Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS
2012 – 2013

Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 2012/13

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

Contents

Art room at Moncrieffe Road

SECTION 1.0

About our Trust

1.0 About our Trust

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.

Who we are

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 (SHSC). 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

With an annual income of around £128 million and more than 3,000 members of staff, 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
- Services that support people with a learning disability and their families and carers
- Inpatient mental health services for adults and older people
- Services for people with dementia
- 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

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 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.

Service User artwork

Mick Rodgers' retirement event

SECTION 2.0
Directors' Report

2.0 Directors' Report

2.1 Foundation Trust Chair's statement

It is a great pleasure to introduce Sheffield Health and Social Care NHS Foundation Trust's Annual Report and Accounts for 2012/13. The Trust has now completed five years as an NHS Foundation Trust (FT) and has made further substantial progress towards delivering the improved service user outcomes that were the main reason for applying to become an FT.

I apologise for the fact that this Annual Report is looking more and more like a doorstep as each year passes. However, there are many aspects that we are legally obliged to report on. Also there are numerous excellent service developments that we simply must draw attention to. Please take some time to examine the information summarised here about the Trust's performance (as assessed by external regulators). The overall picture is extremely positive and, in the third quarter of the financial year, SHSC was awarded Monitor's top ratings for both finance and governance.

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 by 2014/15. For SHSC, this means around £16million over this period, or just over £5million per year. The Trust's total annual income for 2012/13 was £128 million 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.

This Annual Report contains a great deal of information about the quality of the Trust's services. To most members this will be the main point of interest and rightly so. SHSC is required to be registered with the Care Quality Commission (CQC) and, unlike some other Trusts, is registered without conditions. During 2012/13 the CQC did not take any enforcement actions against the Trust, nor has it taken part in any special reviews or investigations by the CQC. The CQC does monitor and review the Trust's services as it does for all Trusts. During 2012/13 the CQC visited seven service locations to review their compliance with essential standards of quality and safety. All but one of the services inspected were fully compliant and the exception had two relatively minor compliance actions to address. Action plans were put in place, reviewed by the CQC and full compliance was achieved. During 2012/13 the CQC also undertook nine visits to inspect the delivery of care and treatment to people detained under the Mental Health Act. They review care processes, the environment in which care is delivered and meet privately with inpatients. No undue areas for concern relating to compliance with essential standards have been identified. (There is also a team of Associate Mental Health Act Managers who review the reasons for detention under the Mental Health Act). As noted above, in the third quarter of 2012/13, the FT Regulator Monitor awarded SHSC its top ratings for financial risk and for governance risk.

As a Foundation Trust we are committed to a constant increase in membership and this now totals 12630 excluding staff. The Trust is very keen to hear from and be responsive to its members. This helps us to be responsive to the needs of the communities we serve and to represent those needs to the commissioners of services. Also important is the representation of members provided by the Council of Governors because they speak on behalf of the membership when they contribute to the development of the Trust's plans (and they do so actively). One of the main opportunities for members to interact with Governors is the Annual Members' Meeting, held each September. Last year's meeting again broke previous records with over 280 participants.

Governors play a crucial role in the life of the Trust. They hold the Board of Director's to account for the management of the Trust and the achievement of its objectives, which they also play a big role in setting. We are very fortunate to have a tremendous group of Governors who are all highly committed to the values of the Trust and, especially, to improving the lives of service users and carers. They do criticise the Trust on various fronts but they do so in a very constructive and ultimately supportive way. At its best this is a highly effective partnership and I am proud of the way that SHSC works with its Governors. No praise can do justice to the role that Sam Stoddart plays in achieving this partnership.

During 2012/13 we said goodbye to 11 Governors whose terms of office had expired or who resigned for other reasons. I want to express the thanks of the whole Trust for their contributions to improving the quality of SHSC services.

Also during 2012/13 one of the NHS's and Sheffield's most outstanding health services managers, Mick Rodgers retired after 42 years of service. It is impossible to summarise the immense contribution that Mick made to the NHS in Sheffield as both a manager of Mental Health and Learning Disability Services, and as a Finance Director. He served with distinction in every post he worked in and always put service users and carers first. He ended his NHS career as Finance Director and Deputy Chief Executive. He was crucial in the Trust becoming an FT in 2008. His leaving event was vastly oversubscribed and, as speaker after speaker paid tribute to his professionalism and personal qualities, it was a fitting tribute to this very special person. The history of the NHS in Sheffield will always have to have a chapter devoted to Mick Rodgers. Thousands and thousands of service users, who have never heard of him, have cause to be thankful for the compassion that led Mick into the NHS in the first place and which made him strive constantly to improve services. As a Finance Director he never lost sight of what the finance is for.

During 2012/13 three Non Executive Directors were reappointed following external competition and a competitive selection process. They are Tony Clayton, Sue Rogers and Mervyn Thomas, and they make major contributions to the work of the Trust.

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

There has, understandably, been much concern focused on quality and standards in the NHS and social care following the recent reports on scandals in hospitals and care homes.

SHSC has always kept quality at the heart of what we do, whilst being mindful of balancing the books. Our challenge is to deliver quality services with less money than we have had available to us in the past. Supporting our workforce to help the people we work with is essential. I am confident overall that the quality of our services is good.

We consistently fare very well compared to other organisations in service user surveys, staff attitude surveys and reports from our regulators.

During 2012/13 and previous years, many of our services have been visited and evaluated by the Care Quality Commission. We consistently receive feedback highlighting that the care they observed was person-centred and dignified. When they have identified areas for us to address, we have always taken immediate action. Service user feedback about the support and care we have provided to them has placed us in the top 10% of mental health trusts for the last 2 years for our mental health services. We are proud to be a high performing organisation. We have consistently delivered the national standards asked of us across our services for primary care, learning disabilities, substance misuse and mental health.

National staff surveys highlight that our staff feel more engaged with SHSC than they do in other comparable Trusts. Our staff are also more likely to recommend us as a place to work or receive treatment than the average for the NHS as a whole. I am confident that all our staff come to work wanting to do the best we can for the people we work with. We recognise that every single member of staff has a role to play in the quality of the service user's experience.

Our message to new members of staff for the last ten years has been that all we expect is that they strive to deliver a service they would be happy for their family and loved ones to experience, and to reflect on how it can be improved.

I would like to take this opportunity to thank all staff for their dedication and commitment. I, along with many members of the Board, spend time out and about amongst front line services either just visiting or doing a shift. Your pride in the services you run is evident and very well deserved. It has been a difficult time over the last year for dedicated staff working in public sector services with both the challenging media focus and financial environment. We should continue to focus on the care we provide, the services we deliver and our ongoing drive to continually improve.

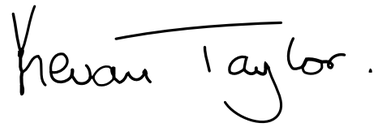
At the end of my statement for last year's Annual Report I said we had made good progress in preparing for changes to improve our services. I am pleased and proud to report, through the rest of this Annual Report, on the real and positive improvements we have made this year.

New services to support older people in a crisis have been introduced, and more people are being supported in the community rather than needing a hospital admission. New liaison services working in partnership with Sheffield Teaching Hospitals NHS FT have been supporting people with dementia to access the right support. Our community mental health teams for working aged adults have been successfully reorganised. We are now seeing more people more quickly than we did before, and supporting most of them to continue with their support in primary care where possible. We have commissioned Rethink to provide a Crisis House service as an alternative to hospital admission, to increase the options for how support is offered to people experiencing a crisis. We have made real progress during the year in reducing significantly our need to send people out of Sheffield to receive hospital care. We have built a new community facility at Firshill Rise, which will significantly improve the quality and experience of care for people with learning disabilities and challenging behaviour. We have developed and introduced innovative tools to significantly increase the provision of basic advice to people about alcohol use.

Whilst service change can be very positive, it can also be unsettling for some. It can create uncertainty for service users and our staff. We recognise this, and the need to ensure we support people through change as much as we can. We will continue to make sure we have a clear and sound basis for the changes we explore for our future. Through making changes however, we can make clear improvements. The service changes I have outlined above, and many more described in this Annual Report, have allowed us to make real improvements in the way we provide our care. Each of them delivers on benefits for the people who use our services and has contributed to improved quality and experiences.

We also know that we do not always get it right. People make mistakes, some services need changing and developing. The key is to have an open culture where people feel able to express their concerns as part of a constructive dialogue. I, as Accountable Officer, and all members of the Board of Directors, see it as a fundamental part of our duty to know what our services are like in respect of safety, effectiveness and experience. The Board has a responsibility to promote an open culture and to listen. I am proud that we report more incidents than many other organisations – that is not a sign that quality is poor, but that staff know that reporting an incident is the right thing to do so that lessons can be learned. It is right that we spend as much time looking at complaints, as we do when things have gone well. People do raise their concerns and we have a duty to listen and respond. Clearly this can create challenges about how we prioritise the steps we need to take. Myself, along with the Board of Directors, are accountable for determining the decisions we take about how we move forward.

And finally, I would like to thank and pay tribute to all the Trust's members, governors and services users who have worked with staff on numerous projects. Your commitment to "giving something back" is one of the most powerful drivers for positive change. Your involvement in this way allows us to be confident that the changes and improvements we make are informed by your views and experiences.



Kevan Taylor

Chief Executive

Common room on Burbage Ward

Turf breaking ceremony for the ISS build

Service User Experience Monitoring Unit event

2.3 The Board of Directors

The Board of Directors provides a wide range of 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 2012/13, the Board of Directors comprised of six Non-Executive Directors, including the Chair, and five Executive Directors, including the Chief Executive.

2.3.1 The Non-Executive Team

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

2.3.2 The Executive Team

At the end of 2012/13 the Executive Team consisted of:

- Kevan Taylor (Chief Executive)
- Clive Clarke (Deputy Chief Executive)
- Professor Tim Kendall (Executive Medical Director)
- Liz Lightbown (Chief Operating Officer/Chief Nurse)
- Paul Robinson (Executive Director of Finance)

During 2012/13 the following also held a position on the Board of Directors:

- Mick Rodgers (Deputy Chief Executive and Executive Director of Finance) retired on the 28th February 2013

Further and more detailed information about the Board of Directors and the changes during 2012/13 can be found in Section 7 of this report.

2.3.3 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.

2.3.4 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.

2.3.5 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.

2.3.6 Our Auditors

External audit services were previously provided to the Trust by The Audit Commission. When this was disbanded in 2012, the staff previously engaged on our contract were transferred to KPMG. Therefore we novated the current contract across to KPMG for the remainder of the contract (until 31st March 2015). The Council of Governors approved the decision, on the basis that it was the best option in terms of providing continuity, and also due to KPMG providing a similar service to the other NHS organisations in Sheffield.

2.4 Operating and Financial Review

2.4.1 An overview of our principle activities

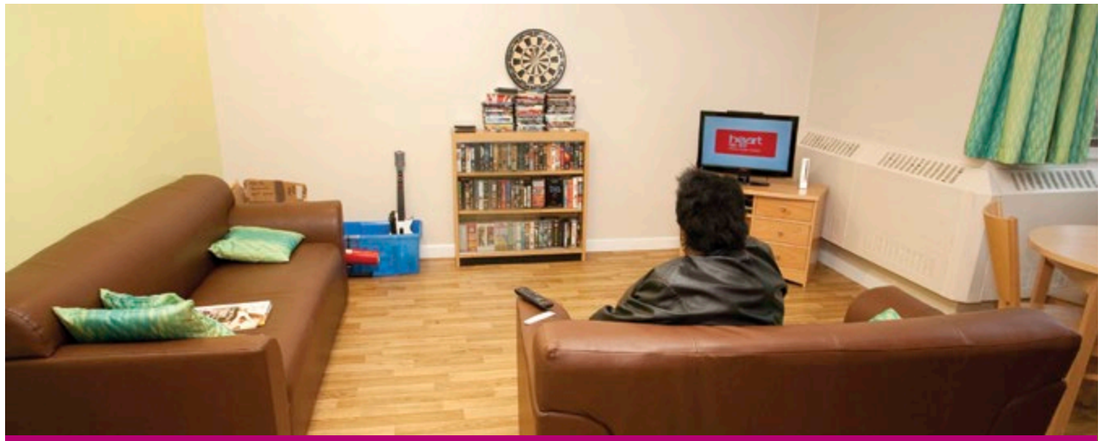
We provide mental health, learning disability, substance misuse, community rehabilitation and primary care services to the people of Sheffield. We also provide some of our specialist services to the wider region. We are a provider of integrated services that meet people's mental, physical, psychological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

2.4.1.1 Acute and Inpatient Directorate

The Acute and Inpatient Directorate manages the inpatient services at the Michael Carlisle Centre at Nether Edge, The Longley Centre on the Northern General Hospital site and the Forest Close site on Middlewood Road. The services included in the directorate provide care and treatment in residential settings for people of all ages with acute mental health problems, those with longer term mental health needs, and also has a number of beds for people in a low-security forensic setting.

2012/13 has seen a number of significant developments and achievements in the directorate which are outlined below:

- In the last year we have taken on the responsibility for commissioning services for people who have been previously managed out of the city. This is providing an opportunity to deliver services closer to home, ensuring high quality standards and saving money to reinvest in mental health provision in Sheffield
- 2012/13 has seen the directorate focus on delivering Respect training for all staff. This training emphasises the importance of staff de-escalating situations and being able to provide safe methods for managing any challenging behaviour. The training has been provided for staff alongside service users who have contributed to the planning and delivery of the training. The feedback from staff who have participated in the training has been very positive. There has been an overall reduction in the use of seclusion for service users since this training has been delivered. This is part of the directorate's focus on delivering compassionate care for all the people who use our inpatient wards
- The focus on enhancing the compassionate care we deliver in the year ahead will continue to be paramount to the services we deliver. We will continue to develop the support and supervision we offer to all staff, the directorate will build on developments in psychology in the last year to ensure that all service users have access to trained psychologists, and we will listen and act on the views of service users and their carers
- Risk assessment and management are key to delivering safe and effective care. The directorate has continued to train all staff in assessing and managing risk. We have reviewed the forms for monitoring risk and planning with the aim that staff only spend the necessary time completing forms to provide effective systems. This has included the implementation of electronic record keeping on all our inpatient wards. The directorate is developing care planning to ensure good engagement of service users with meaningful recovery care plans
- The 22 beds provided at Forest Lodge for low-secure forensic service users have been reviewed as part of the Royal College of Psychiatrists National Accreditation Programme. This external review identified that the service is providing a high standard of care. Forest Lodge is commissioned regionally and has achieved all the quality standards identified through the contract monitoring process



Communal area on Rowan Ward

- The directorate manages beds for rehabilitation and recovery at Forest Close and Pinecroft Ward. These services have continued to provide long term care and have successfully supported service users back into community living.

We have also been working on our Acute Care Reconfiguration project, which has seen progress in the following areas:

- The acute inpatient services are currently undergoing a reorganisation to ensure that we can deliver the highest standard of care and treatment for inpatients. This has already included the review of and changes to the acute care pathway to ensure clear processes from community through to inpatient stay and discharge home for all our service users
- We have started the process of building a new psychiatric intensive care unit that will open in April 2014. The Trust is also reviewing the estate for all the acute inpatient services with a view to providing a high quality environment that we aspire to be at a national benchmark standard
- April 2013 will see the opening of a new Crisis House that has been commissioned by the Trust and is being provided by Rethink. This model of care provides a high quality community alternative to inpatient admission for those service users who require residential care away from home but do not require an admission to hospital.

2.4.1.2 Community Services Directorate

The Community Services Directorate provides community-based services mainly to adults of working age, and during the last year also incorporated the Homeless and Traveller's Service.

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), multi-disciplinary teams made up of health, social care and other allied professionals and support staff. They receive referrals from primary care and other sources, and carry out assessments, provide interventions and care co-ordination for people with complex mental health problems.

We also provide 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 has changing significantly with the introduction of Self-Directed Support (SDS). SDS is 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 SDS process can take time to work through 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.

Homeless and Traveller Health team stand at the Annual Members Meeting

The Directorate also includes primary care-based services such as Improving Access to Psychological Therapies (IAPT) which is aimed at providing time-limited, evidence-based psychological therapies for people suffering from depression and anxiety, through the provision of psychological therapies. Most of the service users seen within the directorate receive treatment from the IAPT service.

During 2012/13, significant service developments have been as follows:

- The Directorate has implemented the reconfiguration of Community Mental Health Teams (CMHTs) which brings together the different elements of community mental health services into a locality based team. As well as making significant financial savings, these changes are designed to enable better access to the service from primary care, and smoother working across acute and community teams. This has been a year of significant change for the teams, and over the next year we will work to evaluate and further embed these changes
- Last year we continued to roll out the Scheduled Care Pathway across all of our adult CMHTs. This provides 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. It will be further developed to take account of SDS and aims to streamline paperwork for front-line staff
- We had a major celebration in January 2013 in aid of the Sheffield Works, a comprehensive pathway combining health and employment interventions supporting unemployed people with severe and enduring mental health conditions to move forwards into work, as part of their recovery. We are also finalising new forward-thinking proposals for Vocational Services that will soon be considered by the Trust's Board of Directors
- The IAPT service was selected this year to be a national pathfinder site for working with patients with long term physical health conditions, or medically unexplained symptoms, as well as depression and anxiety. Depression and anxiety are commonly linked with long term physical conditions, and we know that where people suffer from these problems together, their outcomes are likely to be worse. Therefore, we have been training all of our IAPT staff to better work with this group of patients, and have worked with Health and Medical Psychologists in primary care. This will be evaluated, both locally and nationally, in the next six months, and we will then be looking at the learning from this project as we develop our services in the future
- Our SPACES service has developed a Recovery Education Programme, a 14 week recovery based programme which service users can access either as a stand-alone service or as part of a wider care package. This has generated some excellent service user feedback so far, and the number of people accessing the service continues to grow. We will be working over the next year to develop this further.

As well as the things mentioned above, in the forthcoming year we expect to:

- Facilitate major service user and staff surveys for NHS and social care funded services, as part of actively listening to what our service users and staff tell us
- Increase our focus on national and local quality measures and how we both meet and record them
- Continue to work with the Right First Time Programme, looking at people who suffer from common mental health problems and have long term physical health problems as well, and also looking at the physical health of people who suffer from serious mental illness
- Evaluate recent service developments within the directorate such as the CMHT Reconfiguration
- Seek to expand the Recovery Education Programme within SPACES, a programme that provides short term intensive support for people to get back on track as part of their mental health recovery
- The Specialist Psychotherapy service will be on the move, going from working across three sites (St. Georges, Brunswick House and the Michael Carlisle Centre) to one, as they will all be housed at St. Georges

- Develop provision within our popular mental health respite facility at Wainwright Crescent in light of the new Crisis House opening in Sheffield in spring 2013. This will build on the successful development last year of step-down beds at Wainwright Crescent
- Further implement Self-Directed Support. There are now over 445 people who have an agreed support plan in place and 823 others who have an identified indicative budget and are in the process of developing their support plan. This is a significant increase on what we achieved last year, and well towards our expected number of 1500 people across Sheffield by the 31st March 2016
- Submit a tender for the Mental Health Floating Support Service. This service aims to deliver short term (up to 6 months) intensive support to service users with mental health problems. The support relates to housing issues, to make sure people have sustainable tenancies and includes focusing on crisis situations, hospital discharge etc. This support to clients compliments the work of CMHTs
- Seek to expand the Home Environment Service that helps clients with cleaning support as part of their Recovery, within the Mental Health Floating Support Service.

Beighton Road Learning Disabilities Service

2.4.1.3 Learning Disabilities Directorate

The Learning Disabilities Directorate works in partnership with the Local Authority to provide specialist services as part of the Joint Learning Disabilities Service. The services provided consist of:

- Specialist challenging behaviour and mental health services
- Community multi-disciplinary health support as part of integrated Community Learning Disability Teams
- Accommodation and support services:
  - Nursing and registered care homes in partnership with housing associations
  - Supported living services
  - Tenancy support
- Respite care for people with complex needs, including profound and multiple learning disabilities
- Case Register
- Older Carers Support Service.

The following is a summary of our main activity during the 2012/13 period:

- This year has been a period of considerable change and development for the specialist services – previously the Improving Mental Wellbeing Team, the Community Assessment and Intensive Support Service (CAISS team, for challenging behaviour), and the Assessment and Treatment Unit (ATU). Based on a business case developed to deliver best practice in a new model of community-focussed services, the three services have come together to create the Intensive Support Service (ISS). The focus is on ensuring local capacity to support people with complex needs and maintain provider capability to reduce out of city placements. A new building has been commissioned to replace the current ATU and provide the community base for the ISS, scheduled for opening in May 2013.

  The accommodation services have performed well over the year with all inspected services achieving full compliance with the CQC. They are all part of a commissioning-led reconfiguration programme that is aiming to reduce costs and modernise services. Options are being explored for all these services to enable them to be more personalised, giving people more choice and independence. This will lead to some refurbishments and some restructuring of premises to provide more individualised services. New models of support and staffing structures have been developed and implemented to help meet the aims of the programme, whilst maintaining quality service provision
- New business has been developed to respond to the demand for support for people with complex needs who have personal budgets. We have successfully developed a flexible and responsive service that can provide short or long term support. For example, this has included responding to a crisis need for someone with complex behaviour at risk of having to be placed out of city, as well as long term support for someone coming through the transition from children's to adult's services
- The Community Learning Disability Teams have focussed on developing care and support pathways to ensure effective and timely diagnosis and interventions. These have been completed for dementia, challenging behaviour and autism, with others currently in development, leading to the development of professional practice as well as improved support for carers and providers
- Investment from the PCT to reduce out of city placements has enabled the multidisciplinary Out of City Team to successfully return a number of people with Learning Disabilities to Sheffield. In partnership with the Local Authority, providers have been supported to set up new specialist services for some of the people with the most complex needs. This will be an on-going programme and includes assessing everyone placed out of city and ensuring quality and appropriate services regardless of whether or not they intend to return to the city.

As with the other directorates, we face several current challenges and issues for the future:

- A new requirement for registration with the CQC led to pressures and challenges for some of the services. The premises for the ATU and the specialist respite services based at the Northern General Hospital site were considered insufficient and non-compliant with registration requirements. This was not a new issue and so plans for replacement buildings were already in development and have been accepted by the CQC. The new building for the ISS will bring that service into full compliance, however the solution for the respite service is more elusive and remains a pressure. Active negotiations are underway with potential partners for alternative premises
- There are uncertainties around the future of the accommodation services as the Local Authority considers the best options for each scheme in the reconfiguration programme. The Trust Board has also been considering the best options for the future services of the Trust and concluded that it should not continue to provide registered care home services but should focus on services that provide specialist support for people with more complex needs. Plans are being put in place to de-register the remaining registered care homes, but it is not yet certain how contracts for support will be agreed and managed in the longer term. To mitigate the uncertainty the Trust is currently negotiating new contracts and is an active partner in examining alternatives for the future of directly provided services with the Local Authority

- Changes in demand are starting to be recognised now that Self Directed Support has been established in the Local Authority. Block contracted provision is less likely to be part of the future picture and the local commissioning landscape envisages a tapering of block contracts as individual budgets replace them. As personal health budgets are likely to be a feature during 2013/14 the service has been focussing on understanding future demand. In particular this is likely to have an impact on respite services

The Trust does have the potential to respond to the needs of people with the most complex needs and their families, and the demographics indicate that this is an area of increasing demand. Work is underway to discover the potential choices and preferences in the future and services are looking to develop flexible and affordable models of service around this.

2.4.1.4 Specialist Services Directorate

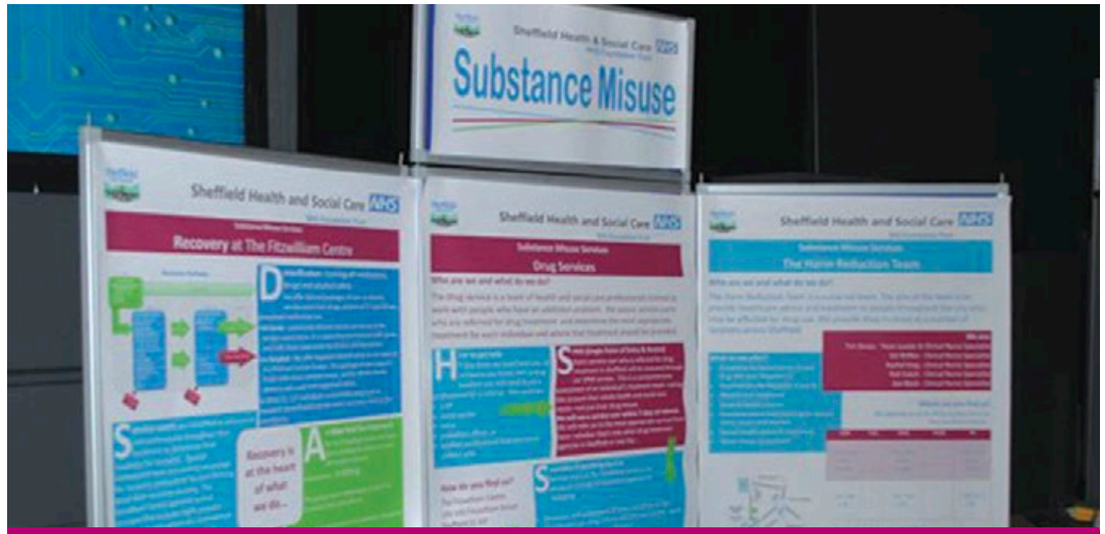
A range of services are hosted under the umbrella of the Specialist Services Directorate. These include:

- Community and bed-based mental health and social care services for older people, including those with dementia
- Screening, assessment, harm reduction and prescribing services to people who experience problems as a result of alcohol and drug use
- Specialist health services, including Perinatal Mental Health; Aspergers and Eating Disorders
- Relationship, sexual and gender identity services
- Psychological Services to Sheffield and surrounding districts
- Therapy Services including Occupational Therapists, Physiotherapists, Speech & Language Therapists, Dietetics and Chaplaincy
- Services for people with a neurological injury or disease that causes long term restrictions in the scope and quality of their everyday lives.

The Specialist Directorate has achieved against a number of significant objectives during 2012/13, including the following:

- We have retained all of our existing service contracts and expanded in a number of key areas. Funded via the city's Right First Time initiative (a city-wide project looking at transforming Sheffield's health services) we have the ability to provide a multi-disciplinary older adult liaison service to older people using Sheffield Teaching Hospitals Foundation Trust (STHFT). This is supported by increased capacity in the community to avoid unnecessary hospital admissions and support earlier discharge. Substance Misuse Services have seen the investment of specialist posts in A&E Liaison, GP Alcohol Liaison and Dual Diagnosis to support its core portfolio. Our Memory Service has had additional investment to support the transfer of non-complex service users to receive their routine reviews by their own GPs
- We have continued to be successful in generating external income from other NHS Trusts and commissioning authorities. This has been particularly true in Psychological Services to Rotherham, Aspergers, Gender Identity and Chaplaincy services to Alpha Healthcare
- The Directorate continues to plan for growth opportunities; we have been particularly focusing on Aspergers, Autism & ADHD, Gender Identity and Substance Misuse Services
- We have continued to look at the way we provide services to ensure they meet the needs of service users, their carers and our commissioners. Detailed work has been undertaken to explore the future configuration of our Dementia Resource Centres which will see less of a reliance on building-based services and more community working as we move into 2013/14
- We have also been looking at the way in which we provide services to people with Long Term Neurological Conditions and our input to Community and bed-based Intermediate Care Services, hosted via Therapy Services. These reviews help to shape the way in which we future configure and provide services to meet the increasing needs of Sheffield's population
- In order to respond to the challenging public health agenda on alcohol misuse, our Substance Misuse Services have been showcasing exciting developments made in-house of an electronic screening and assessment tool which has sparked significant interest regionally and nationally. 2013/14 will see further development of this initiative
- We have continued to develop our services so that we are able to support more people in the community or in their own homes
- Our Psychological Services provision has grown during 2012/13 in areas such as physical health care in Rotherham, and we have been reviewing the way in which we deliver other services. Two examples of this are the Pathfinder pilot with

Eating Disorders Team



Substance Misuse stand at the Annual Members Meeting

IAPT, working in a stepped care manner with people with Long Term Conditions or Medically Unexplained Symptoms in primary care; and the reconfiguration of some older adult psychology sessions to provide a specialist clinical neuropsychology service to stroke patients in the community. This latter development enables a greater number of patients to be seen in a timely manner in community settings. With the aim of improving access to psychological care across care pathways, we have carried out a review of our senior clinical psychology posts in adult mental health and also put some investment into the Acute Mental Health Wards in the last year. We have also held successful practice development events on Consultation and Supervision & Case management in response to governance processes

- The Functional Intensive Community Support Service (FICS) became operational during 2012, working with older people whose hospital admission can be avoided with more intensive community support and also aiding earlier discharge from hospital
- Our Memory Service was accredited as "Excellent" in 2012/13 by the Royal College of Psychiatrists' National Accreditation Programme
- The Directorate met its Cost Improvement Plan for 2012/13 and managed an under-spend position due to fortuitous savings and income generation opportunities in 2012/13
- The Directorate continued to review all service areas to identify efficiencies and shape plans for future financial years.

Other Strategic Achievements in 2012/13 are:

- The reconfiguration of the Older People's Functional Mental Illness and Dementia Resource Centres, resulting in more people being supported by community alternatives
- The reconfiguration of Older People's functional mental illness day hospitals, which resulted in the proposal for the new Functional Intensive Community Service
- Board approval for the formation of Recovery Enterprises
- The continued growth of specialist mental health, relationship, sexual and gender identity services, psychological & therapy services and Substance misuse services to Sheffield and its surrounding districts
- New staffing and clinical service models being negotiated to provide high quality enhanced care. This follows NHS Sheffield's decision to continue to provide Birch Avenue & Woodland View Nursing Homes.

