

# ANNUAL REPORT AND ACCOUNTS **2013 – 2014**



Sheffield Health and Social Care NHS  
Foundation Trust

Annual Report and Accounts 2013/14

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



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# SECTION 1.0

## Introduction

# 1.0

**It is my great pleasure to introduce this Annual Report and Accounts for 2013/14 and to invite you to read about the Trust's objectives and what it has achieved. Sheffield Health and Social Care NHS Foundation Trust (SHSC) has now completed 6 years as a Foundation Trust (FT) and is delivering the improvements in service user experience and outcomes that were the main reason for becoming an FT.**

The evidence for this claim is contained in the following pages, which are packed with information about the services that the Trust provides and its performance against the criteria set by external NHS regulators. As you will see, on all fronts the Trust is doing well. The Trust's Financial Risk Rating by Monitor, the independent FT regulator, is 4 (very good) and its Governance Risk Rating is green (the highest). Of particular importance are the positive assessments by service users themselves of the treatment they receive in many of our services. The Trust is not complacent though: continuing to improve the experience of service users and the outcomes of care are fundamental objectives every year.

Continuous improvement and achieving the Trust's aim to be the first choice for service users, carers and Commissioners is getting harder and harder. Like the rest of the NHS, SHSC faces a hugely challenging financial context as a result of the cuts that the Government has made to the health service. National cuts of £20 billion up to 2015 translate into a reduction of approximately 13% in the Trust's income. One of our key partners, Sheffield City Council, has had its budget cut by 40%. This is at a time when, largely due to the recession, the need for SHSC services is increasing. The result inevitably is a tighter rationing of services. This is difficult to accept when everyone involved with the Trust – Governors, staff, service users, carers and the Board of Directors – passionately want to do much more in terms of both meeting existing needs and in preventing new needs arising.

The Trust is responding to these challenges by reconfiguring services, with the primary aim of improving service quality and recovery rates for service users, while trying to save money at the same time. There has also been a major streamlining of management operations in order to maximise resources for service user care.

I cannot predict what will happen after the May 2015 election but I am certain that there will not be the large injection of cash that is required by the NHS (and justified by the UK's relatively low spending on its health services compared with other countries). Despite that pessimistic outlook I am confident that we can square the circle of improved services and reduced costs. This confidence is based on 4 factors. First, the Trust has a tremendous track record in overcoming obstacles and maintaining service quality. This is due to our shared sense of purpose, dedication to service users and patients and the high quality of staff throughout this organisation. Second, our partnership with service users and carers gets stronger and stronger. This is critical in ensuring the responsiveness and quality of the Trust's services. It will receive a big boost in 2014/15 when we establish a monitoring unit dedicated to the service user experience. Third, the Trust is working in close partnership with GPs in Sheffield and the NHS Sheffield Clinical Commissioning Group. We aim to ensure that our services work as closely as possible with primary care and this is happening already on many fronts. Breaking down the barriers between primary and secondary care, and between health and social care, is essential to maintain and strengthen SHSC services. Fourth, the Council of Governors – consisting of the representatives of service users and carers, the public, staff and key stakeholders – is proving to be a great source of support for the Board of Directors and Trust overall. These 'critical friends' rightly question the Board on many issues but we share a basic commitment to the values and objectives of the Trust. Together we can help to shape the future despite the obstacles placed in our way by politicians.

Some of the main service developments in 2013/14 include:

- The opening of the new Intensive Support Service, Firhill Rise, which is a state-of-the-art facility for people with a learning disability and complex needs, and the creation of a new specialist community team;
- The opening of the Crisis House, in partnership with Rethink Mental Illness, offering an alternative to hospital admission for people with mental health problems;
- The launch of a new Home Environment Service, enabling service users to manage their homes as part of the recovery process;
- The refurbishment of Longley Meadows;
- The award of recurrent funding to continue to provide multi-disciplinary older adult liaison services 7 days per week;
- The award of funding to Darnall Primary Care Centre to implement a Practice Champions programme in partnership with Darnall Wellbeing;
- The provision of a new Adult Autism and Neurodevelopmental Service.

There are many more exciting new developments described later in this report. It is important to note here that many of these service improvements, including Firhill Rise and the Crisis House, have been possible only because of the surpluses we have generated as an FT.

I have already paid tribute to the support provided by the SHSC Council of Governors. In 2013/14 we welcomed 14 new Governors and welcomed back 10 who were re-elected. At the same time we said a fond goodbye to 9 Governors (David Barker, Brandon Ashworth, Dean Chambers, Lindsay Oldham, Ingrid King, Mia Bajin, Amir Afzal and Sue Sibbald), some of whom had been members of Council from the start. The Lead Governor, John Kay, was also re-elected for 2 years in June 2013. The Council of Governors also performed the important task of appointing the Trust Chair, after an openly competitive process (it was in fact a re-appointment).

The membership of the Trust remained static in 2013/14 (12,620 excluding staff members in March 2014 compared with 12,630 at the same point in 2013). In fact membership increased but we also undertook a thorough review of the membership list which resulted in a reduction of several hundred. The Trust continued to respond to and engage with members by holding a successful membership event on dementia, attended by more than 150 people.

I have said that the next few years are going to be difficult for the NHS and this Trust, which means for its staff and the service users and carers we serve. There is less funding and increasing demand. In partnership with our Commissioners, and especially primary care, we will continue to respond wholeheartedly to these challenges. We will only be successful in doing so because of the hard work and dedication of staff and the support of all key stakeholders, especially service users and carers. The spirit that binds us all together in the NHS may be tested severely, as it has been in the past, but it will survive, it must do.



Professor Alan Walker  
Chair

This Annual Report provides a positive account of how we continue to improve the care and support we provide to the people of Sheffield.

SHSC has always had quality as its highest principle, while we all know that we also have to balance the books. The scale of the financial challenge for health and social care services is significant. The NHS organisations in Sheffield, and the City Council, are working to respond to this challenge together. Our challenge is to deliver quality services with less money than we have had in the past. We have a good history of managing our finances effectively. This is really important because it means we can deliver services in a stable environment and are able plan to make the changes we want. As we continue to work to deliver services that will be affordable with the money we will have in the future, I am confident overall that the quality of our services is good.

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

Many of our services have been visited and evaluated by the Care Quality Commission. We receive feedback highlighting that the care they observed was person centred and dignified. When they have identified areas we need to address we have taken action immediately. Service user feedback about the support and care we provide is positive. Overall, we have delivered the national standards required of us across our services for primary care, learning disabilities, substance misuse and mental health. We are a high performing organisation.

National staff surveys highlight that our staff feel more engaged with the Trust than average. Our staff are more likely to recommend us as a place to work or receive treatment in than the average for the NHS as a whole. I am confident that all staff come to work wanting to do the best we can for those we work with. We recognise that every single member of staff has a role to play in the quality of the experience of the individuals we work with.

Following the publication of the Francis report, the Board of Directors undertook a review of our culture. Our review was undertaken with our staff, our clinical leaders and benefited from input from external experts in the field of compassionate care. The Board concluded that our culture is very different from those organisations reviewed in the national reports. But we are not complacent. We operate in the same context and are subject

to the same external pressures that contributed to the failings in those organisations and these are difficult times. Delivering high quality health and social care is becoming more complex and more challenging. Demand for services is increasing and we are currently operating in an environment of reduced public sector spending. Delivering high quality care in this environment is a challenge we are determined to meet.

We have a culture in which, should poor care take place, it is recognised and reported. We do know that we have instances when care is not at the standard we would wish for our friends or families. We are, therefore, keen to learn whatever lessons we can from such occurrences to improve the quality of what we do. We have taken this opportunity to revitalise our commitment that those who use our services are at the heart of everything we do. How we will do this is outlined in the Quality Report section.

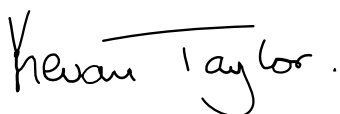
I would like to take this opportunity to thank all staff for their dedication and commitment. I, along with many members of the Board, spend time out and about among front line services either visiting or taking part in a shift. Your pride in the services you run is evident and very well deserved.

Over the last year we have delivered many improvements in the way we are providing care and support to people. New services have opened. Last year saw the opening of Firshill Rise, a purpose built community centre for people with a learning disability and challenging behaviour. In partnership with Rethink Mental Illness a new Crisis House service opened to provide people with more choice about how they are supported. Both of these have been much needed developments and we are proud about the positive impact they are having on people's lives. We have also changed how we deliver some of our services. As a result of this people with dementia are receiving more personalised support in their local communities. We are delivering changes that mean fewer people are receiving in-patient care outside of Sheffield, away from their families and loved ones. These are really positive changes, reflecting our commitment to deliver local care in the community and promoting social inclusion. We continue to improve how we deliver our services. Innovation and improvements are being delivered across our GP Services within the Clover Group, our Substance Misuse services, our IAPT services, and services for people with long

term neurological conditions to highlight a few examples. The Strategic Report section provides a range of information about the developments and improvements we have made.

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 everyone on the Board of Directors sees 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 organisations - this is not a sign that quality is poor, rather that staff know that reporting an incident is the right thing to do in order that lessons can be learned. It is right that we spend as much time looking at complaints as we do considering when someone's experience of care has 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. I, along with the Board of Directors, am accountable for determining the decisions we take about how we move forward.

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 allows us to be confident that the changes and improvements we make are informed by your views and experiences.

A handwritten signature in black ink that reads "Kevan Taylor". The signature is written in a cursive style with a horizontal line above the name.

Kevan Taylor  
Chief Executive



# SECTION 2.0

## Strategic Report

# 2.0

### 2.1 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 01 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.

#### Our vision

Our vision is for Sheffield Health and Social Care NHS Foundation Trust to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. We will be the first choice for service users, their families and Commissioners.

#### Our values

The values of the Trust form the guiding principles and behaviours for the way we do our work and have been ratified by the Trust Board:

- Respect;
- Compassion;
- Partnership;
- Accountability;
- Inclusion and Fairness;
- Ambition.

### The services that we provide

With an annual income of approximately £130 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. In the past 4 years the Trust has grown by 11% with an extra income of £13m.

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;
- In-patient mental health services for adults and older people;
- Specialist services including 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, perinatal 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 in-patient and residential services for individuals who cannot be appropriately helped within their community. Through our Learning

Disability Services we provide supported living to the people who use our services and we work closely with residential care homes and supported living facilities 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 individuals for short periods of time, providing advice and treatment which helps resolve the person's problems. For those 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.



Opening of the new Intensive Support Service at Firhill Rise

## 2.2 An overview of our principal activities

### 2.2.1 Strategy and business model

#### Our purpose

Our purpose is to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community. We will achieve this by providing services aligned with primary care that meet people's health and social care needs, support recovery and improve health and wellbeing.

#### Our approach

We are united by our dedication to meet the needs of people who use our services – those we are here to serve. We measure our success as an organisation by the extent to which we do that and we are committed to working with people who use our services and their carers to improve the quality of everything we do. We welcome checks and balances on what we are doing and take seriously our responsibility to account for how things are.

We can only deliver high standards and quality improvements if it involves all of us. We will only achieve what we are capable of if we work together in partnership, with everyone encouraged to think for themselves and share responsibility to bring about improvements in how we work.

We believe in people's ability to recover and that our role is to work alongside individuals to support them in that journey. We provide recovery oriented services, recognising people's potential and working with optimism and hope. We aim to intervene early to promote independence and self-reliance and prevent loss of independence and wellbeing. We provide services to people within the context of their families and communities, providing specialist interventions and connecting up with community resources.

People's physical, mental and social care needs are interrelated and we are committed to continuing and develop further our range of integrated services aligned with primary care along managed pathways.

We recognise the social determinants of ill health and, therefore, seek to address social inclusion in all that we do. We are committed to equal access and social justice and to tackling stigma and discrimination.

We recognise our shared humanity. The quality of our relationships and the way we treat each other matter, both to service users and to staff. We recognise the importance of maintaining a compassionate workforce and of treating our staff and each other with the same respect and support with which we expect our staff to treat service users and their families. This requires leadership and leaders who recognise, understand and take a stand for humanity in health care and who are concerned with relationships as well as results.

The health and social care system is under considerable pressure, due to increased need and resource constraints. We will work in partnership with the people who use our services to improve quality and reduce inefficiencies by redesigning pathways of care and providing services as close to home as possible.

We work in partnership with the organisations that commission our services – NHS Sheffield Clinical Commissioning Group and Sheffield City Council. This allows us to understand 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 system as a whole. There is a clear drive to change the way services are provided in Sheffield. The focus is on the delivery of community based care with the primary care team at the centre, delivering accessible and integrated care for people's health and social care needs. This is being driven by closer alignment of commissioning strategies with the intention of joint commissioning supported by initiatives such as the Better Care Fund.

#### 2.2.2 Our strategic aims

In order to deliver our purpose and vision we have identified 5 key strategic aims as follows:

1. To continually improve the quality and efficiency of our services in terms of safety, outcomes and service user experience;
2. To retain, transform and develop services along care pathways, enabling early intervention and meeting people's needs closer to home;
3. To recruit, develop, support and retain a skilled, committed and compassionate workforce with effective leadership at every level;
4. To build and develop partnerships that deliver improvements in quality for the benefit of our communities;
5. To continue to perform as a financially viable, effective and well governed organisation.

Within Sheffield there is a clear drive to change the way services are provided. There is a genuine shift to adopt city wide approaches to developing solutions to the future needs of the people of Sheffield. Broader commissioning strategy and policy both locally and nationally sees a continued focus in a shift from hospital to community models of care provision and a growing exploration of integration at the point of delivery across health and social care. NHS Sheffield Clinical Commissioning Group and Sheffield City Council are committed to the delivery of integrated community care that reduces the need for hospital care, is primary care led and focussed on prevention and reablement. This provides a renewed interest in how best to deliver community based support as the main vehicle to improve the health and wellbeing of our local population.

This will impact on the stability of the Trust and how we provide services in the future. We have significant experience of shifting care from a hospital context to a community one, along with delivering successful integrated health and social care services across a range of partnership structures. We are in a good position to share this experience with stakeholders in Sheffield to inform how we move forward as a city wide health and social care economy.

The financial environment is challenging. We will experience significant challenges delivering our services in the current financial environment. The Council is planning for 40-50% savings over 3 years and the NHS provides a headline inflation adjustment for non-tariff services of -1.8%.

Certain vulnerable groups are less resilient to the economic downturn. In particular, people with disabilities, ethnic minorities, the poor, some single mothers (and their children), young, unemployed and older people will be affected. The increased health and social care needs of these groups, the increased expectations for flexible and responsive health and social care delivery in the context of the reduction in NHS and Council spend all combine to pose a major challenge.

Currently, competition within the local economy for the Trust's health services is stable and the Trust performs well in its service delivery. The Trust has performed well in reducing Commissioner expenditure with the private sector for hospital based care and growing its income base at the same time. Some services within the Trust operate within a more competitive landscape. Our Substance Misuse Services face competition from a range of national providers and we are committed to continuing to deliver high quality successful services in the future. As the way in which social care services are provided changes, some of our services will face competition from third sector providers and our ability to compete in the general social care market without new partnerships will be limited. This will have a higher impact on some of our services for people with a learning disability.

Through our joint work with our Commissioners we are well placed to identify new service models of service delivery which deliver improved outcomes for service users at reduced cost. Our joint service development approach ensures we have stability



Daleside Ward

over the short term as we continue to develop plans for the longer term. We have a developing successful track record in delivering service improvements at reduced cost through service transformation. We will build on these approaches with Commissioners.

Our development plans need to ensure we can progress our aims within our local environment. Our service models are increasingly focussed on delivering quick access to shorter-medium term packages of recovery orientated support and treatment. The focus will be to enable more people to continue with their lives independently from secondary services, supported by a broader network of community resources.

Our operating environment over the next 2 years is relatively stable. We have a sound financial footing and a positive history of managing and reducing our costs. The commissioning intentions over the next 2 years are not considered to present risks to the Trust's income and operating stability. Some services are vulnerable to procurement changes and we have identified plans to mitigate against any adverse risks from this and we are confident about how we will move forward. We have a balanced approach to our cost improvement programme with a growing focus on transformative change as we move into the medium term, informed by our positive record to date.

Our plans for the next 2 years have been published and are available here: <http://www.shsc.nhs.uk/about-us/Corporate-Information/annual-plan-and-report>

### 2.2.3 Who our main Commissioners are

As an NHS Foundation Trust, we provide a range of services, covering direct care services, training, teaching and support functions. The main Commissioners of our clinical services are Sheffield Clinical Commissioning Group, Sheffield City Council and NHS England. Housing Associations commission our residential care services.

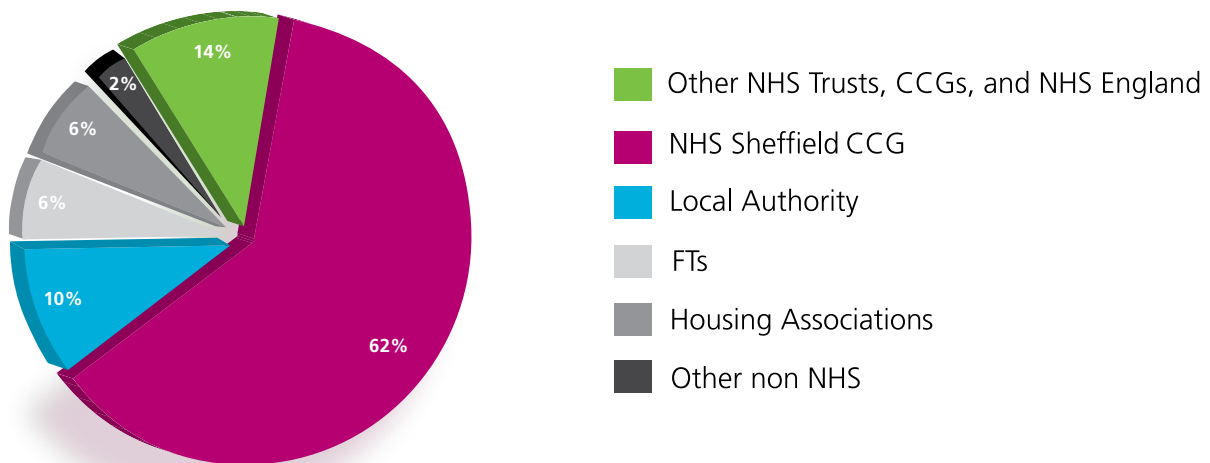
Our non-service user care services are commissioned by NHS Sheffield Clinical Commissioning Group, other NHS Foundation Trusts, NHS Trusts and Whole Government Accounts (WGA) organisations, along with other Clinical Commissioning Groups.

NHS England and Clinical Commissioning Groups commission education, training, research and development from us.

### 2.2.4 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 below and in Section 9 of this report.

## Total Income by Commissioner



Overall, the more significant changes that have been made to our services are summarised as follows:

- We opened our new community centre to support people with a learning disability who also have challenging behaviours. We have invested over £3 million in a new centre at Firshill Rise to support the delivery of integrated care, support and treatment. This new service integrates our community and in-patient teams to enable care and support to be provided seamlessly across community and residential settings. We are proud that this long overdue development has been completed and the new service has commenced. The standard of the care we provided at our previous service, the Assessment and Treatment Unit, was recognised by the Care Quality Commission as being of a very high standard, but delivered in a poor quality environment. Our new purpose built facility will support the service to deliver even better support in the future;
- We launched a new Crisis House service in partnership with Rethink Mental Illness (MI). This development was an important step in the way we are improving the support available to individuals who experience a crisis in their mental health. It provides individuals with support away from home without having to be admitted to hospital. It provides more choice for individuals about how we can support them and it has had a positive impact and been well received by the people who have used it. We have used money that was previously being spent providing hospital care outside of Sheffield to fund this new service. This has resulted in more local care, less out of city admissions, improved experiences for the individuals concerned and better value for money delivering real savings on the previous costs;
- During the year the Trust was commissioned by NHS Sheffield Clinical Commissioning Group to provide a new Adult Autism and Neurodevelopmental Service. This was a significant new development bringing real benefits for the people of Sheffield. Up until this year dedicated services were not available within Sheffield, and the Trust was pleased to be awarded the contract to develop and provide local services;
- Following an engagement and consultation programme led by the Council, we implemented the final stages of our plan to provide better quality respite support for older people who experience emergencies with their support arrangements. The focus of our plan, implemented gradually over the last 2-3 years, was to support individuals to stay at home rather than being admitted to hospital or a care home. It delivered 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. As part of this plan we have established Hurlfield View Resource Centre as the city wide service for Sheffield. Bolehill View Resource Centre was closed in October 2013.



Winner SHSC Staff Awards for Excellence Non-Clinical Individual Bidisha Monda

## 2.2.5 Our regulatory performance

Our Quality Report, in Section 9, describes our performance in delivering quality services over the last year. It outlines the range of performance indicators we use to assess and monitor the quality of services provided. Overall we have performed well and achieved all required healthcare targets by the end of the year. In summary, we achieved:

- All targets for mental health services required by Foundation Trusts, and by the Department of Health, with the exception of Annual Care Reviews for people whose care is delivered under the Care Programme Approach (CPA). We failed to achieve the required targets during the 2nd and 3rd quarters of the year. We put plans in place to address this and achieved the target by the end of the year;
- All targets to improve access to psychological therapies within primary care for common mental health problems;
- All national targets relating to our General Practice services in respect of primary care;
- National targets for the effectiveness of treatment for substance misuse services;
- Required standards of care in respect of the quality of food, privacy and dignity and the environments in which we deliver our services – although areas for improvement were identified.

The Care Quality Commission registers and, therefore, licenses us as a provider of care services as long as we meet essential standards of quality and safety. The Care Quality Commission 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 services the Care Quality Commission visited and inspected is provided in our Quality Report in Section 9.

Our performance, as assessed by our regulator, Monitor is positive. Our risk ratings for financial risks and continuity of service provision were the highest (positive) and our governance risk rating through the year was green (positive). This is summarised in our Quality Report in Section 9.

## 2.3 Our services – a review of the last year

### 2.3.1 In-patient Directorate

#### Our aspiration

The In-patient Directorate has developed a statement that outlines the services we aspire to provide. All the wards have this statement on display welcoming service users and visitors.

We provide an environment where people with mental and physical health problems requiring 24 hour care are supported in their recovery in an environment of respect, kindness and compassion.

The environment will be orderly, tranquil and clean.

Staff are confident, well mannered and have high levels of expertise in providing evidence based assessments, investigations and recovery focussed care while supporting their own and others emotional well being.

Service users and their families are actively listened to and involved in the planning of interventions and care.

#### Our services

The in-patient wards that make up the Directorate are as follows:

• Burbage Ward	• Stanage Ward	• Pinecroft Recovery Ward
• Maple Ward	• Hawthorn Ward	• Forest Close
• Rowan Ward	• Forest Lodge	• Psychiatric Intensive Care
• Daleside Ward		

The Directorate also hosts the Electro-Convulsive Therapy Suite which provides a treatment intervention. The Directorate oversees the Mental Health Act management service that ensures that the rights of service users who are sectioned are protected.

