of the defined benefit obligations are:

	2011/12	2010/11
	£000	£000
At 1 April 2011/1 April 2010	**13,243**	13,413
Current service cost	**357**	437
Interest on pension liabilities	**735**	786
Member contributions	**144**	155
Actuarial (losses) / gains on liabilities	**573**	(404)
Benefits paid	**(245)**	(300)
Past service gain	**-**	(844)
Curtailments	**21**	-
At 31 March	**14,828**	13,243

Movements in the fair value of the scheme's assets were:

	2011/12	2010/11
	£000	£000
At 1 April 2011/1 April 2010	**(11,332)**	(10,293)
Expected return on plan assets	**(744)**	(661)
Actuarial gains / (losses) on assets - current year	**246**	(188)
Employer contributions	**(385)**	(335)
Member contributions	**(144)**	(155)
Benefits Paid	**245**	300
At 31 March	**(12,114)**	(11,332)

The net pension expense recognised in operating expenses in respect of the scheme is:

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Current service cost	**(357)**	(437)
Past service costs	**-**	844
Pension expense gain/(charge) to operating surplus	**(357)**	407
Expected return on plan assets	**744**	661
Interest on pension liabilities	**(735)**	(786)
Effect of curtailments	**(21)**	-
Pension expense credited	**(12)**	(125)
Net pension gain / (charge)	**(369)**	282

The reconciliation of the opening and closing statement of financial position is as follows:

	2011/12	2010/11
	£000	£000
At 1 April 2011/1 April 2010	**(1,911)**	(3,120)
Gains / (Expenses) recognised in the statement of comprehensive income	**(1,188)**	874
Contributions paid	**385**	335
At 31 March	**(2,714)**	(1,911)

Actuarial gains and losses are recognised directly in the Income and Expenditure reserve. However the majority of the gains and losses are covered by the back-to-back agreement with Sheffield City Council (further information is provided at note 1.2). At 31 March 2012, a cumulative amount of £328,000, was recorded in the Income and Expenditure Reserve (31 March 2011 £468,000).

The history of the scheme for the current and prior year is:

	Year ended 31 March 2012	Year ended 31 March 2010
	£000	£000
Present value of defined benefit obligation	**14,828**	13,243
Fair value of scheme assets	**(12,114)**	(11,332)
Net retirement obligation	**2,714**	1,911

Experience gains on scheme liabilities for 2011/12 are £nil (the year ended 31 March 2011 - £15) and experience gains (or loss) on scheme assets are £498 (year ended 31 March 2011 - gain of £188).

16.0 Glossary

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.

Annual Governance Statement

A statement about the controls the FT has in place to manage risk.

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 Value (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

These are assets, which are normally used or disposed of within the financial year.

Current Liabilities

Represents monies owed by the Trust that are due to be paid in less than one year.

Deferred Income

Funding received from another organisation in advance of when we will spend it.

Depreciation

An accounting charge which represents the use, or wearing out, of an asset. The cost of an asset is spread over its useful life.

Donated Asset Reserve

This represents the value of property, plant and equipment which has been, either donated to the Trust, or purchased from donated funds.

EBITDA

Earnings Before Interest, Tax Depreciation and Amortisation – this is a key indicator of financial performance and profitability and indicates the ability to pay the dividends due to the Government in respect of the 3.5% return on assets the Trust is expected to achieve. The EBITDA is used to calculate some of Monitor's risk ratings.

Going concern

The accounts are prepared on a going concern basis which means that the Trust expects to continue to operate for at least the next 12 months.

IFRS (International Financial Reporting Standards)

The professional standards Trusts must use from April 2009 when preparing the annual accounts.

Impairment

A decrease in the value of an asset.

Income and Expenditure Reserve

This is an accumulation of transfers to / from the Revaluation Reserve as well as the cumulative surpluses and deficits reported by the Trust, including amounts brought forward from when it was an NHS Trust.

Intangible asset

An asset which is without substance, for example, computer software.

Inventories

Stocks such as clinical supplies.

Liability

Something which the Trust owes, for example, a bill which has not been paid.

MEA (Modern Equivalent Asset)

This is an instant build approach, using alternative site valuation in some circumstances.