Going forward, we continue to face the following risks and uncertainties which will challenge the future provision of our services:

- The continued increase in competition and re-tendering of core services in a time of financial uncertainty and reduced public sector budgets
- The need to ensure services are able to meet the demand of our service users in line with continued advances in self directed support and payment by results
- Unprecedented budget reductions.

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

- The expected rise in the number of older people within the city
- The continuing need to work across primary and secondary care services and develop and expand our expertise as a reputable provider of primary care solutions
- Further partnership working with the Local Authority and not-for-profit sector to deliver high quality and affordable services
- Continuing to build on our interface with STHFT to increase the provision of services to people presenting in crisis and in need of our support
- Increasing opportunities to generate income in our specialist mental health services, relationship, sexual and gender identity services, substance misuse, psychological and therapy services, through understanding the needs of our customers and ensuring the proactive marketing of our services to external customers.

2.4.1.5 Clover Group

The Clover Group Practices are four GP practices based in Darnall, Tinsley, Jordanthorpe and Mulberry Street in the city centre, which merged to form one 'super practice' in May 2011. The practices serve some of the city's most vulnerable areas and also run a specialist service for asylum seekers. We have a three year Alternative Provider of Medical Services (APMS) Contract and currently have over 15000 registered patients.

The Clover Group's six key priorities during 2012/13 have been to:

1. Continue to develop the Clover model and implement a strong clinical and management structure
2. Work as a key stakeholder in the local commissioning agenda
3. Improve the quality, safety and experience of our services for the people who use our services and their carers by engaging patients in the delivery of services
4. Develop locally accessible services and increase the delivery of enhanced services
5. Support the delivery of high quality care by recruiting and retaining high calibre clinical staff
6. To achieve continued high performance against best practice and regulatory standards.

The following are some of the Clover Group's key achievements in the past year:

- The Clover Group Practices are developing as an APMS multi-site flagship that others can learn from. We are looking at the efficiencies which can be achieved through redesigning both admin and management structures
- We have a Patient Participation Group with over 80 patient members with whom we meet regularly, to enable us to increase awareness of needs and improve health outcomes for hard to reach, BME and vulnerable groups
- The Clover Group continues to provide consistent enhanced service delivery and look for new options to increase our income. We achieved high standards in the Quality and Outcomes Framework and are the first practice in Sheffield to work on Key Performance Indicators, which are a set of areas in which we are monitored on our clinical performance.

The following is considered the main strategic risk and uncertainty that the Clover Group currently faces:

- The contract value decreasing due to meeting efficiency savings, putting the three year APMS contract at risk. The risk of reduced staffing due to cost improvements has the potential to reduce access to our services and patient satisfaction.

New Darnall GP practice building

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 in 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 service users, carers and the public in helping to improve and develop our services is shown in more detail in the Quality Report. One example of an innovative project is involving our service users and carers in mock CQC visits. The Partners in Improving Quality group has been in existence since 2009, and was originally set up to look at how SHSC involved its service users in reviewing the quality of its services, with a focus on CQC standards. The group is made up of a wide range of service users and carers from a range of directorates within the Trust, including people with learning disabilities. The group are currently embarking on more CQC mock visits in a wide variety of different locations.

2.8 How we monitor improvements in service quality

We monitor improvements in service quality through our governance systems and the Quality Report. 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 integral part of the service user journey and is fundamental to the overall quality of each service user's own personal experience of the NHS. Improving information for service users is a commitment in the NHS constitution, and is also cited in the document 'NHS 2010 – 2015: from good to great. Preventative, people centred productive' (2009), and was also part of the recommendations in the Francis Report (2013).

During 2012/13 the Trust has been involved in a range of initiatives that have helped to improve the way we are providing information to those people who use our services, and their carers. These include:

- Throughout 2012/13 our service users and carers have been a part of reading panels, and they have been instrumental in helping to both shape and change a wide range of documents, which include: policies, ward leaflets, booklets and posters. One of our service users who is a prominent member of The Creative Arts Steering Team (CAST) has worked collaboratively with both the Patient and Public Involvement Manager and the Infection Control team in designing the Trust's new Hand Hygiene posters, which can be seen throughout the Trust's sites
- Embracing co-production and working collaboratively with a very wide range of service users and carers, including people with learning disabilities. The Partners In Improving Quality Group has been asked to utilise their own expertise and lived experiences and have designed 'easy-read' pictorial versions of a range of documents, leaflets and reports. Their knowledge is invaluable in helping us to personalise our information to adapt and suit the groups it is meant to serve
- The information that is gleaned from specific projects such as the Quality and Dignity project will be collated, written and also presented by our service users and carers. This information will be written from their own analysis of the findings of questionnaires and will be interpreted using their own words. The Quality and Dignity Project is an excellent example of a project that is being led by service users and carers. The findings from the questionnaires are displayed within the ward environments so that everyone can see the improvements that are taking place.

2.10 How we handle complaints and concerns

The Trust is committed to ensuring that all concerns and complaints are dealt with promptly and investigated thoroughly and fairly.

Both local and national research indicates that when things go wrong, individuals expect Trusts to recognise and acknowledge errors; to offer an apology, to give an explanation for what took place; and to give assurance that measures have been put in place to prevent a recurrence.

Service users, carers, or members of the public who raise concerns can be confident that their feedback will be taken seriously and that any changes made as a result of the findings of the investigations will be fed back in order that services can learn the lessons and make necessary changes.

During 2012/13 the Trust received 133 formal complaints and 241 informal complaints. We responded to an estimated 83% of the formal complaints within our timescale of twenty five working days, and we responded to 100% of the informal concerns within our timescale of five working days.

During the same period the Trust received 1,255 compliments in relation to Trust services and our staff.

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

2.11 Who our main commissioners are

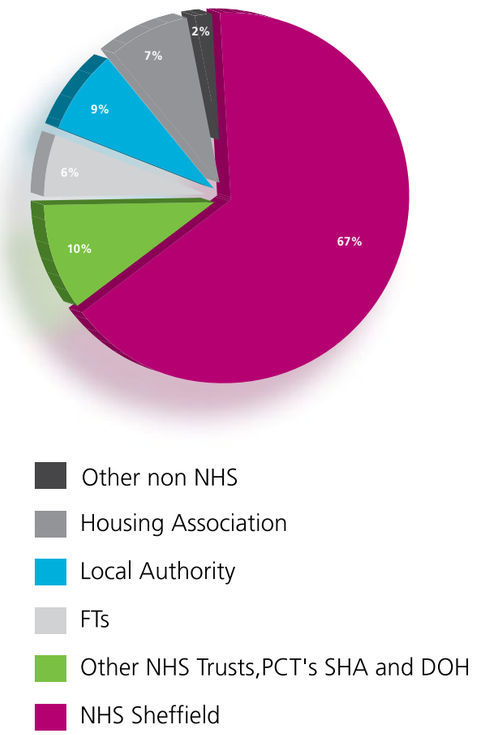
As an NHS Foundation Trust we provide a range of services, covering direct care services, training, teaching and support functions. The main commissioners of our clinical services during 2012/13 are NHS Sheffield, Sheffield City Council and other NHS Primary Care Trusts.

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.

Total Income by Commissioner



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 by Foundation Trusts, and by the Department of Health
- All targets to improve access to psychological therapies for common mental health problems within primary care
- The standards for childhood immunisation, and our performance improved within our General Practice services in respect of primary care and standards for vaccinations
- 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 environments 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 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.

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 have been made to our services are summarised as follows:

- We began building our new community centre to support people with learning disabilities who also have challenging behaviours. We have invested over £3 million in a new centre at Roewood to support the delivery of integrated care, support and treatment. This new service will integrate our community and inpatient teams so that care and support can be provided seamlessly across community and residential settings. We are excited and proud of this long overdue development. The standard of the care we have provided at our previous service, the ATU, has been recognised by the CQC as being of a very high standard, but in a poor quality environment. We look forward to our new purpose-built facility supporting the service to deliver even better support in the future
- We changed the way we provide our CMHT services. Following consultation in 2011/12 we combined our different teams into an integrated service. We now have four teams, each covering a different area of Sheffield. Each team provides for new assessments, liaison and consultation with primary care and short term interventions, crisis support and home treatment and on-going recovery support and treatment where needed. These changes were introduced over the summer and autumn of 2012 and early evaluation of the impact has been positive
- Towards the end of 2011/12 we combined our previously separate day hospitals and discharge support teams for older adults into an integrated crisis and home treatment support team. This type of support was available for working aged adults but not older adults within Sheffield. The new service fully started from April 2012 onwards. The purpose of the service is to provide community based intensive support for people in a crisis as an alternative to hospital admission
- As part of a national pilot our IAPT services have been identified as one of seven Pathfinder sites in the country. The pilot has aimed to explore how best to support people with long term physical health problems, and people with medically unexplained symptoms through better access to psychological therapies. The formal evaluation of the full pilot will not conclude until next year. Initial and emerging results from the pilot indicate that this development has had a real and significant impact on the lives of people in Sheffield
- Under the Sheffield-wide development programme, Right First Time, we have piloted new services into Sheffield Teaching Hospitals NHS Foundation Trust. These services have looked to expand and support the provision of advice, assessment and after care provided to older people with mental health problems, particularly dementia, who have been admitted for general hospital care
- We have developed a new service through our SPACES service. The Recovery Education Programme (REP) is a short-term intensive education programme designed to help people get back on track as part of their mental health recovery. The programme deals with a wide range of issues focussing on the challenges that often block a person's recovery. This approach is part of our overall recovery agenda, to promote and develop ways in which we can help people to better equip themselves to develop their own plans to achieve their own goals
- Following an engagement and consultation programme led by the Council, we implemented our plan to provide better quality and intensive respite support for people who experience emergencies with their support arrangements. Our plans aim to support people to stay at home rather than being admitted to hospital or a care home. We aim to deliver this through a smaller but higher quality respite service, and by supporting more people than at present with individual care packages that are focussed on social and community engagement, delivering respite support in a non-residential way. Part of this plan has brought together services previously provided by the Norbury and Hurlfield View resource centres, and as a result Norbury was closed in March 2013.

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 in the wider population, to influence the commissioning approach taken and to develop new services for the benefit of the people of Sheffield.

We work in partnership with a diverse group of interested parties across the public and third sector, voluntary and local community groups. This allows us to develop better relationships with other organisations who support 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.

2.15.1 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 working aged 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 seamless 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. Together we have established a single joint service model across health and social care.

During this year we entered into a new partnership with Rethink, for the delivery of a Crisis House service in Sheffield. We have commissioned Rethink to provide a Crisis House, run and staffed by them and it is scheduled to open in April 2013.

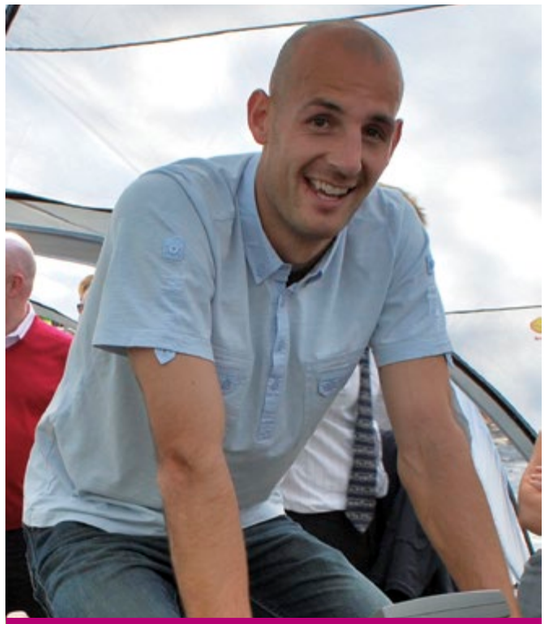
This development is an important step in the way we are improving how we support people who experience a crisis with their mental health. It provides more choice for people about how we can support them. Rethink have a lot of experience in providing crisis house services elsewhere in the country, and we are pleased to be developing this important service in partnership with them.

2.15.2 Intermediate care

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

2.15.3 Improving service user experience

In partnership with MAAT Probe and other service users we have continued the implementation of RESPECT training following extensive review of our services in 2011/12 focussing on the prevention and management of violence and aggression. By working in partnership in this way we have been able to effect significant and positive change to our practice in this challenging area. Information regarding this is provided in more detail in Section 11.



Sheffield Wednesday's Rob Jones helping launch the 12 for 12 campaign

2.15.4 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.

2.16 Valuing our staff

Supporting Staff through Change

The drive to improve and respond positively to changes in our social and economic environment has continued over the past year. Inevitably this has involved both challenge and change. The Trust's policies and procedures to help and support staff continue to be applied, and adapted as necessary, to meet these requirements. The Trust's redeployment process in particular has been successful in helping to ensure that the retention of staff is maximized consistent with skills and service requirements. The Trust also regularly provides the opportunity for staff wishing to apply to leave employment under the Mutually Agreed Resignation Scheme (MARS). This is based on a national model and so far there have been 5 rounds of this scheme since it was introduced in April 2011. This has helped to reduce the headcount across the Trust consistent with the financial plans and situation.

The CMHT reconfiguration has progressed successfully though not without its' challenges, and across the Trust there are a number of similar but smaller scale projects taking place. Currently the Trust is working with other Trusts in the city to re-orientate the arrangements relating to the provision of a number of facilities management and other contracts.

Throughout these processes the Trust has worked closely in conjunction with Staff Side.

The restructuring of Clinical Directorates last year led to the development of closer integration of our senior/middle managers (both between themselves and with the HR team) to enable greater sharing of knowledge and experience as well as helping to ensure common issues are highlighted and addressed. The Executive Team has also reconfigured some of its roles and responsibilities to better match internal and external requirements.

The coming year will see further consideration being given as to how to help facilitate change management, including the provision of additional training, tools and techniques. This is in anticipation and recognition of further changes including those relating to acute care and our social care establishments. More broadly, the Trust has taken forward the development of its Training Prospectus which has assisted staff in ensuring that they have the right skills and competencies for their role.

The recognition of the importance of work-life balance has been demonstrated by our 12 for 12 Campaign to improve staff health and well-being, which concluded in Autumn 2012. This involved 12 sets of activities over 12 months picking up the theme of the Olympic Games. It actively encouraged staff to participate in activities such as cycling, walking, stress reduction, eating well and dancing among other events. The Trust already has a number of existing health and wellbeing initiatives e.g. Workplace Wellbeing, Mindful Employer and staff health and wellbeing web pages on the 'Working for the Trust' section of the SHSC internet site. However we decided that we needed to consider further ways to engage staff around their health and wellbeing. A 15 month 'task and finish' group was established and chaired by Sue Rogers, Non Executive Director. The group had representatives from all the key sites across the Trust including communications, estates, inpatient areas and community teams. The remit of this group was to develop staff engagement around health and wellbeing, review progress of the Boorman report within the Trust and take forward some practical ideas. By offering a variety of experiences aimed at appropriate times of the year over a focused period, we hoped there would be something for most staff and that some would continue with activities after the events. With no NHS funding allocated to the project we successfully applied for £3,000 from the Sheffield Charitable Trust to support '12 for 12'. About 935 people took part in the activities (based on attendances at events, bookings and participation in activities). Whilst we are aware that some of this number were repeat participants, we also know that there were others who accessed the website and used the information but did not attend events. Indeed, the web pages acquired 3560 hits during the campaign period. The Trust was awarded a silver certificate from the NHS Sport & Physical Activity Challenge, a scheme inspired by the 2012 Games to promote a healthy lifestyle and encourage and support staff to get more physically active.

Work-life balance was also addressed through the introduction of our Additional Leave Scheme during 2012/13. This has provided staff with the scope to apply for up to 30 days additional leave as part of a salary exchange agreement. The scheme has proved very successful in terms of take-up with 95 staff taking on average around two additional weeks holiday. This has also contributed significantly to cost savings within the Trust. It has been agreed to run a similar scheme for the 2013/2014 financial year. In addition to this new scheme, the Trust also updated its Flexible Working Policy and renewed the Voluntary Reduction in Hours Scheme.

As part of the 12 for 12 Campaign the Trust introduced a salary exchange scheme for the purchase of cycles. This scheme has been renewed and the Trust is currently in the process of extending salary-exchange schemes to other areas such as mobile phones and computers.

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, which is 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 2012 we published Equality Objectives which have replaced the objectives in the Trust Single Equality Scheme.

Our Equality Objectives are:

- Equality Objective 1 – To improve how we record when service users have physical impairments
- Equality Objective 2 – To improve how we record sexual orientation
- Equality Objective 3 – To improve staff satisfaction for staff from black and minority ethnic (BME) groups
- Equality Objective 4 – To improve information about staff who are carers
- Equality Objective 5 – To identify at least one equality objective annually through the Trust annual quality objective setting
- Equality Objective 6 – To share equality objectives with other local health and social care organisations.

More information about how our Equality Objectives were identified and agreed and how we plan to achieve them can be found on the Trust's website at: www.shsc.nhs.uk/about-us/Equality-Diversity-Human-Rights/Our-Equality-Objectives and in the Trust 2011/12 Annual Equality and Human Rights Report which is published on the Trust website at: www.shsc.nhs.uk/about-us/Equality-Diversity-Human-Rights/Meeting-our-Equality-Duties

The Public Sector Equality Duty means that the Trust has to have 'due regard' in all that it does to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between people protected by the Equality Act and others
- Foster good relations between people protected by the Equality Act and others.

The Trust's Equality and Human Rights report includes information about the actions that the Trust has taken to support this Duty and to meet the goals that the NHS has set in the NHS Equality Delivery System to promote equality.

Equality and Diversity certificate of achievement

Equality and Diversity Highlights of 2012/13

Eliminating discrimination, harassment and victimisation

- In 2012 the Trust updated the range of information published in our Annual Equality and Human Rights reports to include more information about the people who use our services. This information can be found on the Trust's website in the Equality and Human Rights Report – Supplementary Data Report:

www.shsc.nhs.uk/about-us/Equality-Diversity-Human-Rights/Meeting-our-Equality-Duties

Advancing equality of opportunity for protected groups

- The Trust continued to develop three Staff Network Groups, and in 2012 an event was held to mark the official launch of the Trust's BME staff network group. The event was a great success, with accounts from senior staff in the Trust about their personal and professional experiences and an inspiring keynote speech from Uduak Archibong PhD, Professor of Diversity at the University of Bradford. Kevan Taylor, Chief Executive, opened the event and it was also attended by the Deputy Chief Executive Mick Rodgers
- A new policy on Gender Reassignment Support in the Workplace was drafted
- A survey of staff carers took place, i.e. staff who care for a relative or friend. We received over 100 responses and have developed an action plan based on these responses
- We started to develop a new strategy framework to promote equality of opportunity for BME staff and service users

Fostering good relations between people in protected groups and others

- We attended the Sheffield Lesbian, Gay, Bisexual and Transgender Pride event with colleagues from NHS Sheffield to promote our mental health services and anti-stigma work
- The Trust continued its involvement in the development of the city-wide Equality Engagement group – this group aims to be a focus for engagement with groups protected under equality legislation and an opportunity to work in partnership with other NHS Trusts in Sheffield, and Sheffield Local Authority.

2.16.3 Disability employment

In 2012 we renewed our 'two ticks' standard and maintained our action plan to support the Trust as a Mindful Employer. In 2012, 4.69% of staff reported that they have a disability, a slight increase from 4.23% in 2011.

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 the right 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.

In 2012/2013, the Trust has worked in partnership with Staff Side in a number of areas. This includes updating or introducing policies relating to Capability, Flexible Working, Social Media, Gender Re-Assignment, the Management of Sickness Absence and Whistleblowing. This latter policy has been significantly updated in line with current guidance and will be further reviewed in line with the recommendations of the Francis Report. Agreements were reached on a new Protection Policy, on revised pay arrangements for our flexible workers and on the leave arrangements for the Queen's Diamond Jubilee in June 2012. There were two separate national days of action called during the year by Unite and by the British Medical Association. In both cases the Trust worked with the bodies concerned to ensure that patient safety was not compromised.

The Trust also worked with the British Medical Association to put in place the necessary elements for the revalidation of doctors, including a new Appraisal Policy for senior medical staff, and introducing a process for remediation, i.e. the arrangements to apply where there are concerns about the performance of a doctor.

The Trust retains its commitment to work with Staff Side during this challenging period for the NHS.

2.16.5 Sickness Absence

The Trust recognises that in our empowered, committed and team-based workforce, the issue of staff absence is a complex and multi-faceted one. People can be absent for many reasons, and the Trust has attempted to put in place a range of different responses, such as Occupational Health services, Workplace Wellbeing services, consistent Return to Work and staff support plans. The Trust has also improved its' policy on the management of the issue so that it requires improvements in attendance from the relatively small number of staff affected by the formal process, and so that it also addresses the different approaches to short term and long term absence.

The Trust has Board support for establishing a joint Management and Staff-side 'task and finish' working group to analyse and investigate the reasons for absence and to reinforce an 'attendance culture'.

We review the causes of absence, have established suitable and achievable targets for the Trust, teams and individuals and these are regularly monitored. We are working with Trust managers to recognise good attendance and address those individuals with poor attendance, whilst supporting staff genuinely affected by stress (the Trust has a Stress policy and an integral stress measurement tool), along with work redesign and adjustments.

We will continue to treat genuine sickness absence with fairness and compassion and to promote this culture, and to reduce absence figures.

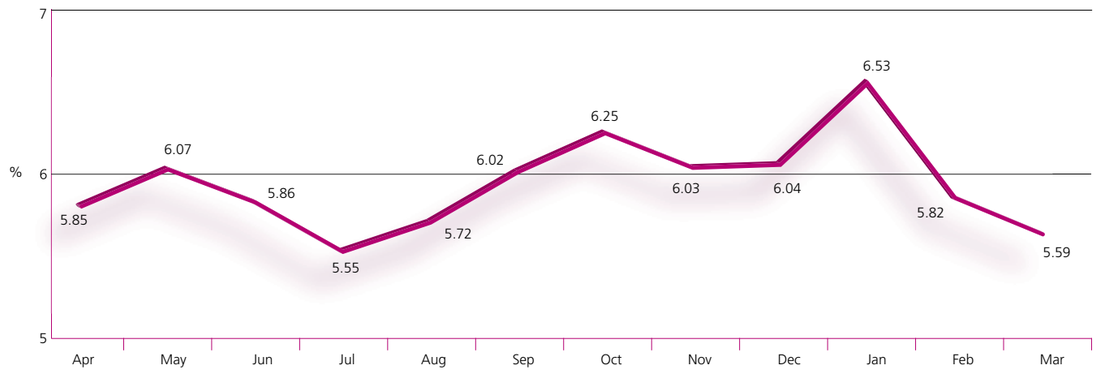
2.16.6 Occupational Health

The Trust approach to Occupational Health involves the following strands:

- The Occupational Health Service – this is undertaken via a contract with Sheffield Teaching Hospitals NHS Foundation Trust
- Workplace Wellbeing – this is our own free confidential staff counselling and consultation service which is available to individuals and groups of staff
- Health and wellbeing – we provide a dedicated section on our Trust website which helps direct staff to a range of useful local, regional and national resources and tools to assist with promoting a healthy and active lifestyle. During 2012/13 these web pages were viewed almost 1700 times
- Training – we provide specific training on key health related areas such as back care/ manual handling and stress awareness/dealing with conflict
- Specific projects – this encompasses both regular initiatives such as the annual flu immunisation campaign as well as one-off initiatives such as the "12 for 12 campaign".

We have been working with our Occupational Health provider to try and both improve and extend our current provision. We are actively looking at the introduction of electronic referrals to help speed up the referral process but also help with compiling more refined data regarding incidence. There have also been discussions regarding the potential for setting up more rapid treatment relating to mental health and musculo-skeletal problems.

Sickness absence figures 2012/13



This year also saw the culmination of our successful "12 for 12 campaign" which was referred to earlier. This was a one-off task and finish project but the Trust will be giving further consideration as to how to help maintain the momentum and keep health initiatives on staff's own agendas.

The Trust has also significantly increased the percentage of front-line staff that have chosen to receive the flu vaccination.

2.16.7 Volunteers

During 2012/13 the Volunteer Development Group completed its work on developing and implementing the new volunteer policy, recruiting to the new volunteer coordinator post and revising the training and support requirements for volunteers to ensure areas such as safeguarding are adequately dealt with.

The further development of the Trust's use of, and work with, volunteers now sits within the Patient and Public Involvement department, reporting to both the Quality Assurance Committee and the HR and Workforce governance meetings.

A dedicated web page has been developed (www.shsc.nhs.uk/patients-and-carers-intro/get-involved-2/Volunteering) with information on volunteering opportunities which the public can access.

2.16.8 Communications

The Trust produced a large amount of proactive publicity during 2012/13 about various aspects of its work and services. Service user and carer case studies have been used to raise awareness with the public, and to contribute to reducing the stigma associated with mental health and related issues. We have achieved good media coverage with case studies in the areas of Spirituality, Transgender services, Service User Employment, Chronic Fatigue and Eating Disorders.

This year we have also been named as one of the top nine Provider Trusts in the country in a study carried out by Manchester Business School, and received positive media attention on this issue.

We will continue to work hard to get our positive PR taken up by the media, and minimise negative publicity over the next year in order to further grow the services and build on our reputation.

The Trust has maintained its Social Media presence during the year (a term covering websites and online tools which allow users to interact with each other in some way) via Facebook and Twitter accounts. These are regularly updated with news, events and photos, and are growing in popularity and cultivating an online dialogue.

Website: www.shsc.nhs.uk

Facebook: www.facebook.com/shscft

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

2.16.9 Education, Training and Development

The Education, Training and Development Department (ETD) is committed to recovery principles and our courses are increasingly being developed with a recovery focus, to meet the essential training and development requirements of Trust staff in their various job roles.

The Trust Training Prospectus has been developed to provide an up-to-date catalogue of Trust training courses and E-learning packages for Mandatory and Non Mandatory training, and the electronic nomination form is now available on the Intranet within the ETD pages. A selection of service user artwork has been included in the prospectus to make it more visual and engaging and it has been well received.

E-learning has been established at 13 sites across the city, giving Trust staff an alternative and flexible way of completing their mandatory training. E-learning is user friendly and can be accessed at any time, meaning learners can fit it around their working day in the clinical environment.

In 2012/13 we have seen an increase of staff attending training: the available places increased from the previous year from 7031 up to 9375. We were successful in achieving 80% Trust compliance in Respect Level 3 and Fire training, and made a significant impact in other areas such as Core Mandatory Training, Clinical Risk, and Respect Level 2 training.

We have introduced mandatory update days during the year, currently including basic life support, fire safety, healthcare records, slips, trips and falls, hand hygiene and waste management, so that staff can achieve their mandatory compliance in an efficient one day format.

We have also introduced TurningPoint, an interactive evaluation system that enables staff to answer questions about the training delivered using a handheld device. We currently use this in our Mandatory update day, Core Mandatory Training and Respect Training.

We have continued to build on our past success with apprenticeships. Ten apprentices completed their training this year with four gaining substantive posts at SHSC, two in other NHS Trusts and four going on to non-NHS employment or higher education. Twenty-five people have started apprenticeships this year across pharmacy, business administration, health and social care and cleaning support services. These are a combination of new recruits and existing staff updating their skills.

In addition to the apprenticeships, forty-three members of staff have enrolled on vocational courses and qualifications this year.

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 four 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 2012/13, we exceeded our planned forecast of a £2,545,000 surplus and achieved a surplus of £3,512,000 with Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £8,876,130 (against a plan of £6,888,688).

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 4 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 met for 2012/13, some of this delivery (approximately, £1.6 million) was 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 two 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 2012 to 31st March 2013 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 achieved a Financial Risk Rating of 4 throughout the year 2012/2013.

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 £128,382,000. A summary of the position is provided below:

	Total 1st April 2012 – 31st March 2013 (£ 000s)	**Total** 1st April 2011 – 31st March 2012 (£ 000s)
Income from activities	93,276	86,961
Other operating income	34,788	35,513
Total income	128,064	122,474
Operating expenses	(122,994)	(118,466)
Profit on disposal of property, plant and equipment	318	73
Interest received and other financial costs	130	101
Movement in fair value of investment property	(20)	0
Public dividend payable	(1,986)	(2,191)
Surplus for the year	3,512	1,991

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 2013 was £22.731 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 2012/13 was £2.901 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 Psychiatric Intensive Care Unit (PICU) commenced in 2012/13, although the majority of expenditure for this will occur in 2013 – 14. The site has been identified, plans drawn up and building work is due to commence in May 2013.

The development of the Intensive Support Service Unit (ISSU), within the Learning Disabilities Service commenced in 2012/13, although some of the expenditure will occur in 2013/14. The building is progressing to the timescales agreed and will be operational in 2013 – 14.

With the exception of the PICU and 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 2012/13 was set at £24.9 million. During the year, we have not borrowed against this limit.

2.17.7 Key financial risks and challenges for 2013/14 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 receive a 1% Agenda for Change inflationary pay award for 2013/4

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 2013/14, there is a national efficiency requirement of 4%, with pay and price inflation uplifts at 2.7%. The application of this formula gives a net reduction for NHS commissioned services of 1.3%. 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

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 2013/14.