This year we have focussed on developing our services in a number of key areas including recovery focussed care, managing risk effectively, improving the environment and physical health. The In-patient Directorate has also been developing and implementing longer term strategies for in-patient care and treatment as well as a rehabilitation strategy.

## Supporting recovery

*"The last 3 months have been very difficult for me but with your help I have found my way back. I am looking forward to enjoying life once more"*

Service User

The Directorate is developing services in line with a recovery approach to mental health. In practice this means promoting the concept that individuals experiencing mental health problems should be supported to have hope for a better future. We are building on the excellent recovery based care plans used at Forest Close and Pinecroft Ward and extending this to all the in-patient wards. We are supporting meaningful activities for individuals who are admitted to the in-patient wards to alleviate boredom and aid the path to recovery.

## Managing risk

*"I am writing to thank you for the excellent care of our son"*

Individuals who are admitted to the in-patient wards are often a risk to themselves and occasionally to others. Therefore we seek to reduce the risk by effective risk management. This year we have

focused on improving our procedures and practice when service users leave the ward for short periods during their admission. We continue to deliver RESPECT training to all staff to ensure they are equipped to manage situations when service users are agitated and upset. The Directorate is also developing supervision for staff to offer a safe place to discuss their practice and development.

## Improving the environment

*"I would like to commend the way cleaning staff look after the ward"*

During 2013/14 we undertook a redecoration programme of our wards. The older adults wards have been brought together on the Michael Carlisle Centre as Dovedale Wards which has included major refurbishment on Dovedale 2 Ward. In previous years we have developed 'green rooms' (quiet spaces on the wards); this idea has been expanded across more wards and all wards have been given access to 'green bags' which include items to support relaxation for service users.



Winner SHSC Staff Awards for Excellence Non-Clinical Team Wensley Street Players



## Physical health

*"We appreciate your kindness and willingness to accommodate our son's needs including diet and activities"* Parent

We recognise that individuals with mental health problems have a significantly increased risk of physical illness. Therefore we have focussed on how we can improve physical health assessment and treatment. All service users receive a detailed physical health assessment on admission. We are also actively promoting more healthy lifestyles. At Forest Lodge we have worked with service users to introduce a smoking ban in outdoor spaces, which has included promoting alternative activities and supporting smoking cessation.

## Acute care reconfiguration

The Trust embarked on a programme of reconfiguring our acute services in 2008. This has continued at pace in 2013/4, including continued development of the acute care pathway across the whole age range. The Directorate has appointed psychologists for all the acute wards, ensuring all in-patients in the Directorate have access to clinical psychology to support evidence-based interventions. The Crisis House opened in April 2013, offering an alternative to admission to hospital to individuals who are suffering distress in the community.

During the past year the occupancy of the acute in-patient wards has reduced and the need to send individuals out of city due to bed shortages has become negligible.

The refurbishment of the psychiatric intensive care unit has been agreed and funding identified. The design of the new ward has involved service users and staff. The building contractors have been appointed and work will begin next year.

As part of the acute care reconfiguration the older adult wards, Hawthorn and Daleside have merged into Dovedale Wards 1 and 2 at the Michael Carlisle Centre.

## Rehabilitation strategy

The Directorate is responsible for managing the care of individuals who are placed in long term locked rehabilitation beds outside of Sheffield in addition to providing unlocked services at Forest Close and Pincroft Recovery Ward. This has given us a unique opportunity to reflect on how we can best provide a recovery based service for these service users.

In the past year we have reviewed all service users who were in locked rehabilitation outside of Sheffield with the result that we have been able to support many of them to return to unlocked rehabilitation or to live in the community.

We have developed a strategy to organise our services to ensure that those individuals with long term needs receive the best possible care and treatment. Over the next year we will be developing new services to support this strategy.

## The year ahead

Our priorities for 2014/15 are:

- Engaging and listening to service users to support the improvement of the services we provide;
- Better engagement with staff who provide our services;
- Improving physical health for the individuals who use our services;
- Supporting a more effective workforce;
- Improving risk assessment and management;
- Developing a culture of compassion and recovery.

We will also continue to reconfigure acute care and develop the rehabilitation strategy.

### 2.3.2 Community Services Directorate

A range of services are provided by the Community Directorate. These include:

- Primary care services such as the Improving Access to Psychological Therapies (IAPT) Service, the Emotional Wellbeing Service and the Homeless and Travellers Team;
- Secondary care services such as the Community Mental Health Teams (CMHTs) which include home treatment services, crisis, and out of hours services. The Directorate also provides the Sheffield Assertive Outreach Team (SORT), the Homeless Assessment and Support Team (HAST), the Transcultural Team and the Community Development Team as well as social care support services such as respite care at Wainwright Crescent, Community Support Services and SPACES;
- Tertiary care services such as the Specialist Psychotherapy Service.

The Community Directorate provided support for approximately 17,000 individuals in Sheffield in the last 12 months.

The Community Directorate has achieved a number of significant objectives during 2013/14, including:

- For a second year, the IAPT service has been a national pathfinder site working with people with long-term conditions, or medically unexplained symptoms. This has included training district nurses, physiotherapists and other community staff in delivering psychological therapies, embedding IAPT staff within district nursing teams, and continuing to improve the skills of IAPT staff in working with individuals with long-term conditions;
- The Specialist Psychotherapy Service has relocated to St George's Hospital. This has enabled the service to improve its efficiency, reducing waiting times significantly across the service;
- Community Support Services have launched a Home Environment Service, enabling service users to manage their home as part of their recovery;
- The CMHTs have continued to embed the major changes made in 2012. This has significantly increased the number of individuals who are assessed, undertaking work to improve the continuity of care for individuals who are discharged from in-patient wards, and supporting the opening of a Crisis House in April 2013. The hard work of the teams has also contributed to the reduction in the number of people having to be admitted to in-patient beds out of Sheffield in 2013/14;
- The out of hours team recently established a pilot project with South Yorkshire Police, in which a nurse or social worker works with the police between 4pm and midnight, 7 days a week, in order to support quicker assessment, improve partnership working and reduce the need to detain people under section 136 of the Mental Health Act. Early feedback has been very positive and the project will be fully evaluated in 2014;
- SPACES have expanded their short-term work to include a 12 week recovery education programme, as well as a range of psycho-education groups. Individuals can now access

this service through their GP or the IAPT Service, as well as through CMHTs, and the number of people using the service has significantly increased over the past year;

- The CMHTs have each established a local service user forum, operating as part of the SUN:RISE group within the Trust. The local forums have been involved in staff recruitment, the design of leaflets and information for individuals newly referred to teams, and are starting to review the physical environments in some team bases;
- The Directorate created the post of a Peer Expert for people with Personality Disorder, and the postholder has, along with psychology staff, developed and delivered a range of training for staff, skills groups for service users and coping groups for carers and families. Feedback for this project has been very positive;
- Wainwright Crescent has been audited by the Care Quality Commission and received an excellent report. We were particularly pleased with the extremely positive feedback from service users identified. This demonstrates how valued the service is as well as reflecting the dedication of the staff team.

### **The year ahead**

In 2014/15 the Community Directorate will focus on:

- Working with staff in the CMHTs to reduce the amount of bureaucracy required of them, and improve systems and processes of work; this is with the intention of enabling staff to have more time to spend working with service users;
- Improving the pathway for individuals referred to the CMHTs with a possible first episode of psychosis;
- Supporting the development of a community team to provide intensive support for service users returning from long-term out of town placements as part of the Trust's rehabilitation strategy;
- Integrating our social care provider services to deliver a service which supports individuals in the community and offers a range of activities, with a focus on recovery and vocational support;
- Supporting the establishment of a recovery college in the Trust;
- Improving the influence and involvement of service users in the Directorate;

- Improving the accessibility of psychotherapy services;
- Continuing to reduce the waiting times in the IAPT service, including referrals between different parts of the IAPT service;
- Ensuring that all staff are well supported and supervised in their jobs;
- Developing the pathways for psychological support, from primary through to secondary and tertiary services.

### 2.3.3 Learning Disability Service

The Learning Disability Service has undergone a period of considerable change during 2013/14, in all areas.

The service consists of:

- The Community Learning Disability Team, based at Love Street in the city centre;
- The Intensive Support Service;
- Respite Care at Longley Meadows and Warminster Road;
- Residential Care and Supported Living Services provided in partnership with housing associations on a number of sites across the city;
- Older Carers Support Service;
- The Sheffield Case Register.

### New Intensive Support Service opens

The new Intensive Support Service building opened at the start of the year. Firshill Rise is a state-of-the-art facility that will benefit people with learning disabilities and complex needs (including challenging behaviour and mental health issues.) It houses an 8 bed unit, with 2 self-contained flats and a fully adapted bathroom and bedroom, multi-sensory, activity and clinical rooms, a multi-faith room for quiet reflection, gardens and patios. A specialist community team is based in the same building. The new service aims to provide support around the individual, whether this is at home or within the bed-based service, should they require a period of assessment and treatment within a safe environment. The hope of the team is always to intervene early, in the community, to prevent admission. The team has also played a role in supporting individuals to return to Sheffield from placements out of the city, in line with long standing local policy and the Winterbourne Concordat.

The range of skilled staff in the Intensive Support Service includes Psychiatry, Nursing, Clinical Psychology, Speech and Language Therapy, Occupational Therapy and Development Workers. Their approach is based on positive behaviour support and working in a compassionate, respectful and person-centred way to provide assessments, formulations, interventions, treatment and support for people with very complex needs. They work in close partnership with other providers, resulting in the most positive outcomes for individuals.



Exterior shot of new Intensive Support Service

## **Refurbishment of Longley Meadows underway**

Longley Meadows provides a respite service for people with profound and multiple disabilities and other complex needs. It is very much valued by the carers whose family members take breaks there. The building is receiving some much needed refurbishment and rebuilding to create more space for different activities, storage for essential equipment and upgraded bedrooms.

*“My son’s journey with the learning disabilities service has been the key to his new lease of life. I really feel that he has turned a corner. What more can I say but a sincere THANK YOU.”* Parent

## **New management and governance arrangements for Learning Disability Services**

The Learning Disability Service was previously led and managed jointly with Sheffield City Council, but during the year, a process of separation of the health from the social care senior leadership has taken place, and separate governance arrangements have been established. Commissioning arrangements have also changed and have been separated into distinct health and social care commissioning.

The intention of all parties is to continue to work together as closely as possible, to try to ensure services are seamless for service users with a learning disability and their families. For example, the NHS members of the Community Learning Disability Team remain co-located with their social care colleagues from the Duty Team and Assessment and Care Management at Love Street.

The separation of the governance arrangements has led to a fresh look at the care and treatment provided. A revitalisation of learning disability governance in the Trust is taking place:

- A new Learning Disability Physical Health Group is leading and co-ordinating the many health improvement initiatives taking place in the different parts of the service. The publication of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) during the year highlighted the health inequalities experienced by people with a learning disability nationally and the difficulties many have accessing timely investigations and treatments. Learning Disability staff play a key role in advocating and enabling people with a learning disability to receive the healthcare they need in primary and secondary healthcare;

- A new Learning Disability Governance Group has been established bringing together senior clinicians and managers from the service with colleagues from the corporate teams, to ensure there is sound scrutiny of the quality and safety of all the Learning Disability services.

The Trust’s Executive Directors’ Group commissioned a Review of Culture and Practice in the residential care and supported living services, in parallel with a City Council review of the Council-led Provider Services. The review was due for completion at the end of March 2014.

The future of the Learning Disability residential care and supported living services was uncertain at the end of 2013/14. The City Council as Commissioners are intending to create a list of approved providers and then put these services out to tender.

## **Improvements to community team working**

The community teams from Love Street and the Intensive Support Service are coming together to develop a single pathway for referrals and multi-disciplinary assessments, to minimise internal referrals, reduce waiting times and improve the co-ordination of care, making sure people with a learning disability receive the right care from the right person at the right time. Service user volunteers and advocates, and colleagues from the voluntary organisation Mencap are working with clinical staff, to make sure the voices and experience of people with a learning disability and their family carers are an essential part of this redesign.

## **Celebrating the Case Register**

The Sheffield Case Register reaches its 40th anniversary in 2014. The Register is an invaluable resource for planning services and for research in learning disability. It provides information to Sheffield Teaching Hospitals NHS Foundation Trust and to GP Practices so that they can ‘flag’ or identify people with a learning disability in their care and make ‘reasonable adjustments’ to meet their needs more sensitively and effectively. Recent academic publications have used anonymous Case Register data to map the changes to life expectancy, morbidity and mortality. This information helps national strategic planning to improve the health and lives of people with a learning disability.

### 2.3.4 Specialist Services Directorate

A range of services are hosted within 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 service for people who experience problems as a result of alcohol and drug use;
- Specialist health services including Perinatal Mental Health, Autism and Eating Disorders;
- Relationship, sexual and gender identity services;
- Psychological services for Sheffield and surrounding districts;
- Therapy Services including Occupational Therapists, Physiotherapists, Speech and Language Therapists, Dietetics and Chaplaincy;
- Services for people with a neurological injury or illness that causes long-term restrictions in the scope and quality of their everyday lives;
- Adult and Older Adult Liaison Psychiatry Services and Alcohol Liaison Services to those presenting at Sheffield Teaching Hospitals NHS Foundation Trust.

The Specialist Directorate achieved a number of significant objectives during 2013/14 including:

- Retaining all our existing service contracts. We have been successful in the award of recurrent funding to continue to provide multi-disciplinary older adult liaison services 7 days per week. Further funding has been provided for the GP Alcohol Liaison nurse, who works with GP Practices and consortiums to facilitate referral for alcohol screening;
- Successful awarding of the contract for Sheffield's Adult Autism and Neurodevelopmental Service which works in parallel with our existing Aspergers Service, provided to non-Sheffield residents;
- Reconfiguring Sheffield's Dementia Resource Centre to timescale and cost, resulting in the provision of a greater menu of community and bed-based social care services for older people with dementia;
- Continuing to explore the most efficient and effective way of providing services to individuals by our Long-Term Neurological Conditions

Teams. In 2014/15 we will move to a new model of service and a refreshed skill and grade mix of staff to meet the needs of service users;

- Continuing to develop growth plans and preparing for the tender of Substance Misuse services for Sheffield and surrounding districts. To support this, investment has been allocated to further build our Alcohol Screening Tool as a product to market and increase our offer to Commissioners;
- Mobilising the Functional Intensive Community Support Service, in collaboration with the In-patient Directorate, to enable a reduction in admissions to our older adult functional mental health wards. The Specialist Directorate will work with key stakeholders to support the case for additional investment in 2014/15;
- Continuing to routinely review all our clinical services to identify good practice, quality improvement and service efficiency to inform future reconfiguration programmes and financial plans;
- Meeting our Cost Improvement and Disinvestment Plan for 2013/14 while delivering a surplus to invest in accommodation changes for G1, Older Adult Community Services and the Memory Service to enhance the quality and efficiency of care provided by these services.

#### The year ahead

In 2014/15 the Specialist Directorate will focus on:

- Reviewing community services to ensure needs-led care;
- Responding to the tender for Sheffield's drug and alcohol services;
- Considering primary care solutions to deliver assessment, diagnosis and follow-up for people requiring the Memory Service;
- Mobilising the new model of service for Long Term Neurological Conditions;
- Working with key stakeholders to consider options to increase liaison services, considering the Keogh recommendations and community alternatives to hospital admission;
- Continuing to review pathways and service models for people referred for relationship and sexual health and gender identity services;

- Continuing to review the quality and effectiveness of services in line with key national drivers to ensure that our services are well governed and adequately resourced;
- Increasing face to face activity with our service users by reducing non value adding and repeated steps in the care pathway;
- Ensuring comprehensive care pathways and packages for all of our services: both those included and excluded for care clustering.

The Specialist Directorate continues to face the following risk and uncertainties which will challenge the future provision of our services:

- The continued increase in competition and choice and re-tendering of services in a time of financial uncertainty and reduced public sector budgets;
- The need to ensure services are able to meet the demands of our service users in line with personalisation and payment by results;
- Increasing numbers of older people within the city and the need to work across partnerships and take a whole system approach to avoid unnecessary hospital admission and delays in discharge.

### 2.3.5 Clover Group

The Clover Group Practices are 4 GP practices based in Darnall, Tinsley, Jordanthorpe and Mulberry Street in the city centre. The Practices serve some of the city's most vulnerable people and also run a specialist service for asylum seekers. We have a 3 year Alternative Provider of Medical Services (APMS) Contract and currently have over 16,000 registered patients.

The Clover Group's 5 key priorities during 2013/14 have been to:

6. Continue to improve service quality, further developing the Clover model and protecting the future;
7. Achieve and maintain high levels of performance and increase income;
8. Real patient engagement and involvement;
9. Ensure governance structures are robust and purposeful;
10. Strategy development of primary care and GP commissioning.

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

- The Clover Group Practices are developing a more streamlined management structure and we have appointed a lead nurse to work alongside the management team;
- The service has a Patient Participation Group with over 40 patient members who meet regularly, to enable the service to increase its awareness of patients' needs and to improve health outcomes for hard to reach, BME and vulnerable groups. The service conducts regular surveys of the wider practice population and this year has collected almost 200 responses regarding reception and customer service, which will be used to develop receptionist training;
- In the past year the service has set up a successful volunteering scheme to give opportunities for people to develop their administrative skills. 3 volunteers have now successfully completed the programme, 2 of whom have gone on to gain NHS employment. The scheme has also benefited the Practices in terms of building capacity in the service and adding a new dynamic to the teams;
- In December 2013, the Darnall Primary Care Centre site was awarded a bid to implement the Practice Champions programme along with voluntary sector partners, Darnall Well Being. This is an exciting scheme which encourages practices to work with local volunteers from the practice population to build healthier communities;
- The Clover Group continues to provide consistent enhanced service delivery and look for new options to increase income. The Clover Group achieved high standards in the Quality and Outcomes Framework and is the first Practice in Sheffield to work on Key Performance Indicators, which monitor the Practices' clinical performance;
- The number of patients registered at the Clover Group has increased by over 3% since April 2013. The Practices have agreed a funding mechanism with Commissioners to compensate for an increase in registered patients and are now able to increase income through attracting new patients to the service thereby offering a more sustainable future.

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

- The contract value is currently under review during which time an extension of the contract has been agreed until September 2014. If efficiencies cannot be made or a justification of current funding is not accepted then there is the potential loss of contract by the Trust.

## 2.4 How we go about our business

### 2.4.1 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 11 of this report.

### 2.4.2 How we monitor improvements in service quality

We monitor improvements in service quality through our governance systems and a range of reports we use to monitor quality. The Board and the Quality Assurance Committee receive regular reports on service quality and improvements. We report on the quality of the services we provide to our Council of Governors. 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 to 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.

We identify a range of areas where we want to make improvements. These are outlined in Section 9, where we state our objectives for improving quality and the progress we have made over the last 2 years. This section also summarises the objectives we agreed with our Commissioners for improving quality under the Commissioning for Quality and Innovation scheme.

### 2.4.3 How we monitor improvements towards meeting national and local targets

Our performance framework ensures we are able to 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. This supports the Board to ensure monitoring and evaluation of progress and outcomes is undertaken and improvement interventions are directed when required. We also report in detail on our performance to our Council of Governors.

### 2.4.4 How we involve service users and the public in improving services

Understanding the experiences of the people who use Trust services is essential if we are to be successful in achieving quality improvement. Asking about service user experience and then acting on that information means we will understand how to improve what really matters to people. Involving service users to improve the quality of services remains a key priority.

Service users are involved in helping us to improve our services in a range of ways. Some examples of this are:

- Providing feedback through surveys – to help us identify areas that need to be improved;
- Training our staff – supporting our staff with their learning needs by either training them or sharing their experiences of receiving care from us;
- Monitoring our services – we have a range of methods that we use to self-inspect. Service users are involved in this process, offering their views about the services we provide.

During this year we held a successful stakeholder event with service users and our public Governors to look at how we are involving service users and make plans for how to improve this as we move forward. Following this event, the Board of Directors has produced and agreed a 3 year development plan to build on our past successes and ensure that service user involvement is further embedded within everything we do. This plan is available online at <http://www.shsc.nhs.uk/about-us/corporate-information/DP> should you wish to read it.

#### **2.4.5 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 investigation will be fed back in order that services can learn the lessons and make changes to practice and protocol, thus raising standards.

During 2013/14 the Trust received 147 formal complaints and 217 informal complaints. We responded to 94% of the formal complaints within the timescales agreed with complainants. 18% of formal complaints were upheld, 29% were partially upheld, and 53% were not upheld. We responded to 100% of the informal concerns within our timescale of 5 working days.

During the same period, the Trust received 1,193 compliments in relation to Trust services and our staff.

More information is provided in our comprehensive Annual Complaints Report (which includes the complainant survey) and is available on our website. It can be accessed via the following link: <http://www.shsc.nhs.uk/about-us/complaints>.

#### **2.4.6 How we are improving service user/carer information**

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

It is our duty to raise the standard of written information for service users and their carers to make sure that the material we produce is clear, concise, relevant, accurate and in everyday language. It is important that service user information is accurate and accessible as service users may, due to stress or unfamiliar language, not remember information that they have been given verbally.

Information is a tool to help individuals make informed decisions about their care. The Trust aims to involve service users, carers and the public in the production of our information.

Throughout 2013/14 service users and carers have been involved in a variety of ways to improve the quality of service user and carer information:

- Involvement in reading panels and evaluating leaflets - service users have been instrumental in helping to shape and change policy documents, ward leaflets and ward information leaflets;
- Involvement of services users in the Specialist Directorate in designing individual leaflets and flyers;
- Regular involvement of service users in the In-patient Directorate in the development of information, enabling them to focus on what information is important from the service user perspective;
- Service user and carer involvement in producing the induction pack for specific courses, for example, the Diploma in Clinical Psychology.

Service user involvement aims to engage all service users from a wide range of services and to listen to their opinions. It is, in essence, about co-production, listening to the voices of service users, however quiet they may be. The Partners In Improving Quality Group is one such group which



is made up of service users and carers from both mental health and learning disability services. This Group is involved in mock Care Quality Commission visits across the Trust and has been instrumental in utilising their individual skills and experiences to design 'easy-read' pictorial versions of a range of documents and leaflets.

The information gleaned from projects such as the Quality and Dignity Project is both written by and presented by the service users involved in the project, becoming a first hand record of experience without the filter of the views and interpretations of others.

#### **2.4.7 How we use our Foundation Trust status to improve service user 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 service user care. The Quality Report, contained in Section 9 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.

We are able to use our money more flexibly to support the priorities we have identified. Key examples of this have been how we have built up our cash reserves in order to improve our estate and in-patient services. We have made real improvements to the services we provide to people with a learning disability with the opening of Firshill Rise, and have committed to a major modernisation and improvement scheme for people in need of psychiatric intensive care services, and other in-patient services.