Monitor

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 cashflows 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

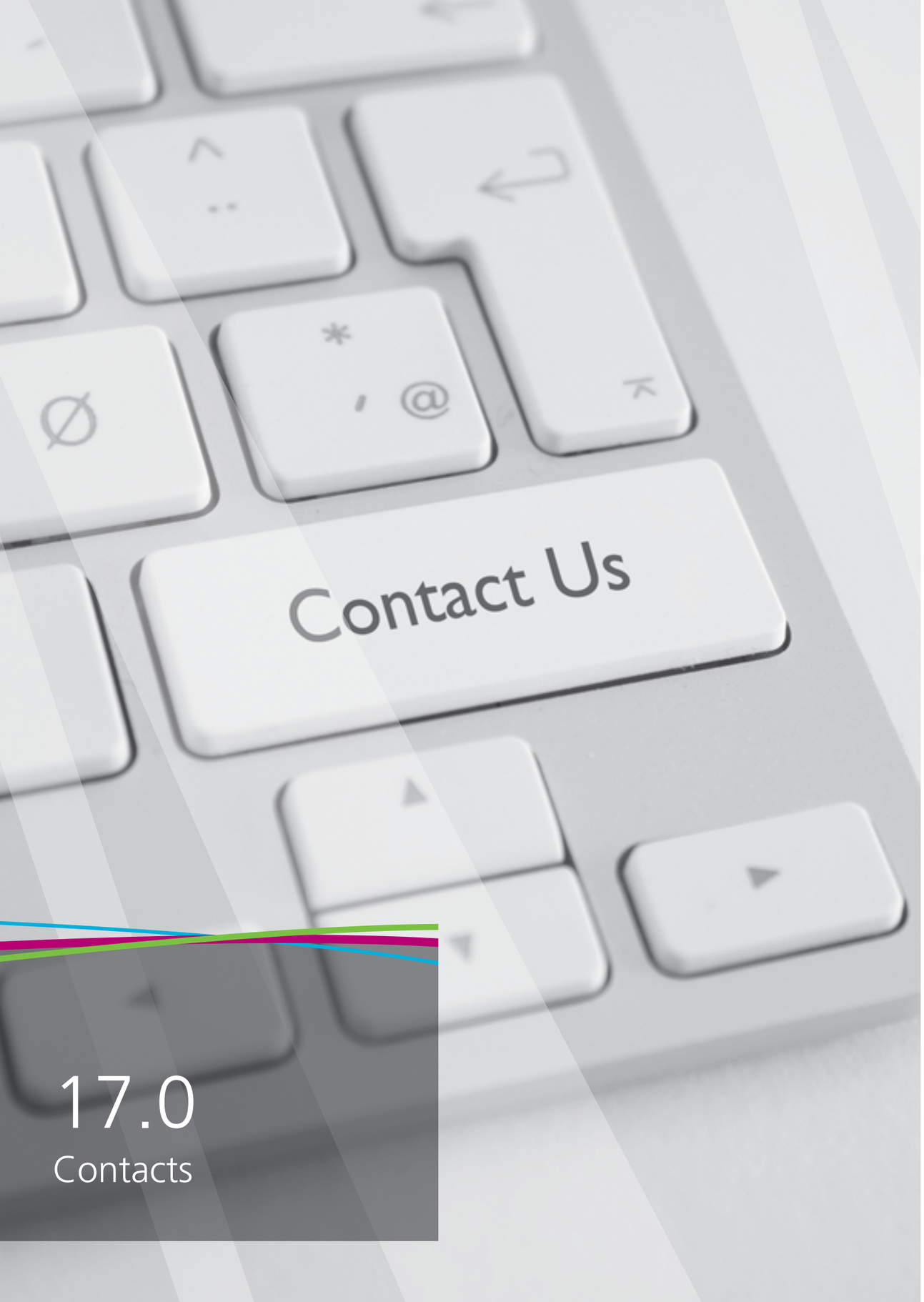
This statement was previously called 'Income and Expenditure Account'. It summarises the expenditure on pay and non-pay running costs less income received, which results in a surplus or deficit.

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.

UK GAAP (Generally Accepted Accounting Practice)

This was the standard basis of accounting in the UK before the international financial reporting standards were adopted.



17.0 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:

Tel: 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**