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 2013/14 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 £22.731m at 31st March 2013. 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 2013/14
- Ensuring that we deliver the sign-off for recurrent savings required for our efficiency plan
- 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 deliver in shadow form, in 2013/14, in conjunction with its service commissioners, the proposed currency model from the Care Pathways and Packages (CPP) Consortium to support and inform currency development as part of the national roll-out of its implementation. This will involve conversion of existing contract values into CPP currency and will run in shadow form in 2013 – 14 alongside existing currency arrangements to ensure that the implementation of the National Payment by Results (PbR) Policy for Mental Health is effectively managed locally. This will be reviewed throughout the year
- 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 two 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 5.5 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 85% in terms of the number of invoices paid and 85% in terms of the value of invoices paid.

2.17.11 Countering fraud and corruption

Sheffield Health and Social Care NHS Foundation Trust fully subscribes to mandatory requirements on countering fraud and corruption across the NHS and is committed to the elimination of fraud within the Trust. Where fraud is proven, we ensure that wrongdoers are appropriately dealt with and steps are taken to recover any assets lost due to fraud.

The Trust has a nominated Local Counter Fraud Specialist (LCFS) carrying out a range of activities that are overseen by the Audit Committee. A fraud risk assessment is carried out annually and proactive fraud exercises are undertaken based on this risk assessment. Where fraud is identified or suspected an investigation is carried out in accordance with the Trust's Fraud Policy and Response Plan.

This year, proactive counter fraud work has focussed on preventative action to ensure the Trust does not fall victim to the current and real threat of organised high value NHS fraud. In the last year the LCFS has formally investigated eleven cases of alleged fraud at the Trust.

The Annual Counter Fraud Report concludes that staff, management and executives have continued to strongly support counter fraud work across the whole organisation in what has been a positive year for counter fraud work at the Trust.

2.17.12 Health and Safety Performance

The Trust recognises its responsibilities for ensuring the health, safety and welfare of our employees, as well as our responsibility to others who may be affected by its work activities. The Trust approach to health and safety is based on risk assessment, which aims to identify, assess and minimise the potential for injury and ill health.

The Health and Safety Committee, chaired by the Executive Director with responsibility for Health and Safety, has met regularly during the last 12 months. This is a joint meeting with representatives from Staff Side and all Trust services. The Committee has overseen the completion of several areas of work including:

- Updating the Display Screen Equipment Policy
- Updating the Security Policy to take account of terrorism threats e.g. bomb scares; improvised explosive devices (IEDs)
- Review of an earlier (2007) report from the Health & Safety Executive to ensure all recommendations had been fully addressed
- Further roll out of the Trust's 'Red Box' system which is an auditing and assurance process related to health & safety issues linked to our buildings
- Introduction of a health & safety inspection scheme by the Health & Safety Advisor at all Trust sites to identify and resolve any local issues as well as acting as an 'early warning' of any organisational systems problems or significant matters
- Consideration of implications of the Lofstedt Report
- Consideration of the Health & Safety Executive's introduction of a cost recovery scheme and identification of actions to be taken by the Trust to manage this change of approach
- Ratification of actions being taken by Estate Services to ensure compliance with the EU Biocidal Products Directive (cessation of use of copper ionisation in legionella control).

The Trust employs 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 a Trust-wide remit for instigating a proactive approach to health and safety. The Facilities Directorate 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.

During 2011/12 the Trust introduced a revised risk-based approach to fire safety training which has proved to be successful, and overall numbers of staff attending face-to-face training or completing e-based training during 2012/13 has increased significantly.

We have also introduced key operated fire alarm points in most of the inpatient wards, which has reduced the number of unwanted fire signals (false alarms) caused by service users inappropriately activating the break glass fire alarm points.

2.17.13 Consultations we have completed

We have not undertaken any formal consultations during the year about proposed service changes.

2.17.14 Consultations we have in progress

At the time of confirming this Annual Report there were no formal consultations in progress.

2.17.15 Consultations we have planned for next year

In line with our established Annual plan for 2013 – 14 we may consult on the development of new acute care services across community and inpatient settings supported by an estate improvement and redesign programme. We will consider the need and requirements for consultation once the options have been reviewed during the year.

2.17.16 Significant research and development activities we have undertaken

The Trust sees research activity as an important element of ensuring quality, supporting innovation and improving productivity, as well as being committed to offering service users access to new treatments and care.

The number of research projects on the National Institute for Health Research (NIHR) National Portfolio underway in the Trust and number of our service users recruited to studies has increased significantly over the last three years. Over the last 12 months in particular, research development activity has focussed on increasing high quality commercial studies on the NIHR portfolio underway in the Trust and developing applications to NIHR funding programmes sponsored by the Trust. In these areas, the Trust was selected as one of five sites in the UK for an international Phase 2 clinical trial of a potential new treatment for negative symptoms in schizophrenia. The Trust is also the sponsor of an application to the NIHR HTA programme for a trial of a non-pharmacological intervention to reduce weight gain in severe mental illness – this has been short-listed to the final application stage. Both of these projects feed into quality improvement areas highlighted in the National Audit of Schizophrenia and to the health inequalities that are shown by different physical health outcomes for those with severe mental illness.

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 1st April 2012 to 31st March 2013.

2.17.18 Political or charitable donations we have made

The Trust has not made any political or charitable donations during the year 2012/13 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 31st March 2013 is appropriate as it has been determined in accordance with the Foundation Trust Annual Reporting Manual 2012/13 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 31st March 2013. 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 1st May 2013.

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:

- Potential agreements to take on responsibility for the Clinical Commissioning Group's C.H.C budget
- 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 and will include the introduction of a Crisis House
- Completion of the new Psychiatric Intensive Care Unit (PICU) building.

SHSC Headquarters at Fulwood House

SECTION 3.0
Remuneration Report

3.0 Remuneration Report

Executive Directors' Remuneration

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

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

The Committee is responsible for monitoring the performance of the Chief Executive, based on an annual review provided by the Trust Chair, and of all the other Executive Directors based on an annual report provided by the Chief Executive. Details of the Committee's meetings during the past year are reported in Section 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 on the following page provides details of Executive Directors' contracts.

The Chief Executive undertakes annual appraisals 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.


Mayfield Conference Suite at Fulwood House

Table of Executive Directors' contracts

Executive Director	Date of contract	Unexpired terms (Years to age 65)
Kevan Taylor	February 2003	13
Mick Rodgers	April 2003 (retired Feb 2013)	3
Clive Clarke	April 2003	16
Liz Lightbown	April 2011	19
Prof Tim Kendall	April 2003	10
Paul Robinson	February 2013	19

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

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 2012/13 are shown in Table A on the following page. The Non-Executive Directors' duration of office is reported in Section 7 of this report.

Directors' Remuneration and pension entitlements

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 B provides details of the current pension and lump sum position for each Director.

A) Salaries and allowances

Name and title	Period 1.4.12 to 31.3.13			Period 1.4.11 to 31.3.12		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in kind (rounded to the nearest £00)
Prof. A Walker, Chairman	25 - 30			25 - 30		
Cllr. M Rooney, Non-Executive Director	10 - 15			10 - 15		
M Rosling, Non-Executive Director	10 - 15			10 - 15		
A Clayton, Non-Executive Director	10 - 15			10 - 15		
M Thomas, Non-Executive Director	10 - 15			10 - 15		
S Rogers, Non-Executive Director	10 - 15			10 - 15		
K Taylor, Chief Executive	135 - 140			135 - 140		
C Clarke, Deputy Chief Executive and Social Care Lead	100 - 105			100 - 105		
M Rodgers, Executive Director of Finance and Deputy Chief Executive	95 - 100			105 - 110		
P Robinson, Executive Director of Finance	15-20			-		
Dr T Kendall, Executive Medical Director	60-65	125-130		60 - 65	125 - 130	
E Lightbown, Chief Operating Officer/Chief Nurse	100 - 105			100 - 105		
Band of Highest Paid Director's Total (Remuneration £000)	190-195			185 - 190		
Median Total Remuneration	19,077			21,798		
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	9.8			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 2013, 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.

B) Pension benefits

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

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5.000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2013 £000	Cash equivalent transfer value at 31 March 2012 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
K Taylor, Chief Executive	0-2.5	0-2.5	45-50	140-145	893	823	27	0
C Clarke, Deputy Chief Executive and Social Care Lead	0-2.5	0-2.5	15 - 20	50-55	300	266	34	0
M Rodgers, Executive Director of Finance and Deputy Chief Executive	(2.5) -0	7.5-10.0	55 - 60	170-175	0	0	0	0
P Robinson, Executive Director of Finance	(2.5)-0	(2.5)-0	35-40	110-115	592	557	5	
Dr T Kendall, Executive Medical Director	0-2.5	0-2.5	50-55	155-160	1,098	1,011	35	0
L Lightbown, Executive Director of Nursing and Integrated Governance	0-2.5	2.5-5.0	25-30	75-80	423	370	34	0

Off-payroll arrangements

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, NHS Foundations Trusts are required to present data in respect of off-payroll arrangements.

The Trust had 5 off-payroll arrangements in place at 31st January 2013 that each cost over £58,200 per annum. Changes between January 31st and March 31st are shown below:

Number of cases at 31st January 2013	**6**
Of which;	
Number that have since come onto the Organisations payroll	0
Of which:	
No that have since been re-negotiated/re-engaged to include contractual clauses allowing the Trust to seek assurance as to their tax obligations	0
No that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the Trust to seek assurance as to their tax obligations.	0
No. that have come to an end.	1
Total balance	**5**

The Trust had 8 new off-payroll engagements between 23rd August 2012 and 31st March 2013, for more than £220 per day and more than 6 months.

Number of new engagements	**8**
Of which:	0
No of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received.	0
Total balance	**8**

Notes

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

Pension liabilities

The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary of State, 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

Support Worker on Stanage Ward

SECTION 4.0
NHS Foundation Trust Code of Governance

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

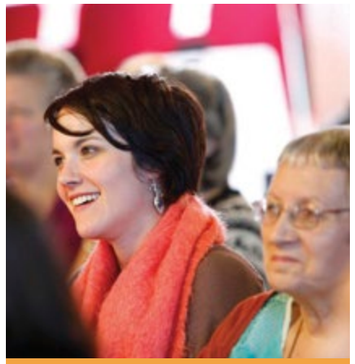
In accordance with the disclosure requirements of the Code, the Board of Directors makes the following disclosures:

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.

Quilt made by the SUKOON craft group at the Longley Centre

Art therapy session on Ward G1



Arts & Wellbeing Conference 2012

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 7 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.

Governors at the Annual Members meeting

SECTION 5.0
Council of Governors

5.0 Council of Governors

5.1 The role of the Council of Governors

Governors play a vital role in the Trust's governance arrangements. They primarily carry out their role through the meetings of the Council of Governors, of which there were five in 2012/13. Please see Table 1 for a 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 for the confidential item only.

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 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 2012/13, the Council of Governors reappointed Anthony Clayton, Mervyn Thomas and Sue Rogers as Non-Executive Directors and set their remuneration and terms and conditions.

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 organizations
- Providing feedback to members
- Developing the Trust's membership strategy.

In doing all these, the Council of Governors ensures that the Board of Directors is held to account by the Trust's key stakeholders.

Council of Governors meeting

David Hardy, a staff award winner at the Annual Members Meeting

Stanage Ward

5.2 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 'stakeholder 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. It is his responsibility to ensure that governor's views are represented at the Board of Directors 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 providing updates at each council meeting.

In 2011 John Kay, Service User Governor was elected as the Lead Governor. This is a role required by Monitor.

Table 1 shows a breakdown of seats on the council and associated governors as at 31st March 2013, including their attendance record at council meetings.

Table 1

Number of seats	Name	Constituency	Date appointed from	Date term of office ends	Meetings attended over total number of meetings eligible to attend
8 Public seats (Elected)	Dorothy Cook	Public South East	01.07.2010	30.06.2013	5/5
	Jules Jones	Public South East	01.07.2011	30.06.2014	5/5
	Brandon Ashworth	Public South West	01.07.2010	30.06.2013	5/5
	Vacancy	Public South West			
	Dave Jones	Public North East	01.07.2011	30.06.2013	5/5
	Trudie Smallwood	Public North East	01.07.2011	30.06.2013	4/5
	Paul Harvey	Public North West	01.07.2011	30.06.2014	5/5
	Susan Wood	Public North West	01.07.2010	30.06.2013	4/5
10 Service user seats (Elected)	Dean Chambers	Service User	01.07.2010	30.06.2013	3/5
	Tyrone Colley	Service User	01.07.2011	30.06.2014	5/5
	Shamshad Hussain	Service User	01.07.2011	30.06.2014	2/5
	John Kay	Service User	01.07.2010	30.06.2013	5/5
	Patrick Moran	Service User	20.03.2013	30.06.2014	0/0
	Sue Sibbald	Service User	21.03.2012	20.03.2015	5/5
	Kate Steele	Service User	01.07.2011	30.06.2014	4/5
	Vacancy	Service User			
	Nev Wheeler OBE	Service User	01.07.2010	30.06.2013	3/5
	Myra Wilson	Service User	01.07.2011	30.06.2014	5/5

Number of seats	Name	Constituency	Date appointed from	Date term of office ends	Meetings attended over total number of meetings eligible to attend
2 Young Service user/ Carer seats (Elected)	Abbey George	Young Service User/Carer	27.07.2012	30.06.2014	2/3
	Vacancy				
4 Carer seats (Elected)	Leon Ballin	Carer	01.07.2011	30.06.2014	3/5
	Ian Downing	Carer	01.07.2010	30.06.2013	5/5
	Jean Nicholson	Carer	01.07.2011	30.06.2014	3/5
	Lindsay Oldham	Carer	01.07.2010	30.06.2013	0/5
8 Staff seats (Elected)	Mia Bajin	Clinical Support Staff	15.12.2010	14.12.2013	2/5
	Vacancy	Nursing Staff			
	Elaine Hall	Allied Health Professionals	01.07.2011	30.06.2014	4/5
	Elliott Hall	Central Support Staff	01.07.2011	30.06.2014	5/5
	Ingrid King	Psychology Staff	01.07.2011	30.06.2014	0/5
	Geraldine Mountain	Social Work Staff	01.07.2011	30.06.2014	4/5
	Paul Miller	Medical & Clinical Staff	01.07.2011	30.06.2014	4/5
	Stephanie Pursehouse	Support Work Staff	01.07.2011	30.06.2014	1/5
11 Appointed governors (Stakeholders)	Professor Peter Woodruff	University of Sheffield	24.08.2011	23.08.2014	2/5
	Joan Healey	Sheffield Hallam University	29.09.2011	28.09.2014	5/5
	Sue Highton	Staffside (Unions)	01.07.2011	30.06.2014	1/5
	Vacancy	Age UK Sheffield			
	Janet Sullivan	Sheffield MENCAP	01.07.2011	30.06.2014	3/5
	Dr Abdul Rob	Pakistan Muslim Centre	24.01.2011	23.01.2014	2/5
	David Bussue	SACMHA	30.07.2012	29.07.2015	1/3
	Cllr David Barker	Sheffield City Council	31.07.2012	30.07.2015	2/3
	Cllr Roger Davidson	Sheffield City Council	14.11.2012	13.11.2015	1/2
	Cllr Clive Skelton	Sheffield City Council	31.07.2012	30.07.2015	1/3
	Dr Amir Afzal	Clinical Commissioning Group	01.04.2012	31.03.2015	1/5

5.3 Changes to the Council of Governors

At the 1st April 2012 there were 41 governors in post. There have been a number of changes throughout the year and at 31st March 2013, there were 38 governors in post. Table 2 shows the governors who left the council during 2012/13.

Table 2

Name	Constituency	Name	Constituency
Patrick Anyomi	Voluntary, Community & Faith Sector (SACMHA)	Nicky Hindmarch	Public South West
Cllr Ali Qadar	Sheffield City Council	Natasha Elliott	Young Service User/Carer
Cllr Jack Scott	Sheffield City Council	Gemma Wake	Young Service User/Carer
Cllr Ibrar Hussain	Sheffield City Council	Jim Buck	Staff – Nursing
Annette Phillips	Service User	Graham Harris	Voluntary, Community & Faith Sector (Age UK)
Jim Tattersall	Service User		

In addition to the governors who left, Table 3 shows new governors to the Council during 2012/13 and their method of appointment. Their terms of office are shown in Table 1.

Table 3

Name	Constituency	Method of appointment
Abbey George	Young Service User/Carer	Elected (polled 2nd highest votes and as per the constitution, was asked to take up the remainder of the term following the resignation of the incumbent)
David Bussue	SACMHA	Appointed
Cllr David Barker	Sheffield City Council	Appointed
Cllr Roger Davidson	Sheffield City Council	Appointed
Cllr Clive Skelton	Sheffield City Council	Appointed
Dr Amir Afzal	Clinical Commissioning Group	Appointed
Patrick Moran	Service User	Elected (polled 2nd highest votes and as per the constitution, was asked to take up the remainder of the term following the resignation of the incumbent)

5.4 Governor activities in 2012/13

The relationship between the Board of Directors and Council of Governors is an important one and its development was supported by sessions between the two and regular meetings with Non-Executive Directors. One of these included the annual development session between Board and Council in which the Board accounts to governors and is questioned by governors on the Trust's performance in the previous year. Support for governors and their development is provided throughout the year. A training event to help governors understand new commissioning arrangements was held as well as a session to explain the new Health and Social Care Act and its implications for governors.

In December 2012 discussions took place between the Board and Council on the Trust's business and quality objectives for 2013/14. Governors provided their thoughts but also sought members' views on the Trust's objectives via an online survey, to which 159 people responded. This information was collated and presented to the Board by governors.

In addition to their statutory duties, governors are involved in a number of other areas of the Trust. These include:

- Acute Care Reconfiguration
- Creative Arts Steering Group (CAST)
- Crisis House/Telephone Helpline project group
- Finance Executive Director Interview Panel
- Finance Sub Committee (to appoint external auditors)
- Human Resources & Workforce Group
- Involve Editorial Group
- Membership & Communications Sub Group
- Nominations and Remunerations Committee
- Personality Disorder Strategy Team
- Planning Priorities Group
- Recovery Strategy Team
- Service User Experience Monitoring Unit Training Development Programme
- Service User Safety Group
- Spirituality Strategy Group
- SUN:RISE Arts and Wellbeing Network
- Supporting the Chaplains in their roles
- Sustainability & Cost Savings Group.

Governors have brought their influence to bear through the Council and by asking questions at the Board of Directors meeting on a number of issues including:

- Both challenging and supporting the Trust's commitment to energy efficiency
- Challenging volunteer dependability at Board level and helping the Chaplaincy Department to access more funding to employ further chaplains
- Identifying the need to address the issue of the quality and quantity of paperwork in CMHTs and contributing to streamlining and improving processes
- New Trust telephone system
- Raising the profile of spirituality within care
- Staff appraisal.

As well as working inside the Trust, governors are representatives on a number of external Committees and groups and attend external events including:

- 50+
- Carers Café
- Cathedral Archer Project
- Chair – Carers and Young Carers Board
- Chair – LDS Partnership Board
- Council for Independent Living
- Foundation Trust Network event.
- Local Involvement Network
- Mental Health Information Project Group
- Mental Health Partnership Board
- Patient Group at the Flowers Medical
- Peoples Parliament for Learning Disabilities
- Physical Health Event with David Shiers
- Public Health Working Group
- Reflections in Health
- Safer and Stronger Communities Scrutiny Board
- Sheffield Anglican Diocese's Board of Faith and Justice including their ethnic minority and mental health subgroups (the latter presents up to 5 mental health study days per year).

Through this wide variety of groups, governors make sure that their views, and the views of their members are heard and listened to – they exert their influence.

Governors are required to declare any material or financial interests in the Trust. For a copy of the register of interests, please contact Karen Jones by emailing Karen.jones@shsc.nhs.uk or telephoning (0114) 2716747.

5.5 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 2012/13 a recruitment process was held for 3 Non-Executive Director posts whose terms were at an end. The process was formal and rigorous, and is summarised below.

The posts were advertised by the Committee in the local media, in addition to NHS Jobs and the NED Link website (NHS Confederation). Applications were shortlisted, and the shortlisted candidates invited to focus group sessions with Governors, and the remaining Non-Executive and Executive Directors. The evaluations from the focus group sessions were summarised and shared with the full Nominations and Remunerations Committee, prior to individual panel interviews with representatives from the Nominations and Remunerations Committee. The Committee successfully selected three 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.

During 2012/13 the following changes have taken place in the membership of the Committee:

- Sue Wood retired from the Committee
- Abbey George, Dave Jones, Sue Sibbald, Professor Peter Woodruff and Paul Harvey joined the Committee following their appointment by members of the Council of Governors

The attendance of the members of the Committee at its meetings that were held during 2012/13 is shown as follows:

Table 4

Name	Position	Number of meetings attended out of total number of those that could possibly be attended by each Committee Member
Alan Walker	Chair	3/3
John Kay	Reserve Chair	2/3
Brandon Ashworth	Committee Member	2/3
Geraldine Mountain	Committee Member	1/2
Lindsay Oldham	Committee Member	1/3
Paul Harvey	Committee Member	2/2
Abbey George	Committee Member	1/2
Professor Peter Woodruff	Committee Member	1/2
Dave Jones	Committee Member	0/2
Sue Sibbald	Committee Member	2/2
Sue Wood	Committee Member	1/1

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

Sheffield Wellbeing Festival 2012

SECTION 6.0
Membership

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.

6.1 Constituencies, eligibility criteria and membership numbers

There are 3 elected membership constituencies, each of which has a number of classes within. Table 1 details each one and its eligibility criteria and where applicable, the number of members in the class.

Table 1

Constituency	Class	Number of members	Criteria
Public	South West	3139	Must live in the following electoral wards: Gleadless Valley, Dore & Totley, Fulwood, Graves Park, Nether Edge, Ecclesall, Beauchief & Greenhill, Crookes
	South East	2581	Must live in the following electoral wards: Darnall, Manor Castle, Arbourthorne, Richmond, Birley, Mosborough, Beighton, Woodhouse
	North West	2345	Must live in the following electoral wards: Stocksbridge & Upper Don, Stannington, Hillsborough, Walkley, Broomhill, Central
	North East	2415	Must live in the following electoral wards: West Ecclesfield, East Ecclesfield, Southey, Firth Park, Burngreave, Shiregreen & Brightside
Service user	Service User	1004	Must have received a service or services from the Trust within the last 5 years
	Carer	654	Must have cared for someone who has received a service from the Trust in the last 5 years
	Young Service User or Carer	108	As service user and carer, but must be 35 years old or younger
Staff	Allied Health Professionals	177	Must have either worked for the Trust continuously for at least 12 months or have a contract of no fixed term (Please note that these staff figures are based on an 11 month period, Apr 2012 – Feb 2013. March 2013 figures were not available at the time of going to print).
	Central Support Staff	318	
	Clinical Support Staff	630	
	Medical & Clinical	188	
	Nursing	568	
	Psychology	194	
	Social Work	82	
	Support Work	1097	

Constituency	Class	Number of members	Criteria
Appointed	Voluntary, Community & Faith Sector Organisations	Not applicable	Not applicable
	University of Sheffield		
	Sheffield Hallam University		
	Staffside (unions)		
	Local Councillors		
	NHS Sheffield		

At the end of March 2013 there were a total of 12,630 members (excluding staff) compared to 12,299 at the same time the previous year. The number of new members recruited was 951. However, the final membership number reflects the number of discontinued members which totalled 598.

6.2 Developing a representative membership

As a successful Foundation Trust, it is our aim to maintain and further develop a membership that involves and reflects a wide representation of our local communities. 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 & Communications Committee, to implement and review this strategy on an annual basis.

As well as defining the membership, this strategy outlines how we plan to:

- Benefit from being a membership-based organisation
- Communicate with and support the development of its membership
- Make sure that the membership is reflective of Sheffield's diversity
- Provide opportunities for our members to become involved with the Trust in ways that suit their needs and wishes.

Some of the actions identified to achieve these four points are:

- 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.

The Trust was successful fulfilling these actions during 2012/13. See Section 6.3 for details of how this was achieved.

According to the 2011 census 16.2% of Sheffield's population is from an ethnic background. 2.9% is from a white background that is not British. The Trust has 12.09% (see Table 2) of members from ethnic backgrounds. However, this increases to 14.41% when White Irish and White Other groups are taken into consideration.

Table 2

	Membership as at 31.3.2013	Sheffield demographic
White (incl White Irish and White other)	87.91%	83.7%
Mixed	1.38%	2.4%
Asian or Asian British	4.9%	8%
Black or Black British	3.78%	3.6%
Other	2.02%	2.2%

Of the new members recruited in 2012/13, 20.8% were from black and minority ethnic backgrounds.

6.3 Membership Recruitment and Engagement

In line with the Trust's membership strategy to both recruit and engagement members from across Sheffield, governors and staff participated in 26 community events, specifically targeting ones in areas of the city with a high ethnicity and also targeting specific groups such as learning disabilities. Some of the events included:

- Sheffield Pride
- SADACCA Health Day
- Pakistani Advice Centre Health Days
- Weston Park Whit Fayre
- Darnall Information Day
- Sheffield Wellbeing Festival
- Firth Park Christmas Festival
- Sheffield Mencap Gateway
- Deaf Advisory Service AGM.

The Trust held a very successful Annual Members' Meeting in 2012 which over 200 staff and members attended. The event celebrated the excellence of staff and volunteers as well as providing an opportunity for members to learn more about the Trust and its services. Governors presented a report on their activities to members.

SHSC Governors at Sheffield Wellbeing Festival 2012

Entertainment at Sheffield Wellbeing Festival 2012

Members event 'All About Dementia'

The Trust continued to respond to and engage with members' issues by holding three very successful membership events on eating disorders, alcohol and dentistry plus dental phobias to which over 400 people attended in all. A programme of events will continue throughout 2013/14, again to reflect the issues members have told us are important to them.

As well as keeping a public profile, the Trust's primary focus of communication is through Involve, our membership magazine. Both governors and members sit on the editorial group to make sure that it keeps its focus on those issues that are important to members. The editorial group also makes sure that the magazine gives information on all aspects of the Trust's services.

The Trust website also provides members with updated information and ensures that they can easily communicate with both the Trust and governors if they want to.

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

Service User artwork at Moncrieffe Road

SECTION 7.0
Board of Directors

7.0 Board of Directors

7.1 The Role 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 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.

The Board may delegate any of the powers conferred upon it to any Committee of Directors or to an Executive Director. The Standing Orders of the Board of Directors provide for the manner in which the Board may arrange the delegation of its powers. The 'Scheme of Reservation and Delegation of Powers' (which forms part of the Board of Directors' Standing Orders) sets out, in detail, those powers which the Board has reserved to itself and those it has delegated and to whom.

The Chair of the Trust 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 ensuring 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.

During 2012/13, 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.

7.2 Composition of the Board of Directors

7.2.1. Non-Executive team

The Board comprises six Non-Executive Directors (including the Trust Chair). During 2012 3 Non-Executive Director's terms came to an end. Following a formal recruitment process, the 3 outgoing Non-Executive Directors were appointed to serve a further term of 3 years. Further information on the recruitment process can be found in Section 5.5 of this report.

7.2.2 Executive team

Five Executive Directors (including the Chief Executive) make up the Board's Executive team. There are also two Associate Directors, in place to support the effective functioning of the Board.

There have been several changes within the Executive team during 2012/13.

Mr Mick Rodgers, Deputy Chief Executive and Executive Director of Finance, retired on the 28th February 2013. Mr Rodgers had worked for the Trust since 1970, starting off as an Accountancy Assistant at Lodge Moor Hospital and working in several roles in the Finance Department over the following years. He became the Director of Finance in 1989, and added to this the role of Deputy Chief Executive in 2002.

The Board wishes to thank Mr Rodgers for his unfailing hard work, support and dedication to the NHS over his 42 years of service, he really will be missed. The Board would also like to welcome Mr Paul Robinson, who was appointed to the role of Executive Director of Finance and took up post on 1st March 2013 following a handover period, and looks forward to working with him in the future.

Due to Mr Rodgers' retirement, changes to other members' roles within the Executive team have taken place:

- Clive Clarke (previously Executive Director of Operational Delivery and Social Care) became Deputy Chief Executive Designate in November 2012 and then Deputy Chief Executive from 1st March 2013
- Liz Lightbown (previously Executive Director of Nursing and Integrated Governance) became Chief Operating Officer/Chief Nurse in November 2012.

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 2012/13, including their attendance at the Board's meetings, is set out on the following page.

Mick Rodgers' retirement event

Name	Position	Term	Number of meetings attended out of the total number that could possibly be attended by each Director
Alan Walker	Chair	3 year appointment from 1/07/10	11/11
Kevan Taylor	Chief Executive	N/A	11/11
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	N/A (retired 28th Feb 2013)	10/10
Clive Clarke	Executive Director of Operational Delivery and Social Care (Apr – Feb)/Deputy Chief Executive Director (Mar – present)	N/A	10/11
Liz Lightbown	Executive Director of Nursing and Integrated Governance (Apr – Oct)/Chief Operating Officer/ Chief Nurse (Nov – present)	N/A	9/11
Professor Tim Kendall	Medical Director	N/A	10/11
Paul Robinson	Executive Director of Finance	N/A	3/3 (attended two meetings as Director of Finance Designate)
Councillor Mick Rooney	Non-Executive Director and Senior Independent Director	3 year appointment from 1/11/11	11/11
Sue Rogers	Non-Executive Director and Vice Chair	3 year appointment from 01/12/12	11/11
Martin Rosling	Non-Executive Director	3 year appointment from 1/11/11	10/11
Anthony Clayton	Non-Executive Director	3 year appointment from 01/12/12	10/11
Mervyn Thomas	Non-Executive Director	3 year appointment from 01/12/12	10/11

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.

7.3 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.

7.3.1 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 seven occasions during 2012/13 and details of members' attendance at its meetings are as shown in the table below.

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.