#### **2.4.8 How we work with our partners**

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

We work in partnership with the other health and social care organisations in Sheffield as we collaborate to provide the best services for the people of Sheffield. There is a clear drive to change the way services are provided in Sheffield, to deliver real improvements in community care and support for individuals' health and social care needs. We have significant experience of relocating care from

a hospital context to a community one, along with delivering successful integrated health and social care services across a range of partnership structures. By working in partnership with all the organisations in Sheffield we are able to inform and shape how we move forward as a city-wide health and social care community.

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 improved 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 individuals can often experience in accessing the services that they need.

We also provide a number of services directly in partnership with other organisations. 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 individuals 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 jointly integrated services for people with a learning disability.

During this year we entered into a new partnership with Rethink Mental Illness (MI), for the delivery of a Crisis House service in Sheffield. We commissioned Rethink MI to provide a Crisis House, run and staffed by them and it opened in April 2013. This development is an important step in improving the way we support individuals who experience a mental health crisis. It provides more choice for individuals about how we can support them. Rethink MI has a great deal of experience in providing Crisis House services elsewhere in the country, and we are pleased to be delivering this important service for the people of Sheffield in partnership with them.

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.

#### **2.4.9 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 our work activities. The Trust's 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. The Committee's role is to promote co-operation between the Trust and its employees, instigating, developing and carrying out measures to ensure the health, safety and welfare of employees and any other affected individuals. The Committee has overseen the completion of several areas of work including:

- Updating the following approved documents:
  - > Health and Safety Policy;
  - > Slips, Trips and Falls Policy;
  - > Backcare and Manual Handling Policy;
  - > Low Voltage Electrical Policy;
- Evaluating newly introduced, revised and existing legislative requirements and codes of practice. Impact assessments have been completed and appropriate controls have been devised and implemented;
- Providing an extensive array of health and safety related training to enable staff to be competent to carry out their duties in a safe manner. Health and Safety in the Workplace, a new health and safety training course was introduced in 2013. This course is aimed at managers and supervisors to educate and empower them to effectively manage risks within their service areas, including carrying out risk assessments and risk action planning;
- Implementing the Trust's estate compliance/'Red Box' system at all Trust sites. The installed systems are subject to monitoring and scheduled support visits to aid continual improvement. The 'Red Box' system is an auditing and assurance

process related to estates health and safety issues linked to our premises. It provides clear information and guidance to staff as well as detailing roles and responsibilities;

- Ensuring a continual programme of health and safety inspections completed by the Health and Safety Advisor at all Trust work sites to identify and resolve any local issues as well as acting as an 'early warning' of any organisational system problems or significant matters. The inspections also acknowledge good practice;
- Installing key operated fire alarm points in in-patient wards, leading to a significant reduction of unwanted fire signals (false alarms) caused by service users inappropriately activating the break glass fire alarm points.

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 Teams, a Senior Infection Control Nurse and a Fire and Security Officer (who also acts as the Local Security Management Specialist). The Trust's Health and Safety Advisor is managed via the Facilities Directorate but has a Trustwide remit for implementing a proactive approach to health and safety. The Facilities Directorate has specific responsibility for ensuring the consideration of health and safety in all aspects of premises' maintenance and design, and for ensuring compliance with a range of statutory requirements.

#### **2.4.10 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, it is investigated and we ensure that wrongdoers are appropriately dealt with and steps are taken to recover any losses 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 and Assurance Committee. Local fraud risk assessments are undertaken throughout the year and used to inform a programme of work that is compliant with NHS Protect Provider Standards on countering NHS fraud. Where fraud is identified or suspected an investigation is carried out in accordance with the Trust's Fraud Policy and Response Plan.

During the reporting year, proactive and reactive work has been delivered by the LCFS in accordance with the approved work programme and is summarised in an annual report on counter fraud activity.

Work this year has focussed on addressing an identified risk of fraud relating to the local management of residents' financial services within the Learning Disability Service.

#### **2.4.11 Consultations**

##### **Consultations we have completed**

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

##### **Consultations we have in progress**

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

##### **Consultations we have planned for next year**

In line with our established Annual Plan for 2014/15 we may consult on the development of new acute care services across community and in-patient 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.

## **2.5 Valuing our staff**

### **2.5.1 Supporting staff through change**

The Trust has continued to review and improve its services and clinical pathways, and is committed to ensuring that staff are fully supported in helping to achieve this outcome. This year has seen the successful re-organisation of services involving staff in Facilities Management, West Wing Grenoside Grange, Resource Centres, Community Mental Health Teams, Psychology and various Corporate departments. The Trust's organisational change and redeployment processes have been kept under review in conjunction with our vacancy control process and together they have helped ensure that almost all staff affected by reconfiguration have been found suitable alternative roles. The Trust recognises the commitment of all those involved in achieving this successful outcome and has worked closely in conjunction with Staff Side.

The Trust has also re-launched, at different points during the year, our Mutually Agreed Resignation Scheme (MARS). This is based on a national model and the Trust has now completed 7 rounds of the scheme since it was introduced in April 2011.

Staffing levels and priorities are also being reviewed following the Government's publication of "Right People, Right Skills, Right Place, Right Time." Where our data highlights concerns regarding staffing levels, development work is underway with those teams.

Senior management roles in the Medical Directorate have been restructured to provide clearer lines of responsibility and a similar exercise has been undertaken within the Specialist Services Directorate. The HR Recruitment team has been re-aligned to provide a clearer link with specific Directorates in line with our Directorate Partner HR model. The Trust also has a work-stream to identify and reduce bureaucracy.

Undoubtedly, further change will be required in the forthcoming year as a result both of the sustained drive for continuous improvement, and also as a result of the financial pressures facing both the Trust and its Commissioners such as Sheffield City Council. The Trust will continue to seek to meet these challenges in a way which ensures requirements for quality and efficiency are met and that staff are fully supported.

The commitment to support staff also covers areas other than change management. In particular, the Trust has been working with Staff Side to promote mediation, where appropriate, in a more structured way to help resolve staff issues primarily around interactions. We have also introduced a new policy to advise staff on issues relating to domestic abuse and revised our scheme for assisting staff where there is financial hardship. The importance of having an occupational pension has also been emphasised during the year through the Trust's implementation of the national automatic enrolment scheme. As part of this process the Trust has engaged with NEST (the National Employment Savings Trust) to be an alternative pension provider where staff are not eligible for the NHS Scheme.

Salary sacrifice schemes which enable staff to acquire benefits in a tax-efficient way have been continued and currently cover childcare, bicycles, mobile phones, computers and additional leave.

Work is in place to improve our supervision and appraisal arrangements. We are focusing on developing our approach to supervision as a key process to support staff. A workshop has taken place to learn from good practice at Rampton Hospital. A joint University of Sheffield and Trust initiative has led to the creation of the first Postgraduate Certificate in Clinical Supervision for In-patient and Complex Care Settings by distance learning. The documentation for appraisals has been reviewed and simplified. The Trust is currently looking to develop a more focused approach to the timing of appraisals. For medical staff, their specific appraisal policy has been revised and updated in line with new General Medical Council documentation on revalidation. We will also be implementing the new arrangements for incremental progression agreed at national level which will include a requirement for completion of appraisals.

There has also been a review of our requirements for mandatory and statutory training to ensure that these are fit for purpose. This has continued alongside the roll-out of the Trust's RESPECT training incorporating service user involvement in de-escalation techniques.

### Section 2.5.2 Equal opportunity statement



In 2013/ 14 the Trust maintained its commitment to fairness and equality and to valuing diversity and promoting inclusion in all that we do. This continues to be demonstrated in our strategic vision, that individuals who use our services will achieve their full potential, living fulfilled lives in their community. Valuing the diversity of individuals 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, sexual orientation, marriage or civil partnership, beliefs, irrespective of social class 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 while 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.

### 2.5.3 Equality and diversity

In 2013/14 we continued to take forward our equality objectives. Each objective has identified milestones and we made good progress with most of these. More information can be found on the Trust website at: <http://www.shsc.nhs.uk/working-for-the-trust/equality>

The Public Sector Equality Duty is 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 produces a separate Equality and Human Rights Report each year. The 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.

The Trust Annual Equality and Human Rights Report is published on the Trust website and can be found at: <http://www.shsc.nhs.uk/working-for-the-trust/equality>

The 2013/14 report will be published in June/July 2014.

Each year the Trust also publishes a range of information about staff and service user diversity. The report for 2012/13 contains information that was current on 31 March 2013 and can be found at: <http://www.shsc.nhs.uk/working-for-the-trust/equality>

## Highlights of 2013/14

### Eliminating discrimination, harassment and victimisation

In 2013/14 the Trust:

- Ratified our Gender Reassignment Support in the Workplace Policy;
- Agreed a new policy - Supporting Employees Experiencing Domestic Abuse;
- Reviewed and updated our Equal Opportunities and Dignity at Work Policy;
- Reviewed and updated our Interpreting and Translation Policy and procedures;
- Undertook action as a result of reviewing staff data.

### Advancing equality of opportunity for protected groups

- Agreed our new Strategy to Promote and Improve Equality Diversity and Inclusion for BME Service Users and Staff;
- Focused on disability in our business objectives for 2013/14. This included:
  - > Developing a specific staff survey;
  - > Review and audit of our facilities for disability access;
  - > An action plan to be taken forward by our Positive about Disability Staff network group.
- Introduced a full day Equality and Diversity for Managers and Leaders Training;
- Undertook Equality Impact Analysis as part of the development process for key projects including development of the new Psychiatric Intensive Treatment Unit and Crisis House provision;
- Set up a project group focused on young carers to support action associated with the Sheffield Carers Strategy action plan focusing on young carers.

### Fostering good relations between people in protected groups and others

- Continued to work in partnership to develop and take forward the city's 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 the Local Authority;
- Involved in Sheffield's 'One Billion Rising', an international event aimed at challenging violence against women and girls;
- Hosted the LGB 50+ exhibition in our conference facility and promoted the LGB50+ booklet. The exhibition celebrates lesbian, gay and bisexual diversity and provides a focus for considering the health of older LGB people.

### Disability employment

In 2013 we renewed our 'two ticks' standard and maintained our action plan to support the Trust as a Mindful Employer. In 2013 4.4% of staff said they had a disability, 52.5% said they did not have a disability and 43.1% were unknown. A data refresh took place in early 2014 with the aim of improving recording and the results are currently being collated. A specific survey of staff focused on disability has been drafted and is due to take place in early 2014.

#### 2.5.4 Staff engagement and working with Staff Side (Trade Unions)

With a workforce of over 3,000 staff including its flexible staffing, the Trust recognises that the right staff are our most valuable asset and is committed to working in partnership with them and ensuring that they are properly informed and engaged.

The Trust has a variety of mechanisms for engaging with staff and continues to abide by and support the NHS Constitution. The NHS Constitution applies to all Trusts and sets out the principles and values of the NHS together with rights, responsibilities and pledges relating to the public, service users and staff.

The national Annual Staff Survey results have recently become available. They indicate that the Trust is again within the top 20% of mental health/learning disability Trusts in the country for overall staff engagement.

A steering group led by the Chief Executive has been established and workshops have been held involving staff, service users and Governors to clarify and develop our values and associated behaviours. A report will be presented to the Board and this will set out priorities in terms of embedding our values into HR processes. A new sub-committee of the Board has been established (the Workforce and Organisation Development Committee) to develop a programme of detailed work and discussion on our approach to staff engagement and related workforce issues. The Chair has met with front line staff and continues to meet with Staff Governors to further the process of engagement. We are exploring with our Cognitive Behavioural Therapy Department how we might roll out 'Mindfulness' training for staff and are working with the Point of Care Foundation to develop Schwarz Rounds – a process of staff support to deal with the emotional aspects of work.

On a continuing basis the Trust engages with Staff Side in a variety of ways and our positive working relationship and partnership assists in dealing with our many challenges. These include the Joint Consultative Forum, the Joint Policy Group and the Bargaining Forum. Staff Side also have representation on the Trust's HR and Workforce Group as do Staff Governors. Matters relating specifically to medical staff are considered by the Joint Local Negotiating Committee.

During this year Staff Side has been involved with the planning and implementation of the pension auto-enrolment exercise, the establishment of a Joint Screening Group to help promote mediation in relation to bullying and harassment claims, the development of a process to consider new injury allowance arrangements, the implementation of the new arrangements regarding mileage expenses and the introduction of the Disclosure and Barring Service which has superseded the Criminal Records Bureau. This is in addition to the development and/or review of a significant number of HR policies/schemes.

The Trust's response to the Francis Report has been shared with Staff Side and they are aware of the various actions which are being planned. This has also included a revision and re-issuing of our Whistleblowing Policy to ensure it is up to date with recent legislative changes.

The Trust also organised, in conjunction with Sheffield City Council, two special events relating to social work staff seconded from Sheffield City Council. This followed on from the results of an in-house survey. The events have led to a number of action plans and it is proposed that the survey exercise be repeated in 2014.

### **2.5.5 Sickness absence**

The Board receives monthly reports on the latest sickness absence figures, trends and causes as well as the absence rates for the individual Directorates. Further data is provided at Directorate and Team level for assessment and action as required. Sickness absence is currently above the Trust's target though the average absence rate has been on a downward trend since January 2013. This has reduced by more than double the national average over the same period.

It is recognised that employees in mental health Trusts undertake demanding roles and that there is no simple answer to ensuring low levels of sickness absence. The Trust established 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. The intention is to go beyond the traditional reliance on absence statistics to understand the patterns of staff attendance and non-attendance. This group has provided interim reports to Board and its work is ongoing. Of particular significance is the desire to establish how engagement can help improve attendance and to utilise the learning available from external and internal research. Linked to this is the contribution which initiatives such as our Mindfulness for Leaders programme can make. This has been introduced in specific areas and is rated exceptionally highly. Initial training is also being undertaken to see how managers can be supported to have 'difficult conversations' and work is ongoing with each Directorate leadership team to develop our concept of the healthy team.

The Trust's policies and management procedures for sickness absence are kept under review as is the available statistical information.

More detailed information on sickness absence is given below:

<b>Staff Sickness Absence</b>	<b>2013/14</b>	<b>2012/13</b>
Days Lost (Long Term)*	44,302	38,103
Days Lost (Short Term)	13,669	14,682
<b>Total Days Lost</b>	<b>57,971</b>	<b>52,785</b>
<b>Total Staff Years</b>	<b>2,300</b>	<b>2,623</b>
Average Working Days Lost	25.2	20.1
Total Staff Employed in Period (Headcount)	3,059	2,949
Total Staff Employed in Period with No Absence (Headcount)	1,053	749
<b>Percentage Staff with No Sick Leave</b>	<b>34.4%</b>	<b>25.4%</b>

\* Long term sickness equates to over 20 consecutive working days

### 2.5.6 Occupational health

The Trust's approach to occupational health involves the following strands:

- 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 counseling and consultation service which is available to individuals and groups of staff;
- Health and Wellbeing - we provide a dedicated page on our Intranet 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;
- Training – we provide specific training on key health related areas such as back care, manual handling, stress awareness and dealing with conflict;
- Specific projects – this encompasses both regular initiatives such as the annual campaign on flu immunisation as well as special initiatives.

From September 2013, the Trust began its annual promotion of the flu vaccine programme. The key focus has been to increase the uptake among frontline staff by running a campaign specific to the Trust. The number of sites to be covered presents logistical issues and this year the Trust has been

able to extend the accessibility of flu vaccinations sessions. The number of front line staff who received a flu vaccination increased again this year.

We continue to work with our Occupational Health provider to try and both improve the referral process and to introduce further guidance on making referrals.

### 2.5.7 Volunteers

During 2013/14 volunteering has undergone significant changes to improve how our volunteers are both recruited and supported.

The volunteer database is now housed in the Patient and Public Involvement Team and contains information relating to all of the Trust's volunteers (over 100 individuals) which is updated on a weekly basis. The Trust welcomes approximately 20 new volunteers every month.

The Trust's Volunteer Co-ordinator has undertaken an extensive marketing campaign to introduce volunteering opportunities into previously unrepresented services. This has resulted in a PAT (Pets as Therapy) dog regularly visiting residents at Woodland View Nursing Home and a fully qualified gym instructor supporting the Occupational Therapy Department at the Michael Carlisle Centre.

The Trust website has dedicated volunteering web pages including information on training, volunteering opportunities and how individuals can get involved ([www.shsc.nhs.uk/about-us/get-involved/volunteering](http://www.shsc.nhs.uk/about-us/get-involved/volunteering)).

### 2.5.8 Communications

The Trust produced a large amount of proactive publicity during 2013/14 about our work and services. We try to ensure that we are as equitable as possible in our proactive publicity across all Trust services. We have achieved good media coverage in the areas of substance misuse, eating disorders, emotional wellbeing service and physical health care.

We will continue to work hard on our positive PR, sharing the stories of the excellent work being undertaken within the Trust and, where possible, illustrating these with case studies which demonstrate the positive impact of our staff and services on the lives of our service users. We aim to minimise negative publicity over the next year in order to build on our reputation, however, we will be open and honest in all our communications with the media (within the constraints of confidentiality).

The Trust has maintained its Social Media presence during the year via Facebook and Twitter accounts. These are regularly updated with news, events and photos, and are growing in popularity.

*Website: [www.shsc.nhs.uk](http://www.shsc.nhs.uk)*

*Facebook: [www.facebook.com/shscft](http://www.facebook.com/shscft)*

*Twitter: [www.twitter.com/shscft](http://www.twitter.com/shscft) or @SHSCFT*

### 2.5.9 Education, training and development

The Education, Training, and Development department (ETD) deliver and commission core mandatory, clinical skills, and specialist training for Trust staff to meet the essential training requirements for their jobs. Our aim is to ensure we always have staff with right skills at the right time to provide high quality, and safe care to our service users. Essential core mandatory training is an organisational priority and during 2013/14 we have delivered increased levels of mandatory and clinical skills training for staff and managers across the Trust. E-learning programmes have also significantly increased during the last year.

We listen to feedback from our learners and their managers and make changes to our training programmes to ensure efficiency, effectiveness, and value for money. For example, this year we have reduced disruption and staff release costs by increasing the provision of e-learning programmes, providing an online training prospectus, and reducing core mandatory training from 4 to 3 days with no reduction in quality.

During 2013/14 we developed a new training and educational pathway for healthcare assistants and support staff to increase their knowledge and skills in recovery and 'values based' approaches to practice and to provide a unique opportunity to employ staff with service user experience. This builds on the recommendations found in both the Francis and Cavendish Reports to ensure effective supervision and training in the workplace. This year we supported the training of 120 nursing students across 34 adult and 8 learning disability placement settings. Placements range from both in-patient and community settings to day care, respite and specialist services.

To support the development of training in physical health ETD provide a number of clinical skills programmes using simulation into training programmes such as Immediate Life Support and Infection Control. We ran a pilot programme in September 2013 for Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS). RAMPPS is aimed at junior doctors and nurses on in-patient wards and offers a day of simulation scenarios drawing on the experience, knowledge and skills of the delegates. There are further programmes developed for 2014, and we are discussing a similar programme for staff working in other areas, eg community teams. The RAMPPS programme is supported by Health Education Yorkshire & Humber.

We work closely in partnership with other NHS Trusts and local training providers to offer a range of apprenticeship opportunities for young people. This year we have recruited a further 14 clinical, 3 pharmacy, and 11 business administration apprentices across the Trust. We are also part of a pilot apprenticeship programme across Yorkshire & Humber and have an apprentice technician for clinical skills and simulation who provides a wide range of technical support and assistance to trainers.

## 2.6 Our financial performance

Through strong financial performance, we have successfully maintained a Financial Risk Rating of 4 and then a Continuity of Service Rating of a 4 from when this replaced the Financial Risk Rating from October 2013 with Monitor, our independent regulator.



In respect of the year 2013/14, we exceeded our planned forecast of a £2,490,000 surplus and achieved a surplus of £2,513,000 with Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £7,447,000 (against a plan of £6,367,000).

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

We are pleased to report that the surplus has exceeded the target identified in the Annual Plan, and this has been achieved through rigorous expenditure control and tight management of our efficiency programmes. We have maintained our surplus to enable us to achieve the maximum Continuity of Service Rating of 4 which provides Monitor with assurance that a Foundation Trust is in good financial health. Our present Continuity of Service Rating has come about due to the effective delivery of our Annual Plan objectives.

While the targets of our Cost Improvement Plans have been met for 2013/14, some of this delivery (approximately £1.345 million) was through non-recurrent measures.

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 2013 to 31st March 2014 are included in full under Section 13 of this Annual Report.

### 2.6.1 Continuity of Service 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.

With effect from October 2013 the Financial Risk Rating was replaced with a new Continuity of Service Risk Rating.

The Continuity of Services Risk Rating incorporates 2 common measures of financial robustness:

- i. Liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown;
- ii. Capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.

In its regulatory oversight in the area of finance, Monitor uses a risk rating of 1 to 4, where 1 represents the highest risk and 4 the lowest risk of failure to comply with an NHS Foundation Trust's terms of authorisation.

## 2.6.2 Our income and expenditure position

In the 12 months covered by this Report, the Trust generated an income totalling £130,030,000. A summary of the position is provided below:

	<b>Total</b> 1st April 2013 – 31st March 2014 (£ 000s)	<b>Total</b> 1st April 2012 – 31st March 2013 (£ 000s)
Income from activities	97,849	93,276
Other operating income	32,181	34,788
Total income	130,030	128,064
Operating expenses	(125,985)	(122,994)
Profit on disposal of property, plant and equipment	-	318
Interest received and other financial costs	56	130
Movement in fair value of investment property	20	(20)
Public dividend payable	(1,608)	(1,986)
Surplus for the year	2,513	3,512

## 2.6.3 Disclosure in relation to other income

The composition of other operating income is disclosed in note 3 to the Annual Accounts contained in Section 13 of this report.

## 2.6.4 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 2014 was £27.673 million. The Trust has reviewed its working capital requirements and due to the high level of cash holdings concluded this was not needed in the medium term. As a result, the Trust does not hold a working capital facility.

## 2.6.5 Capital expenditure

The Trust's investment in capital expenditure for 2013/14 was £1,426 million. The completion of the Intensive Support Service unit was the main capital investment in 2013/14 at £980,000 in year. The spending of capital on other developments has been minimal this year as we continue to review our existing estates strategy. A major part of this review continues to relate to the Acute Care Reconfiguration of mental health services.

## New Build:

As part of the Acute Care Reconfiguration programme work on the new Psychiatric Intensive Care Unit is scheduled to commence in September 2014 and is due to be completed in September 2016 with expenditure of £5.7m over the period (subject to completion of tender process). Further work on the Acute Care Reconfiguration Frail ward of £2.4m is planned to start in 2015/16.

## Other:

The plan incorporates the spending plans identified for IM&T projects, transport and other equipment of £0.364m for 2014/15 and £0.525m for 2015/16. The Trust is presently not seeking to obtain loans to fund capital projects during 2014/15 and will utilise in year depreciation and capital slippage from previous years to fund the requirement for 2014/15 and 2015/16. Cash holdings from I&E surplus will be utilised for future periods.

## 2.6.7 Key financial risks and challenges for 2014/15 onwards

The Trust's on-going financial planning continues on a 5 year cycle with detailed financial modelling and downside/scenario planning underpinning the details provided in this report, only a summary of the base plan for the first 2 years is detailed above.

There is no unplanned pressure expected on cash flow or the ability to meet the liabilities of the Trust as they crystallise throughout the year. Identified below are risks which have already been identified and will require managing:

### **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 no Agenda for Change inflationary pay award for 2014/5. Only those staff not already in receipt of an annual increment (those currently at the top of their pay scale) will receive a uplift of 1%;
- 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 2014/15, there is a national efficiency requirement of 4%, with pay and price inflation uplifts at 2.2%. The application of this formula gives a net reduction for NHS commissioned services of 1.8%. This level of reduction has been taken into account in our refreshed Financial Plan and going forward, the Trust's Continuity of Service Risk Rating will be a 4;
- 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 assumed neutral at present, as this will continue to be in shadow form for 2014/15.

### **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 13).

### **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 2015/16 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 13).

### **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 £27.673m at 31st March 2014. 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 £7.9m in 2014/15. The level of CIP's/Disinvestments required (£7.9m) is the major challenge especially as the majority of income is from block contracts and 81.6% of operating expenditure relates to staffing;
- Loss of business through procurement plans for some Trust services. Services including Learning Disability registered care and supported living services, Substance Misuse services and the Clover Group GP Practices are undergoing some form of contractual review including tendering, and while the Trust has clear plans and strategies in place to inform the direction and a positive track record of managing our existing services, plans have been put in place to manage the risk subject to the outcome of tendering exercises.

### **Risk issues – other**

- The implementation of the Care Pathways and Packages Project continues with a Mental Health tariff run in shadow form for relevant services in 2014/15 in readiness for Mental Health Payment by Outcomes. This will no doubt have implications across a number of our clinical service contracts should a national tariff be implemented. It is not

expected that additional funding will be available for Commissioners nor transitional relief for providers, therefore, the implications will need to be monitored closely and the Trust will need to work with Commissioners to ensure that any implications on costs, demand and outcomes can be managed;

- Integration of Health and Social Care – ‘Better Care Fund’. The full implications of the better care fund are uncertain but it anticipated that the city will have a joint commissioning approach to a number of services.

### 2.6.8 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.

### 2.6.9 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 5.6 in the Annual Accounts based on figures supplied by NHS Pensions.

### 2.6.10 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 91% (last year 85%) in terms of the number of invoices paid and 92% (last year 85%) in terms of the value of invoices paid.

### 2.6.11 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.

## 2.7 Other statements of interest

### 2.7.1 Serious incidents involving data loss or breaches of confidentiality

The Trust experienced 1 incident involving confidential service user information which was reported to the Information Commissioner’s Office (ICO) during 2013/14. The incident was investigated, advice was received from the ICO and corrective actions taken.

**Summary of serious incident requiring investigations involving personal data as reported to the Information Commissioners Office 2013/14**

<b>Date of incident (month)</b>	<b>Nature of incident</b>	<b>Nature of data involved</b>	<b>Number of data subjects potentially affected</b>	<b>Notification steps</b>
August	Disclosed in Error - A copy of a letter to a referrer was sent to the service user’s former address	Service user’s details and history	1	Service user already aware
Further action on information risk	Internal processes reviewed and improvements in training and procedures implemented. Advice received from the ICO has been acted upon.			

Incidents classified at lower severity level

### Summary of other personal data related incidents in 2013/14

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	6
C	Lost in Transit	1
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	0
K	Other	1

*Kevin Taylor.*

Chief Executive

28 May 2014

# SECTION 3.0

## Board of Directors

# 3.0

### 3.1 The Board of Directors

The Board of Directors provide a wide range of experience and expertise which is essential to the effective governance of the Trust. Its members continue to demonstrate the visionary leadership and scrutiny that enables the organisation to fulfill its ambition.

At the end of 2013/14, the Board of Directors comprised of 6 Non-Executive Directors, including the Chair, and 5 Executive Directors, including the Chief Executive.

#### 3.1.1 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

#### 3.1.2 The Executive Team

- 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)

#### 3.1.3 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. 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.

#### 3.1.4 Accounting policies statement

Accounting policies for pensions and other retirement benefits are set out in the Annual Accounts in Section 13 of this report and details of senior employees' remuneration can be found in the Remuneration Report in Section 4 of this report.

#### 3.1.5 Our Auditors

Our external audit service is provided by KPMG and the current contract runs until 31 March 2015.

### 3.2 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 2013/14, the Board met every month (except April) 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.

## **3.3 Composition of the Board of Directors**

### **3.3.1. Non-Executive Team**

The Board comprises 6 Non-Executive Directors (including the Trust Chair). During 2013 the term of the Trust's Chair came to an end. Following a formal recruitment process, the Chair was appointed to serve a further term of 3 years. Further information on the recruitment process can be found in Section 6.5 of this report.

### **3.3.2 Executive Team**

5 Executive Directors (including the Chief Executive) make up the Board's Executive Team. The Director of Human Resources and the Director of Organisation Development/Board Secretary are in place to support the effective functioning of the Board.

There have been no changes within the Executive Team during 2013/14.

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 2013/14, including their attendance at the Board's meetings, is set out below.

<b>Name</b>	<b>Position</b>	<b>Term</b>	<b>Attendance</b>
Alan Walker	Chair	3 year appointment from 01/07/13	11/11
Kevan Taylor	Chief Executive	N/A	10/11
Clive Clarke	Deputy Chief Executive	N/A	11/11
Liz Lightbown	Chief Operating Officer/ Chief Nurse	N/A	11/11
Professor Tim Kendall	Medical Director	N/A	7/11
Paul Robinson	Executive Director of Finance	N/A	10/11
Councillor Mick Rooney	Non-Executive Director and Senior Independent Director	3 year appointment from 01/01/11	11/11
Sue Rogers	Non-Executive Director and Vice Chair	3 year appointment from 01/12/12	10/11
Martin Rosling	Non-Executive Director	3 year appointment from 01/11/11	11/11
Anthony Clayton	Non-Executive Director	3 year appointment from 01/12/12	11/11
Mervyn Thomas	Non-Executive Director	3 year appointment from 01/12/12	11/11

### **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, the Director of Human Resources and the Director of Organisation Development/Board Secretary. The EDG meets on a weekly basis to ensure that its delegated duties are appropriately discharged.



### 3.4 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.

#### 3.4.1 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 Martin Rosling

Also in attendance at the Committee's meetings are the Executive Director of Finance, the Chief Operating Officer/Chief Nurse, the Director of Organisation Development/Board Secretary, the Deputy Director of Finance, 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.

#### Significant issues considered by the Committee

The Audit and Assurance Committee have an annual review cycle in place in relation to reviewing and considering the effectiveness and ongoing compliance.

The Committee has met on 5 occasions during 2013/14 and details of members' attendance at its meetings are as shown in the table below:

Name	Position	Attendance
Martin Rosling	Committee Chair and Non-Executive Director	3/5
Anthony Clayton	Committee Member and Non-Executive Director	5/5
Mervyn Thomas	Committee Member and Non-Executive Director	4/5
Councillor Mick Rooney	Committee Member and Non-Executive Director	5/5
Susan Rogers	Committee Member and Non-Executive Director	5/5

The Audit and Assurance Committee met on 24th April 2014 in part to consider the financial statements for the period 2013/14 and as part of the annual review cycle considered the following issues in relation to financial statements, operations and compliance.

- Accounting Policies review for inclusion in the Financial Statements and Annual Report, including the appropriate treatment for Charitable Funds;
- The Going Concern status of the Trust. The Committee agreed that the 2013/14 Annual Accounts be prepared on a 'going concern' basis;
- Material Estimates pertinent to the financial statements, including Assets' valuation endorsing the methodology and accounting treatment;
- Due consideration of the organisation's risks and controls, particularly the Board Assurance Framework, Corporate Risk Register and elements of risk identified in the External Audit plan and the annual Internal Audit report and opinion;
- Statutory Financial Statements and Annual Report and Accounts (including the Quality Report) received and approved by the Committee prior to being submitted to the Board of Directors for final approval.

In addition, the Audit and Assurance Committee receives regular updates and feedback in relation to the progress against plan of Internal Audit and counter fraud.

Any issues arising were addressed by the Committee and any matter of governance will be incorporated into the Annual Governance Statement.

### **External Audit**

The Trust's External Audit function is carried out by KPMG. The External Audit contract was due for renewal on 1st April 2014. In accordance with the terms of the current tender, the contract option was exercised to extend KPMG as the Trust's external auditors for a further year. A full tender process will be carried out in 2015/16 to ensure compliance with regulatory requirements.

The statutory audit fee for the 2013/14 audit was £59,200 plus VAT.

The effectiveness of the External Audit function is assessed annually by the members of the Audit and Assurance Committee utilising the methodology provided for such an evaluation by The Audit Committee Institute. Given the high level of satisfaction it was recommended to the Council of Governors that the External Audit service was extended for a further year in line with tender provisions.

Provision of non-audit services by the External Auditor: KPMG has carried out reviews of our Residential Financial Services and of our compliance with the Provider Licence. We assessed that auditor objectivity and independence would not be compromised in relation to these services. The larger of the reviews was also subject to a formal competitive tendering process.

### **Internal Audit**

The Trust's internal audit function is performed by 360 Assurance. The annual audit plan is derived following an overarching risk assessment and is translated into the annual Operational Plan and a 3 year Strategic Plan based on:

- The adequacy of our internal controls with particular focus on the assurances placed reliance upon as documented in the Trust's Board Assurance Framework / Risk Register;
- Key systems to ensure that audit coverage and frequency reflect system risk and materiality;

- Strategic objectives and risks;
- Key local and national priorities and risks which may impact the Trust;
- Managed and mandated audit requirements;
- External Audit and Counter Fraud coverage.

A report is taken to every Audit and Assurance Committee meeting detailing progress against the Plan and drawing attention to any concerns.

Both the Internal and External Auditors have the opportunity to meet with Audit and Assurance Committee members in private (without Executives present) to discuss any concerns relating to the performance of management.

### **Local Counter Fraud**

Local Counter Fraud services were provided by 360 Assurance. The role of the Local Counter Fraud Service assists in creating an anti fraud culture within the Trust, deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud.

The Audit and Assurance Committee receives regular progress reports from the Local Counter Fraud Service during the course of the year and also receives an annual report.

### **3.4.2 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 Chief Operating Officer/Chief Nurse, the Executive Director of Finance and the Deputy Chief Executive.

Also in attendance at the Committee's meetings are the Director of Organisation Development/ Board Secretary, who serves as the secretary to the Committee, the Head of Integrated Governance, the Director of Planning and Performance and a

representative of NHS Sheffield Clinical Commissioning Group, 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 11 occasions in the course of 2013/14 and details of members' attendance at its meetings are shown in the table below:

<b>Name</b>	<b>Position</b>	<b>Attendance</b>
Mervyn Thomas	Committee Chair and Non-Executive Director	10/11
Martin Rosling	Committee Member and Non-Executive Director	8/11
Anthony Clayton	Committee Member and Non-Executive Director	11/11
Councillor Mick Rooney	Committee Member and Non-Executive Director	10/11
Susan Rogers	Committee Member and Non-Executive Director	10/11
Professor Tim Kendall	Committee Member and Executive Medical Director	4/11
Liz Lightbown	Committee Member and Chief Operating Officer/Chief Nurse	8/11
Clive Clarke	Committee Member and Deputy Chief Executive Director	9/11
Paul Robinson	Committee Member and Executive Director of Finance	10/11

### **3.4.3 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 Director of Organisation Development/Board Secretary. The current Chair of the Committee is Anthony Clayton.

The Committee met on 11 occasions during 2013/14 and Committee members' attendances at its meetings are as shown in the table below:

<b>Name</b>	<b>Position</b>	<b>Attendance</b>
Anthony Clayton	Committee Chair and Non-Executive Director	10/11
Mervyn Thomas	Committee Member and Non-Executive Director	8/11
Susan Rogers	Committee Member and Non-Executive Director	10/11
Clive Clarke	Committee Member and Deputy Chief Executive Director	8/11
Liz Lightbown	Committee Member and Chief Operating Officer/Chief Nurse	4/11
Paul Robinson	Committee Member and Executive Director of Finance	9/11

### **3.4.4 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 Director of Human Resources and the Director of Organisation Development/Board 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 4 of this report.

The Committee met on 4 occasions during 2013/14 and Committee members' attendance at its meetings are as shown in the table below:

<b>Name</b>	<b>Position</b>	<b>Attendance</b>
Professor Alan Walker	Committee Chair	4/4
Anthony Clayton	Committee Member and Non-Executive Director	4/4
Martin Rosling	Committee Member and Non-Executive Director	3/4
Mervyn Thomas	Committee Member and Non-Executive Director	4/4
Susan Rogers	Committee Member and Non-Executive Director	4/4
Councillor Mick Rooney	Committee Member and Non-Executive Director	4/4

### 3.4.5 Workforce and Organisation Development Committee

The Workforce and Organisation Development Committee was established as a Board Committee in 2013/14. It is responsible for providing assurance to the Board on the effectiveness of the Trust's systems and processes for supporting employees in the provision and delivery of high quality, safe service user care and ensuring that the Trust is meeting its legal and regulatory duties in relation to its employees.

The Workforce and Organisation Development Committee of the Board of Directors comprises Non- Executive Directors and Executive Directors. The Committee is chaired by Sue Rogers, the Trust Vice Chair.

The Director of Human Resources and the Director of Organisation Development/Board Secretary attend the Committee's meetings to provide advice and professional support to its members.

The Committee met on 3 occasions during 2013/14 and Committee members' attendance at its meetings are as shown in the table below:

Name	Position	Attendance
Sue Rogers	Committee Chair	3/3
Martin Rosling	Committee Member and Non-Executive Director	3/3
Councillor Mick Rooney	Committee Member and Non-Executive Director	3/3
Clive Clarke	Committee Member and Non-Executive Director	3/3
Liz Lightbown	Committee Member and Chief Operating Office/Chief Nurse	3/3
Paul Robinson	Committee Member and Executive Director of Finance	3/3
Professor Tim Kendall	Committee Member and Executive Medical Director	1/3

### 3.5 Executive and Non-Executive Directors' qualifications and experience

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**Professor Alan Walker**

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

**Chair**

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Professor Walker is a widely celebrated and published academic in social policy and social gerontology 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 3 years from 1st July 2013 followed a rigorously competitive recruitment and selection process. It also demonstrates the Council of Governors' confidence in his ability to provide outstanding 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). He was appointed for a first full term of 3 years from 1st July 2010 by the Council of Governors, also following a rigorously competitive recruitment and selection process.

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

**Tenure of office:** 1st July 2013 to 30th June 2016.



**Kevan Taylor**

BA (Dual Honours) Degree in Sociology and Social Administration

**Chief Executive**

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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. He led the Trust through its achievement of both Care Trust and Foundation Trust status. He also served as Director of Commissioning of the Sheffield Health Authority. Kevan has a background as a practitioner in Social Care and as a Local Authority Manager.

Kevan leads the Sheffield 'Right First Time' (RFT) partnerships on behalf of the City Council and all Sheffield NHS organisations. RFT seeks to co-ordinate services across the Local Authority and NHS to ensure that people are supported to maintain their health and wellbeing in the community and to ensure the most effective and highest quality of social and healthcare when that is required.

Kevan has coached and managed junior football and serves as a Club Welfare Officer at Hallam and Redmires Rangers Junior Football Club.



**Clive Clarke**

Diploma in Social Work (CQSW)

**Deputy Chief Executive**

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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 29 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 and Performance, Commercial Relations, Estates, IT (which includes information governance) and Clinical and Corporate governance, a responsibility he shares at Board Level with Professor 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. Since March 2013 Clive has been the Deputy Chief Executive.

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**

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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, the United States of America 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 and is Associate Editor of the British Journal of Psychiatry. 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. More recently, Professor Kendall has worked with the Organisation for Economic Co-operation and Development (OECD) helping with a review of mental health across all OECD countries, including an in-depth review of mental health services in South Korea. He is currently on the Care Quality Commission Expert Panel for Mental Health and is chairing one of the pilot inspections of NHS Trusts. His clinical work is as Consultant Psychiatrist for homeless people in Sheffield.



**Paul Robinson**

ACMA, CGMA

**Executive Director of Finance**

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Paul joined us in January 2013 and has over 20 years experience in NHS Finance within provider and commissioning organisations in South Yorkshire, Derbyshire and Lincolnshire. Prior to his appointment he was the inaugural Director of Finance and Deputy Chief Executive for Lincolnshire Community Health Services NHS Trust which he helped to establish as a standalone organisation in 2011. Paul is a Chartered Management Accountant and has completed the NHS Strategic Financial Leadership Programme. Married with 3 children, Paul is Sheffield born and bred.





**Liz Lightbown**

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

**Chief Operating Officer/Chief Nurse**

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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.

Liz is the Trust's Chief Nurse, Director of Infection Prevention and Control (DIPC) and Executive Lead for Safeguarding Adults and Children. Since April 2012 Liz has been the Executive Lead for the Trust's International Health Partnership with Gulu Regional Referral Hospital in Northern Uganda.

In November 2012 Liz became the Trust's Chief Operating Officer and Executive Lead for all Health Professions (non-medical).



**Susan Rogers**

MBE, BA (Hons) History, Certificate of Education

**Non-Executive Director (Vice-Chair)(Chair of the Workforce and Organisational Development Committee)**

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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 3 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 3 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 to 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 3 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 Local Action Panel. Councillor Rooney was a member of Cabinet for 9 years. He served 2 years as Cabinet Member for Communities, 1 year as Cabinet Member for Social Inclusion and 6 years as Cabinet Member for Social Services/Adult Services.

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 3 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.

In March 2013 Tony was appointed as an independent auditor on the Joint Independent Audit Committee, South Yorkshire Police, for a term of 3 years.

Tony served a 3 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 3 years with effect from 1st December 2012.

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



**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)**

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Appointed with effect from 1st September 2009 (for a term of 3 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 other health organisations and his role as Chairman of the South Yorkshire Probation Trust 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 3 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 3 years with effect from 1st December 2012.

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



**Martin Rosling**

CPFA

**Non-Executive Director  
(Chair of the Audit and Assurance Committee)**

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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 to 31st October 2010, which was extended for a further period of 12 months. He was reappointed to serve for a further term of 3 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.

### 3.5.1 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 Board Secretary and is available for inspection by members of the public on request.

Please submit any requests to Rosie McHugh, Director of Organisation Development/Board Secretary, by ringing 0114 2716370 or email [rosie.mchugh@shsc.nhs.uk](mailto:rosie.mchugh@shsc.nhs.uk).

### 3.5.2 Board Evaluation

There were 7 Board development sessions this year which aimed to build the strategic capability of the Board. The Board considered key developments in the external environment and this informed the development of the Trust strategy, annual and financial plans and led to the development of a revised vision, corporate strategy and Trust values. The Board considered the model of the learning board and reviewed its decision making processes and the effectiveness of the delivery of major change programmes, identifying areas for improvement. A number of sessions were focused on the Trust's quality agenda, including the Learning Disability Service and its quality assurance processes. The Board also went through a 360 degree feedback exercise, gaining feedback on its performance from key stakeholder groups (Commissioners, Governors, staff and senior Directors). The Board will be having follow up development sessions separately with the Governors and the Directors, to deepen understanding of the feedback. 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.

The Board's Audit and Assurance Committee, Finance and Investment Committee, Quality Assurance Committee and Remuneration and Nominations Committee have assessed their performance against the terms of reference to determine their effectiveness in discharging their respective functions. All committees reviewed the work over the previous year and its members were confident that they were properly carrying out their functions.

The Board 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 and identified areas for development.

Following the Non-Executive Directors' appraisals last year, the process has been developed to include greater input from the Council of Governors who are now individually invited to comment on the performance of each Non-Executive Director. This information is fed into the appraisal process in which the Lead Governor plays a key role. The Chair went through a rigorous recruitment process resulting in reappointment. 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 4, 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 performance of the Chief Executive, Executive Directors, the Director of Human Resources and the Director of Organisation Development/Board Secretary was also discussed in detail by the Remuneration and Nominations Committee. 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.

## **3.6 Additional statements and declarations**

As part of its Annual Report the Directors confirm that the following statements and disclosures have been made.

### **3.6.1 Political or charitable donations we have made**

The Trust has not made any political or charitable donations during the year 2013/14 as it is not lawful for an NHS Foundation Trust to make such donations.

### **3.6.2 Significant events affecting us after the end of the financial year**

These are disclosed in note 23 in the Annual Accounts contained in Section 13.

### **3.6.3 An indication of likely future developments at the NHS Foundation Trust**

This is disclosed in Section 2.2 and 2.3.

### **3.6.4 An indication of any significant activities in the field of research and development**

This is disclosed in Section 9, Part 2b.

### **3.6.5 An indication of the existence of branches outside the UK**

The Trust has no branches outside of the UK.

### **3.6.6 Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities**

This is disclosed in Section 2.5.3.

### **3.6.7 Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period**

This is disclosed in Section 2.5.3.

### **3.6.8 Policies applied during the financial year for the training, career development and promotion of disabled employees**

This is disclosed in Section 2.5.3.

### **3.6.9 Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees**

This is disclosed in Section 2.5.

### **3.6.10 Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests**

This is disclosed in Section 2.5.

### **3.6.11 Actions taken in the financial year to encourage the involvement of employees in the NHS Foundation Trust's performance**

This is disclosed in Section 2.5.

### **3.6.12 Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS Foundation Trust**

This is disclosed in Section 2.5.

### **3.6.13 In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS Foundation Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity**

This is disclosed in Section 2.6.

# SECTION 4.0

## Remuneration Report

# 4.0

### 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 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 3 of this report.

The Executive Directors are on permanent contracts, and 6 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 6 months' notice. Any other liability, such as unfair dismissal compensation, would depend on the circumstances of the case. The table below provides details of Executive Directors' contracts:

**Table of Executive Directors' contracts**

Executive Director	Date of contract	Unexpired terms (Years to age 65)
Kevan Taylor	February 2003	12
Clive Clarke	April 2003	15
Liz Lightbown	April 2011	18
Prof Tim Kendall	April 2003	9
Paul Robinson	February 2013	18

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.

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 although this position will be kept under review in the forthcoming year.

During the current year, the Committee reviewed the salaries of the Executive Team. The review took into account the position in respect of these salaries since the review in October 2006 as well as current relativities both externally and internally and the financial climate. This included looking at the ratio of the Chief Executive's salary to the top of Band 5 as well as the salaries of more senior staff. After consideration it was agreed that the salaries should be increased by 6% and that the percentage relationship between the Deputy Chief Executive and Chief Executive should be increased to reflect the level of responsibility involved.