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	7/7
Anthony Clayton	Committee Member and Non-Executive Director	6/7
Mervyn Thomas	Committee Member and Non-Executive Director	6/7
Councillor Mick Rooney	Committee Member and Non-Executive Director	5/7
Susan Rogers	Committee Member and Non-Executive Director	6/7

7.3.2 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 ten occasions in the course of 2012/13 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	9/10
Martin Rosling	Committee Member and Non-Executive Director	9/10
Anthony Clayton	Committee Member and Non-Executive Director	9/10
Councillor Mick Rooney	Committee Member and Non-Executive Director	8/10
Susan Rogers	Committee Member and Non-Executive Director	9/10
Professor Tim Kendall	Committee Member and Executive Medical Director	7/10
Liz Lightbown	Committee Member and Executive Director of Nursing and Integrated Governance (Apr – Oct)/Chief Operating Officer/ Chief Nurse (Nov – present)	8/10
Clive Clarke	Executive Director of Operational Delivery and Social Care (Apr – Feb)/Deputy Chief Executive Director (Mar – present)	10/10
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	8/8
Paul Robinson	Executive Director of Finance	2/2

7.3.3 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 12 occasions during 2012/13 and Committee members' attendances 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	11/12
Mervyn Thomas	Committee Member and Non-Executive Director	11/12
Mick Rodgers	Deputy Chief Executive and Executive Director of Finance	10/11
Susan Rogers	Committee Member and Non-Executive Director	11/12
Clive Clarke	Executive Director of Operational Delivery and Social Care (Apr – Feb)/Deputy Chief Executive Director (Mar – present)	11/12
Liz Lightbown	Committee Member and Executive Director of Nursing and Integrated Governance (Apr – Oct)/Chief Operating Officer/ Chief Nurse (Nov – present)	8/12
Paul Robinson	Executive Director of Finance	3/3

7.3.4 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 met on two occasions during 2012/13 and Committee members' attendances 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
Professor Alan Walker	Committee Chair	2/2
Anthony Clayton	Committee Member and Non-Executive Director	2/2
Martin Rosling	Committee Member and Non-Executive Director	2/2
Mervyn Thomas	Committee Member and Non-Executive Director	2/2
Susan Rogers	Committee Member and Non-Executive Director	2/2
Councillor Mick Rooney	Committee Member and Non-Executive Director	2/2

Sally Bramley receiving an NHS Heroes award

7.4 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 Community Health Sheffield and 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 Chief Executive of the predecessor Trust and prior to that as Executive Director of Planning and Performance Management of Sheffield Care Trust. He also served as Head/ Director of Commissioning of the Sheffield Health Authority. Kevan has a background as a practitioner in Social Care and as a Local Authority Manager. He is heavily involved in junior football and serves as Club Welfare Officer at Hallam and Redmires Rangers.

Mick Rodgers

CPFA, MAAT, MIHSM

Executive Director of Finance and Deputy Chief Executive (retired Feb 2013)

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

Mick 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 included 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.

Mick retired from the Trust in Feb 2013.

Clive Clarke

Diploma in Social Work (CQSW)

Executive Director of Operational Delivery and Social Care (April 2012 – Feb 2013)

Deputy Chief Executive Designate (Nov 2012 – Feb 2013)

Deputy Chief Executive (March 2013 – present)

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 28 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 Sheffield Care Trust.

Since November 2012 Clive took on the role of Deputy Chief Executive Designate with responsibility for Planning & Performance, Commercial Relations, Estates, IT (which includes information governance) and Clinical and Corporate governance, a responsibility he shares at Board Level with Prof. Tim Kendall. The new role enables Clive to continue to drive the closer working relationship between clinical services and corporate/support services with the aim of improving service quality.

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 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, was awarded the "Lancet Paper of the Year" for publishing work on Selective Serotonin Reuptake Inhibitors (SSRIs) and the Treatment of Childhood Depression.

Liz Lightbown

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

Executive Director of Nursing and Integrated Governance (April 2012 – Nov 2012)

Chief Operating Officer/Chief Nurse (Nov 2012 – present)

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.

In November 2012 Liz took over the role of Chief Operating Officer/Chief Nurse.

Paul Robinson

ACMA, CGMA

Executive Director of Finance

Paul has over 20 years experience in NHS Finance serving in provider and commissioning organisations in South Yorkshire, Derbyshire and Lincolnshire. Prior to his appointment he was the inaugural Director of Finance & Deputy Chief Executive for Lincolnshire Community Health Services NHS Trust which he helped to establish as a standalone organisation in 2011.

Susan Rogers

MBE, BA (Hons) History, Certificate of Education

Non-Executive Director (Vice – Chair)

Sue Rogers has extensive experience in the teaching profession, as well as industrial relations. She has served at the highest level of NASUWT (National Association of Schoolmasters Union of Women Teachers), the largest teachers' trade union in the United Kingdom, both as President and Treasurer.

From 2005 to 2009, Sue served as the Chair of AQA (Assessment and Qualifications Alliance), the largest unitary awarding body for public examinations in the United Kingdom.

Sue was 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.

Sue served a three year term as a Non-Executive Director from 2009 to 2012. Following the advertisement of the post on the NHS Jobs website, the Nominations and Remunerations Committee formally interviewed her for the post and recommended that she be appointed as a Non-Executive Director of the Trust. The Council accepted this recommendation and appointed Sue for a further term of three years with effect from 1st December 2012.

Her appointment has enhanced the Board's ability to address the organisation's human resource needs and its strategic capacity in general.

Tenure of office: 1st December 2012 – 30th November 2015.

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 reappointed to serve for a further term of three years in 2011. 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.

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.

Tony served a three year term as a Non-Executive Director from 2009 to 2012. Following the advertisement of the post on the NHS Jobs website, the Nominations and Remunerations Committee formally interviewed him for the post and recommended that he be appointed as a Non-Executive Director of the Trust. The Council accepted this recommendation and appointed Tony for a further term of three years with effect from 1st December 2012.

Tenure of office: 1st December 2012 – 30th November 2015.

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. He was reappointed to serve for a further term of three years in 2011.

Martin 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.

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.

Mervyn served a three year term as a Non-Executive Director from 2009 to 2012. Following the advertisement of the post on the NHS Jobs website, the Nominations and Remunerations Committee formally interviewed him for the post and recommended that he be appointed as a Non-Executive Director of the Trust. The Council accepted this recommendation and appointed Mervyn for a further term of three years with effect from 1st December 2012.

Tenure of office: 1st December 2012 – 30th November 2015.

7.4.1 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. Please submit any requests to Clive Clarke, Deputy Chief Executive, by ringing 0114 2263978 or email clive.clarke@shsc.nhs.uk.

7.4.2 Board Evaluation

There were six Board development sessions this year which aimed to build the strategic capability of the Board. The development sessions informed the development of Trust strategy, annual and financial plans. Sessions were designed to include key changes in the external context, such as the Health and Social Care Act 2012. One session was dedicated to improving the service user experience. The Board also has an annual development session with the Governors which included a presentation and Question and Answer session where the Governors hold the Board to account for the year's performance.

Members of the Board's Audit and Assurance Committee, and its Finance and Investment Committee have completed questionnaires and are using the responses to these to help 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 took place during 2012/13 during which the members discussed the operation of the Committee. It was agreed that the Committee continues to discharge its duties effectively and efficiently.

The Trust Chair will be carrying out performance evaluations of each of the Non-Executive Directors during 2013/14.

The formal evaluation of the Chair's performance began with Board members and Governors responding to a formal questionnaire on the Chair's performance in various aspects of his role. The questionnaire responses were then considered by the Reserve Chair/Lead Governor and the Senior Independent Director, and a report will be presented 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 and this can be seen in the biographical details of Board members as set out above.

SECTION 8.0
Staff Survey

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.

Creative Potters' turtle at the Longley Centre

Service Users and staff on Stanage Ward

8.1 Survey results 2012

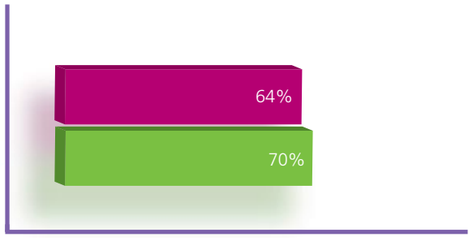
The Trust has maintained its high score in respect of overall staff engagement, including the question relating to staff recommending the Trust as a place to work or receive treatment.

The top 5 / bottom 5 ranking scores are set out below:

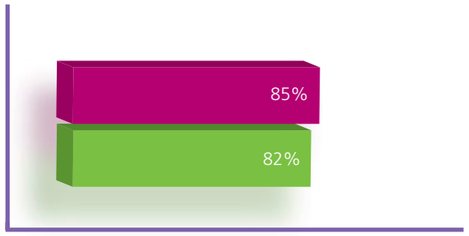
Top five ranking scores

Trust score for 2012 — National Av for mental health/learning disability Trusts

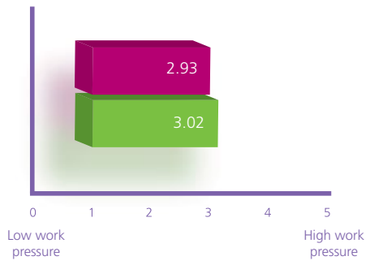
KF5 The % of staff working extra hours



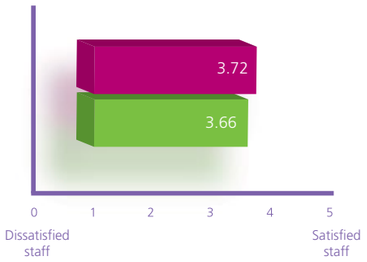
KF6 The % of staff receiving job-relevant training, learning or development in last 12 months



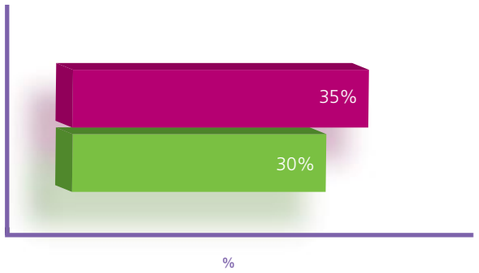
KF3 Work pressure felt by staff



KF23 Staff job satisfaction



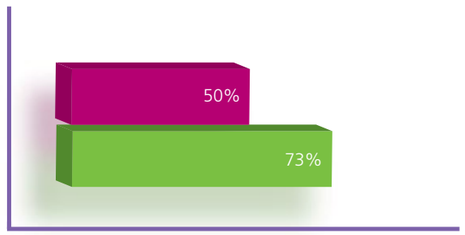
KF21 % of staff reporting good communication between senior management and staff



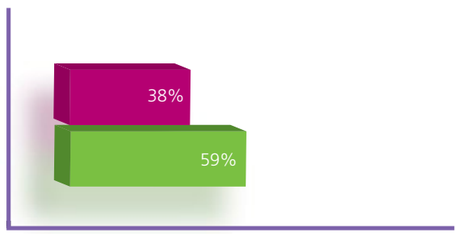
Bottom five ranking scores

Trust score for 2012 — National Av for mental health/learning disability Trusts

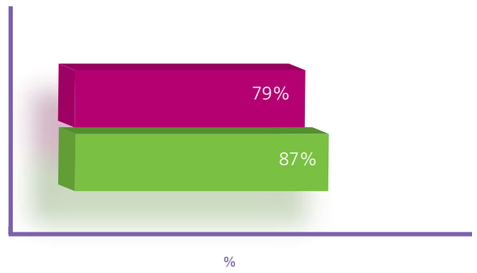
KF10 % of staff receiving health and safety training in last 12 months



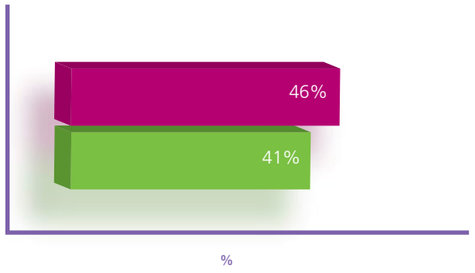
KF26 % of staff having equality and diversity training in last 12 months



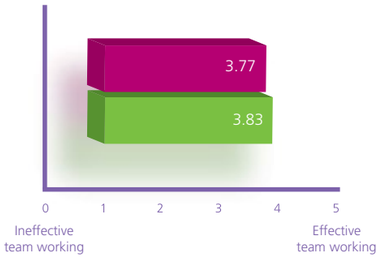
KF7 % of staff appraised in last 12 months



KF11 % of staff suffering work-related stress in the last 12 months



KF4 Effective team working



In addition, the percentage of staff agreeing that their role makes a difference to patients and the percentage agreeing that they feel able to contribute towards improvements at work were both above average.

Although the Trust still needs to significantly improve in respect of certain elements of its training, the survey shows the Trust as being amongst the best 20% in terms of receiving job-relevant training, learning or development in the last 12 months.

On appraisal, the Trust's relative ranking has declined, however, although there was a slight improvement in the percentage figure, the rate of improvement fell below that of other Trusts.

A further area for continued consideration is the percentage of staff reporting work-related stress. However at the same time the largest change since the 2011 survey is in respect of the improvement in staff satisfaction; with the Trust now being in the top 20% of comparable Trusts.

Art therapy session on ward G1

SECTION 9.0
Regulatory Ratings

9.0 Regulatory Ratings

The Care Quality Commission (CQC) registers, and therefore licenses us as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to make sure we continue to meet these standards. We have remained compliant with the terms of our registration during the year. Information about the CQC's visits and inspections of our services is provided in Section 11.

Our performance against the regulatory requirements set for is by Monitor, the independent regulator of NHS Foundation Trusts over the year 2012/13 is summarised as follows:

2012/13 risk ratings compared to annual plan

	Annual Plan 2012/13	Quarter 1 2012/13	Quarter 2 2012/13	Quarter 3 2012/13	Quarter 4 2012/13
Financial risk rating	4	4	4	5	4
Governance risk rating	Green	Green	Amber/Green	Green	Green

We performed well during the year. We failed to achieve one of the quality targets required of us in the second quarter of the year. Information about this is provided in Section 11.

The gardens at Beighton Road

SECTION 10.0
Sustainability

10.0 Sustainability Report

Our approach to sustainability is reflected in our Sustainable Development Policy. The objectives of the policy are for the Trust to continually improve upon and manage its environmental impact 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, and training and educating staff, involving them in developing new ideas and initiatives.

The intended outcomes will be the ability to meet legislative and regulatory requirements; contribute to the NHS carbon reduction target; demonstrate the Trust's commitment to other organisations, and have better engaged and informed staff who actively contribute to the outcomes.

The Trust has taken a number of actions during 2012/13 to improve its sustainability performance.

We have introduced a Sustainability & Cost Savings Working Group, comprising of management and staff members, as well as staff and public governor representatives. The Group has overseen several areas of work including:

- Energy and sustainability roadshow displays at the Trust's Annual Members Meeting and several of our main sites
- Implementation of a revised 'water flushing procedure' (legionella control) to reduce wastage of water
- Building on the success of a Voltage Optimisation Unit (VOU) installed at our headquarters building in 2011/12, a further 4 VOUs have recently been installed at other sites. There is an early indication that these units will also reduce electricity consumption by around 10% at each site
- Working with the cleaning/catering contractor for Fulwood House (Sodexo), paper hand towels on this site have been replaced with hot air hand dryers. This simple change has reduced cleaning costs by £13,000 per annum, and waste disposal costs by nearly £3,000 per annum – all by ceasing purchase and disposal of paper hand towels
- Sodexo have worked in partnership with the Trust to improve their own sustainability practices including offering used coffee grounds for staff to take away as garden mulch, and introducing an incentive for staff to bring their own mugs when purchasing hot drinks from the café, in return for a reduced-price drink. This reduces the quantity of disposable cups used
- "Paper lite" meetings have been adopted for several Trust meetings (members are requested not to print out all papers and these are displayed during the meeting via audio-visual equipment). We are obtaining costs for installing audio-visual equipment in the Tudor Boardroom at Fulwood House which would enable meetings such as the Trust Board to minimise the use of paper
- Establishment of an intranet page for staff to access information related to sustainability.

In addition to this, the Transport Service has continued to replace older vehicles with smaller, more efficient models and to review its practices to minimise the number of vehicles required to provide a range of services.

Grenoside Grange

Reporting Table/Metrics

Area	Type	Non-financial information	Financial information
Greenhouse Gas Emissions	Direct Greenhouse Gas Emissions	In 2012/13 the Trust consumed 13,549,645 kWh of Gas which equates to 2791 tonnes of Co2e*	In 2012/13 the Trust spent £454,093 purchasing Gas
	Indirect Energy Emissions	In 2012/13 the Trust consumed 3,356,717 kWh of Electricity which equates to 1803 Tonnes of Co2e*	In 2012/13 the Trust spent £348,212 purchasing Electricity
	Official Business Travel Emissions	Grey Fleet (inc Lease Car Mileage)**: In 2011/12*** mileage travelled by the Grey Fleet amounted to 1,703,395 miles. The figure for Co2e is not currently available.	Grey Fleet (inc Lease Cars): In 2011/12 the Trust spent £728,910.05 on mileage for the Grey Fleet.
Waste Minimisation and Management	Domestic Waste: For 2012/13 the figures for Domestic Waste are as follows: Total Waste Arising: 492,457 kg Waste to Landfill: 128,900 kg Waste Recovered/Recycled: 363,557 kg Waste Incinerated: 0 kg		Domestic Waste: In 2012/13 the cost of disposing of Domestic Waste was £76,715
	Healthcare Waste: For 2012/13 the figures for Healthcare Waste are as follows: Total Waste Arising: 14,404 kg Waste Incinerated: 2,870 kg		Healthcare Waste: In 2012/13 the cost of disposing of Healthcare Waste was £15,098
Finite Resources	In 2012/13 the Trust consumed 35,586 m3 of water and sent away 33,807 m3 in the form of sewage		In 2012/13 the total water and sewage cost was £97,884

* Co2e = Carbon Dioxide Equivalent which is a way of reporting all greenhouse gas emissions or reductions as one standard unit
** Grey Fleet = employee-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

We are developing several bids for a Department of Health capital fund for energy efficiency projects which has recently been made available. The majority of planned bids relate to replacement of outdated and inefficient boiler plant, as well as schemes to replace lighting at our Headquarters building. We plan to replace some of the boilers with Combined Heat and Power (CHP) units which would also reduce our electricity consumption from the national grid. We will know later in the year if any of the bids have been successful.

We will also be reviewing the potential to introduce small changes such as devices to reduce water consumption in washrooms, and to reduce electricity consumption by commercial refrigerator and freezer appliances.

Art therapy session on Ward G1

SECTION 11.0
Quality Report

11.0 Quality Report

Part 1: Quality account 2012/13 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Account for 2012/13.

This Quality Account is our way of sharing with you our ongoing commitment to achieve better outcomes and deliver better experiences for our service users and their carers.

In this report we will outline our progress against the priorities we set last year, and look ahead to the areas we will continue to focus on for the coming year. Through the report we aim to be transparent and accountable for the quality of service that we provide.

Our vision is that people who use our services will achieve their full potential, living fulfilled lives in their community. We will deliver our vision by providing services that are world class in terms of quality, safety, efficiency and choice. Our services will deliver outcomes for individuals that are world class in terms of effectiveness of treatment, experience of care, recovery, independence and social inclusion.

The information in this Quality Account demonstrates how we are working to deliver this.

We achieve many improvements in quality by changing how we deliver services across the city. We may expand services, re-organise how we provide them, develop better partnerships with other services in Sheffield. Change and improvements are delivered in this way, and you will find information about these changes in our full Annual Report for 2012/13.

There is also significant potential to deliver improvements in quality, safety, effectiveness and experience through focussing on quality improvements within the day to day care and support we provide. Our ongoing challenge and commitment is to reflect on what we learn about the experiences of those who use our services and identify how it could be improved. Across the Trust we have many initiatives and development programmes which are designed to improve quality and you will find many examples detailed in this Quality Account.

When we look at how we are doing against most of the ways we evaluate our services, we are providing a good standard of care, support and treatment. This is something we are rightly proud about. However we also know we can do better, and need to do better. We have much to do to ensure the quality of what we provide is of a consistent high standard, every time, for every person in respect of safety, effectiveness and experience.

This Quality Account reflects our determination to develop our understanding and measurement of quality as experienced by the people who use our services, and our ambition to deliver continuous quality improvement in all our services.

In publishing this report the Board of Directors have reviewed its content and verified the accuracy of the details contained in it. Information about how they have done this is outlined in Annex B to this report.

To the best of my knowledge the information provided in this report is accurate and represents a balanced view of the quality of services that the Trust provides. I hope you will find it both informative and interesting.

Kevan Taylor

Chief Executive

Adelaide Mukasa, Rowan Ward Manager

Beighton Road, Learning Disability Service

Service User pottery at Moncrieffe Road

Part 2A: A review of our priorities for quality improvement in 2012/13 and our goals for 2013/14

We established our priorities for quality improvement in February-March of 2012. The people who use our services and the membership of our foundation trust have been instrumental in deciding what our priorities are. When we identified our priorities we agreed a two year plan to deliver improvements over the longer term.

In order to establish these areas as our priorities our Board of Directors:

- Reviewed our performance against a range of quality indicators
- Considered our broader vision and plans for service improvement
- Continued to explore with our Council of Governors their views about what they felt was important
- Engaged with our staff to understand their views about what was important and what we should improve.

We then consulted on our proposed areas for quality improvement with a range of key stakeholders. These involved our local Clinical Commissioning Group, Sheffield City Council and members of LINk (now Healthwatch).

This report confirms how we have progressed over the first year of our two year plan. It also confirms what actions we will continue to take and focus on next year to make further progress and improvement.

In reviewing our progress over the first year and finalising our plans for next year we have continued to engage with our members. Our Governors have undertaken this on our behalf and we have received comments and feedback from over 150 of our members about our proposals for next year. From this review the Council of Governors have reviewed our plans and we have taken on board their feedback.

Through next year we will report on progress against our quality improvement objectives through the following ways:

- The Board's Quality Assurance Committee
- The Board of Directors
- To our Council of Governors formally at their meetings during the year
- To our Commissioners.

We identified 5 quality improvement priorities for this year and the year ahead. They cover the following areas:

Improving safety	**Quality objective 1:** To reduce the number of falls that cause harm to service users
	Quality objective 2: To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion
Improving clinical effectiveness	**Quality objective 3:** To improve the identification and assessment of physical health problems in at-risk client groups
Improving the delivery of positive service user experiences	**Quality objective 4:** To improve the experience of first contact with the Trust's services
Improving access, equality and inclusion	**Quality objective 5:** To improve access to the right care for people with a dementia

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

We chose this priority because

Falls cause direct harm to service users because of injury, pain, restrictions on mobility and community participation. This harm impacts on people's quality of life and well-being. Three years ago, the National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust's older people's inpatient areas than the national average rate of falls. There were 13.5 falls per 1000 bed nights compared with 8.4 falls nationally.

Our own data showed that during 2011/12 1,605 incidents of slips, trips and falls for service users were reported by the Trust. 32.1% (n=516) resulted in harm or injury to the service user concerned.

Guidance was available on how to reduce the severity, frequency and impact of falls from NICE. We believed there were clear opportunities to deliver real improvements in this important area. This was also a priority area for Sheffield Clinical Commissioning Group who incentivised improvement in this area under the Cquin scheme) (see section 2.3 within this Quality Report).

We said we would

Introduce a two year plan that started in 2012/13 and will continue into 2013/14. Within this plan we said we would:

- Implement MFRA (Multi-factorial Risk Assessment) screening tool for falls for all older people admitted to inpatient areas
- Carry out environmental falls risk assessments in all inpatient and residential areas
- Identify appropriate training packages for staff and deliver a programme of training.

The outcome we wanted to achieve was

- To reduce the number of falls that result in harm to service users by 5% by the end of this year and by 10% next 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
- That by the end of this year all older people admitted to inpatient areas will be assessed to see if they are vulnerable to experiencing a fall.

Beighton Road, Learning Disability Service

How did we do?

We have made really good progress. We have introduced screening for falls within 72 hours of admission, Personal Falls Plans, improved assessment of our building environments for falls hazards and hazard reduction opportunities. We have supported our staff through better training and are exploring ways to use Assistive Technology to reduce falls (for example, using alarms and sensors in beds and chairs so we know when someone is getting up).

The consistent approach to assessing people's needs, along with the staff support provided has made a clear difference this year. However we need to establish better ways of monitoring that this happens.

In 2011/12 there were 516 falls that resulted in harm. This year we wanted to reduce that by 5% to 490. The number of falls resulting in injury has reduced by 21% to 403 this year.

Service User falls that resulted in harm 2012/13

Of those who experienced harm from a fall, 52 people needed to attend hospital or A&E for treatment, compared to 61 in 2011/12.

Next year we intend to

Continue with our plans, as they have had a positive effect this year. We plan to

- Ensure falls that result in harm do not exceed 439 (our original two year target)
- Ensure people admitted to our older adult wards are assessed for risk of falling and monitor this effectively
- Evaluate the use of assistive technology, such as the bed and chair sensors
- Implement the risk assessment process (MFRA) to the residential care services that we provide support to.

Quality objective 2: To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion

We chose this priority because

When violence or the potential for violence happens, it causes harm, distress, anxiety and fear for both service users and our staff. This will clearly have an impact on how people feel in receiving care or providing care within our inpatient services. It is in everyone's interest to reduce violence and the fear and anxiety associated with violence.

In the past we have reported lower rates of violence and aggression when compared to other mental health trusts. Benchmarking information from the National Patient Safety Agency for the first 6 months of 2011/12 showed that 15.5% of patient safety incidents reported by the Trust were related to disruptive, aggressive behaviour, in comparison with 19% of incidents reported by mental health trusts nationally.

However, our own data showed that violent incidents made up a large proportion of our overall incidents. As well as this the CQC Staff Survey for 2011 showed 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 previous year. The proportion of staff who said they had experienced harassment, bullying or abuse from patients, relatives or the public in the previous 12 months was also above the national average.

We said we would

We have introduced a programme called RESPECT which is an ethical approach to managing aggression and violence.

Its aim is to support staff to empathise with the service user, to understand that the service user may well be frightened and that may be what is informing their aggressive presentation. The programme promotes early recognition of the signs of pending aggression which supports more appropriate de-escalation approaches but also acknowledges that, on occasion, violence will be instrumental and that intervening physically will be the only safe response.

We have trained our staff to respond to these circumstances safely and with sensitivity. The programme will touch everyone in the organisation as it also focuses on exploring the environment and the context that the aggression is displayed within and what we can do to make improvements to the way we provide our care generally.

Through this programme, during 2012/13 our plans were to:

- Continue to deliver the Respect training for all of our ward staff by the end of this year
- Continue to monitor the incidents of violence and aggression at team level, and analyse trends over time
- Establish reliable and consistent methods for the recording of restraint and seclusion on all inpatient areas, and establish clear baselines to inform ongoing evaluations
- Establish service level plans for the reduction of the use of restraint and seclusion in all inpatient areas
- Establish reliable and consistent reporting on the use of restraint in our community settings, establish baselines and set local reduction targets and agree actions.

The outcome we wanted to achieve was

By the end of this year we wanted to ensure all inpatient nursing and support worker staff within our inpatient services had been trained in the Respect Approach.

Through this year and by the end of next year we wanted to:

- To reduce the use of seclusion and the use of restraint
- To increase the percentage of service users in acute wards who report experiencing a safe environment in local surveys
- To reduce the number of staff reporting that they have experienced physical violence and harassment, bullying or abuse from service users, relatives or the public in the CQC Staff Survey.

How did we do?

We believe we are making good progress in delivering real improvements for the longer term. Over the year the data is varied in what it shows across the different indicators.

The extensive staff development work we have done has had a positive impact in conveying expectations and the need to ensure all types of violence are accurately captured to ensure we fully understand day to day circumstances.

We believe at this stage that this is the main reason why reported incidents of violence towards staff has been increasing, especially over the last year. Detailed analysis highlights that the vast majority of these incidents are 'lower level' types of violence, such as pushing and shoving, that may well have not been reported previously.

The practice development work we have done, through the RESPECT programme and the introduction in some areas of designated spaces and facilities to support people to work through their agitation (such as 'Green Rooms') are showing positive results with reduced use of seclusion and restraint.

Incident type	2010/11	2011/12	2012/13
Incidents reported where service users had been			
• Secluded	91	80	71
• Restrained	168	105	85
• Assaulted	398	387	386
• Caused harm from assault	78	89	72
Proportion of all reported patient safety incidents related to disruptive			
• Within our Trust		15.5%	20.6%
• National averages for mental health trusts NPSA Benchmarking data		19%	18.2%
Percentages of service users who report feeling unsafe in local surveys	25%	25%	32% July 23% Dec
Incidents reported where staff working in inpatient services			
• Had been assaulted	324	364	608
• Caused harm from assault	97	110	101
Number of staff who reported to the national CQC staff survey that they had experienced from patients, relatives or visitors			
• Physical violence	17%	17%	22%
• Harassment, bullying or abuse	19%	19%	30%

This is a complex issue to report on. The threat of violence and actual violence clearly causes fear and psychological distress. The impact and consequences for people are individual to them. Reporting through data about incidents does not capture this fully, yet it is important to have an awareness of overall incident levels. That is what we report on here.

Overall at this stage in our development plan we believe we have made good and positive progress. This puts us in a positive position to continue to deliver improvements into next year and beyond.

Next year we intend to

- Reduce further the incidents of seclusion and restraint from the levels in 2012/13
- Continue with our investment in the Respect development programme
- Implement a range of new policy guidance that defines and supports expected practice, incorporating all our learning over the last 2 years
- Implement a programme of practice reviews focussing on seclusion, de-escalation, physical health monitoring, post-incident reviews, use of green rooms
- Continue with our staff training programme
- Undertake a review of staff experiences of delivering care and how we can better support them to deliver respectful and compassionate care
- Complete an initial assessment of the experiences of service users and staff in our non-residential and inpatient settings.