## 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 6 of this report.

Details of the remuneration paid to all of the Directors during 2013/14 are shown in Table A on the following page. The Non-Executive Directors' duration of office is reported in Section 3 of this report. Information on the re-appointment of the Trust's Chair is reported in Section 6 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 3 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.



Winner SHSC Staff Awards for Excellence Service User/Volunteer Mark Thorpe

## A) Salaries and allowances

Name and title	Period 1.4.13 to 31.3.14						Total (bands of £5000)
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance -Related Bonuses (bands of £5000)	Long-Term Performance -Related Bonuses (bands of £5000)	Pension -Related Benefits (bands of £2500)	
Prof. A Walker, Chairman	25-30	0					25 - 30
Cllr. M Rooney, Non-Executive Director	10-15	0					10-15
M Rosling, Non-Executive Director	10-15	0					10-15
A Clayton, Non-Executive Director	10-15	0					10-15
M Thomas, Non-Executive Director	10-15	0					10-15
S Rogers, Non-Executive Director	10-15	0					10-15
K Taylor, Chief Executive	140-145	0			7.5-10		150-155
C Clarke, Deputy Chief Executive and Social Care Lead	115-120	0			30-32.5		145-150
M Rodgers, Executive Director of Finance and Deputy Chief Executive	0	0				0	0
P Robinson, Executive Director of Finance	105-110	0				0	105-110
Dr T Kendall, Executive Medical Director	60-65	125-130				10-12.5	200-205
E Lightbown, Chief Operating Officer/Chief Nurse	105-110	0				40-42.5	145-150



**Period 1.4.12 to 31.3.13**

<b>Name and title</b>	<b>Salary (bands of £5000)</b>	<b>Other Remuneration (bands of £5000)</b>	<b>Taxable Benefits (rounded to the nearest £00)</b>	<b>Annual Performance -Related Bonuses (bands of £5000)</b>	<b>Long-Term Performance -Related Bonuses (bands of £5000)</b>	<b>Pension -Related Benefits (bands of £2500)</b>	<b>Total (bands of £5000)</b>
Prof. A Walker, Chairman	25-30	0					25 - 30
Cllr. M Rooney, Non-Executive Director	10-15	0					10-15
M Rosling, Non-Executive Director	10-15	0					10-15
A Clayton, Non-Executive Director	10-15	0					10-15
M Thomas, Non-Executive Director	10-15	0					10-15
S Rogers, Non-Executive Director	10-15	0					10-15
K Taylor, Chief Executive	135-140	0				(10-12.5)	120-125
C Clarke, Deputy Chief Executive and Social Care Lead	100-105	0				5-7.5	105-110
M Rodgers, Executive Director of Finance and Deputy Chief Executive	95-100	0				(32.5-35)	60-65
P Robinson, Executive Director of Finance	15-20	0				(15-17.5)	0-5
Dr T Kendall, Executive Medical Director	60-65	125-130				(10-12.5)	170-175
E Lightbown, Chief Operating Officer/Chief Nurse	100-105	0				22.5-25	120-125

Paragraph 4 - 16 inclusive of Part 3 of Schedule 8 to the Regulations requires the disclosure of the remuneration figures detailed above and includes a single remuneration for each senior manager who served during the year in tabular form as shown above.

M Rodgers retired from the Trust in 2012/13.

## The Hutton disclosure

	<b>1.4.13 to 31.3.14</b>	<b>1.4.12 to 31.3.13</b>
Band of Highest Paid Director's Total (Remuneration £000)	190-195	190-195
Median Total Remuneration	19,268	19,077
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	9.9	9.8

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).

In this calculation 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>Directors and Governors Expenses</b>	<b>2013/14</b>	2012/13
Expenses shown in £00s		
Aggregate sum of expenses paid to Governors	<b>6</b>	8
Aggregate sum of expenses paid to Directors	<b>31</b>	26
<b>Total</b>	<b>37</b>	34

	Number in Office		Number receiving expenses	
	<b>2013/14</b>	2012/13	<b>2013/14</b>	2012/13
Governors	<b>42</b>	48	<b>6</b>	11
Directors (excluding the Chair and Non-Executives Directors)	<b>5</b>	6	<b>5</b>	6

## 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.

<b>Name and title</b>	<b>Real increase in pension at age 60 (bands of £2,500) £000</b>	<b>Real increase in pension lump sum at age 60 (bands of £2,500) £000</b>	<b>Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000</b>	<b>Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000</b>	<b>Cash equivalent transfer value at 31 March 2014 £000</b>	<b>Cash equivalent transfer value at 31 March 2013 £000</b>	<b>Real increase in cash equivalent transfer value £000</b>
K Taylor, Chief Executive	0-2.5	0-2.5	45-50	145-150	964	893	51
C Clarke, Deputy Chief Executive and Social Care Lead	0-2.5	5-7.5	15 - 20	55-60	351	300	45
P Robinson, Executive Director of Finance						592	
Dr T Kendall, Executive Medical Director	0-2.5	2.5-5	55-60	165-170	1,184	1,098	61
L Lightbown, Chief Operating Officer/Chief Nurse	0-2.5	5-7.5	25-30	85-90	602	423	170

## 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.

**For all off - payroll engagements as of 31st March 2014, for more than £220 per day and that last for longer than 6 months.**

<b>Number of existing engagements as of 31 March 2014</b>	<b>24</b>
Of which;	
Number that have existed for less than 1 year at time of reporting.	21
Number that have existed between 1 and 2 years at time of reporting.	1
Number that have existed between 2 and 3 years at time of reporting.	2
Number that have existed between 3 and 4 years at time of reporting.	0
Number that have existed for 4 or more years at time of reporting.	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

**For all new off-payroll engagements, or those that reached 6 months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than 6 months.**

<b>Number of new engagements, or those that reached 6 months in duration, between 1 April 2013 and 31 March 2014</b>	<b>16</b>
Number of the above which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations.	0
Number for whom assurance has been requested.	0
Of which;	
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

**For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014.**

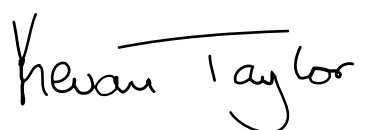
Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

## Notes

### Pension liabilities

The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary for State, in England and Wales. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. A small number of staff are, however, members of South Yorkshire Pensions scheme. Further details can be found in the Annual Accounts at note 1.2.

Paul Robinson opted out of the scheme in 2013/14



Kevan Taylor  
Chief Executive

# SECTION 5.0

## 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 3 and 6 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 3 and 6 of this report.

The number of meetings of the Board of Directors, its Committees and the attendance by individual Directors are shown in Section 3 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:

- None of them is employed by the Trust or has been in the last 5 years;
- None of them has, or has had, within the last 3 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;

- 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;
- None of them has close family ties with any of the Trust's advisers, Directors or senior employees;
- None of them holds cross-directorships or has significant links with other Directors through involvement (with those other Directors) in other companies or bodies;
- None of them is a member of the Council of Governors;
- None of them has served on the Board of this NHS Foundation Trust for more than 10 years.
- A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls is contained in Section 11 of this report;
- An explanation of the Directors' approach to quality governance is contained in Section 11 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 6 of this report;
- A statement describing how any disagreements between the Council of Governors and the Board of Directors will be resolved is contained in Section 6 of this report;

Other information relating to the Directors is as follows:

- A description of each Director's expertise and experience is contained in Section 3 of this report;
- A statement on the Board of Directors' balance, completeness and appropriateness is contained in Section 3 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 3 of this report;
- A statement on how the performance of the Board, its Committees and individual Directors was evaluated is contained in Section 3 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 3 and 12 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;
- The names of the Governors, details of their constituencies, whether they are elected or appointed, the duration of their appointment and details of the nominated Lead Governor are contained in Section 6 of this report;
- The number of meetings of the Council of Governors and the individual attendance by Governors and Directors is contained in Section 6 of this report;
- A statement about how the Governors have canvassed the opinion of the Trust's members and the public, and for appointed Governors the body they represent, on the Trust's forward plan, including its objectives, priorities and strategy, and how their views were communicated to the Board of Directors is contained in Section 6 of this report;
- Information on monitoring how representative the Trust's membership is and the level and effectiveness of member engagement is contained in Section 7 of this report;
- The Council of Governors has not exercised their power under paragraph 10c of Schedule 7 of the NHS Act 2006, and this matter is therefore not reported on;
- 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 work of the Audit and Assurance Committee in discharging its responsibility including significant issues that the Committee considered in relation to financial statements, operations and compliance and how these were addressed and an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditors, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted is contained in Section 3 of this report;
- The Trust's auditors do not provide any non-audit services to the Trust and this matter is therefore not reported on;
- A statement from the external auditor about their reporting responsibilities is contained in Section 12 of this report;
- The Trust has an Internal Audit function. Information on how the function is structured and what role it performs is included in Section 3 of this report;
- Members wishing to communicate with Governors and/or Directors may do so by informing the Trust's Membership Manager or the Trust's Board 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 6 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.

# SECTION 6.0

## Council of Governors

# 6.0

### 6.1 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 6 in 2013/4. 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.

While 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 among 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 2013/14, the Council of Governors re-appointed Professor Alan Walker as Chair of the Trust and set his 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 organisations;
- Providing feedback to members;
- Developing the Trust's membership strategy.

As a result, the Council of Governors ensures that the Board of Directors is held to account by the Trust's key stakeholders.

If a disagreement arises between the Board of Directors and the Council of Governors it is the role of the Chair to ensure that any communication difficulties are addressed and resolved. If a disagreement arises between the Chair and the Council of Governors, it is the role of the Senior Independent Director to mediate and resolve the issue.

### 6.2 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 3 year term and can hold their position for a total of 3 terms. 11 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 Governors' views are represented at the Board of Directors and that information from the Board is fed back to the Council of Governors. He fulfils this responsibility through a monthly letter to Governors as well as providing updates at each Council of Governors meeting. The Chair also gives Governors the opportunity to meet every year.

It is a requirement of the regulator Monitor that all Foundation Trusts have a Lead Governor. John Kay, Service User Governor was re-elected as such on 13 June 2013 for a 2 year term.

6 Council of Governors meetings took place during 2013/14. The individual attendance of each Governor is shown in Table 1, which also shows a breakdown of seats on the Council of Governors and associated Governors as at 31 March 2014, including their term of office.



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
<b>8 Public seats (Elected)</b>	Dorothy Cook	Public South East	01.07.2010 01.07.2013	30.06.2013 30.06.2016	6/6
	Jules Jones	Public South East	01.07.2011	30.06.2014	6/6
	Brandon Ashworth	Public South West	01.07.2010	30.06.2013	2/2
	Tina Levitt	Public South West	01.07.2013	30.06.2016	2/4
	Tamsin Ryder	Public South West	01.07.2013	30.06.2016	2/4
	Dave Jones	Public North East	01.07.2011	30.06.2014	3/6
	Trudie Smallwood	Public North East	01.07.2011	30.06.2014	3/6
	Paul Harvey	Public North West	01.07.2011	30.06.2014	2/6
	Susan Wood	Public North West	01.07.2010 01.07.2013	30.06.2013 30.06.2016	3/6
<b>10 Service User seats (Elected)</b>	Dean Chambers	Service User	01.07.2010	30.06.2013	1/2
	Tyrone Colley	Service User	01.07.2011	30.06.2014	6/6
	Shamshad Hussain	Service User	01.07.2011	30.06.2014	0/6
	John Kay	Service User	01.07.2010 01.07.2013	30.06.2013 30.06.2016	5/6
	Neel Khan	Service User	24.04.2013	30.06.2014	6/6
	Pat Molloy	Service User	01.07.2013	30.06.2016	3/4
	Patrick Moran	Service User	20.03.2013	30.06.2014	0/1
	Russell Shepherd	Service User	22.04.2013	30.06.2014	5/6
	Sue Sibbald	Service User	21.03.2012	28.02.2014	3/5
	Kate Steele	Service User	01.07.2011	30.06.2014	5/6
	Nev Wheeler OBE	Service User	01.07.2010 01.07.2013	30.06.2013 30.06.2016	5/6
	Myra Wilson	Service User	01.07.2011	30.06.2014	4/6
Doug McCallum	Service User	12.02.2014	20.03.2015	0/0	
<b>2 Young Service User/ Carer seats (Elected)</b>	Abbey George	Young Service User/Carer	27.07.2012	30.06.2014	2/6
	Jean-Michel Bellas	Young Service User/Carer	01.04.2013	30.06.2016	4/6

Number of seats	Name	Constituency	Date appointed from	Date term of office ends	Meetings attended over total number of meetings eligible to attend
<b>4 Carer seats (Elected)</b>	Leon Ballin	Carer	01.07.2011	30.06.2014	4/6
	Ian Downing	Carer	01.07.2010 01.07.2013	30.06.2013 30.06.2016	6/6
	Jean Nicholson	Carer	01.07.2011	30.06.2014	2/6
	Lindsay Oldham	Carer	01.07.2010	30.06.2013	2/2
	Susan Roe	Carer	01.07.2013	30.06.2016	4/4
<b>8 Staff seats (Elected)</b>	Mia Bajin	Clinical Support Staff	15.12.2010	13.09.2013	1/3
	Joan Davies	Psychology Staff	11.11.2013	10.11.2016	2/2
	Elaine Hall	Allied Health Professionals	01.07.2011	30.06.2014	4/6
	Elliott Hall	Central Support Staff	01.07.2011	30.06.2014	4/6
	Diane Highfield	Clinical Support Staff	11.11.2013	10.11.2016	2/2
	Ingrid King	Psychology Staff	01.07.2011	08.07.2013	0/2
	Geraldine Mountain	Social Work Staff	01.07.2011	30.06.2014	4/6
	Paul Miller	Medical and Clinical Staff	01.07.2011	30.06.2014	5/6
<b>11 Appointed Governors (Stakeholders)</b>	Stephanie Pursehouse	Support Work Staff	01.07.2011	30.06.2014	3/6
	Vin Lewin	Nursing Staff	01.04.2013	31.03.2016	4/6
	Professor Peter Woodruff	University of Sheffield	24.08.2011	23.08.2014	1/6
	Joan Healey	Sheffield Hallam University	29.09.2011	28.09.2014	4/6
	Sue Highton	Staffside (Unions)	01.07.2011	30.06.2014	3/6
	Teresa Barker	Age UK Sheffield	26.11.2013	25.11.2016	1/2
	Janet Sullivan	Sheffield MENCAP	01.07.2011	30.06.2014	2/6
	Dr Abdul Rob	Pakistan Muslim Centre	24.01.2011	23.01.2014	5/6
	David Bussue	SACMHA	30.07.2012	29.07.2015	4/6
	Cllr David Barker	Sheffield City Council	31.07.2012	11.06.2013	1/1
	Cllr Roger Davidson	Sheffield City Council	14.11.2012	13.11.2015	5/6
Cllr Clive Skelton	Sheffield City Council	31.07.2012	30.07.2015	2/6	
Cllr Jenny Armstrong	Sheffield City Council	11.06.2013	10.06.2016	0/5	
Dr Amir Afzal	Clinical Commissioning Group	01.04.2012	17.12.2013	3/5	

## 6.3 Changes to the Council of Governors

In 2013 a number of elections took place. Details of the constituencies, number of candidates and outcomes are detailed below.

**Table 2**

<b>Constituency</b>	<b>Number of candidates</b>	<b>Successful Candidate/s</b>
Public (North West)	3	Sue Wood (re-elected)
Public (North West)	1	Sylvia Hartley
Public (North East)	2	Afra Alkheili Lorraine Ricketts
Public (South East)	2	Dorothy Cook (re-elected)
Public (South West)	5	Tina Levitt Tamsin Ryder
Carer	4	Sue Roe Ian Downing (re-elected)
Carer	2	Leon Ballin (re-elected) Gill Holt
Service User	6	John Kay (re-elected) Pat Molloy Nev Wheeler OBE (re-elected)
Service User	4	Tyrone Colley (re-elected) Russ Shepherd (re-elected) Andrew South Kate Steele (re-elected)
Staff: Clinical Support	1	Diane Highfield
Staff: Psychology	1	Joan Davies
Staff: Social Work	1	Dan Creber
Staff: Allied Health Professionals	1	Elaine Hall
Staff: Medical & Clinical	1	Paul Miller
Young Service User/Carer	1	Abbey George (re-elected)

## 6.4 Governor activities in 2013/14

The Board takes specific steps to cement its relationship with the Council of Governors in addition to the action it takes throughout the year to ensure that it fully understands the views of Governors. This takes the form of an annual development session in which Governors scrutinise the Trust's annual performance through the questioning of individual Board members. The relationship between Governor and Non-Executive Director is key and to ensure that there is regular and open dialogue between the two, Non-Executive Directors meet with the Governors prior to each Council meeting where a sharing of information takes place and where Non-Executive Directors agree to pursue any issues with the Board that Governors raise. Along with the Chief Executive and Non-Executive Directors, other Board members attend Council meetings when information needs to be shared or discussed.

Additional measures have taken place in 2013/14 to strengthen the Governors' ability to hold the Board to account through the formation of a Council subgroup entitled the Performance Overview Group. This provides an opportunity for Governors to spend more time with key Board members scrutinising Trust performance of aspects of HR and workforce, finance, quality and governance. Detailed information is provided which is then analysed and scrutinised by Governors in discussion with Executive Directors.

The Board also holds an annual session with Governors to discuss the Trust's future plans. This is undertaken prior to firm objectives being set so that the views of Governors can assist in shaping objectives. In addition, Governors then seek the views of their members so that objectives can be fully informed by members. Governors do this via the membership magazine and via an electronic and paper survey. This method resulted in over 300 members' responses, a 100% increase on the previous year. Governors presented the outcome of the survey to the Board in February 2014. Governors were also invited to contribute to the Trust's work plan which arose out of the Francis Report.

To further strengthen the Board's accountability and increase its scrutiny, Governors are invited to ask questions of the Board at each meeting. The responses to these are formalised in the minutes of Council of Governors meetings. Governors have used this mechanism to question the Trust on staff sickness, staff morale, smoking policy, support for carers, staff appraisal, challenging organisational culture, the implementation of care programmes, providing benefits advice to service users, supporting staff who suffer from drug or alcohol misuse, identifying inefficiencies and how they have been addressed and supporting staff following serious incidents.

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

- Acute Care Reconfiguration;
- Arts and Wellbeing Network;
- Clover Group Patient Participation Group;
- Creative Arts Steering Group (CAST);
- Crisis House Project Group;
- Human Resources and Workforce Group;
- In-patient Directorate Care Planning;
- In-patient Forum;
- Involve Editorial Group;
- Local Authority Scrutiny Committee;
- Membership and Communications Sub Group;
- Mental Health Partnership Board;
- National Institute for Mental Health Research;
- Nominations and Remunerations Committee;
- Patient Led Assessments of the Care Environment (PLACE);
- Physical Health Group;
- Recovery Strategy Team;
- Service User Safety Group;
- Spirituality Strategy Group;
- SUN:RAYS;
- SUN:RISE;
- Supporting the Chaplains in their roles;
- Sustainability and Cost Savings Group.

Through their wider interests, the Governors are able to bring a broader spectrum of views to the Council of Governors.

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.

## 6.5 The Nominations and Remuneration Committee of the Council of Governors

While 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 2013/14 a recruitment process was held for the Trust Chair whose term was at an end. The process was formal and rigorous, and is summarised below.

The role profile, person specification and appointment process were agreed and then proposed to the Council of Governors for its approval. After advertisement, a Long List of potential candidates was drawn up and considered by the Nominations and Remuneration Committee. The candidates were then invited to a stakeholder event with Governors (who were not on the Selection Panel), Non-Executive Directors and Executive Directors. This was followed by a formal interview by the Panel drawn from the Nominations and Remuneration Committee. The Committee selected a candidate for appointment as Chair of the Trust and recommended the appointment to the Council of Governors. The Council accepted the Committee's recommendations and Professor Alan Walker was re-appointed as Chair for a further 3 year term from 1 July 2013.

The attendance of the members of the Committee at its meetings that were held during 2013/14 is shown as follows:

**Table 3**

<b>Name</b>	<b>Position</b>	<b>Attendance</b>
Alan Walker	Chair	0/0*
John Kay	Reserve Chair/Lead Governor	1/1
Brandon Ashworth	Committee Member	1/1
Lindsay Oldham	Committee Member	0/1
Paul Harvey	Committee Member	1/1
Abbey George	Committee Member	1/1
Professor Peter Woodruff	Committee Member	0/1
Dave Jones	Committee Member	0/1
Sue Sibbald	Committee Member	0/1

\* The Chair did not attend this meeting due to a conflict of interest.

Note: the Committee held a total number of 1 meeting during the period covered by this report.



SHSC Charity Launch

# SECTION 7.0

## Membership

7.0

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.

### 7.1 Constituencies, eligibility criteria and membership numbers

There are 3 elected membership constituencies, each of which has a number of classes within it. The table below details each one and its eligibility criteria and, where applicable, the number of members in the class as at 31 March 2014.

**Table 1**

Constituency	Class	Number of members	Criteria
<b>Public</b>	South West	3149	Must live in the following electoral wards: Gleadless Valley, Dore and Totley, Fulwood, Graves Park, Nether Edge, Ecclesall, Beauchief and Greenhill, Crookes
	South East	2531	Must live in the following electoral wards: Darnall, Manor Castle, Arbourthorne, Richmond, Birley, Mosborough, Beighton, Woodhouse
	North West	2283	Must live in the following electoral wards: Stocksbridge and Upper Don, Stannington, Hillsborough, Walkley, Broomhill, Central
	North East	2439	Must live in the following electoral wards: West Ecclesfield, East Ecclesfield, Southey, Firth Park, Burngreave, Shiregreen and Brightside
<b>Service User</b>	Service User	1011	Must have received a service or services from the Trust within the last 5 years
	Carer	643	Must have cared for someone who has received a service from the Trust in the last 5 years
	Young Service User or Carer	109	A service user or carer, but must be 35 years old or younger

Constituency	Class	Number of members	Criteria
<b>Staff</b>	Allied Health Professionals	178	Must have either worked for the Trust continuously for at least 12 months or have a contract of no fixed term
	Central Support Staff	313	
	Clinical Support Staff	622	
	Medical & Clinical	186	
	Nursing	574	
	Psychology	208	
	Social Work	85	
	Support Work	1089	
<b>Appointed</b>	Voluntary, Community & Faith Sector Organisations	Not applicable	Not applicable
	University of Sheffield		
	Sheffield Hallam University		
	Staff Side (unions)		
	Local Councillors		
	NHS Sheffield		

At the end of March 2014 there were 12,620 members (excluding staff) compared to 12,630 at the end of March 2013.

## 7.2 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 and Communication 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 our 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 4 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 the manner of their choice.



### 7.3 Membership recruitment and engagement

In line with the Trust's membership strategy to both recruit and engage members from across Sheffield, Governors and staff participated in a number of community events, specifically targeting areas of the city with diverse ethnic populations and also focussing on specific groups such as people with a learning disability. Some of the events included:

- Weston Park Whit Fayre;
- Learning Disability Day;
- Sharrow Festival;
- Wellbeing Festival;
- Firth Park Christmas Festival;
- Women's International Day.

The Trust held a very successful Annual Members' Meeting in 2013 which was attended by over 300 staff and members. 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.

The Trust continued to respond to and engage with members' issues by holding a successful membership event on dementia which over 150 people attended. A programme of events will continue throughout 2014/15 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's website also provides members with updated information and ensures that they can easily communicate with both the Trust and Governors if they so wish.

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

The Council of Governors  
FREEPOST  
SHSC NHS FOUNDATION TRUST



Joint Winner SHSC Staff Awards for Excellence Clinical Team G1 Ward Team

# SECTION 8.0

## Sustainability Report

# 8.0

The Trust's 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 includes 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 are an ability to meet legislative and regulatory requirements, contribute to the NHS carbon reduction target, demonstrate the Trust's commitment to other organisations, and to have a better engaged and informed staff who actively contribute to these outcomes.

During 2014 the NHS is launching a revitalised national Sustainability Strategy and Trust representatives attended a local launch event in Nottingham during February. Following this we are revising our Policy and strategic approach to take into account the new national aims, objectives and priorities.

The Trust has taken a number of actions during 2013/14 to improve its sustainability performance:

- A full range of recycling arrangements is in place at our 8 largest properties. These include the recycling of cardboard, paper, plastics, tins and glass. All of this waste is diverted from landfill and has resulted in cost savings of £4,000. Plans are in place to roll out these arrangements to additional Trust properties during 2014/15;
- In February 2014 we entered into a contract with a new waste disposal provider, Healthcare Environmental Services (HES). HES are a local company based at Normanton near Wakefield. As part of the new contract, collection of all 'black bag' or domestic type waste is sub-contracted to Veolia. Veolia are responsible for managing the Sheffield incinerator plant which

generates green heat and power, supplying city homes and businesses with heating and hot water. A number of NHS properties, including some Trust properties, are connected to the green heat and power circuit. A further benefit of this arrangement is that 100% of our domestic waste is diverted from landfill;

- Through our energy contract via the Government Procurement Services framework, we purchase electricity of which 25% is generated from renewable sources;
- Installation of up to date audio-visual systems in the Tudor Boardroom at Fulwood House, enabling key meetings such as Trust Board to be held with minimum use of paper;
- Further development of an Intranet page for staff to access information related to sustainability. The next step is to provide staff with direct access to details of energy consumption in their workplaces, via 'league tables', to incentivise local reductions in energy use;
- The Trust was successful in obtaining Department of Health Energy Efficiency Fund money for two bids:
  - > Implementation of a software system to shut down Personal Computers (PCs) when these are not in use. It is anticipated that this will generate cost savings of approximately £12,000 per annum and reduce greenhouse gas emissions by 112.876 tonnes;
  - > Replacement of out-dated boilers and installation of a Combined Heat and Power (CHP) unit at the Michael Carlisle Centre. This is anticipated to generate cost savings of approximately £23,500 per annum and reduce greenhouse gas emissions by 141.654 tonnes.

Both these schemes are on track for completion by the end of March 2014.

In the summer of 2013, the Trust opened its new building for Learning Disability Services, Firshill Rise. This building provides accommodation for in-patient care for service users and day attendees, and offices for community staff teams.

The building is being assessed under the national BREEAM (Building Research Establishment Environmental Assessment Methodology) scheme and we anticipate it will be awarded an 'Excellent' certificate. The building includes sustainability features such as a green roof, photovoltaic roof panels, a ground source heat pump and underfloor heating, complemented by the most up-to-date standards of installation and building construction.

## Future priorities and targets

As already indicated, we are revising the Trust's Sustainable Development Policy and strategy in line with the new national strategy recently launched.

An independent review of our Transport Service is being undertaken, following which we expect to agree a strategy for future service provision including a different mix of vehicles, where appropriate these may include hybrid/dual fuel or electric vehicles.

As part of our estates strategy to support clinical service developments, we will seek funding to replace more out-dated boiler plants and introduce other energy efficiency technologies which are demonstrated to provide value for money.

We have agreed a protocol to reduce the range of chemicals used for cleaning within the Trust: this will be implemented during 2014/15.

Area	Type	Non-financial information	Financial information
Greenhouse Gas Emissions	Direct Greenhouse Gas Emissions	In 2013/14 the Trust consumed 10,280,000 kWh of Gas which equates to 2118 tonnes of Co2e*	In 2013/14 the Trust spent £374,000 purchasing Gas
	Indirect Energy Emissions	In 2013/14 the Trust consumed 3,316,000 kWh of Electricity which equates to 1780 Tonnes of Co2e*	In 2013/14 the Trust spent £360,000 purchasing Electricity
	Official Business Travel Emissions	Grey Fleet (Including Lease Car Mileage)** In 2013/14 mileage travelled by the Grey Fleet amounted to 1,466,647	Grey Fleet (inc Lease Cars): In 2013/14 the Trust spent £666,115 on mileage for the Grey Fleet.
Waste Minimisation and Management	Domestic Waste	For 2013/14 the figures for Domestic Waste are as follows: Total Waste Arising:- 319,923 kg Waste to Landfill:- 222,896 kg Waste Recovered/Recycled:- 95,527 kg Waste Incinerated:- 1,500 kg	Domestic Waste: In 2013/14 the cost of disposing of Domestic Waste was £73,500
	Healthcare Waste	For 2013/14 the figures for Healthcare Waste are as follows: Total Waste Arising:- 7,067 kg Waste Incinerated:- 2,741 kg	Healthcare Waste: In 2013/14 the cost of disposing of Healthcare Waste was £16,000
Finite Resources		In 2013/14 the Trust consumed 46,900 m3 of water and sent away 44,450 m3 in the form of sewage	In 2013/14 the total water and sewage cost was £136,230

\* 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)

# SECTION 9.0

## Quality Report

### Part 1: Quality Account 2013/14 Chief Executive's welcome

#### I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Account for 2013/14.

This Quality Account is our way of sharing with you our commitment to achieve better outcomes and deliver better experiences for our service users and their carers. We will report the progress we have made against the priorities we set last year, and look ahead to the areas we will continue to focus on for the coming year.

Our vision is to be recognised nationally as a leading provider of high quality health and social care services and recognised as world class in terms of co-production, safety, improved outcomes, experience and social inclusion. We will be the first choice for service users, their families and Commissioners. 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 2013/14.

There is also significant potential to deliver improvements in quality by focussing on improvements within the day to day care and support we provide. Our on-going 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.

During this year we have prioritised 2 major development programmes that will help us to continue to improve quality in the future:

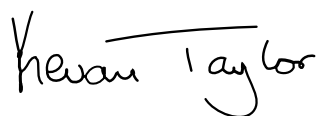
- Making resources available to support frontline clinical teams and our support services to effect quality improvement locally using evidence based methods;
- Improving how we involve people who use our services and better understand their experiences, so we can make better choices about what we want to improve.

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 Annexe 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

## Part 2A: A review of our priorities for quality improvement in 2013/14 and our goals for 2014/15

We established our priorities for quality improvement in 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 2 year plan to deliver improvements.

In order to establish these areas as our priorities the 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 will show the progress we have made over the last 2 years. We will then confirm what new priorities have been identified for the future.

In reviewing our progress over the last 2 years 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 300 of our members about our priorities for the future. 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 and Healthwatch.

Our priorities for this year are:

<b>Improving safety</b>	<b>Quality Objective 1:</b> To reduce the number of falls that cause harm to service users
	<b>Quality Objective 2:</b> To reduce the incidence of violence and aggression and the subsequent use of restraint and seclusion
<b>Improving clinical effectiveness</b>	<b>Quality Objective 3:</b> To improve the identification and assessment of physical health problems in at-risk client groups
<b>Improving the delivery of positive service user experiences</b>	<b>Quality Objective 4:</b> To improve the experience of first contact with the Trust's services
<b>Improving access, equality and inclusion</b>	<b>Quality Objective 5:</b> 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 peoples quality of life and well-being.***

The National Falls and Bone Health Audit in 2011 showed that during 2010/11 falls were higher in the Trust's older people's in-patient areas than the national average rate of falls. 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 NHS Sheffield Clinical Commissioning Group who incentivised improvement in this area under the CQUIN scheme (see page 94)

### **We said we would**

Introduce a 2 year plan that started in 2012/13 and continued 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 in-patient areas;
- Carry out environmental falls risk assessments in all in-patient 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 15% ;
- 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 in-patient areas will be assessed to see if they are vulnerable to experiencing a fall.



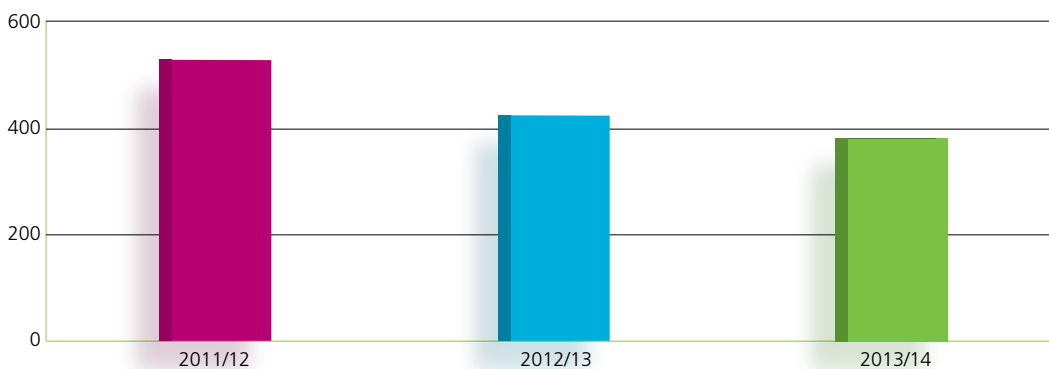
Clive Clarke (Deputy Chief Executive) at Sheffield Wellbeing Festival

### How did we do?

We have made really good progress and the amount of harm is being reduced. We have introduced screening for falls within 72 hours of admission, Personal Falls Plans and improved assessment of our building environments for falls hazards. We have supported our staff through better training and have introduced Assistive Technology to reduce falls where needed (for example, using alarms and sensors in beds and chairs).

In 2011/12 there were 516 falls that resulted in harm. We wanted to reduce that by 15% to 439 during this year. The number of falls resulting in harm has reduced by 25% to 387 this year.

### Service User falls that resulted in harm last 3 years



The severity of the harm experienced by people is also reducing:

How many people	2011/2012	2012/2013	2013/2014
Needed to attend hospital or A&E	62	52	52
Experienced minor harm	116	90	69
Experienced moderate harm	17	17	14
Experienced major harm	1	0	1

The numbers of falls that caused harm have reduced which is really positive. However, this has partly been influenced by the reduction in the amount of care we are providing in residential type services. As we have developed better community services we have had less need for in-patient or residential type support services. The amount of care we have delivered has reduced by around 11% over the 2 years. Within our older people's services the reduction has been around 40%.

## How will we keep moving forward?

We will ensure people admitted to our older adult wards are assessed for risk of falling and monitor this effectively.

We will continue to support practice improvement and awareness raising across our residential services.

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

### We chose this priority because

***Violence is not usual in our services.***

***Most people's experience of care is safe and positive. However, sometimes people are agitated, distressed or scared and can behave aggressively. 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 in-patient 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. 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 that 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 service users, relatives or the public.

### We said we would

Introduce 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 2013/14 our plans were 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 programme of practice reviews focussing on seclusion, de-escalation, physical health monitoring, post-incident reviews, use of green rooms;
- Undertake a review of staff experiences of delivering care and how we can better support them to deliver respectful and compassionate care.

### The outcome we wanted to achieve was

- All in-patient nursing and support worker staff had been trained in RESPECT;
- Reduce the use of seclusion and restraint;
- Increase the percentage of service users in acute wards who report experiencing a safe environment in local surveys;
- 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 improvements for the longer term. Over the year the data is varied in what it shows across the different indicators.

The use of seclusion has increased significantly over the last year when we wanted it to decrease. The incidents are mainly within our Psychiatric Intensive Care Unit. We have reviewed this throughout the year and the Board's Quality Assurance Committee is assured that the high increase is a reflection of changes to service user needs and the way we are delivering care:

- We are seeing more people in Sheffield. In previous years we sent over 30 people a year to other hospitals when they were acutely distressed. Now we are seeing them in Sheffield, which is a positive improvement. As we care for more acutely ill and distressed people our use of seclusion has increased;
- We opened our new service for people with a learning disability in April-May (see page 109). During this time we cared for some people in our Psychiatric Intensive Care Service while waiting for the new service to open. The environment was not as well equipped as our new service for people with a learning disability and challenging behaviours. The individuals on the ward needed caring for in a low stimulus environment for periods of time;
- Overall, we are caring for more people who have more complex needs. The current ward environment is not best suited for the care of this vulnerable client group. The service has limited options for supporting service users in low stimulus environments.

In response to this we have agreed plans (see below) that focus on practice development and a clear commitment to improve the ward facilities and environment.

Our development approach has been to work extensively with service users. We have worked with Maat Probe in support of their campaign for RESPECT, and they now commend our approach to other services. We have developed our training programmes in partnership with our service users who directly train our staff in RESPECT.

The RESPECT programme continues to be implemented as part of ongoing practice. We have successfully trained all our staff. This 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 that this is the main reason why reported incidents of violence towards staff has been increasing (see rows 4 and 6 below). 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 (see row 5 below).

Incident type	2011/12	2012/13	2013/14
Incidents reported where service users had been			
• Secluded	82	74	276
• Restrained	105	90	178
• Assaulted	387	388	381
• Caused harm from assault	89	72	73
Proportion of all reported service user incidents related to disruptive or aggressive behaviour			
• Within our Trust	15.5%	18.6%	19.3%
• National averages for mental health Trusts NPSA Benchmarking data	19%	17.4%	17%
Percentages of service users who report feeling unsafe in local surveys			
	25%	34% July 23% Dec	29% Aug 25% Mar
Incidents reported where staff working in inpatient services			
• Had been assaulted	364	606	592
• Caused harm from assault	110	99	108
Level of harm caused from the assault			
• Negligible harm	91	68	88
• Minor or moderate	19	31	20
• Major and above	0	0	0
Number of staff who reported to the national CQC staff survey that they had experience from service users, relatives or visitors			
• Physical violence	17%	22%	26%
• Harassment, bullying or abuse	19%	30%	34%

This is a complex issue to report on. Overall the reported incidents increased last year, but the majority of the incidents resulted in no harm or insignificant/negligible harm. Our conclusion is that this is a positive position for our services indicating that violent incidents are unusual. We will continue our development in this area by continuing with the RESPECT programme.

### **How will we keep moving forward?**

We have developed a multi-disciplinary group that will take an overview of seclusion use in the Trust and will develop a strategic response that will aim for a reduction in use overall.

The Board has recognised the role and importance of the ward environment, and the need to improve our current service. The Board has approved an investment of £6.4 million to build a new Intensive Treatment Service ward.

We will continue with the successful RESPECT development programme.

### **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 a learning disability 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**

Continue our current plans to bring together achievable actions within the Trust and external to partner organisations. We planned to build on existing and planned developments to ensure that we and our partner organisations work collaboratively to ensure the 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 among 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.

### 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 people's smoking circumstances with appropriate support provided;
- Diabetes link nurses in all in-patient 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 Quality Outcome Framework (QOF) targets on physical health checks for dementia and BMI for people with psychosis.

### How did we do?

We have made progress across all our development areas. A summary is provided below:

**Smoking** – We have improved the way we gather information about if people smoke and have encouraged staff to be more proactive about this. We have piloted a new project, to reduce smoking in people with serious mental illness, in one of our Community Mental Health Teams. This has involved working alongside Sheffield Right First Time and Sheffield Stop Smoking Services. A report on the outcomes from this pilot will be published.



Joint Winner SHSC Staff Awards for Excellence Clinical Individual  
Wendy Hastings Quainoo

**Alcohol** - The Alcohol Screening Tool that we have developed is now incorporated into the citywide Hidden Harm Protocol as the standard for identification, intervention and onward referral of those affected by alcohol misuse. The Hidden Harm Protocol is intended to protect vulnerable children whose parents are affected by substance and alcohol misuse. We are pleased with the success we have had in promoting increased access across Sheffield to advice and screening for alcohol use. We now plan to focus more on raising awareness within our own services.

**Obesity** - Following the appointment of a dietician, further resources were identified to support the appointment of an assistant dietician. Considerable improvement has taken place through the work of the nutritional strategy implementation group. An e-based version of the malnutrition universal screening tool (MUST) tool and associated training, has been implemented across most of the in-patient areas with plans to roll out to the rest of the services in 2014/2015. We have improved the quality of diet available and the experience of dining within residential services. Advice on diet is being made readily available including improved methods for measuring and recording hydration of vulnerable individuals.

**Diabetes** – We have continued to develop the role of our Physical Health Leads. This has led to an improvement in competency of staff in the use of related equipment and we are better able to respond to the needs of service users. A wide range of training programmes have been developed and are being implemented that contain diabetes related skills and knowledge, including Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS), Foot Care, Physical Assessment, Apprentice Programmes.

**Dental** – We have developed links and joint working with the Dental Public Health Service. Initial work is being undertaken to identify a research proposal aimed at examining and improving the link between mental health and dental health services. Training programmes are being developed in partnership with Sheffield Teaching Hospitals NHS Foundation Trust in oral health care and will be available during 2014/15.

**Physical health checks** - The recording of physical health assessment has improved across our in-patient services, with a plan to address shortfalls in place. Revised protocols for the use in malnutrition universal screening tool (MUST), falls, patient safety thermometer, and the introduction of local audits in a number of areas, has improved the ability to provide accurate audits that feed into local governance. While this is positive, we recognise that we have much more to do to support people with their physical health needs across all of our services.

#### **How will we keep moving forward?**

We have a strategy in place that will continue to direct our work in improving people's physical health. We will confirm our annual development programme, which will outline the work we will be focussing on next year.

We have prioritised on-going improvements for physical health care and support as 1 of our Quality Objectives for next year.

### **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 service user survey for questions about a 24 hours 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 MI. We were keen to learn from the pilot and provide on-going 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**

- 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 Improving Access to Psychological Therapies (IAPT) Service (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).

### **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;
- Reduce the waiting times experienced by people to access services.



Gender Identity Service at the Trust's Annual Members Meeting

## How did we do?

We have made positive progress with the provision of helpline support for service users. We opened a new Crisis House service, in partnership with Rethink MI, in April 2013. It has provided support to around 300 people a year as an alternative to needing hospital care. As part of Crisis House service Rethink MI also provide the crisis helpline service for our service users. During 2013/14 the crisis helpline received over 8,500 calls, which reflects how well it is being used.

All in-patient staff have benefited from the RESPECT development and training programme, 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	2011/12	2012/13	2013/14
Awareness of crisis support available through telephone helpline (National Patient Survey)	5.0 out of 10	5.3 out of 10	n/a see note
Ensure all in-patient staff have benefited from RESPECT development programme	155 staff	Extra 209 364 in total	Extra 332 (all trained)
Service users reporting they are treated with respect (National Patient Survey)	9.5 out of 10	9.4 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 have successfully recruited a team of service users to help us introduce the 15 Steps Challenge programme. This approach helps us to understand people's feelings and experiences of entering services for the first time. We have piloted this on 2 wards, and will be rolling it out across services next year.

During the year we wanted to reduce the waiting times for key services. We have made good progress within our IAPT Service and across our adult Community Mental Health Teams.

During the year we introduced a range of improvement approaches to 8 identified GP practices where patients were experiencing the longest waiting times for IAPT Services. Through better team working with primary care services and the introduction of simpler booking systems we have seen a really positive improvement. People are now able to access advice and support and start treatment much earlier than previously. As the year progressed waiting times have improved significantly (see row 2 below).

During 2012/13 we changed the way we organised our adult Community Mental Health Teams. One of the main reasons for this was to reduce waiting times by working more closely with primary care services. As the new services have been established during 2013/14 we are pleased to report that waiting times for assessments have significantly improved and we have made progress in reducing how long people have to wait overall. However, we want to make further improvements and to see more people within 2 weeks – which we did not manage to improve significantly over the last year.

To reduce waiting times	2012/13	2013/14
Average waiting time to access IAPT Services for treatment	5.6 weeks	5.3 weeks
Average waiting time to the 8 Practices with the longest waiting times	14.2 weeks	6.8 weeks annual average 3.7 weeks for the 2nd half of the year
Average waiting times for people to be assessed for a routine appointment within Community Mental Health Teams	10.9 weeks	6.1 weeks
Proportion of people referred to Community Mental Health Team services for a routine assessment who were assessed within 2 weeks of referral	23.8%	24.6%

## How will we keep moving forward?

We will continue to roll out the 15 Steps Challenge programme.

We have prioritised further improvements in reducing waiting times as a Quality Objective for next year and will report on progress in future reports.

## 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, NHS 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 Sheffield 63.6% of the expected number of people with a dementia have been registered, compared to the national average of 44.2%. In 2013 this had increased to 68.1% and 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 Service a specific dementia care pathway has been developed because of the increased risk of early dementia in people with Down's Syndrome.

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

## We said we would

- Recognise the clear disparity in waiting times for people needing to access our Memory Services compared to other routine services we provide. To address this we planned to review the options to deliver real improvements in waiting times for our Memory Services and confirm the targets we wish to deliver upon. We agreed to report on this in next year's Quality Account, along with the progress we have made;
- 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.

## The outcome we wanted to achieve was

- Support over 900 people with memory assessments, and reduce service waiting times from 14 weeks;
- Establish a reliable baseline for the number of people with a learning disability receiving memory assessments;
- Evaluate experience through service user and carer experience surveys for people receiving dementia services from the Memory Service;
- Establish reliable baseline figures for people from different black and minority ethnic groups use of dementia services.

## How did we do?

Over the last year we have not made the progress we wanted to in reducing waiting times for people to access our Memory Services.

Working with our Commissioner and primary care services in Sheffield we have delivered many improvements over the last 2 years.

Over the last 3 years we are seeing more people, and more people are being diagnosed and are receiving help and support than the national average. We have achieved this through a range of service improvements.

When compared to other Clinical Commissioning Groups in England and Wales Sheffield ranks 2nd for its diagnostic rate performance in 2013. So overall more people are accessing support and treatment in Sheffield than elsewhere – however people are having to wait to access support longer than we would want them to.

<b>Access</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>
Number of people assessed and diagnosed by the service	876	846	884
Waiting time to access an assessment	14 weeks	15.4 weeks	15.8 weeks

We have been working hard with our Commissioners to agree the best way forward – so that we can continue to see more people and see them quickly.