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

We chose this priority because

Physical health was a priority for our governors and service users, as many of our service users are at higher risk of developing physical health problems. The evidence clearly shows that people with severe mental illness and people with learning disabilities have reduced life expectancy and greater morbidity, as do people who are homeless and people who misuse drugs and alcohol.

We were 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 introduction of physical reviews for people with long term mental health problems in primary care presented additional opportunities to make further improvements.

Audits of care records across our mental health and learning disability services in November 2011 showed overall in 78% of service users' records their physical health status was checked and documented. This was less across our community mental health service areas. Our GP services performed well across a range of areas in meeting the physical health care needs of people with mental health problems, although performance was poor for people newly diagnosed with dementia.

We said we would

- Implement the electronic Medical Examination on Admission and Lifestyle Assessment across all relevant services
- Train additional 30 staff to become 'healthy chat' key trainers with roll out training to a further 180 staff
- Develop and roll-out obesity care pathway supported by patient information resources, improved menu labelling and healthier set menus for inpatient services
- Ensure smoking status of all inpatients is recorded, with an increase in referrals to Stop Smoking Service and the introduction to inpatient services of smoking cessation experts
- Our GP services would improve the recording of BMI in people with psychosis and the completion of physical health checks for people newly diagnosed with dementia.

The outcome we wanted to achieve was

- '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
- Improved awareness of peoples smoking circumstances with appropriate support provided
- 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.

How did we do?

We continue to implement an Annual Physical Health Work Plan that looks to focus on the following areas:

- Smoking, Alcohol, Obesity, Diabetes, Physical Health Check recording, Annual Health Checks

During the year we have developed, piloted and introduced an innovative on-line screening tool that provides access to advice and assessment of peoples alcohol use. This has been a really positive and exciting development that allows people receiving support from across GP surgery's, Pharmacists, other health and social care services to get quick and tailored advice along with information about support services should they be needed. Over this year 914 people have benefitted from advice in this way.

We have also made progress in the following areas:

- 39 'health chat' key trainers have been trained
- 99% of sampled care plans in pilot services had evidence of health checks being done
- Our knowledge of peoples' smoking status increased from 55% in April 12 to 95% in December 12
- We have introduced diabetes link nurses within 10 of our Wards
- Our Clover Group of GP practices had completed 84% of physical health checks for people with dementia – against a target of 70%
- Completed 84% of BMI assessments of people with a psychosis – against a target of 90%.

OT exercise session at the Longley Centre

Next year we intend to

Continue our current plans to bring together achievable actions within the Trust and external to partner organisations. We will build on existing and planned developments to ensure that we and our partner organisations work collaboratively to ensure health of service users continues to improve.

The priorities for this year are continued work to improve the physical health of service users by focussing on:

- Smoking - Offering advice guidance and referrals to the smoking cessation service to decrease smoking amongst service users
- Alcohol - Provide alcohol screening across services to ensure timely referral to appropriate services
- Obesity - provide advice and support to address the issue of poor lifestyle choices, encouraging healthy diet and exercise
- Diabetes - To ensure those at risk, in particular those individuals who may experience weight gain due to their medication or lifestyle choices, are effectively screened for the risks of diabetes and are offered appropriate treatment, advice and guidance
- Dental - To ensure that Dental Care is included in both physical and lifestyle assessments and that access to dental care is made more readily available
- Physical Health Checks and annual health checks for vulnerable service users - Ensure that all service users have appropriate physical health checks, whether completed by our services or within our partner organisations.

Quality objective 4: To improve the experience of first contact with the Trust's services.

We chose this priority because

Our Governors and service users had identified this issue as a priority for positively influencing the service users' overall experience of the services we provide. 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.

Following low scores on the CQC Annual Community Mental Health for questions about a 24 hour phone line, the Trust had piloted an out-of-hours phone line to give advice and help to service users and carers, in partnership with Rethink. We were keen to learn from the pilot and provide ongoing support to service users

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, and we wanted to support this programme to deliver improvements to the day to day experiences of our service users.

We said we would

- Pilot an out of hours telephone helpline, evaluate how it worked and develop a plan for a sustainable service
- Deliver RESPECT training for all inpatient staff
- Review and revise standard communications relating to first contact including initial appointment letters and information leaflets sent out with initial appointments, and ward welcome packs
- Implement 15 Steps Challenge with our non -executive directors, staff and service users in inpatient areas and 1 community team.

The outcome we wanted to achieve was

- Improved awareness of services users about the support available through the crisis helpline
- More staff trained in customer care as part of the roll out of Respect training
- Better information provided to support service users entering our services
- To remain in top 20% of mental health trusts in CQC Annual Community Mental Health Survey for being treated with dignity and respect.

How did we do?

We have made positive progress with our helpline services, which have continued over this year. We will have opened a new Crisis House service, in partnership with Rethink, in April 2013. We expect it to provide support to over 300 people a year as an alternative to needing hospital care. As part of that service we have commissioned Rethink to provide the helpline service for our service users.

All inpatient staff have benefited from the RESPECT development and training programme by the summer of 2012, and it is having a positive effect across our services. We continue to provide the training to support new staff who have since joined the service, and to provide updates to existing staff who have been trained previously.

Areas of experience	2010/11	2011/12	2012/13
Awareness of crisis support available through telephone helpline (National Patient Survey)	51 out of 100	5.0 out of 10	n/a see note
Ensure all inpatient staff have benefited from Respect development programme	Nil	155 staff	Extra 209 364 in total
Service users reporting they are treated with respect (National Patient Survey)	95 out of 100	9.5 out of 10	n/a see note

*Note: We will use the national patient survey as a way of assessing feedback and progress over this year. Unfortunately the national survey had not been completed in time for us to include the results in this Report.

We did not make the progress we wanted to regarding reviewing the information we share with service users. We will address this better next year.

Next year we intend to

- Continue with the Respect development programme for new staff and the 15 Steps Challenge to support the delivery of improved experiences
- Continue to review service user experiences through local surveys
- Complete the review of the range of information we provide to service users and agree improvements
- Focus on supporting service users to access our services quickly. To support this we will confirm improvement targets in respect of our IAPT services (assessed within 4 weeks of referral) and our Community Mental Health teams (assessed within 2 weeks of referral) and establish targets for our Memory services (see Quality Objective 5).

Stanage Ward

Quality objective 5: To improve access to the right care for people with a dementia

We chose this priority because

Improving dementia care is a priority for the Trust, governors, the City Council, Sheffield Clinical Commissioning Group, and Healthwatch. The incidence of dementia is predicted to rise with Sheffield's aging population. We know that 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.

Overall 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 by their GP in primary care. In 2012 in Sheffield 63.6% of the expected number of people with a dementia have been registered, compared to the national average of 44.2%. Sheffield is the 2nd best performing area in England and Wales.

We wanted to build on the delivery of the NICE Quality Standard for Dementia and positive development work already underway over the last few years to improve access to our services and reduce waiting times. Within our learning disability services a specific dementia care pathway has been developed because of the increased risk of early dementia in people with Downs syndrome.

We have worked successfully in partnership with Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Clinical Commissioning Group to improve access to dementia support and care for people who require access to general hospital.

We said we would

- Continue the development of our Memory management services so we could provide more assessments and reduce waiting times
- Implement and evaluate the dementia pathway for adults with a learning disability
- Develop and implement a plan to improve access to services by people from Black and Minority Ethnic Groups
- Survey service users and carers of dementia services about their experience of care and respond to any issues raised.

The outcome we wanted to achieve was

- Support over 900 people with memory assessments, and reduce service waiting times from 14.7 weeks
- To 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 use of dementia services.

Art therapy session on Ward G1

How did we do?

We have made good progress in improving access, though we have further work to do to continue to reduce waiting times. While we have managed, through a range of service improvements to see more people, waiting times have got worse over the year.

Areas of experience	2010/11	2011/12	2012/13
Number of people who received an assessment and diagnosis	749	876	918
Average waiting times to access memory services	21.9 weeks	14.5 weeks	16.3 weeks
Number of people with a learning disability who were assessed for dementia	Not available	40 approx	29

We have completed an exciting project to gather the views and experiences of people with dementia. The 'Involving People with Dementia Project' aims to extend the good practice around service user involvement that already exists in SHSC by exploring how people with dementia could be better involved in service feedback, evaluation and planning. The project has resulted in a film being produced. The film aims to demonstrate that, given the opportunity, people with dementia have important things to contribute to services and society through their experience of dementia. The film powerfully shows how people with dementia have a voice and they want their voice to be heard. We are using this film to help raise awareness across Sheffield, both for our own staff and staff from other areas of health and social care.

Our Memory Services benefited from a review with the Royal College of Psychiatrist's Memory Service National Accreditation Programme, which involved surveying independently the views of service users and their carers. The feedback from the accreditation is very positive and encouraging about the standard and quality of the care we provide, awarding our services an 'Excellent' rating.

We successfully implemented and evaluated a dementia pathway for adults with a learning disability.

We developed and introduced a programme of 'awareness raising' for BME Community groups about dementia and local services.

During the year we also worked in partnership with Sheffield Teaching Hospitals NHS Foundation Trust to support them to provide better care and treatment for people with dementia in their hospitals. The aim of this pilot was to increase access to specialist dementia trained staff to inform the decisions made about people's care and support needs. It has been successful so far, although the evaluation still continues into the next year.

We have continued to work closely during the year with Sheffield CCG and Sheffield City Council. Through these partnerships and commissioning relationships we have been able to make progress in improving access to community focused care and support.

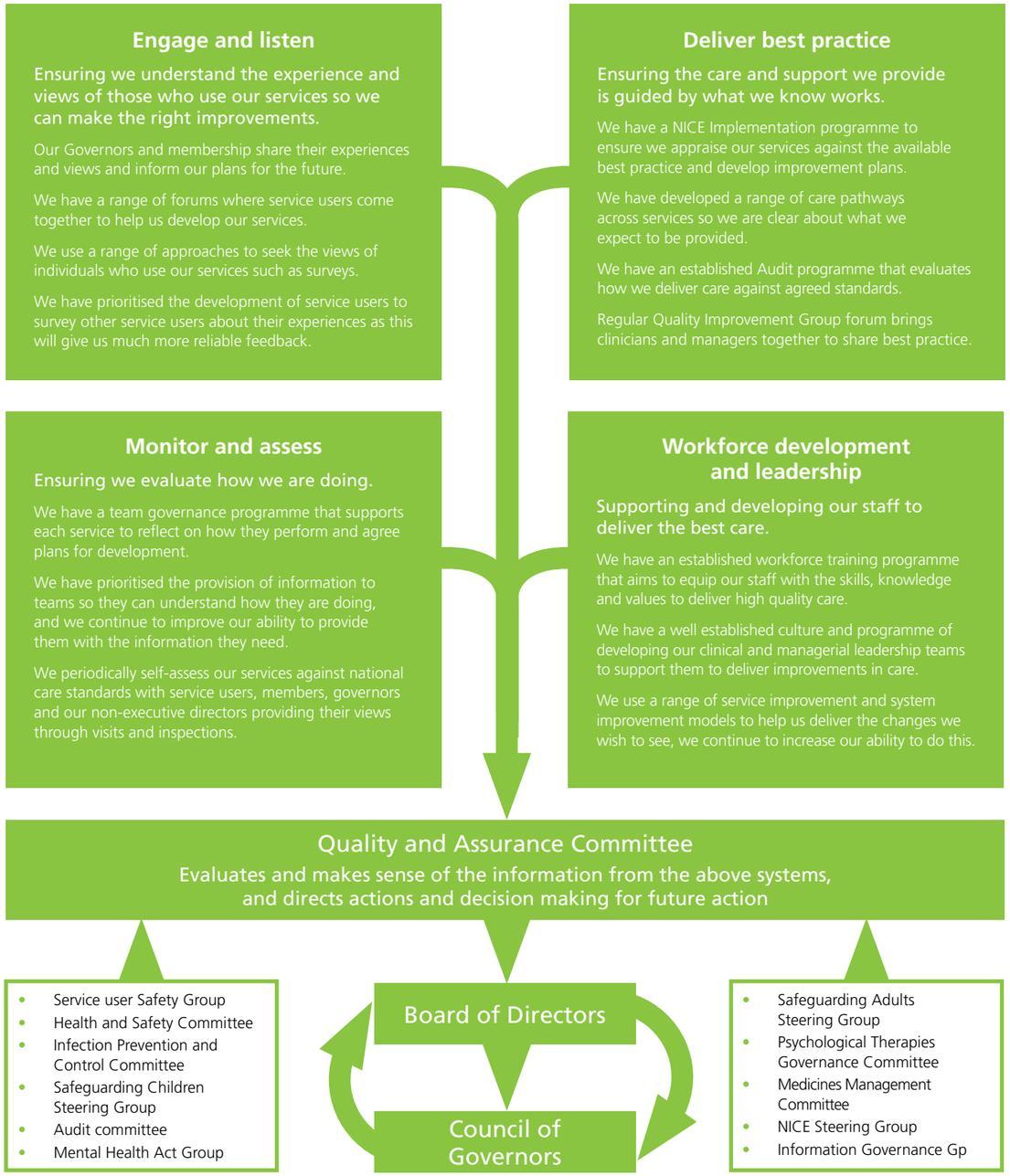
Sheffield CCG has identified the need to support primary care services to better be able to monitor people at lower risk of developing dementia. They have developed proposals with us to provide specialist support to GP's to help with this. The expectation is that this will reduce some of the work of the existing memory services, freeing up time to see people who are newly referred quicker.

With the City Council we continue to implement city wide plans for the development and improvement of social care support for people with dementia. These plans are focussed on increasing our resources to provide more individually focussed support packages within local community areas, and reducing the level of resource allocated for residential based respite care and support. Over the last few years people have been using our 'resource centres' less and less for residential respite and so we are planning to use the resource to provide a different service in the future. This is expanded upon in our fuller Annual Report for 2012/13.

- Next year we intend to
- We recognise the clear disparity in waiting times for people needing to access our memory services compared to other routine services we provide. We want to address this. We will review the options to deliver real improvements in waiting times for our memory services and will confirm the targets we wish to deliver upon. We will then report on this in next year's Quality Account, along with the progress we have made
- We will work with GP practices in Sheffield, and the Clinical Commissioning Group to support more people who have been assessed for memory problems to receive their on-going monitoring with their GP, rather than needing to attend a specialist service
- Evaluate the effectiveness of the pilot liaison services into the local general hospital and agree future needs
- Build on the 'Involving People with Dementia Project' and introduce more ways to gain regular feedback from people with dementia
- Use the 'Voice of Dementia' film to support awareness raising and training for members of the public and staff across Sheffield working in relevant sectors.

How do our structures help ensure we are able to develop our quality improvement capacity and capability to deliver these improvements?

Our governance arrangements and structures support us to focus our efforts on improving the quality and effectiveness of what we do, and deliver on the objectives we have set



Part 2B: Mandatory statements of assurance from the board relating to the quality of services provided

2.1 Statements from the Care Quality Commission (CQC)

Sheffield Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission and our current registration status is registered without conditions and therefore licenced to provide services.

The Care Quality Commission has not taken enforcement action against the Trust during 2012/13. The Trust has not participated in any special reviews or investigation by the CQC during the reporting period.

The CQC registers, and therefore licenses the Trust as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to make sure we continue to meet these standards.

During 2012/13 we assumed the CQC registration of Woodland View Nursing Home, which was previously registered by Guinness Northern Counties Housing Association.

Planned/unplanned reviews

During 2012/13 the CQC visited the following locations as part of their review of our compliance with essential standards of quality and safety:

- Residential homes for people with a learning disability
  Buckwood View, Handsworth, Mansfield View, East Bank Road, Beighton Road
- Respite Care services for people with a learning disability
  Longley Meadows
  136a Warminster Road
- Respite Care services for adults
  Bolehill View, Hurlfield View
  Wainwright Crescent
- Inpatient Services
  Grenoside Grange.

All services inspected were fully compliant with the exception of Bolehill View, where compliance actions were received for:

- Consent to care and treatment and
- Care records.

Following the feedback received from the CQC we took immediate improvement action over the following month and the Commission confirmed following a repeat inspection that we were fully compliant with the required standards.

The reports from the planned reviews of compliance are all available via the Care Quality Commission website at www.cqc.org.uk.

At the publication date of the Trust Quality Account all improvement and compliance actions have been addressed and the Trust was fully compliant with the requirements of registration.

Mental Health Act reviews

During 2012/13 the CQC has undertaken 9 visits to services to inspect how we deliver care and treatment for inpatients detained under the Mental Health Act. They review our processes for care, the environment in which we deliver our care and meet privately with inpatients. They have visited the following services:

- Michael Carlisle Centre
  Stanage, Burbage, Daleside, Maple, Pinecroft
- Longley Centre
  Hawthorne, Intensive Treatment Service
- Forest Lodge
  Assessment & Rehabilitation wards

The feedback from these visits is helpful and allows us to ensure, and be assured, that we provide care in accordance with legislation and best practice guidelines. These reviews and inspections confirm that we continue to meet all essential standards.

2.2 Monitors' compliance framework

The Trust submits quarterly declarations to Monitor in relation to governance and finance. Monitor reviews the Trust's declaration and publishes a quarterly risk rating for each element. This information is available at www.monitor-nhsft.gov.uk.

The governance assessment (rated as either red, amber/red, amber/green or green) is based on the Trust's self-declaration by the Board of Directors against the following areas:

- Compliance with its constitution
- Growing a representative membership
- Maintaining appropriate structures

- Co-operating with other bodies
- Risk management
- Service performance and improvement in service quality.

The tables below feature our ratings for the four quarters of the last two years compared with the Trust's expectation at the beginning of the year as stated in our Annual Plans.

2011/12

The Trust was rated as Amber/ Red risk under governance following a review of its Inpatient Services by the Care Quality Commission in the previous year 2010/11. The CQC identified some moderate/ minor areas of concern that the Trust needed to address.

The Trust implemented a development plan that was agreed with the CQC, and the Amber/ Red assessment remained until the action plan was completed.

At the beginning of the year the Trust planned to have completed the required actions by September 2011, which it did so successfully.

The progress made by the Trust was reviewed and acknowledged by the CQC and the Trust continued with a Green risk rating for Governance for the rest of the year.

During the 2011/12 year the Trust achieved in each quarter all the quality standards required of a Mental Health NHS Foundation Trust.

2012/13

The Trust achieved all healthcare targets for each Quarter with the exception of Quarter 2.

During Quarter 2 the Trust failed to achieve the requirement to provide follow up care within 7 days of discharge from inpatient care for people under the Care Programme Approach. A range of improvement actions were implemented and the Trust continued to achieve the target for the rest of the year.

2011/12 Risk ratings compared to annual plan

	Annual plan 2011/12	Quarter 1 2011/12	Quarter 2 2011/12	Quarter 3 2011/12	Quarter 4 2011/12
Financial risk rating	4	4	4	4	4
Governance risk rating	Amber/ Red	Amber/ Red	Amber/ Red	Green	Green

2012/13 Risk ratings compared to annual plan

	Annual plan 2012/13	Quarter 1 2012/13	Quarter 2 2012/13	Quarter 3 2012/13	Quarter 4 2012/13
Financial risk rating	4	4	4	5	4
Governance risk rating	Green	Green	Amber/ Green	Green	Green

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2012/13 £1,639,911 of the Trust's contracted income was conditional on the achievement of these indicators. For the previous year, 2011/12, the associated monetary payment received by the Trust was £661,000. A summary of the indicators agreed with our main local health commissioner Sheffield Clinical Commissioning Group for 2012/13 and 2013/14 is shown below.

Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	Goal during 2012/13	Is it a continued Goal for 2013/14
NHS Safety Thermometer Improve collection of data We wanted to improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE. This was to ensure we were effectively monitoring safety. We were successful in implementing this programme during the year.	✓ Achieved	✓
Reducing variation in waiting times for patients referred to the IAPT services Some GP practices in Sheffield were experiencing longer waiting times than others. We wanted to reduce the waiting times in these practices by 10%. We were successful with this. Waiting times reduced from 7 weeks to 5.4 weeks.	✓ Achieved	✓
Reduced admissions to Acute Older Adult Wards through improved community are for people in a crisis We had established new community services to provide alternatives to hospital admission. As a result of this we wanted to incrementally reduce the numbers of people who needed hospital care over the year. We were partially successful in achieving this goal, with less people needing hospital care in 3 of the 4 quarterly periods during the year.	✓ Partially achieved	✓
Improved recording of employment & vocational circumstances of people using mental health services To support our broader rehabilitation and recovery strategies we wanted to improve the information we had about individuals circumstances to help us better understand their needs and the progress made in supporting their recovery. We were successful in this, with 95.7% of service users in the target client group having the information updated in their care records.	✓ Achieved	No
Reduction in the number of falls causing harm This goal supported our Quality Objective No 1. We successfully achieved our target of reducing harm caused from falls by 5% this year (See Quality Objective 1 for details).	✓ Achieved	✓

Improving the management of Violence and Aggression within inpatient services This goal supported our Quality Objective No 2. The focus was to improve the service user and staff experience in relation to violence and aggression. We successfully reduced incidents in relation to seclusion and restraint. (See Quality Objective 2 for details)..	✓ Achieved	✓
People using mental health services should have an agreed plan to help reduce and manage the persons risk We wanted to increase the numbers of service users who had risk reduction plans in place following their initial risk assessment. We did not make the progress we expected to make this year, and will continue to deliver this objective next year.	✓ Did not achieved	✓
People who are referred for a routine assessment will be assessed within 2 weeks of the referral Following changes to our community mental health team services we wanted to deliver quicker access to our services following referral from GPs. We set a goal to see more people within 2 weeks of the referral being made. We were successful with this. We have made significant progress on this and in the second half of the year (Oct-March) 175% more people were being assessed within 2 weeks.	✓ Achieved	✓
People using mental health services should have a care plan agreed with them and in place within 6 weeks of the assessment In line with the above service changes, we wanted to ensure that following an assessment, those who needed on-going support and treatment then had a plan of care in place quickly. We did not make the progress we wanted to make. Over the year 57% of people had a care plan agreed within 6 weeks. We will continue to deliver on this objective next year.	✓ Did not achieved	✓
Patients receiving acute inpatient care should benefit from care and treatment from clinical psychologists We wanted to recruit and introduce clinical psychologist to work directly on our inpatient wards. During the year we undertook a range of development work with the ward teams to support the successful introduction of the new posts. We had wanted the new staff to start working on the wards during the year, however this did not happen as planned. The staff have been recruited and we will fully implement this goal from April 2013 onwards.	✓ Did not achieved	No
People with long term neurological conditions needs at level 2 or 3 should have agreed care plans in place We wanted to increase the proportion of people who had a care plan to co-ordinate their care with other services from 40% to 80% by the end of the year. We were partially successful and overall made good progress on this objective, achieving a 77% rate by the end of the year.	✓ Partially achieved	No
People with long term neurological conditions with a care plan (see above) should benefit from a holistic screening of need and client action plan We wanted to ensure service users benefited from a holistic plan of care. We agreed a target to achieve this for 90% of service users, and we achieved 100% through the year.	✓ Achieved	No
Improved use of electronic discharge communications between inpatient services and GP's This is a new goal for next year.	No	
Improved and standardised approaches to surveying service user experiences across all service areas This is a new goal for next year.	No	

2.4 Review of services

During 2012/13 SHSC provided and/or sub-contracted 54 services. These can be summarised as 36 NHS services, 7 integrated health and social care services and 11 social care services. The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2012/13.

The Trust has reviewed all the data available on the quality of care in these services. The Trust reviews data on the quality of care with Sheffield CCG, other CCGs, Sheffield City Council and other NHS commissioners.

The Trust has agreed quality and performance schedules with the main commissioners of its services. With Sheffield CCG and Sheffield City Council these schedules are reviewed on an annual basis and confirmed as part of the review and renewal of our service contracts. We have formal and established governance structures in place with our commissioners to ensure we report to them on how we are performing against the agreed quality standards.

Our governance systems ensure we review quality across all our services.

2.5 Health and Safety Executive/ South Yorkshire Fire and Rescue visits

Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2012/13.

South Yorkshire Fire and Rescue

During 2012/13 the South Yorkshire Fire and Rescue service visited and audited 9 of the Trust's premises. No notices regarding improvement actions were issued by the Fire service. The sites audited where as follows;

Hurlfield View, Grenoside Grange, Bolehill View, Longley Centre, Wardsend Road, Woodhouse Clinic, St Georges, Wainwright Crescent, Ivy Lodge.

2.6 Compliance with NHS Litigation Authority (NHSLA) risk management standards

The NHSLA handles negligence claims made against the NHS and works to improve risk management. Their risk management standards cover organisational, clinical, non-clinical and health and safety risks.

The Trust is compliant at Level 1 with the standards having last been assessed in March 2013. This means our processes for managing risks have been properly described and written down. We will be assessed again in March 2015.

2.7 Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 555.

We adopt a range of approaches to recruit people to participate in research. Usually we will focus on individuals appropriate to the area being researched, staff involved in their care will make them aware of the opportunity to participate and they will be provided with a range of information to allow then to take informed decisions about if they wish to participate.

The Trust was involved in conducting 36 clinical research projects which aimed to improve quality of services, increase service user safety and deliver effective outcomes.

Areas of research in which the Trust has been active over the last 12 months include:

- Improving the quality and effectiveness of therapies and self-management in depression
- Understanding and improving the safety of psychological therapies
- Developing interventions to improve the physical health of those with severe mental illness
- New treatments for service users with schizophrenia
- New treatments for service users with dementia (including Alzheimer's disease).

Research is a priority for the Trust and is one of the key ways by which the Trust seeks to improve quality and initiate innovation. Over the last year the Trust has worked closely with the East Midland and South Yorkshire Mental health Research Network to increase opportunities for our service users to participate in commercial clinical trials of new treatments and with academic partners, including the Clinical Trials Research Unit at the University of Sheffield, to initiate research projects sponsored by the Trust.

SHSC has been actively involved in the establishment of the Yorkshire and Humber Academic Health Sciences Network and will seek to maximise opportunities arising from this towards the goals of improving population health, transforming healthcare and wealth creation for the region.

2.8 Participation in clinical audits

National clinical audits and National confidential enquiries

During 2012/13 14 national clinical audits and 3 national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2012/13 the Trust participated in 100% national clinical audits and 100% national confidential inquiries which it was eligible to participate in.

The table below lists the national clinical audits and national confidential inquiries the Trust participated in, along with the numbers of cases submitted by the Trust in total and as a percentage of those required by the audit or inquiry.

Name of national audit SHSC participated in	Number of cases submitted	Number of cases submitted as a percentage of those asked for
Guideline audits		
National Audit of Schizophrenia (registered for re-audit) - To measure the Trusts performance against national NICE guidelines	150	100%
National Audit of Psychological Treatments - To measure the Trusts performance against national NAPT guidelines	4009	100%
National Parkinsons Audit - To measure the Trusts performance against National standards	53	100%
POMH UK		
Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards (Topic 1) – To ensure prescribing is appropriate within BNF limits	144	100%
Lithium Monitoring (Topic 7c) – To ensure Lithium is prescribed in accordance with NICE guidelines	108	100%
Prescribing antipsychotics for people with Dementia (Topic 11b)	279	100%
Metabolic side effects of antipsychotic (Topic 2f)	261	100%
Prescribing for people with a personality disorder (Topic 12a)	65	100%
Other audit programmes		
NHS LA – Records audit	579	N/A
Diabetes audit – Clover Group	1026	100%
Suicide audit	5	N/A
Food and nutrition	134	N/A
Safeguarding children – Baseline audit of knowledge	252	N/A
National confidential inquiries		
Inquiry into suicide and homicide by people with mental illness	16	30%*
Inquiry into suicide and homicide by people with mental illness Out of District Deaths	0	0%
Inquiry into suicide and homicide by people with mental illness Homicide data	4	33%*

*Note: the percentage figure represents the numbers of people who we reported as having prior involvement with as percentage of all Inquiries made to us under the National Confidential Inquiry programme. i.e. in 70% of all inquiries, we had not record of having had prior involvement with the individual concerned.

The reports of 14 national clinical audits were reviewed by the Trust in 2012/13 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

National audit	Results and actions
National audit of Schizophrenia	**Results** – We did well on polypharmacy (top 10%) but below average on user experience, monitoring of physical health and our prescribing of clozapine for treatment resistant patients. **The actions we have taken are:** Additional staff training has been provided on how to screen and intervene with patients physical health.

National audit of psychological treatments	**Results** – We did well on waiting times, skills and training of staff and our monitoring of outcomes of the treatment we provided, but below average on satisfaction and the outcomes of the treatment provided. **The actions we have taken are:** Reviewed the way we organise our services, improved our shared care with GP's and reduced the bureaucracy in our referral processes. Since then we have seen a 10% improvement in DNA rates, 5% improvement in recovery rates and significant improvement in client outcomes.
National Parkinsons audit	Data was submitted in December for 53 patients. A report will be available in June 2013.
Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards	**Results** – We have made improvements on the previous year's audit (2010) regarding the number of people who were prescribed higher dosages of drugs than the recommended limits, however this was not consistent across all of our services. **The actions we have taken are:** We have made it easier for staff to access to information regarding the effect of combining antipsychotics on the percentage maximum dose prescribed.
Lithium monitoring – To ensure Lithium is prescribed in accordance with NICE guidelines	**Results** – Our monitoring of lithium side effects is at 60%, which compared well in the audit, however we need to improve how we monitor lithium toxicity. **The actions we have taken are:** Services continue to monitor how we are doing. We will improve how we monitor risks relating to toxicity, and undertake a repeat audit to evaluate progress.
Prescribing antipsychotics for people with Dementia	**Results** – Most people were benefiting from a review and had evidence of having a plan in place regarding what works best if they experience a crisis. We need to improve how we communicate why we have prescribed the medication we have and when different treatment plans started. **The actions we have taken are:** We will improve the documentation of the clinical reason for proscribing the most recent antipsychotic and the duration of prescription of benzodiazepine.

Metabolic side effects of antipsychotic	**Results** – We did well on monitoring peoples blood pressure, but need to improve how we monitor peoples weight and encourage people to stop smoking. **The actions we have taken are:** We will improve practice and the documentation of smoking cessation, obesity and BMI. We have approved a Trust wide plan about improving peoples overall physical health.
NHS Litigation Authority – Records audit	**Results** – Compared to the previous years audit we have made significant improvement in the quality of the information we have about peoples circumstances, such as HoNOS assessments, sexual vulnerability, child/ adult protection issues. However we still need to improve key areas such as advance directives, risk prevention planning and communicating plans with GP's. **The actions we have taken are:** All services are developing plans to address the underperforming standards. We are already implementing a roll out of improved electronic patient records focussing on areas of risk and assessment, which will support improvements.
Diabetes audit	**Results** – We are doing well in how we monitor a range of risk issues for people who have diabetes (such as weight) and the treatment they are on (such as statins and ACE-inhibitors). We weren't doing as well in the supporting people to access well-structured education programmes. **The actions we have taken are:** To re-launch a patient education programme.
Suicide audit	**Results** – We were compliant with the majority of standards for the care plans that we audited. We need to improve how we communicate with families and carers after such tragic events, making sure they have information about what happened. **The actions we have taken are:** We have put plans in place to ensure information is shared with families and carers in an appropriate and supportive way.

Safeguarding children	**Results** – The audit identified that the majority of staff have 'some' understanding of the kinds of child abuse (particularly type of abuse). Most staff know who to contact if a child has been abused (this includes line manager, safeguard lead) **The actions we have taken are:** We will continue with our training programme to maintain and improve awareness.
Food and nutrition	**Results** – The audit has revealed that nutritional assessments are being done on admission for 96% of patients on the older adult wards. We need to extend this practice to our other wards. **The actions we have taken are:** We will extend the practice of undertaking nutritional assessments to our adult wards.

Local audit activity

Local clinical audits are conducted by staff and teams evaluating aspects of the care they themselves have selected as being important to their teams. Our main commissioner, Sheffield CCG, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities. On a quarterly basis the Board review the progress of other local audits.

2.9 Data quality

Good quality information underpins the effective delivery of care and is essential if improvements in quality care are to be made. Adherence to good data quality principles (complete, accurate, relevant, accessible, timely) allows us to support teams and the Board of Directors in understanding how we are doing and identifying areas that require support and attention.

External Auditors have tested the accuracy of the data and our systems used to monitor the following indicators:

- 7 day follow up – everyone discharged from hospital should receive support in the community within 7 days of being discharged
- 'Gate keeping' – everyone admitted to hospital should be assessed and considered for home treatment

As with previous years, the audit has confirmed the validity and accuracy of the data used within the Trust to monitor, assess and report our performance.

The Trust submitted records during 2012/13 to the Secondary uses service (SUS) for inclusion in the Hospital episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was 99.9% for admitted care. The percentage of records in the published data which included the patients valid General Practitioner Registration Code was 95.7% for admitted care. No other information was submitted.

The latest published data from the SUS regarding data quality under the mental health minimum data set is for April 2012- December 2013. The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2012/13	National average
NHS Number	99.9%	99.4%
Date of birth	100%	99.7%
Gender	100%	99.4%
Postcode	99.6%	99.0%
Commissioner code	100%	99.3%
GP Code	99.5%	98.3%
Primary diagnosis	100%	98.5%
HoNOS outcome	100%	88.9%

The data and comparative data is from the published MHMDS Reports for the Q1 – Q3 periods inclusive

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

2.10 Information governance

We aim to deliver the best practice standards in Information Governance by ensuring that information is dealt with legally, securely and effectively in order to deliver the best possible care to our service users.

Concerns were highlighted in a number of areas during 2011/12. The Trust undertook development and improvement actions in response to the following issues:

- Information governance management - Improving the provision of training about information governance
- Clinical information assurance - Completion of staff training and audit for clinical coding
- Corporate information assurance - Completing a review and audit of corporate records.

During the year we completed our assessments through the NHS Connecting for Health Information Governance Toolkit. The Trust undertook and submitted a baseline assessment in October 2012 and a final assessment and submission in March 2013.

Following the improvement actions we had undertaken, Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2012/13 was 69% for the 45 standards and was graded satisfactory/green.

Achieved

Criteria	2011/12	2012/13	Current grade
Information Governance Management	66%	73%	Satisfactory
Confidentiality and Data Protection Assurance	74%	74%	Satisfactory
Information Security Assurance	64%	66%	Satisfactory
Clinical Information Assurance	73%	73%	Satisfactory
Secondary Use Assurance	41%	66%	Satisfactory
Corporate Information Assurance	22%	66%	Satisfactory
Overall	60%	69%	Satisfactory

Part 3: Review of our quality performance

3.1 Safety

Overall number of incidents reported

The Trust traditionally reports a high number of incidents compared to other organisations. This is viewed as a positive reflection of the safety culture within the Trust. It helps us to be able to really understand what the experience of care is like, spot trends and make better decisions about what we want to address and prioritise for improvement. The National Patient Safety Agency consistently assesses our performance, using the data supplied through the National Reporting Learning System (NRLS) as in the highest (best performing) 25% of Trust's for actively encouraging the reporting of incidents. For the 6 month period April - September 2012, SHSC was the 10th highest performer of 56 mental health trusts.

Nationally, based on learning from incidents and errors across the NHS, the National patient Safety Agency has identified a range of errors that should always be prevented. These are often referred to as 'never events', because with the right systems to support care and treatment in place they should never need to happen again. None of the incidents that occurred within the Trust over the last year were of this category.

Patient safety alerts

The NHS disseminates safety alerts through a Central Alerting System. The Trust responded effectively to all alerts communicated through this system. During 2012/13 the Trust received 70 non-emergency alert notices, of which 100% were acknowledged within 48 hours, 4 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 37 emergency alerts were received an acted upon straight away.

Patient safety information on types of incidents

Self-harm and suicide incidents

The risk of self-harm or suicide is always a serious concern for mental health and substance misuse services. The NPSA figures show 11.3% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 18.1% for mental health trusts nationally. This is similar to the previous year where the figures were 11.4% and 18.7% respectively.

During the last two years clinical risk training was provided for SHSC staff and new clinical risk assessment and management tools have been introduced throughout the Trust. Last year 1,329 staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. We had planned to train 2,000 members of staff. The main reason leading to our under achievement of our target has been capacity to support the release of staff from front line service delivery. We are reviewing our approaches to this for next year to ensure we can deliver improvements.

Violence, aggression and verbal abuse

In previous years the Trust has reported relatively low incidents of disruptive and aggressive behaviour within our services compared to other mental health organisations. This has increased during 2012/13 in line with the position reported in Section 2. 20.6% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 18.2%, based on NPSA benchmarking data for first 6 months of the year. In the previous year, 2011/12 the figures were 15.4% and 19% respectively.

Medication errors and near misses

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. 6.1% of patient safety incidents reported by the Trust related to medication, compared with 8.4% in mental health trusts nationally. There has been little change in the number of medication incidents reported by the Trust over the last 3 years.

Cleanliness and infection control

The Trust is committed to providing clean safe care for all our service users and ensuring that harm is prevented from irreducible infections.

To achieve this an annual programme is produced by the Infection Prevention and Control Team that details the methods and actions required to achieve these ends.

The programme includes:

- Processes to maintain and improve environments
- The provision of extensive training and education
- Systems for the surveillance of infections
- Audit of both practice and environment and
- The provision of expert guidance and information to manage infection risks identified.

The efficacy of this programme is monitored both internally and externally by the provision of quarterly and annual reports detailing the trusts progress against the programme. These reports are publicly available via the internet.

Single sex accommodation

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and inpatient settings. During 2012/13 we have reported no breaches of these guidelines.

Safeguarding

The Trust fully complies with its responsibilities and duties in respect of Safeguarding Vulnerable Adults, and Safeguarding Children. We have a duty to safeguard those we come into contact with through the delivery of our services. We fulfil our obligations through ensuring we have:

- Robust systems and policies in place that are followed
- The right training and supervision in place to enable staff to recognise vulnerability and take action
- Expert advice available to reduce the risks to vulnerable people.

Reviews and investigations

We aim to ensure that we review all our serious incidents in a timely manner and share conclusions and learning with those effected, and our commissioners.

We monitor our performance in respect of completing investigations within 12 weeks and undertaking investigations that are assessed as being of an 'excellent/ good' standard. Historically we have experienced challenges in this area and we continue to prioritise our efforts to improve our review processes.

Improvements and lessons learnt

All incidents are reviewed to ensure we are able to identify how we can make improvements and take corrective action to maintain and improve safety.

We formally review all serious incidents and the Trust's Quality Assurance Committee and Board of Directors reviews the findings and lessons learnt from the incidents. We review and share all findings with our Commissioners and review our improvement plans with them.

Examples of the types of improvement actions we have been able to take following reviews of serious incidents are

- Involving service user families/carers in their care/decision making
- Comprehensive and timely record keeping, ensuring the rationale for decisions made is recorded
- Making sure that urgent referrals into the Trust are easily identified
- Communication between NHS professionals to be strengthened to ensure information is shared appropriately.

Using incident data to prioritise improvement actions

From the incident data on the next page, and our review of the types of incidents that occur across our services, we prioritised falls and violent incidents for attention. Our plans, and progress against those plans is reported in detail in Quality Objectives 1 and 2 in this report.

Overview of incidents by type

The table on the next page reports on the full number of incidents reported within the Trust. It then reports on the numbers of those incidents that were reported to result in harm for service users and staff.

Incident type	2010/11	2011/12	2012/13
All incidents	5981	6408 (a)	6260
All incidents resulting in harm	1627	1689	1508
Serious incidents (investigation carried out)	38	45	34
Patient safety incidents reported to NRLS (d)	3359	3598	3340
Patient safety incidents reported as 'severe' or 'death'	28	41	42
Expressed as a percentage of all patient safety incidents reported to NRLS	0.8%	1.1%	1.3%
Slips, Trips and Falls incidents	1449	1652	1180
Slips, Trips and Falls incidents resulting in harm	554	558	420
Self-harm incidents	365 (a)	369 (a)	425
Suicide incidents (in-patient or within 7 days of discharge)	1	2 (b)	0 (c)
Suicide incidents (community)	24	13	5 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1485	1644	1930
Violence, aggression and verbal abuse incidents resulting in harm	267	276	240
Medication Errors	354 (a)	360 (a)	321
Medication Errors resulting in harm	0	0	1
Infection Control			
Infection incidents			
MRSA Bacteraemia	0	0	1
Clostridium difficile Infections	0	0	0
Periods of Increased infection/Outbreak			
• Norovirus	7 (52)	7 (60)	3 (28)
• Rotavirus	1 (5)	0	0
• Influenza	0	0	1 (3)
Showing number of incidents, then people affected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	n/a	2%	39%
Staff Influenza Vaccinations	20%	37.6%	56%

(a) The incident numbers have increased from those reported in the 2011/12 Quality Account report due to additional incidents being entered onto the information system after the completion of the report.

(b) The figure has decreased from that reported in last year's Quality Account report due to an HM Coroner's inquest which has not yet been held. It is likely that this figure will increase in next year's report

(c) Figures are likely to increase pending the conclusion of future HM Coroner's inquests. This will be reported in next year's report.

(d) The NRLS is the National Reporting Learning System, a comprehensive database set up by the former National Patient Safety Agency that captures patient safety information.

3.2 Effectiveness

The following information summarises our performance against a range of measures of service effectiveness.

Primary Care Services – Clover Group GP Practices

The Quality Outcomes Framework (QoF) provides a range of good practice standards for the delivery of GP services. Traditionally the 4 practices that have formed the Clover Group have been below the Sheffield averages in their performance against these standards have previously been in the lowest quartile in the city. The practice serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield. This brings a number of acknowledged challenges for the service to deliver the range of standards.

Over the last 2 years, significant progress and achievements have been made. In 2011/12 the Clover Group of practices improved to be in the highest quartile in Sheffield and their challenge this year was to sustain this improvement. They have achieved this, which is an excellent achievement and demonstrates that real improvements are being implemented for the longer term benefit of the communities the practices serve.

In 2011/12 the service achieved a total of 98.7% of all the QoF standards, with a Sheffield-wide average of 97%. This year in 2012/13 the service achieved 98.2% of the standards.

The following table summarises performance against national standards for GP services. Health screening for the practice population is challenging and influenced by the high proportion of the patient group being from BME communities. The service has been working closely with its community groups to increase awareness and access arrangements for health screening programmes to support improvements. Uptake in the programmes gradually increases over the years.

Primary Care – Clover GP's	This years target	How did we do in year 2011 – 12	How did we do this year	
Flu vaccinations				
Vaccinate registered population aged 65 and over	75%	75%	78%	✓
Vaccinate registered population aged 6 months to 64 years in an at risk population	70%	50%*	56%	↑
Vaccinate registered population who are currently pregnant	70%	45%*	51%	↑
Childhood immunisations				
Two year old immunisations	70-90%	90%	90%	✓
Five year old immunisations	70-90%	81%	85%	
Cervical cytology	60-80%	66.7%	66.4%	

*Note: The target for 2011/12 was 50% & 45% respectively
Information source: System One and Immform

Drug and alcohol services

The service continues to prioritise ensuring timely access to primary and secondary care treatment. The service aims to ensure all of Sheffield's population that would benefit from the range of services provided in drug and alcohol treatment are able to access support. The service adopts a range of approaches to engage with people from this vulnerable service user group.

Priorities for next year including further expansion of the universal screening tool to increase the number of people accessing primary care services for alcohol problems and maximising the numbers of people supported and ready to finish treatment drug and/or alcohol free.

Drug and alcohol services	This years target	How did we do in year 2011 – 12	How did we do this year
Drugs			
No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100% ✓
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100% ✓
No Premium client should wait longer than 48 ours from referral to medical appointment	100%	100%	100% ✓
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100% ✓
% Problematic drug users retained in treatment for 12 weeks or more	90%	94%	95% ✓
Alcohol single entry and access			
No client to wait longer than 1 week from referral to assessment	100%	100%	100% ✓
No client to wait longer than 3 weeks from Single Entry and Access Point assessment to start of treatment	100%	100%	100% ✓
Outcomes, self care			
Initial Treatment Outcome Profile (TOP) completed	100%	96%	98% ✓
Review TOP completed	100%	80%	71% ✓
Discharge TOP completed	100%	100%	100% ✓
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100% ✓
Number of service users and carers trained in overdose prevention and harm reduction	240	292	272 ✓
% Successful completions for the provision of treatment for injecting-related wounds and infections	75%	85%	94%

Information source: National Drug Treatment System

Learning disability services

A key area of focus has been ensuring that people with complex and challenging behaviours are supported through community focused support packages within Sheffield and the individual's local community as far as possible.

During the last year the service has made good progress in supporting people to return to Sheffield from out of town placements. Within our local inpatient services we have ensured that individual clients do not experienced prolonged periods in hospital beyond what the client needs. We have delivered care that is well co-ordinated and focus on the needs of individuals, and delivered in a personalised and dignified way (as evidenced by visit reports from the CQC).

Learning disability services	This years target	How did we do in year 2011 – 12	How did we do this year
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil to date ✓
All clients receiving hospital care should have full health assessments	100%	100%	100% ✓
Assessments and supporting plans for their communication needs	100%	100%	100%

Information source: Insight & Trust internal clinical information system

Dementia services

Our specialist inpatient service for people with dementia and complex needs has prioritised its focus on improving the care pathway to ensure discharge in a timely manner either home or as close to a person's home as possible. This results in much better outcomes for the individual concerned. This has enabled more throughput into the ward but recognises the increasing complexity of the service users admitted.

We continue to explore ways to build on the excellent success of the memory service in improved access and improved diagnosis rates within Sheffield. Making further improvements in this area is a priority for us next year.

Dementia services	This years target	How did we do in year 2011 – 12	How did we do this year
Discharges from acute care (G1)	30	34	53 ✓
Number of assessments for memory problems by memory management services	900	876	918 ✓
Rapid response and access to home treatment	350	338	339 ✓
Waiting times for memory assessment	N/A	14.5 weeks	16.3 weeks projected ↓

Information source: Insight & Trust internal clinical information system

Independent living and choice

Independent living and choice	This years target	How did we do in year 2011 – 12	How did we do this year
Access to equipment • Community equipment to be delivered within 7 days of assessment	95% of items to be delivered within 7 days	95.3%	95.2% project ✓
Choice and control • People accessing direct payments to purchase their own social care packages	N/A	263 people with budgets agreed Further 203 actively exploring	454 people with budgets agreed Further 312 actively exploring ✓

Information source: Insight & Trust internal monitoring systems

Mental health services

Services continue to perform well across a range of measures used to monitor access and co-ordination of care, achieving all national targets expected of mental health services. A range of key service changes have been introduced during the last year (for information about them see our Annual Report), and the Trust has ensured that performance levels have been maintained during times of extensive change.

The table below highlights our comparative performance on 7 Day follow up and Gatekeeping indicators. Sheffield Health and Social Care NHS Foundation Trust believes that its above average performance on gatekeeping is due to its robust care pathway arrangements across community mental health team, home treatment and inpatient services. The Trust is below average in respect of 7 day follow up standards. This is influenced mainly by failures to achieve the standard in the second quarter of the year. Following review at the time our discharge arrangements were strengthened further. Sheffield Health and Social Care NHS Trust has taken the following actions to improve this.

- Improved information sharing and monitoring of client circumstances to ensure the follow up happened as planned
- Combined with all service users who are discharged receiving additional telephone based support immediately after their discharge, in addition to the planned follow up visit.

These measures will support improvements in the quality of our services over the next year.

Mental health services	This years target	How did we do in year 2011 – 12	How did we do this year
Improving access to psychological therapies			
• Number of people accessing services	5,364	10,661	10,735 ✓
• Numbers of people returning to work	89 people	396 (18.6%)	344 (31%) (a)
• Number of people achieving recovery	50%	49.5%	46%
Early intervention • People should have access to early intervention services when experiencing a first episode of psychosis	90 new cases per year	136 new clients accessed services	107 new clients accessed services ✓
Access to home treatment • People should have access to home treatment when in a crisis as an alternative to hospital care	1,202 episodes to be provided	1,443 episodes provided	1,418 episodes provided ✓
'Gate keeping' • Everyone admitted to hospital is assessed and considered for home treatment	90% of admissions to be gate-kept	99.4% National average 97.4% (b)	99.5% National average 98.2% (b) ✓
Delayed transfers of care • Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	4.2%	4.7% ✓
7 day follow up • Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged	95% of patients to be followed up in 7 days	96.8% National average 97.3% (b)	95% National average 98.2% (b) ✓
Annual care reviews			
• Everyone on CPA should have an annual review with their care coordinator	95%	98.7%	98% ✓
• Everyone on CPA should have a formal review of their care plan	90%	89.5%	86.3%

Information source: Insight & Trust internal clinical information system

Note

(a) 31% represents the % of those who were not in work at the beginning of treatment, who had returned to work at the end of treatment. During 2012/13 1,099 of the 10,735 people seen where not in work at the beginning of treatment. 344 of them (31%) returned to work by the time treatment had been completed.

(b) Comparative information from Health and Social Care Information Centre. 2012/13 national average figure based on data published for the Apr 12-Dec12 period.

3.3 Service user experience

Complaints and compliments

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (the people who have made the complaint) about their experience of the complaints process and if they felt their concerns were appropriately addressed and taken seriously.

All complaints are investigated and if we agree with the concern being raised we will put in place an action plan to address the problem. The following summarises the numbers of complaints and positive feedback we have received:

We do use complaints as an opportunity to improve how we deliver and provide our services. Examples of some of the changes we have made from reviewing concerns that people have raised with us are:

- Sheffield Aspergers Service to produce a written information pack for service users with ADHD
- Improved the information we provide to service users about how to reduce side effects from medication
- Development of peer support networks for service users with personality disorders
- Introduced improvements within inpatient wards to provide a reasonable variety and quantity of diet to meet service user needs, e.g. halal and vegan meals.

Number of	2010/11	2011/12	2012/13 (*)
Formal complaints	86	97	143
Informal complaints	286	215	260
Compliments	1,559	1,401	1,368

Data is for Apr – Dec: 3 Quarters

During the last year 12 people referred their concerns to the Health Services Ombudsman because they were dissatisfied either with the Trust's response or the way we investigated their concerns. The Ombudsman did not feel there was a need to undertake any further investigations into the issues within these complaints.

Over the last year we have implemented a range of changes to how our services are delivered. We have re-organised our community mental health teams and closed some day centres and bed based services as we have provided more care in more appropriate community based settings. All service changes can bring a feeling of uncertainty and disruption to continuity of care. We have placed great emphasis on reducing the impact on the people who use our services while we introduce these changes. We are pleased that our service changes have not been a notable cause or reason for why people have raised concerns about their care through complaints or other means of feedback.

Improving the experience through better environments – investing in our facilities

The environment of the buildings in which we deliver care has an important part to play and has a direct impact on the experience of our service users.

The design, availability of space, access to natural light, facilities and access to outside areas are all fundamental issues. Getting them right has a direct impact on how people feel about the care and treatment they are receiving. We have made significant progress this year in addressing key areas where our buildings haven't been as good as we have wanted them to be.

Firshill Rise – services for people with a learning disability and challenging behaviour

Our current facilities, the Assessment and Treatment Unit, were inappropriate and very limiting. Despite this the CQC recognised that we were providing excellent care despite the poor facilities.

Intensive Treatment Service – secure care for people who are acutely mentally ill and in need of intensive care and support

Our current ward facility is too small and it does not provide access for the service users to outside space. This significantly impacts on the experience of care for the individuals on the ward, as well as the staff delivering care.

Recognising this, we have approved an investment of £2.8 million to design and build a new Ward on our Longley Centre site. This will result in real improvements to the design and feel of the Ward, much better facilities and access to dedicated gardens and outdoor space. The work on the commissioning of the new ward has started during this year, and we look forward to it opening towards the end of 2013/14.

We have invested £3.2 million over two years in a new purpose built community facility to provide residential based care and treatment for people with challenging behaviour as part of the Intensive Support Service. The new facility has been built this year and will open in May 2013. We see this as a tremendous move forward for us, and are excited about the significant improvements in care and support that we will be able to provide, and the real improvements in the experience for the individuals we support with the opening of this new facility.

General environment

During 2012/13 no external reviews of our facilities took place. The previous PEAT assessment took place in 2010/11. The conclusion of the review is summarised as follows:

Site Location	Environment Score	Food Score	Privacy and Dignity Score
Longley Centre	4 Good	5 Excellent	4 Good
Michael Carlisle Centre	4 Good	5 Excellent	4 Good
Forest Close	4 Good	5 Excellent	4 Good
Forest Lodge	4 Good	5 Excellent	4 Good
Grenoside Grange	5 Excellent	5 Excellent	5 Excellent

The reviews are helpful in providing the Trust with external feedback about the environment in which we are providing our services. The review team involves people external to the Trust, including service users and carers to gain their perspective and view about our facilities.

What do people tell us about their experiences?

That national patient survey for mental health trusts suggests that the experience of our service users compares well to other mental health trusts.

Mental health survey

Issue – what did service users feel and experience regarding	2010 Survey that reported in 2011		2011 Survey that reported in 2012	
	Score	Top 10 of 65 Trusts?	Score out of 10	Top 10 of 60 Trusts?
Their Health & Social Care workers	8.9	Yes	9	Yes
Medication	7.6	Yes	7.5	Yes
Access to Talking Therapies	7.4		8.0	Yes – highest
Support from Care Co-ordinator	8.5	Yes	8.6	
Their Care Plan	7.0		7.3	Yes
Care Reviews	8.0	Yes	7.7	
Awareness about support options for Crisis Care	6.5		5.9	
Day to day living	6.0		6.0	Yes
Overall view of care	7.2	Yes	7.2	Yes
Overall score	**7.5**	**Yes Joint 2nd**	**7.5**	**Yes joint 3rd**

	2010 Survey that reported in 2011			2011 Survey that reported in 2012		
	Lowest 20% score	Top 20% score	Our score	Lowest national score	Top national score	Our score
Patient Survey						
How well did people who use our services comment on their experience of contact with a health or social care worker?				8.2 overall	9.1 overall	9.0 overall
Did staff listen carefully to you?	8.6	8.9	9.3	8.2	9.3	9.1
Did staff take your views into account?	8.3	8.7	8.9	7.9	9.0	8.9
Did you have trust and confidence in them?	8.1	8.5	8.5	7.6	9.0	8.7
Did they treat you with dignity and respect?	9.1	9.4	9.5	8.8	9.7	9.5
Were you given enough time to discuss your condition?	8.0	8.5	8.6	7.7	8.7	8.6

The table opposite highlights our comparative performance on service user experience in respect of contact with our staff. Sheffield Health and Social Care NHS Foundation Trust is proud of this positive position. We believe that this position is due to our focus on ensuring the individual client is the focus of our care planning and review processes, supported by clear information about their care, delivered by staff with strong focus on service user engagement

Sheffield Health and Social Care NHS FT will continue to take actions to maintain this current positive position regarding the quality of our services. Our ongoing development programmes, such as the RESPECT programme, our Quality Objectives, and our focus on supporting individual teams to understand their own performance are some of the key actions that will support this.

Working with the people who use our services to make the changes they want to see

We engage with service users in a range of ways to understand their experiences and then use that information to make improvements. The following is provided to give an illustration of examples of this.

Learning disabilities services

Connections forum – Service users feedback they feel they belong more and are helping to improve their service. This involvement has given them greater confidence in themselves.

Autism – Through asking the client base what they felt was required in the brochure, the service was able to create a brochure that clients feel would be more useful to them.

	2010 Survey that reported in 2011			2011 Survey that reported in 2012		
	Lowest 20% score	Top 20% score	Our score	Lowest national score	Top national score	Our score
Staff Survey						
What percentage of staff would recommend the trust as a provider of care to their family or friends	3.30	3.56	3.6	3.36	3.68	3.63
	Average score 3.42			Average score 3.54		

The above table highlights our comparative performance regarding the quality of our services from the perspective of our staff. Sheffield Health and Social Care NHS Foundation Trust considers this positive position is a result of our efforts to engage with our staff and involve them in the plans and decisions regarding how we move forward and focus on improving the quality of our services. We place increasing emphasis on ensuring staff in teams are aware how we are performing, making best use of the information we have to support this.

Sheffield Health and Social Care NHS FT intends to continue with its programme of improving team governance to improve further the involvement of staff in reviewing how we are doing and taking decision locally about how to make further improvements.

Eating disorders

Satisfaction has improved in four out the eight standards since 2011. Survey feedback has led to services looking at flexible appointments and how we provide post discharge support.

Mental health assertive outreach services

Survey feedback has highlighted we are getting better at planning activities jointly with service users. Service users are feeling more involved.

Community mental health teams

Feedback has led to improved access to information regarding employment and vocational services around Sheffield.

Memory services

Surveys have led to steps to ensure that the cafes (support networks for carers and service users) offer what the service user and their carer/supporter want each week rather than what the service think they might want.

GP services – Clover Group

Improving access to health services has been a major work-stream for the Clover Group year on year.

Despite major service developments to improve access and patient satisfaction, the Clover Group has not seen the desired impact of the service re-designs in increasing patient satisfaction with the system. Surveys continue to highlight a high level of dissatisfaction and frustration from the people who use the practices. Nationally the satisfaction rates in the GP National Survey for all GP services suggest that respondents from black and ethnic communities are on average up to 20% less satisfied in some indicators, than their white British counterparts, specifically from Asian or Asian British communities. This experience is replicated locally in the Clover practices.

The Clover Group have a constant programme of service developments to improve services to patients and engage the community. All of the practices have implemented a system offering an open access/ drop-in clinic which has resulted in a significant increase in access to available appointments.

3.4 Staff experience

National NHS staff survey results

Engagement	Previous year		This year	
	2011/12	2012/13	National averages	Comparisons
Overall staff engagement	3.69 out of 5	3.73		Better than average
Able to contribute to improvements	70%	73%	71%	
Recommend Trust as place to work or receive treatment	3.59 out of 5	3.63	3.54	
Top 5				
% Of staff working extra hours	53%	64%	70%	Top 20% getting worse
% Receiving job related training and learning	n/a	85%	82%	Top 20%
Work pressures felt by staff		2.93 out of 5	3.02	Top 20%
Job satisfaction	3.6 out of 5	3.72	3.66	Top 20% Got better
Good communications with senior management		35%	30%	Top 20%
Worse 5				
% Of staff receiving H&S Training	70%	50%	73%	Worse 20% Got worse
% Of staff receiving equality and diversity training	32%	38%	59%	Worse 20%
Staff appraisals	78%	79%	87%	Worse 20%
% Staff suffering work related stress	34%	46%	41%	Worse 20% Got worse
Effective team working	3.73 out of 5	3.77	3.83	

Overall the Trust is encouraged with the above results. The positive feedback around engagement continues to support our ongoing work and focus in improving quality and delivering our plans for service improvement.