Following development work during the year, and testing new approaches to provide follow up support in primary care rather than in our specialist clinics, we have agreed a new model with our Commissioners. Jointly we feel this is the best way forward for the people of Sheffield. We plan to:

- Continue to see more people for assessments and treatment in our specialist centres;
- Provide follow up support and reviews in partnership with primary care services, reducing the need for people to travel across Sheffield for their check ups.

We will finalise our agreements about how this is to be implemented.

We have established an aim to ensure people are able to access services for an assessment within 6-8 weeks during 2015/16 after all our changes have been introduced.

We have made good progress in developing innovative ways to better understand the experiences of people with dementia.

The Involving People with Dementia Project has been successful. We have developed a range of methods and approaches to gather feedback on people's experiences, such as gaining real time feedback, observational exercises, small group work using peer feedback. We are using these approaches to ensure we have an on-going awareness of people's experience, and use this knowledge to identify areas where we can make improvements.

The Voice of Dementia film has been a positive and exciting resource that we have developed. It is now used as an educational resource that promotes discussion and awareness raising about people with dementia and their ability to have a say about their lives. It is being used to support training of staff in Sheffield Teaching Hospitals NHS Foundation Trust and within the voluntary sector in Sheffield.



## How will we keep moving forward?

We have agreed a development plan for service change with our Commissioners. The aim of this plan is to help us see more people and see them quickly. We will implement this plan during 2014/15 and report on progress in our future reports.

We have prioritised reducing waiting times over the next year as one of our Quality Objectives for the next year. We will continue to report on the experience of waiting times for Memory Services as part of this objective and our progress towards achieving our aim of waiting times of 6-8 weeks.

## Our quality goals for next year

We consistently fare well compared to other Trusts in service user surveys, staff attitude surveys and reports from our regulators. The rest of this Quality Account report supports this view. 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 we need to address we have taken action immediately.

Following concerns identified by Trust Executives and senior managers regarding 2 of our residential/ supported living homes for people with a learning disability we undertook a comprehensive review of culture and practice across all of our residential and supported living homes. The review looked at: management and leadership (including financial management), working practices, the service culture/ethos, the experience of service users and their families, and the overall quality of care. Areas of weakness in how care and support were being provided to people were identified and in a number of areas standards were below what we would expect to see. We have taken immediate action to address all such areas of concern.

We fully acknowledge the need to ensure an individualised approach to each person's needs and we are continuing with a detailed programme of continuous quality and service improvement including enhancing the senior operational and clinical leadership of residential and supported living Learning Disability Services.

Overall we are a high performing organisation. We perform well in delivering the national standards asked of us across our services for primary care, learning disability, substance misuse and mental health. As we plan for the next 2 years there are no areas of concern identified from our on-going engagement with our regulators, Commissioners or our performance against the national standards required of us that indicate we need to prioritise improvement action.

Following the publication of the Francis report the Board of Directors undertook a review of our culture. The review was carried out with our staff, our clinical leaders and benefited from input from external experts in the field of compassionate care.

The Board concluded that our culture is very different from those organisations reviewed in the national reports. But we are not complacent. We operate in the same context and are subject to the same external pressures that contributed to the failings in those organisations and these are difficult times. Delivering high quality health and social care is becoming more complex and more challenging. Demand for services is increasing and we are currently operating in an environment of reduced public sector spending. Delivering high quality care in this environment is a challenge we are determined to meet.

We have a culture in which, should poor care take place, it is recognised and reported. We do know that we have instances when care is not at the standard we would wish for our friends or families. We are therefore keen to learn whatever lessons we can from such instances to improve the quality of what we do.

We have taken this opportunity to revitalize our commitment that the people who use our services are at the heart of everything we do.

We will ensure the successful delivery of our commitments to:

- Express more clearly and make real our commitment and expectations that service users are at the heart of all that we do;
- Strengthen service user feedback and engagement;
- Increase our openness and transparency;
- Strengthen staff engagement;
- Continue to develop engaging leadership at all levels;
- Enhance our governance processes;
- Develop the role of our Governors;
- Work in partnership with our Commissioners.

We have worked with our Governors to understand their views about what will make the most difference to improve the experience of people who use our services.

Our Governors surveyed the Trust's membership about our developing priorities and we received responses from over 300 members. Through a workshop and surveys our Governors have told us that we should focus on the following areas:

- To continue to support staff to have an appreciation and awareness of what it is like to receive care. This includes strengthening the culture of the organisation and our workforce, along with improving how we gather feedback about people's experiences. We have agreed objectives that will improve how we do this through monitoring service user experience, led by service users, alongside better workforce development that involve service users in the delivery of training to our staff;
- To continue to improve how quickly people can access support and care. This includes waiting times generally, access to preventative support and support during times of crisis. Feedback also highlighted that we should give attention to what happens when people receive care and support from different teams and reduce the amount of repeated assessments that people undergo. We have agreed a number of objectives that focus on reducing waiting times in key areas. We will review care pathways to simplify arrangements and reduce duplication for service users;



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- To prioritise our initiatives that are about freeing up staff time so they can spend more time providing direct care and support. There was a concern that we should ensure we have the right numbers of staff working within teams, particularly within our in-patient services. We will review our staffing levels across services and report on what we believe they should be and then monitor our delivery against those standards. We will work with teams to support them to review how they work and report on how we have reduced unnecessary bureaucracy as a result of this.

## Our quality objectives for the next 2 years

We have reviewed the progress we have made over the last 2 years. We have made good progress in reducing falls that result in harm, and in improving the experience for service users and staff in relation to violent incidents and the use of seclusion. Practice and standards of care have improved. On-going development work will ensure the improvements are sustained and further gains are made. As we look to the next 2 years we plan to focus our priorities for improvement in the following 3 areas:

### 1. Responsiveness: We will improve access to our services so that people are seen quickly.

*Why have we identified this?*

- When we met with our Governors this was a key area of concern for them. They wanted us to ensure that people are seen quickly when required;
- Improving access is an area prioritised by our Commissioners and they are supportive of improvement and service reconfigurations to help us achieve this;
- We have already identified areas we wish to improve, and reduce the time people are having to wait. We have made some progress, but not as much as we would want to;
- We have identified the IAPT Service, our Community Mental Health Teams and our Memory Services as key areas in which to deliver improvements.

### 2. Safety: We will improve the physical health care provided to our service users.

*Why have we identified this?*

- As we have developed our plans our clinicians have told us this was a key area they wished to focus on to deliver improvements;
- It is a key priority across health and social care in Sheffield to help deliver improved outcomes and achieve a reduction in the gap in life expectancy for people with serious mental health illnesses and people with a learning disability;
- We know from reviewing progress against our Physical Health Strategy and national audits that we have further improvements still to make.

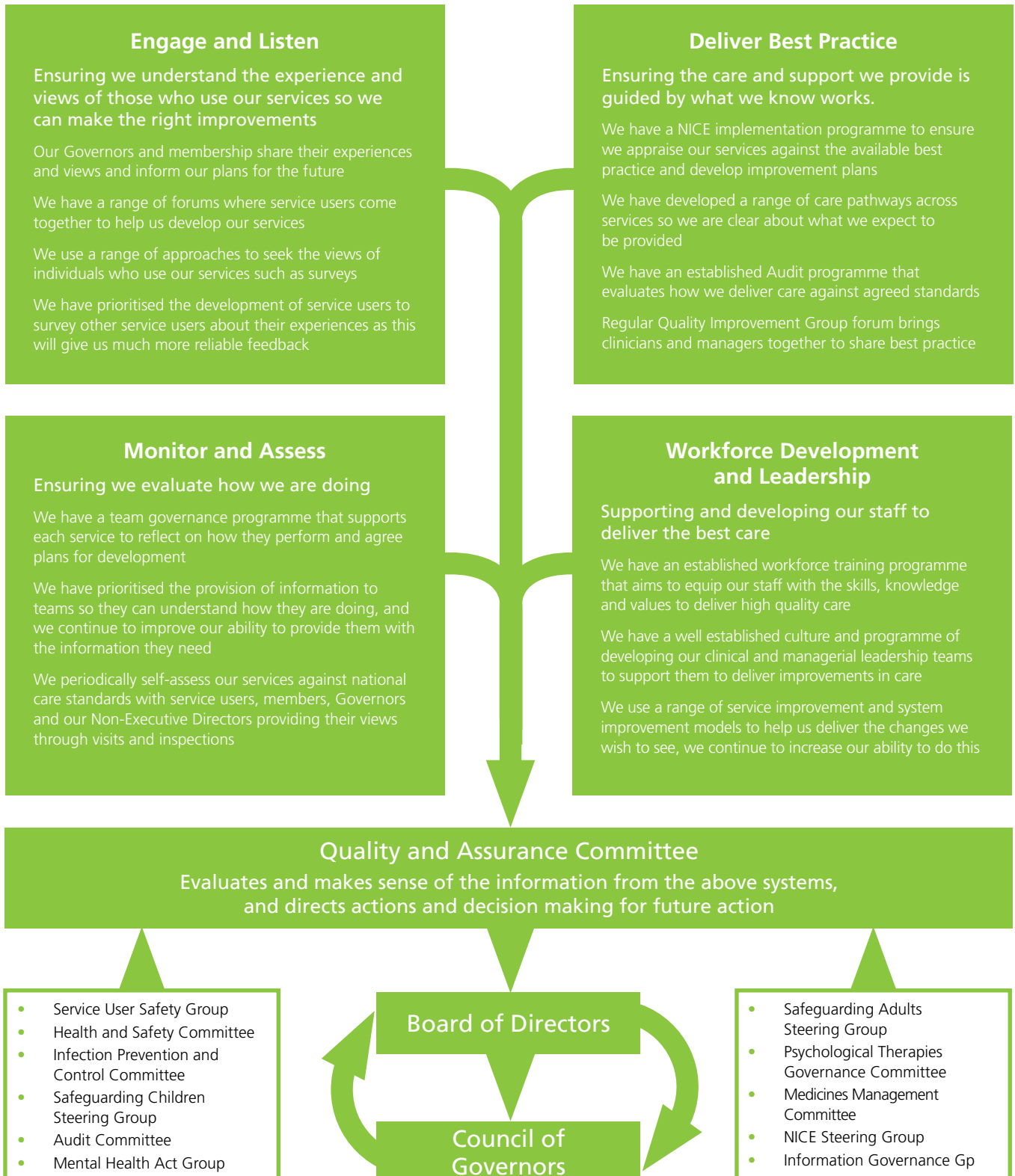
### 3. Experience: We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust.

*Why have we identified this?*

- Understanding the experiences of the people who use Trust services is essential if we are to be successful in achieving quality improvement:
- During this year we held a successful stakeholder event with service users and our public Governors to look at how we are involving service users – and make plans for how we want to do it better as we move forward;
- When we met with our Governors to look at priorities for next year they told us that we should continue to support staff to have an appreciation and awareness of what it is like to receive care and to improve how we gather feedback about people's experiences.

## 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



The Board, through its Audit and Assurance Committee, commissioned an Internal Audit review of our assurance processes. The aim of the review was to assess the effectiveness of the Board's arrangements to gain assurance on progress against the following 4 themes:

- Engagement on quality;
- Gaining insight and foresight into quality;
- Accountability for quality; and
- Managing risks to quality.

The review identified no high risk issues, and recommended that we finalise arrangements for the following:

- To finalise the review and re-launch of our overarching Quality Strategy;
- To satisfy itself that the Trust's arrangements for ensuring data quality provide appropriate assurance;
- To review the availability of national and local benchmarking information has been adequately assessed and is used where appropriate;
- To improve the effectiveness of its clinical audit function by implementing its improvement plan for audit.

## 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 2013/14. 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 2013/14 we de-registered Rutland Road (a respite care service for people with a learning disability) and Bolehill View (a respite care service for people with dementia) from our registration, as a result of the services moving to other locations.

We registered 136 Warminster Road as a respite care service for people with a learning disability.

### Planned/Unplanned reviews

During 2013/14 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  
*Cottam Road, Birch Avenue, East Bank Road, Beighton Road;*
- Residential homes for people with dementia  
*Woodland View;*
- Respite Care services for people with a learning disability  
*Longley Meadows, 136 Warminster Road;*
- Respite Care services for adults  
*Hurfield View, Wainwright Crescent;*
- In-patient Services  
*Forest Lodge;*
- Supported Living services for people with a learning disability  
*Mansfield View.*

All services inspected were fully compliant with the exception of Beighton Road, Cottam Road and Mansfield View, where compliance actions were received for:

- Records (*Beighton Road, Cottam Road, Mansfield View*);
- Supporting Staff (*Mansfield View, Cottam Road*).

Following the feedback received from the CQC we have taken immediate improvement actions and are awaiting repeat inspections by the Commission to confirm that we are fully compliant with these standards.

The reports from the reviews of compliance are all available via the Care Quality Commission website at [www.cqc.org.uk](http://www.cqc.org.uk).

We also participated in a survey regarding places of safety. The results from this national survey will be published on the Commission's website.

## Mental Health Act reviews

During 2013/14 the CQC has undertaken 10 visits to services to inspect how we deliver care and treatment for in-patients detained under the Mental Health Act. They review our processes for care, the environment in which we deliver our care and meet privately with in-patients. They have visited the following services:

- Michael Carlisle Centre  
*Stanage Ward;*
- Longley Centre  
*Hawthorn, Intensive Treatment Service  
Maple, Rowan;*
- Forest Close  
*Bungalows 1, 1A, 2, 3;*
- Grenoside Grange  
*G1*
- Assessment and Treatment Unit

We have also participated in a review of how we manage Community Treatment Orders.

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, inspections and feedback confirm that we continue to meet all essential standards.

## 2.2 Monitors' Assessment

Monitor reviews our performance and publishes a quarterly assessment on how we are doing. This information is available at <http://www.monitor-nhsft.gov.uk>.

The governance assessment (rated as either red or green) is based on the Trust's self-declaration by the Board of Directors alongside Monitor's own assessment of how we are performing. In considering this Monitor considers the following information:

- Our performance against national standards;
- CQC views on the quality of our care;
- Information from third parties;
- Quality governance information;
- Continuity of services and aspects of financial governance.

The tables below feature our ratings for the last 2 years.

## 2012/13 Governance assessment of our performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Risk Rating	4	4	5	4
Governance Risk Rating	Green	Amber/ Green	Green	Green

Note: During 2012/13 Monitor assessed performance under the Compliance Framework

## 2013/14 Governance assessment of our performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Financial Risk Rating	5	5	n/a	n/a
Continuity of Services Rating	n/a (4)	n/a (4)	4	4
Governance Risk Rating	Green	Green	Green	Green

Note: During 2013/14 Monitors' assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial Risk Rating was replaced by a Continuity of Services Rating. To help with comparisons we have shown what we would have been in Q1 and Q2 under the new framework.

## 2012/13

We 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 in-patient 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.

## 2013/14

The Trust's performance overall was assessed as Green for the year. This means that there were no evident concerns regarding our performance.

We did experience challenges in delivering 1 of the national indicators during the year. Our provision of annual care reviews for people whose care was delivered under the Care Programme Approach was not at the standard it should have been. We aimed to have ensured 95% or more of people under the CPA had received a review of their needs within the year. At the end of the 2nd and 3rd quarters we only achieved this for 89% of people. We introduced a range of changes that were focussed on:

- Reducing the need to have to re-organise planned care review meetings;
- Reviewing people more frequently than every 12 months.

This enabled us to make improvements and we achieved the target by the end of the year.

## 2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2013/14 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 (CQUIN) payment framework.

For 2013/14 £1,814,117 of the Trust's contracted income was conditional on the achievement of these indicators. We achieved all the targets and improvement goals that we agreed with our Commissioners. Therefore we received 100% of the income that was conditional on these indicators. For the previous year, 2012/13, the associated monetary payment received by the Trust was £1,639,911.

A summary of the indicators agreed with our main local health Commissioner, NHS Sheffield Clinical Commissioning Group for 2013/14 and for next year is shown below.

<b>Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences</b>	<b>Goal during 2013/14</b>	<b>Continued into 2014/15</b>
<p><b>NHS Safety Thermometer Improve collection of data</b></p> <p>We wanted to monitor incidents of pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE. This was to ensure we were effectively monitoring safety. We agreed improvement targets to reduce incidents of falls and achieved them.</p>	<p>✓ Fully Achieved</p>	<p>✓</p>
<p><b>Reducing variation in waiting times for patients referred to the IAPT services</b></p> <p>We identified 8 GP Practices where people were experiencing very long waiting times to access our IAPT services. We wanted to reduce the waiting times from an average of 15 weeks to below 10 weeks for these 8 Practices. We were very successful with this. Waiting times reduced to 4.5 weeks for the period September 2013 to March 2014. Next year we will continue to work to reduce waiting times.</p>	<p>✓ Fully Achieved</p>	<p>✓</p>
<p><b>Reduced admissions to Acute Older Adult Wards through improved community care for people in a crisis</b></p> <p>We had established new community services to provide alternatives to hospital admission. As a result of this we wanted to gradually reduce the numbers of people who needed hospital care. We were successful with this goal. As a result of providing better community services the need for hospital care reduced by 36% this year compared to 2 years ago.</p>	<p>✓ Fully Achieved</p>	<p><b>No</b></p> <p>We have made the progress we wanted to. Routine monitoring will continue</p>
<p><b>Reduction in the number of falls causing harm</b></p> <p>This goal supported our Quality Objective 1. We successfully achieved our target of reducing harm caused from falls by 15% over the last 2 years. This has been achieved with incidents of harm reduced by 25% . (See page 77 for details)</p>	<p>✓ Fully Achieved</p>	<p><b>No</b></p> <p>We have made the progress we wanted to. Routine monitoring will continue</p>
<p><b>Improving the management of Violence and Aggression within in-patient services</b></p> <p>This goal supported our Quality Objective 2. The focus was to improve the service user and staff experience in relation to violence and aggression. We implemented a successful development and service improvement programme. (See page 79 for details)</p>	<p>✓ Fully Achieved</p>	<p><b>No</b></p> <p>We have made the progress we wanted to. Routine monitoring will continue</p>



Incentivising improvements in the areas of Safety, Access, Effectiveness and User experiences	Goal during 2013/14	Continued into 2014/15
<p><b>People using mental health services should have an agreed plan to help reduce and manage the person's risk</b></p> <p>We wanted to increase the numbers of service users who had risk reduction plans in place following their initial risk assessment. We achieved the target and by the end of this year 78.2% of people receiving on-going mental health care support had a risk reduction plan in place.</p>	<p>✓ Fully Achieved</p>	<p><b>No</b></p> <p>We have made the progress we wanted to. Routine monitoring will continue</p>
<p><b>People who are referred for a routine assessment will be assessed within 2 weeks of the referral</b></p> <p>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 for the number of people we would see for assessment within 2 weeks of the referral being made. We were successful with this.</p>	<p>✓ Fully Achieved</p>	<p>✓</p>
<p><b>People using mental health services should have a care plan agreed with them and in place within 6 weeks of the assessment</b></p> <p>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. By the end of the year 77.7% of people had a care plan agreed within 6 weeks.</p>	<p>✓ Fully Achieved</p>	<p>✓</p>
<p><b>Improved use of electronic discharge communications between in-patient services and GPs</b></p> <p>During the year we introduced ways to send GPs information about a service user's care plan electronically rather than through the post. We piloted this and had a successful system in place by the end of the year on the pilot wards. This has improved the way we let GPs know about the arrangements for someone's care and treatment when they leave hospital. Next year we will complete its development and extend this to all wards.</p>	<p>✓ Fully Achieved</p>	<p>✓</p>
<p><b>Improved and standardised approaches to surveying service user experiences across all service areas</b></p> <p>We improved the way we asked people about their experience of the care and treatment we provided them. We introduced the Friends and Family Test as a pilot in some of our in-patient and community services</p>	<p>✓ Fully Achieved</p>	<p>✓</p>
<p><b>Introducing the Friends and Family test for service users and staff</b></p> <p>This new national CQUIN indicator will be introduced next year. It will help us get better feedback from the people who use our services, and our staff, about the quality of the care we are providing. This will help us make better choices about what we prioritise for improvement in the future.</p>	<p>No</p>	<p>✓</p>
<p><b>Improving physical healthcare to reduce premature mortality in people with severe mental illness</b></p> <p>This new national CQUIN indicator will be introduced next year. It will focus on improving the way we provide support for peoples physical health care needs in conjunction with primary care services.</p>	<p>No</p>	<p>✓</p>

The table above summarises the goals that we agreed with our Commissioners, and the progress that we made. Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at [www.shsc.nhs.uk](http://www.shsc.nhs.uk).

## 2.4 Review of services

During 2013/14 SHSC provided and/or sub-contracted 52 services. These can be summarised as 43 NHS services and 9 social care services. The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2013/14.

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 NHS Sheffield Clinical Commissioning Group, other Clinical Commissioning Groups, Sheffield City Council and other NHS Commissioners.

The Trust has agreed quality and performance schedules with the main Commissioners of its services. With NHS Sheffield Clinical Commissioning Group 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 2013/14.

### South Yorkshire Fire and Rescue

During 2013/14 the South Yorkshire Fire and Rescue service visited and audited 2 of the Trust's premises. These were Forest Lodge, one of our in-patient services, and Woodland View, one of our residential homes. No notices regarding improvement actions were issued by the Fire service following these inspections.

## 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 former risk management standards cover organisational, clinical, non-clinical and health and safety risks.

The Trust was last assessed in March 2013 and was deemed to be compliant at Level 1 with the standards. Since then, the NHSLA has made changes to its processes and is now using individual claim history to assess Trusts. We are still awaiting further information as to the likely impact this will have for us.

## 2.7 Participation in clinical research

The number of service users receiving relevant health services provided or sub-contracted by Sheffield Health and Social Care NHS Foundation Trust in 2013/14 who were recruited during that period to participate in research approved by a research ethics committee was 822.

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

The Trust was involved in conducting 60 clinical research projects which aimed to improve the 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:

- 10 centre randomised controlled trial of an intervention to reduce or prevent weight gain in schizophrenia (NIHR funded, SHSC is the sponsor and lead Trust);
- Stigma and discrimination aimed at mental health service users;
- DNA polymorphisms in alcohol misuse and schizophrenia;
- 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 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, efficiency and initiate innovation. Over the last year the Trust has worked closely with the East Midlands and South Yorkshire Mental Health Research Network and South Yorkshire Comprehensive Local 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.