The full survey will be available via the CQC site. The survey provides a vast amount of detail around complex issues. The Trust looks to take a balanced view on the overall picture, recognising that some of the lines of enquiry may appear contradictory. For example, the survey indicates we are in the best 20% of Trusts for staff not feeling pressures from work, and the worse 20% for staff suffering work related stress.

The areas we have prioritised for ongoing and further development work are as follows:

Stress within our workforce

It remains important for us to focus on this issue, especially in light of the range of change programmes we are pursuing. We have developed improved access arrangements to occupational health services. We have our own dedicated staff counselling services and we are making better use of this service to support staff whose services are undergoing change.

Staff appraisals

We will continue to focus our efforts to improve both the frequency and the quality of the appraisals and development plans for our staff. To support this we are introducing more simpler arrangements and procedures to ensure this can happen.

Training

We have an extensive training programme in place. During 2012/13 we reviewed all our training provision alongside a needs analysis of what was required to support our staff with the skills they needed to deliver high quality care. We introduced a new training prospectus that defines the training that should be provided to staff working in our different service areas. Through the next year we will continue to monitor how this is being delivered.

Annexe A

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

Healthwatch

Healthwatch Sheffield is grateful for sight of the Sheffield Health and Social Care NHS Foundation Trust's Draft Quality Account for 2012-13 and welcomes the opportunity to provide comments.

These comments are based on the Draft 5 version of the Quality Accounts for 2012-13 dated 5 April 2013 and following a meeting with the Trust on 26th April. Paragraph and page numbers cited below refer to this version.

We felt that a regular dialogue throughout the Quality Account's production would be beneficial to all parties, and it was unfortunate this had not happened this year. We look forward to a productive relationship between SHSCFT and Healthwatch Sheffield in the forthcoming year.

We were surprised not to see a mention of the impact of the Francis Report (Mid Staffs) on the work and approach of the Trust. It was explained to us that the Trust felt this was not part of this Quality Report. However the Trust will include it in all their work and keep the service users up to date with changes made due to the Francis Report.

We were pleased to learn that two other versions of the full report would be made: an "Easy Read" version for certain groups of service users, and a more accessible version for the general public.

We felt that the review of priorities in 2012-13 and goals for 2013-14 (pages 3 to 11) was very clearly set out under a set of consistent sub-headings which helped understanding and commend the Trust on this.

Objective 1 (page 4): We look forward to learning how "assistive technologies" have helped to reduce falls in next year's report. Similarly we are pleased that the learning from the inpatient service improvement programme is to be applied to residential care services.

Objective 2 (page 6): Violence to staff. Where the term "lower level" is used we think an example would be useful. It would also be helpful to have some comparable data from other Trusts and with the national average.

Objective 3 (page 7-8): It is pleasing to see the progress made in respect of physical health. We would like to see a work stream on physical health and medication and suggest that the online screening tool could perhaps be extended to include medication.

Objective 4 (page 10): First contact with the Trust's services, It would be helpful to see the last 2 years data for comparison, rather than just the last year.

We welcome the new Crisis House service (page 9) and look forward to learning about it in next year's Quality Account. We hope the use of this facility will be on an emergency basis only as its capacity is small; long term needs of patients being catered for elsewhere.

Objective 5: We agree that it is regrettable that waiting times to access memory services have increased, We appreciate that those identified as emergencies must take priority for this service. Again it would be helpful to see 3 years data and also comparative data with other Trusts which would put the data into perspective.

We note the information on working in partnership with Sheffield Teaching Hospitals which is very positive for those patients with dementia. We would have liked to see mention of the Trust's work in partnership with Sheffield City Council as the Council has closed a dementia resource centre during 2012-13 and is planning to close a second leaving just one centre operational.

We are happy to see references to web links for further information (as on page 15) but would also like to see how this information could be accessed in other ways.

Page 17 section 2.7: Participation in Clinical Research. It is good to see that research is playing an important role in the Trust. We assume that the Trust follows the NICE guidance in recruiting patients and staff to participate in research and feel this would be worth mentioning.

3.1 Safety (pages 22-24): We appreciate the space constraints and would like to suggest more detail could be offered via the website plus other means for those not connected to the web.

Sheffield LINk always asked Trusts to include information on **Patient Safety Alerts (PSAs)** in Quality Accounts. Therefore we are pleased to see (page 22) the action taken on the PSAs received during 2012-13.

We would also like to see reported in the Quality Account information on any **Coroners Rule 43 Requests** that were received by the Trust in 2012-13 such as the number of Requests received during the year, their subjects, the actions taken and status of the Trust in respect of each.

3.2 Effectiveness (pages 25-29): The tables are very clear and we found the use of symbols to indicate performance helpful. Again the last 2 years data would have been helpful. We are pleased to see some primary care indicators from the Clover Group of practices.

Complaints and compliments (page 27). It would be helpful to have information on the nature of complaints and the learning from them and action taken.

Service User Experience (page 32). We commend the Trust on its showing in the national patient survey for mental health trusts.

We are pleased about the new buildings and garden proposed for Longley Centre and how these will provide considerable benefit to patients as this has been an area of focus for the LINk/ Healthwatch Sheffield.

We would have liked to have seen included a report on the services at Woodland View Care Home as these are now run by the Trust.

Finally we are pleased to say that the Trust and Healthwatch have agreed to work jointly to improve awareness of each other's roles and that the suggestion of an article in the Trust's staff magazine on Healthwatch has been welcomed.

Mike Smith (Chair Sheffield LINk to March 2013)

Pam Enderby (Chair Healthwatch Sheffield)

9 May 2013

Our response

We welcome the helpful feedback from Healthwatch. As a result of the feedback we have been able to make some changes to the report to make it clearer. We have provided information about previous years performance when relevant and we have explained better some of the statements we have made. We have reduced the reference to web based sources of information by expanding further on some of the information provided in the main Report.

With regard to specific areas of feedback. It was always within our plans for physical health (Quality Objective 3) to recognise the important role of medication and the impact this can have on people's physical health. We have made clearer reference to the focus on this area in our on-going plans. Comparative information is provided within the report, for example where we report on rates of aggressive behaviour. Unfortunately we do not have comparable data for specific service waiting times, such as memory services. We have expanded on the areas of partnership work with the CCG and the City Council in respect of the development of services for people with dementia.

We have provided examples of the types of research we are mainly involved in, and examples of the learning and changes we have made following the conclusions from complaints or incident investigations. We have not had any Coroners Rule 43 Requests during 2012/13.

We welcome the opportunity to raise awareness of the role of Healthwatch during the next year. We will also be exploring with Healthwatch how we can maintain an on-going dialogue through the year to report on the progress we make over the next 12 months.

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee

Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee welcomes the opportunity to comment on the Trust's Quality Account.

The Committee is pleased to see the progress made against the quality priorities, although notes that at the time of consideration full year information was not yet available. From the information presented, progress against reducing harm from falls, and improving the identification and assessment of physical health problems in at risk client groups was notable.

We were reassured to hear that the significant increase in staff reporting incidents of violence and assault is due to improved staff awareness as a result of the staff development work that has been undertaken.

It was harder for the Committee to comment on the performance information relating to Quality Objective 4 – improving the experience of first contact with the Trust's services – due to figures being unavailable at that time. We look forward to seeing progress in this area over the coming year.

On Quality Objective 5 – improving access to the right care for people with dementia, the Committee has concerns around the length of time people are waiting to access the Memory Clinic. We share the Trust's ambition of reducing waiting times, and will be monitoring progress on this over the next year. We welcome the progress made on the 'Involving People with Dementia' Project, and suggest that the film produced as a result of the project is shared widely across the city. We offer our assistance in doing this.

The Committee is pleased to note the involvement of the Trust Governors and Service Users in the development of the Quality Account – and feels that this should be emphasised. We also feel that further emphasis could be given to the Trust's built environment, and work going on around Capital developments and improvements in the Quality Account.

In terms of presentation, the Committee welcomes plans to develop an easy read version of the final document. We would like to see where possible, trend information provided over a 3 year period. Including benchmarking and comparisons with other areas within the report would help to give a clearer picture of Trust performance. Consideration could also be given to including information about internal Trust structures and their contribution to quality development.

We look forward to working with the Trust over the coming year, and progressing the quality priorities further.

26 April 2013

Our response

We welcome the feedback from the Healthier Communities and Adult Social Care Scrutiny Committee. We have made a range of amendments to our Quality Report to incorporate the feedback provided to give a broader view on our progress in improving quality.

We share the Committee's concern regarding the length of time people have to wait to access our memory services. We have made good progress in previous years, supported by our Commissioner for the service Sheffield CCG. We will continue to progress options to make further improvements over the next year and will report on our progress during the year.

Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has had the opportunity to review and comment on the information in this quality account prior to publication. Sheffield Health and Social Care NHS Foundation Trust has considered our comments and made amendments where appropriate. We are confident that to the best of our knowledge the information supplied within this report is factually accurate and a true record, reflecting the trust's performance over the period April 2012 – March 2013.

Sheffield Health and Social Care NHS Foundation Trust provides a range of general and specialised mental health, learning disability, substance misuse, community rehabilitation and primary care services to the people of Sheffield, 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.

Our overarching view is that Sheffield Health and Social Care NHS Foundation Trust continues to provide high quality services, which are underpinned by strong contractual performance. This quality account evidences that the trust has achieved positive results against its objectives for 2012-13 and highlights where further improvement has been identified for 2013-14. The CCG is in agreement with the trusts identified objectives for quality improvement (identified below) in 2013-14 and has used the 2013-14 CQUIN scheme to support the trust to deliver these priorities.

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

Quality Objective 2: To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion.

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

Quality Objective 4: To improve the experience of first contact with the Trust's services.

Quality Objective 5: To improve access to the right care for people with a dementia.

Moving forward into 2013-14 the CCG will build on existing good clinical and managerial working relationships to progress the development of initiatives that will drive for quality and deliver the required levels of efficiency.

9 May 2013

Our response

We welcome the feedback from Sheffield Clinical Commissioning Group. We have made a range of amendments to our Quality Report to incorporate the feedback provided to give a broader view on our progress in improving quality.

We are pleased that we have a broad agreement on the areas and priorities that need improving. The use of the CQUIN scheme to incentivise progress in the same areas is a positive reflection of this.

We look forward to delivering further benefits and improved outcomes with the support of our main health commissioner, alongside agreed efficiency improvement programmes.

Annexe B

2012/13 Statement of directors' responsibilities in respect of the quality report

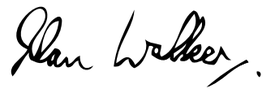
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate 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 content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the commissioners dated 3 May 2013;
- Feedback from governors dated 25 April 2013;
- Feedback from LINks/ Healthwatch dated 9 May 2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012;
- The [latest] national patient survey issued in 2012;
- The national staff survey issued February 2013;
- The Head of Internal Audit's annual opinion over the trust's control environment dated 28 May 2013; and
- Care Quality Commission quality and risk profiles issued monthly during 2012/13;
- The Quality Report presents a balanced picture of the NHS 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; and
- 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).

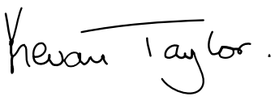
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



Chairman

28th May 2013



Chief Executive

28th May 2013

Annexe C

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

We have been engaged by the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust to perform an independent assurance engagement in respect of Sheffield Health and Social Care NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital;
- Admissions to inpatient services had access to crisis resolution home treatment teams; and

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from Sheffield City Councils Healthier Communities and Adult Social Care Scrutiny Committee dated 26 April 2013;
- Feedback from the Commissioners dated 3 May 2013;
- Feedback from local Healthwatch organisations dated 9 May 2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012;
- The national patient survey issued in 2012;
- The national staff survey dated February 2013
- Care Quality Commission quality and risk profiles issued monthly during 2012/13; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 28 May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust as a body, to assist the Council of Governors in reporting Sheffield Health and Social Care NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Sheffield Health and Social Care NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Sheffield Health and Social Care NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP, Statutory Auditor

Leeds

29th May 2013

Rivelin Boardroom at Fulwood House

SECTION 12.0

Statement of Accounting Officer's Responsibilities

12.0 Statement of Accounting Officer's Responsibilities

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 Monitor.

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

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

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

The Accounting Officer is responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time, the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Kevan Taylor

Kevan Taylor

Chief Executive

Date: 28th May 2013

Craft group at the Longley Centre

Service user postcards, SPACES South

Kevan Taylor, Dave McCarthy, Dan Jarvis MP and Tony Russell, Arts & Wellbeing Conference 2012

Staff Area, Burbage Ward

SECTION 13.0
Annual Governance Statement

13.0 Annual Governance Statement

13.1 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.

13.2 The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Health and Social Care NHS Foundation Trust, 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 2013 and up to the date of approval of the Annual Report and Accounts.

13.3 Capacity to Handle Risk

13.3.1 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). During the year leadership for risk management and governance has changed from the Executive Director of Nursing and Integrated Governance (current title Chief Operating Officer/ Chief Nurse) to joint leadership between the Deputy Chief Executive and the Medical Director. This 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 Risk Management Strategy. 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.

13.3.2 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 2012/13 has included various workshops on annual planning, looking at the external and internal environment, service and financial planning, financial challenges, optimising value in care and the implications of the Health and Social Care Bill 2012.

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 (including root cause analysis);
- 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 up-dates for their staff during the year.

National Institute for Health and Clinical Excellence (NICE) guidance and evidence-based practice continue to be incorporated into clinical practice. NICE guideline implementation groups are established for all mental health guidelines, progress is reported 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.

Art therapy at Moncrieffe Road

OT exercise session at the Longley Centre

Dan Jarvis MP, Arts and Wellbeing Conference 2012

13.3.3 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 is ensuring that service users' families and carers are involved in care planning and decision making. The Trust is continuing to improve record keeping to ensure comprehensive and timely records are made. Communication between NHS professionals also needs to be strengthened to ensure information is shared appropriately.

Learning is also shared through the Service User Safety Group, as well as through a variety of communications, for example Risk Management Update and Litigation 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.

13.4 The Risk and Control Framework

13.4.1 Risk Management Strategy

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 Risk Management Strategy, which was renamed and revised during 2012/13 and ratified in March 2013, 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 Risk Management 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 processes;
- Key components of risk management, namely:
  - Board Assurance Framework
  - Risk Registers
  - Incident and Serious Incident Reporting
  - Identification and analysis, control and monitoring,
  - Learning and sharing learning from Incidents, Complaints and Claims;
- Staff Learning and Development
- Involving Service Users and Carers;
- The Trust's operational approach to risk management;
- Using evidence-based practice;
- Using information effectively.

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 Risk Management Strategy. A system is in place to prompt the review and revision of policies as required.

13.4.2 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 former 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.

All high level risks are reported to the Executive Directors Group and the Board of Directors monthly using a Board Risk Profile. The Corporate Risk Register is reviewed and reported to the Executive Directors' Group, the Quality Assurance Committee and the Audit and Assurance Committee quarterly.

Risks are also highlighted via feedback from incidents, including serious incidents, complaints, concerns, claims and other queries. The Executive Directors' Group, Clinical, Service and Support Directors receive a monthly overview of all on-going serious incidents. Directorates also receive monthly 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 (responsibilities passed to National Commissioning Board) 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.

13.4.3 Board Assurance Framework

The Board has an approved Board Assurance Framework for the period 1st April 2012 to 31st March 2013, which was last approved by the Board in March 2013. 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 to take into account recommendations from Internal Audit reports. 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 2013, there are no high level risks recorded on the Assurance Framework. There are, however, a number of risks graded as moderate or below. The Board Assurance Framework records risks associated with the achievement of the Trust's strategic objectives and acknowledges and identifies areas where improvements are required. However, none of the areas identified are deemed to be significant or pose a serious risk to the effectiveness

of the systems of internal control. All residual risks and actions will carry forward into the 2013/2014 Board Assurance Framework and the underlying risks 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 2012/13 that is consistent with Department of Health guidance. The framework is considered to be fit for purpose and reflective of the principal risks that could impact on the achievement of the Trust's strategic objectives, thereby acting as a key evidence source for the Trust in its preparation of the Annual Governance Statement.

13.4.4 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 In-patient 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) to be replaced by Healthwatch Sheffield from April 2013. 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 CQC's Essential Standards of Quality and Safety, as well as being involved in the former Patient Environment Action Team (PEAT) assessments (replaced with PLACE (Patient-Led Assessments of the Care Environment) from April 2013.

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 up-dates 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.

13.4.5 Quality Governance Arrangements

The Foundation Trust is fully compliant with the registration requirements of the CQC.

The CQC carried out a Review of Compliance at the following locations during the year:

Hurlfield View (June 2012)

Mansfield View (July 2012)

Longley Meadows (July 2012)

Bolehill View (January 2013 and March 2013)

Wainwright Crescent (February 2013)

136a Warminster Road (February 2013)

Grenoside Grange (February 2013)

From these inspections all locations with the exception of Bolehill View, were deemed to be fully compliant against the Essential Standards of Quality and Safety that were reviewed. Bolehill View received two compliance actions against outcome 2 (consent to care and treatment) and outcome 21 (records). However, during a further review in March 2013, both compliance actions were lifted and the location is fully compliant again.

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, being assessed in March 2013 and is aiming to be assessed at Level 2 during 2014/15.

13.4.6 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 Deputy Chief Executive) and information risks and incidents are reviewed and monitored through the Information Governance Steering Group, which is a sub-group of the Quality 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 2013 and has met the required level on all items. A work programme is in place to ensure further progress 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 implemented an encryption system for external e-mails.

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 presented to staff when accessing the Trust's main patient information system, and all staff are expected to complete annual online information governance training.

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 2012 and 31st March 2013.

13.4.7 NHS Pensions Scheme Regulations

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

13.4.8 Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under Equality and Human Rights legislation are complied with.

The Trust is committed to eliminating discrimination, promoting equal opportunity and fostering good relations in relation to the diverse communities it serves and its staff, taking account of all protected characteristics as defined within the Equality Act 2010. Policy, procedure, systems and lead posts (for example safeguarding) are in place to oversee practice and ensure that Human Rights are considered and maintained in Trust services.

The Trust has identified Equality Objectives and published these in April 2012. Progress on the Public Sector Equality Duty is published in the Trust Annual Equality and Human Rights Report alongside a report which contains detailed data and information relating to people who use Trusts services and people employed by the Trust. These are made publicly available through the Trust's website.

The Trust has a lead Director responsible for Equality and Human Rights who reports to the Trust's Executive Directors' Group.

An update on Equality and Diversity for 2012/13 can be found in Section 2.16.2.

13.4.9 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.

13.5 Review of Economy, Efficiency and Effectiveness of the Use of Resources

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 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.

The organisation has strong leadership through its operational Directors, where a Service and Clinical Director have joint management of clinical directorates and Support Directors have the same responsibility for Central or Corporate Directorates. Each of these Directors have had budget training and are 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 2012/13 internal audit has, as part of the Trust's annual internal audit plan, conducted operational/value for money reviews, including a review of Clover Group Governance and; in human resources, in respect of Performance Development Reviews (PDRs). The areas reviewed by internal audit link to the efficient and effective operation of the Trust.

13.6 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.

During the year the Board of Directors has continued to review performance against its quality indicators and designated quality objectives. The Board does this through the reports and reviews undertaken to the Quality Assurance Committee (a formal sub-Committee of the Board of Directors) and to the Directors directly. This has enabled the Board to remain appraised of our current performance in respect of quality.

Additionally, joint meetings of the Board of Directors' and Council of Governors have reviewed areas of importance to be progressed in the future.

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, e.g. the CQC. Service user feedback and information collected through team governance has also been used in the production of the report.

National reviews and guidance reports on Quality Accounts from Monitor, and the Audit Commission 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 Healthier Communities and Adult Social Care Scrutiny Committee, Healthwatch Sheffield and NHS Sheffield Clinical Commissioning Group. It has also been received and considered by the Board of Directors' Quality Assurance Committee, Audit and Assurance Committee and by the Board of Directors itself.

In reviewing and confirming its Quality objectives the Trust supported the Governors to undertake engagement with our Members on their opinions and thoughts on our planned improvement areas. Over 150 members commented on our proposals and their views and opinions have informed our final plans as outlined in the Quality Account.

Our Quality Report is contained in Section 11 of this Annual Report.

13.7 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 into 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 External Audit;
- Reports from Internal Audit;
- External assessments by the National Health Service Litigation Authority;
- External assessments by the CQC, including Mental Health Act Commissioners;
- Full registration with the CQC 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 (replaced in April 2013 with PLACE);
- Service User Surveys;
- Information Governance Toolkit assessment.

13.7.1 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.

13.7.2 Audit and Assurance Committee

The Audit and Assurance Committee 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, 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.

13.7.3 Quality Assurance Committee

The Quality Assurance Committee 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.

13.7.4 Finance and Investment Committee

The Finance and Investment Committee provides assurance on the management of the Trust's finances and financial risks.

13.7.5 Remuneration and Nominations Committee

The Remuneration and Nominations 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.

13.7.6 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 Deputy Chief Executive and the Medical Director have joint executive responsibility for risk and governance.

13.7.7 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.

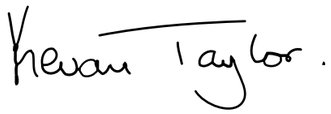
The HR and Workforce Group, Business Planning Group, Health and Safety Committee, Service User Safety Group, Operational Delivery Group and the Information Governance Steering Group cover relevant aspects of risk. For example, the HR and Workforce Group considers staff-related risks such as the Trust's 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.

13.8 Conclusion

In my opinion, no significant control issues have been identified for the period 1st April 2012 to 31st March 2013.



Kevan Taylor

Chief Executive

28th May 2013

Service user artwork at Moncrieffe Road

SECTION 14.0
Auditor's Report

14.0 Auditor's Report

Independent auditor's report to the council of governors of Sheffield Health and Social Care NHS Foundation Trust

We have audited the financial statements of Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2013. 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 applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

This report is made solely to the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us 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 accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- Give a true and fair view of the state of Sheffield Health and Social Care NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- Have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Sheffield Health and Social Care NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Damian Murray CPFA

For, and on behalf of, KPMG LLP

Statutory Auditor

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW
29th May 2013

Service user postcards for Sheffield Wellbeing Festival 2012

SECTION 15.0
Annual Accounts

15.0 Annual Accounts

Director of finance's introduction to the accounts

The Financial Plan for 2012/2013 submitted to and agreed by Monitor (the Independent Regulator), has been successfully delivered to the target surplus, however, the significant cost improvements required by the Government has only been achieved by non-recurrent measures.

The effort and work undertaken by Directors and staff alike has been excellent, although the continued request for financial efficiency savings is now becoming more difficult to achieve recurrently. For the second year running there is an increasing amount of non-recurrent cost improvements of around £3m to carry forward into next year.

The NHS, along with all other public services, will be facing even more financial challenges over the next few years. It is, therefore, pleasing to see we have achieved and exceeded our targets in the last 4½ years as a Foundation Trust.

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

- Achievement of surplus of £3,512k
- Delivery of EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation)
- Delivery of planned financial risk rating of 4 with the Independent Regulator, Monitor
- An expectation that the Trust will pay its non-NHS creditors within 30 days. We achieved 84.85% by value and 85.34% by number averaged over the year, however improvements to payment processes saw the Trust achieve 90.42% by value and 88.83% by number in March 2013. It is incumbent upon public bodies like the Trust to support the general economy and ensure this target is increased where possible, especially in the economic downturn which will be facing the broader economy over the next few years.

A major benefit of Foundation Trust status is that the organisation can retain any income and expenditure surplus. This has resulted in a healthy cash balance. This cash will enable the Trust to spend on its buildings to ensure we have a quality environment, fit for the population we serve.

We have already committed funds for:

- Intensive Support Service Unit (new build) for our Learning Disability client group (circa £3m)
- Psychiatric Intensive Care Unit to replace existing cramped environment (circa £3m)
- Vehicle replacement; various IT schemes and equipment replacement (circa £600k)

The major project will be to upgrade our in-patient facilities and this will be another significant challenge as we need approximately £25m to complete this scheme.

During the financial year the Trust's external auditors, the Audit Commission, who are appointed by the Trust's Governors, were disbanded and following agreement with Governors, their contract was transferred to KPMG, which is a globally recognised company of accountants and financial advisors.

We have seen a number of financial challenges over the years and we have been successful in delivering financial performance and care quality standards, by targeting inefficient areas of high cost. The financial challenges facing the Trust over the coming years is unprecedented, combined with significant cuts in other public services, including the Local Authority, will make the delivery of financial savings targets even more difficult at the same time as delivering safe, quality services to the population we serve.

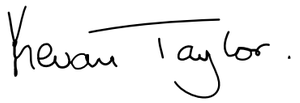
Paul Robinson

Executive Director of Finance

Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts for the year ended 31st March 2013 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)

28th May 2013

The Accounts of Sheffield Health and Social Care NHS Foundation Trust for the period ending 31st March 2013 follow. The four primary statements; the Statement of Comprehensive Income (SOCI), the Statement of Financial Position (SOFP), the Statement of Changes in Taxpayers' Equity (SOCITE), and the Statement of Cashflows (SCF) are presented first. These are followed by the supporting notes to the accounts.

Note 1 outlines the Foundation Trust's accounting policies. Subsequent notes provide further detail on lines in the four primary statements and are cross referenced accordingly.

The financial statements (Accounts) were approved by the Board on 28th May 2013 and signed on its behalf by:

Signed: Yvonne Taylor. (Chief Executive) Date: 28th May 2013

Statement of comprehensive income for the year ended and this year end

	Note	**2012/13 £000**	2011/12 £000
Operating income	2, 3	**128,382**	122,547
Operating expenses	2, 4	**(122,994)**	(118,466)
Operating surplus		**5,388**	4,081
Finance costs:			
Finance income	6	**234**	189
Finance expense – financial liabilities	7	**(87)**	(88)
Unwinding of discount on provisions	18	**(17)**	0
Public dividend capital dividends payable		**(1,986)**	(2,191)
Net finance costs		**(1,856)**	(2,090)
Movement in fair value of investment property	10	**(20)**	0
Surplus for the year		**3,512**	1,991
Other comprehensive income			
Impairments (losses)		**(1,587)**	(19)
Revaluation gains/(losses)		**416**	258
Actuarial gains on defined benefit pension schemes		**987**	778
Actuarial losses on defined benefit pension schemes		**(1,122)**	(819)
Total comprehensive income for the year		**2,206**	2,189

Statement of financial position as at and this year end

	Note	**31 March 2013 £000**	31 March 2012 £000
Non-current assets			
Intangible assets	8	**16**	15
Property, plant and equipment	9	**54,528**	55,342
Investment property	10	**180**	200
Trade and other receivables	12	**3,751**	2,921
Total non-current assets		**58,475**	58,478
Current assets			
Inventories	11	**106**	163
Trade and other receivables	12	**3,465**	3,798
Cash and cash equivalents	13	**22,731**	17,028
Total current assets		**26,301**	20,989
Total assets		**84,777**	79,467
Current liabilities			
Trade and other payables	15	**(5,776)**	(4,910)
Taxes payable	15	**(1,868)**	(2,013)
Provisions	18	**(1,131)**	(201)
Other liabilities	16	**(216)**	(204)
Total current liabilities		**(8,991)**	(7,328)
Non-current assets plus net current assets		**75,786**	72,139
Non-current liabilities			
Provisions	18	**(680)**	(392)
Other liabilities	16	**(3,867)**	(2,714)
Total non-current liabilities		**(4,547)**	(3,106)
Assets less liabilities		**71,239**	69,033
Financed by taxpayers' equity:			
Public dividend capital		**33,572**	33,572
Revaluation reserve		**17,191**	18,523
Income and expenditure reserve		**20,476**	16,938
Total taxpayers' equity		**71,239**	69,033

Statement of changes in taxpayers' equity

	Public dividend capital £000	Revaluation reserve £000	Income & Expenditure Reserve £000	Total £000
Taxpayers' equity at 1 April 2012	33,572	18,523	16,938	**69,033**
Surplus for the year	-	-	3,512	**3,512**
Impairments on property, plant and equipment	-	(1,587)	-	**(1,587)**
Revaluations on property, plant and equipment	-	416	-	**416**
Actuarial loss on defined benefits pension scheme	-	-	(135)	**(135)**
Other reserve movements	-	(161)	161	**-**
Taxpayers' equity 31 March 2013	**33,572**	**17,191**	**20,476**	**71,239**
Changes in taxpayers' equity for 2011 – 12				
Taxpayers' equity at 1 April 2011	33,572	18,600	14,672	66,844
Surplus for the period	-	-	1,991	1,991
Impairments on property, plant and equipment	-	(19)	-	(19)
Revaluations on property, plant and equipment	-	258	-	258
Actuarial loss on defined benefits pension scheme	-	-	(41)	(41)
Other reserve movements	-	(316)	316	-
Taxpayers' equity at 31 March 2012	33,572	18,523	16,938	69,033

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

Statement of cash flows for the year ended and this year end

	Note	2012/13 £000	2011/12 £000
Cash flows from operating activities			
Operating surplus	SOCI	**5,388**	4,081
Depreciation and amortisation	9	**2,049**	2,075
Impairments and reversals	9	**172**	-
(Gain) on disposal	3	**(318)**	(73)
(Increase) in trade and other receivables	SOFP	**(496)**	(1,479)
Decrease in other assets	SOFP	**-**	174
Decrease in inventories	SOFP	**57**	36
Increase/(decrease) in trade and other payables	SOFP	**721**	(170)
Increase in other liabilities	SOFP	**1,165**	657
Increase/(decrease) in provisions	SOFP	**1,218**	(211)
Other movements in operating cash flows	SOFP	**(245)**	(93)
Net cash generated from operations		**9,711**	4,997
Cash flows from investing activities			
Interest received	6	**149**	94
Payments for intangible assets	8	**(4)**	(15)
Purchase of property, plant and equipment	9	**(2,741)**	(678)
Receipts from disposal of property, plant and equipment	9	**644**	73
Net cash generated used in investing activities		**(1,952)**	(526)
Cash flows from financing activities			
PDC dividends paid		**(2,056)**	(2,132)
Net cash generated (used in) financing activities		**(2,056)**	(2,132)
Net increase in cash and cash equivalents		**5,703**	2,339
Cash & cash equivalents at 1st April		**17,028**	14,689
Cash & cash equivalents at 31st March	13	**22,731**	17,028

SUPPORTING NOTES TO THE ACCOUNTS

Note 1. Accounting policies

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 2012/13 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.

Employer's 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) 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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011 – 12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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 2013, the deficit on the scheme was £3,867,000 (31 March 2012 – £2,714,000), which is offset by a non-current receivable of £3,402,960 (31 March 2012 – £2,388,000). 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 Institution 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.

An interim valuation exercise was undertaken by the Trust's valuers, GVA Grimleys, during 2012/13. The valuation methodology detailed above was utilised within this revaluation, which was performed as at 1 April 2012.

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

Software

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.6 Investment property

Investment property comprises properties that are held to earn rentals or for capital appreciation or both. It is not depreciated but is stated at fair value based on regular valuations performed by professionally qualified valuers. Fair value is based on current prices for similar properties in the same location and condition. Any gain or loss arising from the change in fair value is recognised in the Statement of Comprehensive Income. Rental income from investment property is recognised on a straight line basis over the term of the lease.

1.7 Government 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 2012/13 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 cashflows are discounted using the short- (-1.8%); medium- (-1.0%); and/or long-term (+2.2%) real discount rates published by the HM Treasury, except for early retirement provision and injury benefit provisions which both use the HM Treasury's pensions discount rate of 2.35% (2.8% 2011/12) in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 18 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 19 where an inflow of economic benefits is probable. As at 31st March 2013 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 in to 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 but have not yet been adopted by the EU and are therefore not reflected in the Foundation Trust Annual reporting Manual. We have considered these changes 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 interim revaluation took place on 1 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. See note 26.

1.21 Merger accounting and transforming community services

For functions that have been transferred to the trust from another NHS or local government body, the assets and liabilities are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets or liabilities transferred is recognised within income or expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets or liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the foundation trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

No assets or liabilities were transferred to, or from, Sheffield Health and Social Care NHS Foundation Trust in 2012 – 13. However, we expect to take on £583,330 worth of assets, mostly buildings and IT equipment from NHS Sheffield on the closure of the Primary Care Trust. These assets will transfer on the 1st April 2013. For more information see note 23.

2. Operating segments

The Trust considers that it has one operating segment, that being the provision of health and social care. All revenues are derived from within the UK.

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

	2012/13 £000	2011/12 £000
Income from patient care activities		
Cost & Volume income	**3,046**	2,986
Block contract income	**83,242**	76,026
Clinical partnerships providing mandatory services (including Section 31 agreements)	**4,446**	5,520
Clinical income for the secondary commissioning of mandatory services	**-**	11
Other clinical income from mandatory services	**2,542**	2,418
	93,276	86,961
Other operating income		
Research and development	**570**	540
Education and training	**6,587**	6,216
Non-patient care services to other bodies	**22,760**	27,149
Other income	**712**	559
Profit on disposal of land and buildings	**313**	-
Profit on disposal of other tangible fixed assets	**5**	2
Gain on disposal of assets held for sale	**-**	71
Reversal of impairments of property, plant and equipment	**23**	-
Rental revenue from operating leases – minimum lease receipts	**34**	33
Income in respect of staff costs where accounted for on a gross basis	**4,102**	1,016
	35,106	35,586
Total operating income*	**128,382**	122,547

*Income is almost totally from the supply of services. Income from the sale of goods is immaterial.

3.2 Private patient income

The Trust has no private patient income.

3.3 Operating lease income

Rental income from operating leases

	2012/13 £000	2011/12 £000
Rents recognised as income in period	**34**	33

Future minimum lease payments due

	2012/13 £000	2011/12 £000
Receivable on leases of buildings expiring		
Not later than one year	**14**	13
Later than one year and not later than five years	**42**	50
Later than five years	**-**	-
	56	63

3.4 Operating income by type comprises

	2012/13 £000	2011/12 £000
Income from patient care activities		
NHS foundation trusts	**16**	47
NHS trusts	**-**	1
Primary care trusts	**87,459**	80,500
Local authorities	**4,446**	5,520
Non-NHS: Other	**1,355**	893
	93,276	86,961
Other operating income		
Research and development	**570**	540
Education and training	**6,587**	6,216
Charitable and other contributions to expenditure	**-**	-
Non-patient care services to other bodies	**22,760**	27,149
Income in respect of staff costs (gross basis)	**4,102**	1,016
Rental revenue from operating leases	**34**	33
Other income	**712**	559
	34,765	35,513
Total operating income	**128,041**	122,474
Profit on disposal of plant and equipment	**5**	2
Profit on disposal of land and buildings	**313**	-
Reversal of impairments of property, plant and equipment	**23**	-
Gain on disposal of assets held for sale	**-**	71
Total income	**128,382**	122,547

4. Operating expenses

4.1 Operating expenses comprise:

	Note	2012/13 £000	2011/12 £000
Services from NHS Foundation trusts		**1,286**	1,216
Services from NHS Trusts		**68**	-
Services from PCT's		**1,288**	864
Purchase of healthcare from non-NHS bodies		**3,307**	98
Employee expenses – Executive Directors	5.1	**805**	796
Employee expenses – Non-executive Directors		**97**	99
Employee expenses – Staff	5.1	**98,709**	99,444
Drug costs		**1,200**	1,390
Supplies and services – clinical (excluding drug costs)		**1,390**	1,357
Supplies and services – general		**1,176**	1,090
Establishment		**2,435**	2,344
Research and development		**64**	66
Transport		**576**	405
Premises		**4,933**	4,176
Increase/(decrease) in provision for impairment of receivables		**-**	(1)
Inventories written down (net, including inventory drugs)		**5**	-
Rentals under operating leases – minimum lease receipts	4.2	**774**	707
Depreciation on property, plant and equipment		**2,046**	2,075
Amortisation on intangible assets		**3**	-
Impairments of property, plant and equipment		**195**	-
Audit fees: statutory audit*		**69**	65
Other auditors remuneration: other services		**1**	-
Clinical negligence		**233**	261
Legal fees		**238**	121
Consultancy costs		**374**	286
Training, courses and conferences		**468**	507
Patient travel		**108**	106
Car parking and security		**92**	71
Redundancy	5.1	**320**	-
Publishing		**6**	-
Insurance		**167**	121
Losses and ex gratia payments		**17**	47
Other		**544**	755
		122,994	118,466

* There is a £1,000,000 limit on Auditors liability.

4.2 Operating leases

4.2.1 Payments recognised as an expense

	2012/13 £000	2011/12 £000
Minimum lease payments	**774**	707

4.2.2 Future minimum lease payments

	2012/13 £000	2011/12 £000
Payable:		
Not later than one year	**646**	597
Later than one year and not later than five years	**1,261**	1,348
Later than five years	**9,078**	8,432
	10,985	10,377

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

	2012/13 £000	2011/12 £000
Salaries and wages	**79,503**	81,340
Social security costs	**5,854**	6,081
Employer contributions to NHS pension scheme	**8,903**	9,279
Employer contributions to Local Authority scheme	**389**	385
Termination benefits	**1,603**	446
Agency/contract staff	**3,589**	2,746
	99,841	100,277
Less costs capitalised as part of assets	**(7)**	(37)
Total	**99,834**	100,240

5.2 Directors remuneration

	2012/13 £000	2011/12 £000
Fees to non-executive directors	**91**	92
Executive Directors – Salaries*	**643**	635
Executive Directors – Benefits (NHS Pension scheme)	**85**	83
	819	810

* Salaries stated are all emoluments paid to Executive Directors, including payments for clinical responsibility within the Trust and excluding national insurance contributions.

Further information about the remuneration of individual directors and details of their pension arrangements is provided in the Remuneration Report and Note 5.3

5.3 Directors' remuneration

Name and title	Period 1.4.12 to 31.3.13				Period 1.4.11 to 31.3.12			
	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	-	16	19	135-140	-	17	19
C Clarke, Deputy Chief Executive and Social Care Lead	100-105	-	12	14	100- 105	-	12	14
M Rodgers, Deputy Chief Executive/ Executive Director of Finance	95-100	-	12	14	105 - 110	-	13	15
P Robinson, Executive Director of Finance	15-20	-	2	3	-	-	-	-
Dr T Kendall, Executive Medical Director	60-65	125-130	23	21	60 - 65	125 - 130	23	21
E Lightbown, Chief Operating Officer/Chief Nurse	100-105	-	12	14	100 - 105	-	12	14

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 £643,000. 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 £85,000.

5.4 Average number of people employed

	2012/13 Number	2011/12 Number restated
Medical and dental	**152**	151
Administration and estates	**526**	542
Healthcare assistants and other support staff	**166**	176
Nursing, midwifery and health visiting staff	**1,202**	1,296
Scientific, therapeutic and technical staff	**365**	377
Social care staff	**117**	134
Bank and agency staff	**133**	64
	2,661	2,740

*2011/12 restated to exclude non-executive directors

5.5 Early retirements due to ill health

During 2012/13 there were 4 (2011/2012 – 1 case) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £168,478 (2011/2012 – £33,000). 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.

5.6 Exit packages

The table below summarises the total number of exit packages agreed during 2012/13. Included within these are compulsary redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	**3 (0)**	19 (2)	22 (2)
£10,000 – £25,000	**2 (0)**	38 (4)	40 (4)
£25,001 – £50,000	**0 (0)**	8 (8)	8 (8)
£50,001 – £100,000	**0 (0)**	4 (1)	4 (1)
£100,000 – £150,000	**2 (0)**	0 (0)	2 (0)
Total number of exit packages by type	**7 (0)**	69 (15)	76 (15)
Total resource cost £*	**320,000 (0)**	1,283,000	1,603,000
		(446,188)	(446,188)

*Figures in brackets relate to 2011 – 12

6. Finance income

	2012/13 £000	2011/12 £000
Interest income		
Bank accounts	**153**	101
Finance income associated with the Local Authority pension scheme*	**81**	88
Other loans and receivables	**-**	-
Total	**234**	189

7. Finance costs

	2012/13 £000	2011/12 £000
Finance costs associated with the Local Authority pension scheme*	**87**	88

No payments were made during 2012/13 under The Late Payment of Commercial Debts (Interest) Act 1998 (year ended 31 March 2012 – £nil).

*2011/12 finance income and costs associated with the local Authority pension scheme presented gross for comparison purposes

8. Intangible assets

Computer software

	2012/13 £000	2011/12 £000
Gross cost at 1 April	**23**	8
Additions	**4**	15
Disposals	**-**	-
Gross cost at 31 March	**27**	23
Amortisation at 1 April	**8**	8
Provided during the year	**3**	-
Disposals	**-**	-
Amortisation at 31 March	**11**	8
Net book value – closing		
At 31 March	**16**	15

9. Property, plant and equipment

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
2012/13:								
Cost or valuation at 1 April 2012	9,034	49,583	378	966	482	2,056	149	62,648
Additions purchased	-	-	2,714	103	40	44	-	2,901
Impairments charged to revaluation reserve	(265)	(1,322)	-	-	-	-	-	(1,587)
Reclassifications	-	-	(124)	59	-	65	-	0
Revaluation surpluses	-	(4,518)	-	-	-	-	-	(4,518)
Reclassified as held for sale	(100)	(230)	-	-	-	-	-	(330)
Disposals	-	-	-	-	(33)	-	(3)	(36)
At 31 March 2013	**8,669**	**43,513**	**2,968**	**1,128**	**489**	**2,165**	**146**	**59,078**
Depreciation at 1 April 2012	-	5,036	-	551	281	1,315	123	7,306
Provided during year	-	1,667	-	98	63	208	10	2,046
Reversal of Impairments	-	(23)	-	-	-	-	-	(23)
Reclassifications	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	-	195	-	-	-	-	-	195
Revaluation surpluses	-	(4,934)	-	-	-	-	-	(4,934)
Reclassified as held for sale	-	(4)	-	-	-	-	-	(4)
Disposals	-	-	-	-	(33)	-	(3)	(36)
Depreciation at 31 March 2013	**-**	**1,937**	**-**	**649**	**311**	**1,523**	**130**	**4,550**
Net book value								
Purchased	9,034	43,964	378	415	201	741	26	54,759
Donated	-	583	-	-	-	-	-	583
Total at 1 April 2012	**9,034**	**44,547**	**378**	**415**	**201**	**741**	**26**	**55,342**
Net book value								
Purchased	8,669	41,012	2,968	479	178	641	16	53,963
Donated	-	564	-	0	-	1	-	565
Total at 31 March 2013	**8,669**	**41,576**	**2,968**	**479**	**178**	**642**	**16**	**54,528**
Analysis of property, plant and equipment - net book value								
Protected	4,510	31,416	-	-	-	-	-	35,926
Unprotected	4,159	10,160	2,968	479	178	642	16	18,602
Total at 31 March 2013	**8,669**	**41,576**	**2,968**	**479**	**178**	**642**	**16**	**54,528**

No assets were held under finance leases or hire purchase contracts as at 31 March 2013

Prior year	Land	Buildings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
2011/12:	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£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 loss	-	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 period	-	1,708	-	103	60	191	13	2,075
Impairments charged to SOCI	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Revaluation surpluses	-	(36)	-	-	-	-	-	(36)
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(28)	(183)	-	(211)
Depreciation at 31 March 2013	**-**	**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 1st 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

10. Investment property

10.1 Investment property – carrying value

	31 March 2013 £000	31 March 2012 £000
As at 1 April	**200**	200
Acquisitions in year	**-**	-
Impairments recognised in expenses	**(20)**	-
As at 31 March	**180**	200

10.2 Investment property expenses

	2012/13 £000	2011/12 £000
Direct operating expense arising from investment property generating rental income in the year	**10**	13

10.3 Investment property income

	2012/13 £000	2011/12 £000
Investment property income	**34**	33

11. Inventories

11.1 Inventories

	31 March 2013 £000	31 March 2012 £000
Consumables	**106**	163

11.2 Inventories recognised in expenses

	2012/13 £000	2011/12 £000
Inventories recognised as an expense in the period*	**1,862**	1,794
Write-down of inventories (including losses)	**5**	7
	1,867	1,801

*Inventories recognised as an expense in the period (consumed) are recorded against additions in the period.

12. Trade and other receivables

12.1 Trade and other receivables

	Current		**Non-current**	
	31 March 2013 £000	31 March 2012 £000	**31 March 2013 £000**	31 March 2012 £000
NHS receivables	**1,645**	1,362	**-**	281
Receivables due from NHS charities	**3**	-	**-**	-
Other receivables with related parties	**878**	248	**3,403**	2,388
Provision for impaired receivables	**(18)**	(18)	**-**	-
Prepayments	**431**	468	**348**	252
Accrued income	**24**	1,357	**-**	-
Interest Receivable	**8**	11		
PDC receivable	**66**	-	**-**	-
VAT receivable	**144**	65	**-**	-
Other receivables	**284**	305	**-**	-
	3,465	3,798	**3,751**	2,921

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 2013 £000	31 March 2012 £000
Up to three months	**2**	-
In three to six months	**3**	-
Over six months	**13**	18
	18	18

12.3 Receivables past their due date but not impaired

	31 March 2013 £000	31 March 2012 £000
By 0 – 30 days	**359**	174
By 30 – 60 days	**223**	82
By 60 – 90 days	**51**	58
By 90 – 180 days	**53**	20
Over 180 days	**186**	50
Total	**872**	384

12.4 Provision for impairment of receivables

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	**18**	19
Increase in provision	**-**	-
Unused amounts reversed	**-**	(1)
Balance at 31 March	**18**	18

13. Cash and cash equivalents

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	**17,028**	14,689
Net change in year	**5,703**	2,339
Balance at 31 March	**22,731**	17,028
Made up of		
Cash at commercial banks and in hand	**181**	106
Cash with the Government Banking Service	**22,447**	4,285
Other current investments	**103**	12,637
Cash and cash equivalents as in statement of financial position	**22,731**	17,028

14. Non-current assets held for sale

Current year: 2012/13	Property, plant and equipment £000	Other assets £000	Total £000
As at 1 April 2012	**-**	-	**-**
Assets classified as available for sale in the year	**226**	100	**326**
Assets sold in year	**(226)**	(100)	**(326)**
Impairment of assets held for sale	**-**	-	**-**
As at 31 March 2013	**-**	**-**	**-**

Prior year: 2011/12	Property, plant and equipment £000	Other assets £000	Total £000
As at 1 April 2012	**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	**-**	**-**	**-**

At 31 March 2013 there were no properties declared surplus to operational requirements.

15. Trade and other payables

	Current	
	31 March 2013 £000	31 March 2012 £000
NHS payables	**33**	135
Amounts due to other related parties	**1,160**	1,250
Trade payables – capital	**212**	52
Other trade payables	**931**	778
Other payables	**-**	-
Accruals	**3,440**	2,691
PDC dividend payable	**-**	4
Total excluding taxes	**5,776**	4,910
Taxes payable	**1,868**	2,013
Total	**7,644**	6,923

16. Other liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Deferred income	**216**	204	**-**	-
Net pension scheme liability	**-**	-	**3,867**	2,714
	216	204	**3,867**	2,714

17. Prudential borrowing limit

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

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

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

The Trust's prudential borrowing limit is:

	31 March 2013 £000	31 March 2012 £000
Total long term borrowing limit set by Monitor	**24,900**	23,500
Working capital facility approved by Monitor	**8,100**	8,100
Total prudential borrowing limit	**33,000**	31,600

Neither of the above facilities were utilised by the Trust in 2012/13 or in the year to 31 March 2012.

The financial ratios for 2012/13 and 2011/12 as published in the Prudential Borrowing Code are shown below, together with the actual level of achievement by the Trust.

Financial ratio	Actual ratios 2012/13	Approved PBL ratios 2012/13	Actual ratios 2011/12	Approved PBL ratios 2011/12
Minimum Dividend Cover	4.5	>1x	3	>1x
Minimum Interest Cover	1.5	>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 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Legal claims	**81**	95	**-**	-
Redundancy	**926**	-		
Injury Benefits	**49**	46	**680**	392
Compromise Agreement	**-**	60	**-**	-
Other	**75**			
Specialist Registrars	**-**		**-**	-
Total	**1,131**	201	**680**	392

	Legal claims £000	Redundancy £000	Injury benefits £000
At 1 April 2012	**95**	-	438
Arising during the year	**65**	926	339
Used during the year	**(46)**	-	(48)
Reversed unused	**(33)**	-	-
At 31 March 2013	**81**	926	729
Expected timing of cash flows:			
Not later than one year	**81**	926	49
Five years	**-**		182
Later than five years	**-**		498
	81	926	729

	Compromise agreement £000	Other £000	Total £000
At 1 April 2012	60	-	593
Arising during the year	-	75	1,405
Used during the year	(60)	-	(154)
Reversed unused	-	-	(33)
At 31 March 2013	-	75	1,811
Expected timing of cash flows:			
Not later than one year	-	75	1,131
Five years	-	-	182
Later than five years	-	-	498
	-	75	1,811

Legal claims relate to claims brought against the Trust for Employer's 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 £729,000 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 2012 – £438,000).

Previously £314,000 of provisions in 2011/12 were covered by 'back-to-back' income arrangements with Sheffield Primary Care Trust. Due to the demise of Primary Care Trusts as at 31st March 2013, Sheffield Primary Care Trust cleared their outstanding liability with the FT during 2012/13. Therefore, there are no back to back arrangements with effect from 1st April 2013.

£3,585,000 is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of Sheffield Health and Social Care NHS Foundation Trust (31 March 2012 – £1,743,000).

19. Contingent liabilities

	31 March 2013 £000	31 March 2012 £000
Legal claims	**(66)**	(58)
Redundancy	**(412)**	
	(478)	(58)

Legal claims contingent liabilities represent the consequences of losing all current third party legal claim cases. Redundancy contingent liabilities represent potential redundancies where there may be an outflow of resources embodying future economic benefits in settlement of: a) a present obligation; or b) a possible obligation whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust.

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 2013 are in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts and Local Authorities, which are financed from resources voted annually by Parliament. The Trust finance its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is therefore not exposed to significant liquidity risks.

20.1 Financial assets

	31 March 2013 £000	31 March 2012 £000
Denominated in £ Sterling – Floating interest rate*	**22,664**	16,963

*This excludes cash in hand of £67,000 (2011/12 £65,000)

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 2013 £000	31 March 2012 £000
Loans and receivables		
NHS receivables	**1,666**	1,643
Other receivables with related parties	**4,284**	2,604
Provision for irrecoverable debts	**(18)**	(18)
Accrued income	**11**	1,368
Other receivables	**247**	305
Cash at bank and in hand	**22,731**	17,028
	28,921	22,930

20.4 Financial assets by category

	31 March 2013 £000	31 March 2012 £000
Other financial liabilities		
NHS payables	**533**	135
Other payables with related parties	**1,161**	1,250
Trade payables – capital	**212**	52
Other trade payables	**931**	778
Accruals	**3,439**	2,691
Provisions under contract	**-**	60
Total at 31 March	**5,776**	4,966

20.5 Fair values

The fair value of the Trust's financial assets and financial liabilities at 31 March 2013 equates to the book value.

21. Third party assets

The Trust held cash of £4,342,736 at bank and in hand at 31 March 2013 (31 March 2012 – £3,960,418) 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 97 cases (the year ended 31 March 2012 – 72 cases) of losses and special payments totalling £50,417 (the year ended 31 March 2012 – £216,000) approved during the year ended 31 March 2013.

23. Events after the reporting period

The Trust expects to take on £583,330 worth of assets, mostly buildings and IT equipment, from NHS Sheffield on the closure of the Primary Care Trust. These assets will transfer on the 1st April 2013 and relate to the transfer of Highgate Clinic and Albert Terrace Road.

24. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements are:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment*	**477**	34

*These relate to the Trust's Intensive Support Service development and capital developments at the Longley Centre

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 to Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Sheffield Teaching Hospitals NHS FT	**1,564**	**3,247**	**166**	**459**
University of Sheffield	**528**	**152**	**83**	**14**
Royal College of Psychiatrists	**23**	**97**	**-**	**-**
Turning point	**36**	**5**	**-**	**4**

The relationships are:

- The wife of one of the Trust's non executive directors is a non executive director at Sheffield Teaching Hospitals NHS Foundation Trust
- The Executive Medical Director is Deputy Director of the Royal College of Psychiatrists.
- The Chair is Professor of Social Policy at the University of Sheffield.
- One of the non executive directors receives a pension from Turning Point.
- One of the non 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:

	2012/13		2011/12	
	Income £000	**Expenditure £000**	Income £000	Expenditure £000
Department of Health	**123**	**-**	106	-
Other NHS bodies	**105,010**	**3,664**	97,252	3,227
Charitable funds	**-**	**-**	-	-
Other bodies (including WGA)	**12,028**	**16,662**	12,452	17,682
	117,161	**20,326**	109,810	20,909

*2011/12 figures include minor reclassification for comparable data

The value of transactions with board members and key staff members in 2012/13 is £nil (2011/12 – £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 2013		31 March 2012	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
Department of Health	**66**	**-**	-	18
Other NHS bodies	**1,666**	**644**	2,743	840
Charitable funds	**-**	**-**	-	-
Other bodies (including WGA)	**4,456**	**3,285**	3,201	3,557
	6,188	**3,929**	5,944	4,415

Value of balances (other than salary) with board members and key staff members at 31 March 2013 is £nil (31 March 2012 – £nil).

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2013 is £9,223 (31 March 2012 – £nil). In addition, the value of balances (other than salary) with related parties in relation to the writing off of receivables during 2012/13 is £nil (2011/12 – £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 NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Leeds Partnership NHS FT
- 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 2012/13 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £420,000 (the year ended 31 March 2012 a loss of £369,000). A pension deficit of £3,867,000 is included in the statement of financial position as at 31 March 2013 (31 March 2012 – £2,714,000 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 2013, the deficit on the scheme was £3,867,000 (31 March 2012 – £2,714,000 deficit), the majority of which is offset by a non-current receivable of £3,402,960 (31 March 2012 – £2,388,000).

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 2013 %	31 March 2012 %
Rate of inflation	**2.4**	2.5
Rate of increase in salaries	**4.15**	4.25
Rate of increase in pensions and deferred pensions	**2.4**	2.5
Discount rate	**4.2**	4.9
Expected rate of return on assets	**0.5 - 7.0**	0.5 - 7.0

The current life expectancies at age 65 underlying the accrued liabilities for the scheme are:

	31 March 2013 Years	31 March 2012 Years
Non retired member – Male (aged 65 in 20 years time)	**23.7**	22.8
Non retired member – Female (aged 65 in 20 years time)	**26.6**	25.8
Retired member – Male	**21.8**	21.5
Retired member – Female	**24.7**	24.2

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	Scheme assets %	**31 March 2013 £000**	Scheme assets %	31 March 2012 £000
Equities	**61.4**	**8,405**	62.3	7,547
Government Bonds	**11.1**	**1,520**	17.0	2,059
Other bonds	**10.2**	**1,396**	7.7	933
Property	**9.3**	**1,273**	9.9	1,199
Cash/liquidity/other	**8.0**	**1,096**	3.1	376
Total fair value of assets	**100.0**	**13,690**	100.0	12,114
Present value of defined benefit obligation		**(17,557)**		(14,828)
Net retirement benefit deficit		**(3,867)**		(2,714)

Movements in the present value of the defined benefit obligations are:

	2012/2013 £000	2011/2012 £000
At 1 April	**14,828**	13,243
Current service cost	**372**	357
Interest on pension liabilities	**723**	735
Member contributions	**126**	144
Actuarial (losses)/gains on liabilities	**2,146**	573
Benefits paid	**(638)**	(245)
Past service gain	**-**	-
Curtailments	**-**	21
At 31 March	**17,557**	14,828

Movements in the fair value of the scheme's assets were:

	2012/2013 £000	2011/2012 £000
At 1 April	**(12,114)**	(11,332)
Expected return on plan assets	**(675)**	(744)
Actuarial gains/(losses) on assets – current year	**(1,024)**	246
Employer contributions	**(389)**	(385)
Member contributions	**(126)**	(144)
Benefits paid	**638**	245
At 31 March	**(13,690)**	(12,114)

The net pension expense recognised in operating expenses in respect of the scheme is:

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Current service cost	**(372)**	(357)
Past service costs	**-**	-
Pension expense gain/(charge) to operating surplus	**(372)**	(357)
Expected return on plan assets	**675**	744
Interest on pension liabilities	**(723)**	(735)
Effect of curtailments	**-**	(21)
Pension expense credited	**(48)**	(12)
Net pension gain/(charge)	**(420)**	(369)

The reconciliation of the opening and closing statement of financial position is as follows:

	2012/2013 £000	2011/2012 £000
At 1 April	**(2,714)**	(1,911)
Expenses recognised	**(420)**	(369)
Actuarial losses recognised	**(1,122)**	(819)
Contributions paid	**389**	385
At 31 March	**(3,867)**	(2,714)

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 2013, a cumulative amount of £463,000, was recorded in the Income and Expenditure Reserve (31 March 2012 £328,000).

The history of the scheme for the current and prior year is:

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Present value of defined benefit obligation	**17,557**	14,828
Fair value of scheme assets	**(13,690)**	(12,114)
Net retirement obligation	**3,867**	2,714

Experience gains on scheme liabilities for 2012/13 are £nil (the year ended 31 March 2012 – £nil) and experience gains on scheme assets are £1,699 (year ended 31 March 2012 – £498).

SECTION 16.0
Glossary

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 Results

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 Cash Flows

Shows the cash Flows in and out of the Trust during the period.

Statement of Changes in Taxpayers' Equity

This statement shows the changes in reserves and public dividend capital during the period.

Statement of Comprehensive Income

This statement was previously called 'Income and Expenditure Account'. It summarises the expenditure on pay and non-pay running costs less income received, which results in a surplus or deficit.

Statement of Financial Position

A year-end statement which provides a snapshot of the Trust's financial position at a point in time. The top half shows the Trust's total net assets (assets minus liabilities). The bottom half shows the Taxpayers Equity or investment in the Trust.

UK GAAP
(Generally Accepted Accounting Practice)

This was the standard basis of accounting in the UK before the international financial reporting standards were adopted.

SECTION 17.0

Contacts

17.0 Contacts

Sheffield Health and Social Care NHS Foundation Trust Headquarters

Headquarters
Fulwood House
Old Fulwood Road
Sheffield
S10 3TH

Tel: 0114 271 6310 (24 hour switch board)

www.shsc.nhs.uk

Human Resources

If you are interested in a career with Sheffield Health and Social Care NHS Foundation Trust, visit the Trust's website (www.shsc.nhs.uk) and click on the 'Working for the Trust' tab.

Communications

If you have a media enquiry, require further information about our Trust or would like to request copies of this report please contact the Communications Manager.

Email: communications.shsc@shsc.nhs.uk

Tel: 0114 2263302

Membership

If you want to become a member of the Trust or want to find out more about the services it provides, please contact the Membership Manager on 0114 271 8825.

Contacting members of the Council of Governors

The Governors can be contacted by emailing governors@shsc.nhs.uk or by phoning 0114 2718825.

Sheffield Health and Social Care NHS
NHS Foundation Trust

Sheffield Health and Social Care NHS Foundation Trust
Fulwood House
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