## 2.8 Participation in Clinical Audits

### National Clinical Audits and National Confidential Enquiries

During 2013/14 4 national clinical audits and 3 national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2013/14 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
<b>Guideline audits</b>		
National Audit of Schizophrenia (re-audit) - To measure the Trust's performance against national NICE guidelines	200	100%
<b>POMH UK</b>		
Prescribing for ADHD (Topic 13) - To ensure service users with ADHD cared for in accordance with NICE guidelines	45	100%
Prescribing antipsychotics for people with dementia (Topic 11b) - To ensure national guidance are followed	33	100%
Prescribing anti-dementia drugs (Topic 4b) - To ensure national guidance are followed (Note 1)	Note 1	tbc
<b>National confidential inquiries</b>		
Inquiry into suicide and homicide by people with mental illness	16	30% (Note 2)
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 2)

### Other local audit programmes

Falls audit – To support the CQUIN scheme, see 2.3	31	n/a
Patient and staff safety - To support the CQUIN scheme, see 2.3	165	n/a
Patient safety thermometer - To support the CQUIN scheme, see 2.3	261	100%
NHS LA Care Records - To ensure risk assessment documentation is adhering to guidelines (Note 1)	Note 1	n/a
Suicide Audit - An audit in Community Teams of the NPSA suicide toolkit	7	100%
Food and nutrition – To ensure that in-patients are being screened for nutrition on admission and discharge	118	n/a
Safeguarding children and adults - A baseline audit of staff knowledge	480	n/a

Note 1: This audit commenced during 2013/14 but did not conclude until the following year. We will publish the findings in next year's Quality Account report.

Note 2: 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. ie in 70% of all inquiries, we had no record of having had prior involvement with the individual concerned.

The reports of 4 national and local clinical audits were reviewed by the Trust in 2013/14 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

National Audit of Schizophrenia

#### Results and actions

**Results** – The audit findings have yet to be published. We know we need to improve and get better at monitoring of physical health.

**The actions we have taken are:**

To be confirmed when the audit findings are published.

Prescribing for people with ADHD

**Results** – We need to improve the range of information we gather to understand the needs of the service users we provide support for.

**The actions we have taken are:**

We will improve the information and educational support we provide to service users about medication and their needs. We will review how we provide support in conjunction with primary care services and improve the information we provide at the point of discharge.

Prescribing antipsychotics for people with dementia

**Results** – People with dementia who had been prescribed an antipsychotic medication had been prescribed it appropriately in line with guidelines. However we could improve how we involved carers in the decisions made regarding medication.

**The actions we have taken are:**

We will continue to monitor prescribing practices, paying attention to the above issues.

Prescribing anti-dementia drugs

**Results** – This audit was at the data collection stage during the drafting of this report. We will publicly report findings in next year's Quality Account.

**The actions we have taken are:**

To be established as the audit is concluded.

**Local audit**

**Results and actions**

Falls Audit

**Results** – Our achievement of the practice standards relating to falls assessment at admission, and establishing falls reduction plans for those at risk of falling improved during the year.

**The actions we have taken are:**

The detailed overview of the progress we have made is outlined on page 77 regarding our quality objective to reduce harm caused from falls.

Patient and staff safety

**Results** – Following the last survey done in December 2012 there have been improvements in all 6 questions on safety within the audit.

**The actions we have taken are:**

The detailed overview of the progress we have made is outlined on page 79 regarding our quality objective to reduce incidents of violence and aggression.

Patient safety thermometer

**Results** – The Trust continues to be at least 99% harm free, according to the 'snap shot' patient safety thermometer.

**The actions we have taken are:**

To continue to monitor progress and incidents of harm.

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Suicide audit

**Results** – From the audit sample we were compliant with all the best practice standards in the NPSA Suicide Toolkit. We found isolated examples where we could improve communication with family members following such tragic events.

**The actions we have taken are:**

We will review the current arrangements in place to ensure information is shared with families and carers in an appropriate and supportive way.

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Safeguarding Children and Adults

**Results** – The audit identified that the majority of staff reported they knew what to do if they had concerns regarding the safeguarding of children or adults. However the level of confidence staff felt they had in this area was variable.

**The actions we have taken are:**

We plan to ensure that more staff are able to receive training.

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Food and nutrition

**Results** – We wanted to extend the nutritional assessments that were being done successfully on our Older Adult wards to our other in-patient services. The audit found that this was happening, but some wards still needed to make improvements.

**The actions we have taken are:**

We had previously appointed a dietician to support staff training and improve practice, and this is having a positive impact. We will continue to monitor the practice across all in-patient 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, NHS Sheffield Clinical Commissioning Group, 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;
- Waiting times – as prioritised by our Governors.

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 2013/14 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 for admitted care which included the patient's valid:

- NHS number was 98.5%;
- Registered GP was 96.0%; and
- GP Practice was 98.88%.

No other information was submitted.

The latest published data from the SUS regarding data quality under the mental health minimum data set is for January 2014. The Trust's performance on data quality compares well to national averages and is summarised on the following page.



Joint Winner SHSC Staff Awards for Excellence Clinical Individual Esther Carr

Percentage of valid records	Data quality 2013/14	National average
NHS Number	100%	99.5%
Date of birth	100%	99.6%
Gender	100%	100%
Postcode	99.7%	99.3%
Commissioner code	100%	99.8%
GP code	97.3%	98.4%
Primary diagnosis	100%	99%
HoNOS outcome	100%	90.3%

The data and comparative data is from the published MHMDS Reports for January 2014

### Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 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.

During the year we completed our assessments through the NHS Connecting for Health Information Governance Toolkit.

Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 68% for the 45 standards and was graded satisfactory/green.

The summary of our performance is provided below.

Criteria	Achieved		Current grade
	2012/13	2013/14	
Information Governance Management	73%	73%	Satisfactory
Confidentiality and Data Protection Assurance	74%	66%	Satisfactory
Information Security Assurance	66%	66%	Satisfactory
Clinical Information Assurance	73%	66%	Satisfactory
Secondary Use Assurance	66%	76%	Satisfactory
Corporate Information Assurance	66%	66%	Satisfactory
Overall	69%	68%	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 Trusts for actively encouraging the reporting of incidents. For the 6 month period April- September 2013, we were average in terms of the numbers of incidents we reported, with an incident rate of 27.07% per 1,000 bed days. Sheffield Health and Social Care NHS FT considers that this data is as described due to other Trust's improving their reporting. Overall the numbers of incidents we reported was similar to previous years (see page 106). We believe this reflects that other Trusts are improving their rates of reporting in line with our historical higher levels.

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 2013/14 the Trust received 182 non-emergency alert notices, of which 100% were acknowledged within 48 hours, 6 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 49 emergency alerts were received and 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 11.7% of all patient safety incidents reported by the Trust were related to self harm, in comparison with 20.4% for mental health Trusts nationally (Apr-Sep13). This is similar to the previous year where the figures were 12.6% and 19% respectively.

During the last 3 years clinical risk training was provided for SHSC staff and new clinical risk assessment and management tools have been introduced throughout the Trust. Since 2011 881 staff from all professional groups received the training, which covers the principles and practice of risk assessment and management. We had planned to train 1,200 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 the last 2 years in line with the position reported in Part 2. 19.3% of patient safety incidents reported by the Trust were for aggressive behaviour in comparison with a national average of 17.4%, based on NPSA benchmarking data for first 6 months of the year. In the previous year, 2012/13 the figures were 18.6% and 17.4% 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. 5.8% of patient safety incidents reported by the Trust related to medication, compared with 8.8% in mental health Trusts nationally for the period April - September 2013. In the previous year, 2012/13 the figures were 5.6% and 8.4% respectively.

## **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;
- 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 Trust's progress against the programme. These reports are publicly available via Trust's website.

## **Single sex accommodation**

The Trust is fully compliant with guidelines relating to providing for appropriate facilities for men and women in residential and in-patient settings. During 2013/14 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.

We have experienced difficulties in maintaining training for our staff. By the end of this year we had significantly increased training, and 72% of relevant staff have received adult safeguarding training

and 82% of relevant staff have received level 3 Safeguarding Children training. We will continue to extend this next year.

## **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 affected, 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 review 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.

## **Overview of incidents by type**

The table on the following 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.

<b>Incident Type</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>
All incidents	6407 (a)	6274 (a)	6408
All incidents resulting in harm	1678 (a)	1459 (a)	1416
Serious incidents (investigation carried out)	45	34	32
Patient safety incidents reported to NRLS (d)	3591 (a)	3371 (a)	3587
Patient safety incidents reported as 'severe' or 'death'	32 (a)	38 (a)	39
Expressed as a percentage of all patient safety incidents reported to NRLS	0.9%	1.1%	1.1%
Slips, Trips and Falls incidents	1651 (a)	1180	1171
Slips, Trips and Falls incidents resulting in harm	557 (a)	419 (a)	421
Self-harm incidents	369	425	443
Suicide incidents (in-patient or within 7 days of discharge)	3 (b)	1 (b)	0
Suicide incidents (community)	15 (b)	19 (b)	4 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1644	1934 (a)	2129
Violence, aggression and verbal abuse incidents resulting in harm	276	237 (a)	266
Medication Errors	360	321	337
Medication Errors resulting in harm	0	1	1
Infection Control			
Infection incidents			
MRSA Bacteraemia	0	1	0
Clostridium difficile Infections	0	0	1
Periods of Increased infection/Outbreak			
• Norovirus	7 (60)	3 (28)	1 (12)
• Rotavirus	0	0	0
• Influenza	0	1 (3)	0
Showing number of incidents, then people affected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	2%	39%	47%
Staff Influenza Vaccinations	37.6%	56%	50%

(a) The incident numbers have increased from those reported in the 2012/13 Quality Account report due to additional incidents being entered onto the information system, or incidents being amended after the completion of the report.

(b) The figure has decreased from that reported in last year's Quality Account report due to the conclusion of an HM Coroner's inquest.

(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

There are many performance targets allocated to GP Practices locally and nationally. The 4 Practices who form the Clover Group have been below the Sheffield averages in some of their performance standards mainly due to the high levels of complex patients registered. The Practices serve a majority multi-ethnic migrant population in areas of social deprivation within Sheffield, with 65% of the registered population from ethnic minority backgrounds and Slovak Roma and asylum seeking populations (16,500 total population). This brings a number of acknowledged challenges for the service to deliver the range of performance standards as patients struggle to understand the importance of the range of health screening, and chaotic lifestyles mean that patients do not attend for their planned care.

The Quality Outcomes Framework (QoF) provides a range of good practice quality standards for the delivery of GP services. Significant progress and achievements have been made and in 2011/12 the Clover Group of Practices improved to be in the highest quartile in Sheffield and their challenge since then has been 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 2012/13 the service achieved a total of 98.3% of all the QoF standards, with a Sheffield wide average of 96.3%. This year in 2013/14 the service achieved 94% of the standards, however this reduction is in relation to the introduction of many new standards and an increase in % thresholds making QoF harder to achieve.

The following table summarises performance against national standards for GP services.

Primary Care – Clover GPs	This years target	How did we do?		This year 2013/14
		2011/12	2012/13	
<b>Flu vaccinations</b>				
Vaccinate registered population aged 65 and over	75%	75%	78%	75% ✓
Vaccinate registered population aged 6 months to 64 years in at risk population to 64 years in an at risk population	70%	50% (1)	56%	58% Working to improve
Vaccinate registered population who are currently pregnant	70%	45% (1)	51%	46% Working to improve
<b>Childhood immunisations</b>				
2 year old immunisations	70-90%	90%	90%	90% ✓
5 year old immunisations	70-90%	81%	85%	82% ✓
<b>Cervical cytology</b>	60-80%	66.7%	66.4%	66.2% ✓

Note 1: The target for 2011/12 was 50% & 45% respectively  
Information source: System One and Immform

## Substance Misuse Services

The 4 commissioned services continue 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 include the further expansion of the universal screening tool to increase the number of people accessing support 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?		This year 2013/14
		2011/12	2012/13	
<b>Drugs</b>				
No client to wait longer than 3 weeks from referral to medical appointment	100%	100%	100%	100% ✓
No drug intervention client to wait longer than 5 days from referral to medical appointment	100%	100%	100%	100% ✓
No Premium client should wait longer than 48 hours from referral to medical appointment	100%	100%	100%	100% ✓
No prison release client should wait longer than 24 hours from referral to medical treatment	100%	100%	100%	100% ✓
% problematic drug users retained in treatment for 12 weeks or more	90%	94%	95%	96% ✓
<b>Alcohol Single Entry and Access</b>				
No client to wait longer than 1 week from referral to assessment	100%	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%	100% ✓
<b>Outcomes, Self Care</b>				
Initial Treatment Outcome Profile (TOP) completed	80%	96%	98%	83% ✓
Review TOP completed	80%	80%	71%	89%
Discharge TOP completed	80%	100%	100%	67% ✓ (2 out of 3 clients)
All clients new to treatment receive physical health check as part of comprehensive assessment	100%	100%	100%	100% ✓
Number of service users and carers trained in overdose prevention and harm reduction	240	292	272	258 ✓
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	85%	94%	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 in-patient services we have ensured that individual service users do not experienced prolonged periods in hospital beyond what the service user needs. We have delivered care that is well co-ordinated and focussed on the needs of individuals, and delivered in a personalised and dignified way.

Learning Disability Services	This years target	How did we do?		This year 2013/2014
		2011/12	2012/13	
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil	Nil to date 
All clients receiving hospital care should have:				
<ul style="list-style-type: none"> <li>Full health assessments</li> </ul>	100%	100%	100%	100% 
<ul style="list-style-type: none"> <li>Assessments and supporting plans for their communication needs</li> </ul>	100%	100%	100%	100%

Information source: Insight and Trust internal clinical information system

## 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.

The table overleaf highlights our comparative performance on 7 Day follow up and Gatekeeping indicators. Sheffield Health and Social Care Trust considers that this data is as described for the following reasons:

- Priority we have placed on ensuring effective and appropriate care pathways are in place;
- Effective leadership within our clinical services;
- Performance monitoring that is focussed on ensuring services have information they need to deliver care.

Sheffield Health and Social Care Trust intends to ensure the above approaches continue to support our on-going positive performance on these indicators.

We did experience challenges in delivering one of the national indicators during the year. Our provision of annual care reviews for people whose care was delivered under the Care Programme Approach was not at the standard it should have been. We aimed to have ensured 95% or more of people under the CPA had received a review of their needs within the year. At the end of the 2nd and 3rd quarters we only achieved this for 89% of people. We introduced a range of changes that were focussed on:

- Reducing the need to have to re-organise planned care review meetings;
- Reviewing people more frequently than every 12 months.

This enabled us to make improvements and we achieved the target by the end of the year. For the 4th quarter we achieved 95.7%

Mental Health Services	This years target	How did we do?		This year 2013/14
		2011/12	2012/13	
<b>Improving Access to Psychological Therapies</b>				
• Number of people accessing services	8,904	10,661	10,735	11,611 ✓
• Numbers of people returning to work (a)	89 people	396 (19%)	344 (31%)	300 (12%)
• Number of people achieving recovery	50%	49.5%	46%	47%
<b>Early intervention</b>				
• People should have access to early intervention services when experiencing a first episode of psychosis	90 new clients per year	136 new clients accessing services	107 new clients accessing services	106 new clients accessing services ✓
<b>Access to home treatment</b>				
• 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	1,415 episodes provided ✓
<b>'Gate keeping'</b>				
• 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)	99.8% National average 98.3% (b) ✓
<b>Delayed transfers of care</b>				
• Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	4.2%	4.7%	6.0% ✓
<b>7 day follow up</b>				
• 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)	96.1% National average 98.1% (b) ✓
<b>Annual care reviews</b>				
• Everyone on CPA should have an annual review	95%	98.7%	98%	95.7% (c) ✓

Information source: Insight & Trust internal clinical information system

Note

(a) 12% 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 2013/14 2,459 of the 11,611 people seen were not in work at the beginning of treatment. 300 of them (12%) returned to work by the time treatment had been completed.

(b) Comparative information from Health and Social Care Information Centre. 2013/14 national average figure based on data published for the Apr 13-Dec13 period.

(c) The 95.7% figure represents the Trust's performance at the end of the year. During the year the Trust failed to meet this target in Q2 and Q3 with performance levels at 89% for both quarters.

## Dementia Services

Our specialist in-patient 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. We have not reduced waiting times over the last year, and without changes to the way we provide services waiting times will start to get longer as we see even more people. Making further improvements in this area is a priority for us next year, and we have outlined how we plan to do this in previous sections of this report (see Quality Objective 5 on page 86).

Dementia Services	This years target	How did we do?		This year 2013/14	
		2011/12	2012/13		
Discharges from acute care (G1)	27	34	53	43	✓
Number of assessments for memory problems by memory management services	930	876	846	884	↑ Getting better
Rapid response and access to home treatment	350	338	339	349	✓
Waiting times for memory assessment	N/A	14 weeks	15.4 weeks	15.8 weeks	↓ Getting worse

Information source: Insight and Trust internal clinical information system

## Independent Living and Choice

Independent Living and Choice	This years target	How did we do?		This year 2013/14	
		2011/12	2012/13		
<b>Access to equipment</b> <ul style="list-style-type: none"> <li>Community equipment to be delivered within 7 days of assessment</li> </ul>	95% of items to be delivered within 7 days	95.3%	95.2%	96.7%	✓
<b>Choice and control</b> <ul style="list-style-type: none"> <li>People accessing direct payments to purchase their own social care packages</li> </ul>	N/A	263 people with budgets agreed Further 203 actively exploring	454 people with budgets agreed Further 312 actively exploring	635 people with budgets agreed Further 219 actively exploring	✓

Information source: Insight and Trust internal monitoring systems



### 3.3 Service User Experience

#### Complaints and compliments

We are committed to ensuring that all concerns are dealt with positively and are used as an opportunity to make sure we are providing the right care and support. If our service users remain unhappy following this and feel the need to formally complain we are committed to ensuring complaints are dealt with promptly and investigated thoroughly and fairly.

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 investigation will be used as an opportunity to learn from the experience and make changes to practice and procedures.

We 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:

- An 'alert' system implemented within the IAPT Service to identify people who have been on the waiting list for more than 2 months so their circumstances can be reviewed;
- Administration systems reviewed and improved so we can monitor what stage individuals' application for Self-Directed Support packages are at;
- The Trust's Managing Substance Misuse and Harmful Substances on In-patient Wards Policy reviewed to include all substances that may impact on the health and wellbeing of individuals.

The following summarises the numbers of complaints and positive feedback we have received.

Number of	2011/12	2012/13	2013/14
Formal complaints	110	142	147
Informal complaints	235	260	217
Compliments	1,401	1,396	1193

During the last year 9 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. In 1 case the Ombudsman asked the Trust to provide an update on the action plan arising from the complaint investigation and to issue a small ex-gratia payment. The Trust did so. In all other cases the Ombudsman has taken no action.

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints Report. This includes feedback from the complainants about their experience of the complaints process and if they felt their concerns were taken seriously and appropriately addressed. The report can be accessed via the following link:

<http://www.shsc.nhs.uk/about-us/complaints> .

During this year, following our review of the Francis report we have started publicly publishing information about complaints and compliments on our website on a quarterly basis.

#### 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.

During 2011/12 we invested £3.2 million 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. We were proud and excited when the new centre was formally opened in May 2013 by one of our service users, Mr Rex Coldwell. This has provided a great opportunity for us to improve on the personalised care we were already providing. The standard of the new community centre and its positive impact on the environment in which we can now deliver high quality care has been commended by the CQC when they visited to inspect the new service.

**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, the Board of Directors approved an investment of £6.4 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 started during this year, and we look forward to it opening over the next 18 months.

**Dovedale Ward – improving in-patient care for older people**

Our 2 wards for older people on the Longley and Michael Carlisle Centre sites are not as well designed as they need to be. There is limited communal space and many of the bedroom areas are small and don't provide en-suite facilities for service users. We are developing plans to deliver significant improvements in the design and environment within our in-patient wards.

As part of this work we invested £328,000 to improve facilities and moved Hawthorn Ward to Dovedale Ward. The newly refurbished ward was opened in April 2014. This means that service users now have better access to en-suite facilities and an improved ward environment.

**Longley Meadows – respite services for people with a learning disability**

Following feedback from service users and carers we have invested £250,000 to improve the environment at Longley Meadows. This involved a refurbishment programme to improve the environment and décor within the centre.

**General environment**

During 2013/14 no external reviews of our facilities took place. The Patient Led Assessment of the Care Environment (PLACE) took place at the end of 2012/13. The conclusion of the review is summarised as follows:

Site Location	Cleanliness	Food and Hydration	Privacy and Dignity	Condition and Appearance
Longley Centre	89%	92%	89%	79%
Longley Meadows	83%	87%	53%	65%
Michael Carlisle Centre	95%	94%	94%	80%
Forest Close	93%	88%	85%	77%
Forest Lodge	83%	89%	96%	73%
Grenoside Grange	84%	92%	87%	80%
Trust average	88%	90%	84%	75%
National average	95%	84%	88%	88%

Following the review the Board approved a development plan to address a range of improvements and overall décor across the estate, with the more sustainable improvements planned for Longley Meadows facilities.

## What do people tell us about their experiences?

The National Patient Survey for mental health Trusts highlights 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	2011 Survey		2012 Survey		2013 Survey	
	Score	Top 10	Score	Top 10	Score	Top 10
Their Health & Social Care workers	8.9	✓	9	✓	8.7	✓
Medication	7.6	✓	7.5	✓	7.0	
Access to Talking Therapies	7.4		8.0	✓	7.6	✓
Support from Care Co-ordinator	8.5	✓	8.6		7.7	
Their Care Plan	7.0		7.3	✓	6.6	
Care Reviews	8.0	✓	7.7		7.3	
Awareness about support options for Crisis Care	6.5		5.9		6.1	
Day to day living	6.0		6.0	✓	5.1	
Overall view of care	7.2	✓	7.2	✓	7.0	
<b>Overall score</b>	<b>7.5</b>	<b>Joint 2nd</b>	<b>7.5</b>	<b>Joint 3rd</b>	<b>7.0</b>	<b>Joint 5th</b>

The following table relates specifically to the nature of the relationship service users experienced with the staff involved in their care and treatment.

	2011 Survey that reported in 2012			2012 Survey that reported in 2013		
	Lowest 20% score	Top 20% score	Our score	Lowest national score	Top national score	Our score
<b>Patient Survey</b>						
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	8.0 overall	9.0 overall	8.7 overall
Did staff listen carefully to you?	8.2	9.3	9.1	8.2	9.2	8.9
Did staff take your views into account?	7.9	9.0	8.9	7.9	8.9	8.6
Did you have trust and confidence in them?	7.6	9.0	8.7	7.5	8.7	8.6
Did they treat you with dignity and respect?	8.8	9.7	9.5	8.6	9.5	9.4
Were you given enough time to discuss your condition?	7.7	8.7	8.6	7.4	8.8	7.9

The table overleaf highlights our comparative performance on service user experience in respect of contact with our staff. Sheffield Health and Social Care Trust is pleased about this positive position. While the scores are slightly reduced compared to the previous year the CQC survey analysis highlights that this reduction is not significant.

Sheffield Health and Social Care NHS FT considers that this data (the survey scores in the above table) is as described for the following reasons:

- During 2012/13, when the survey was being undertaken, we were undertaking extensive service re-organisation across our Community Mental Health Teams;
- In the context of so much change, we are pleased that the feedback results are in line with previous scores;
- 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.

Sheffield Health and Social Care NHS Foundation Trust will continue to take actions to maintain this current positive position regarding the quality of our services. Our ongoing development programmes, 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.

The below table highlights our comparative performance regarding the quality of our services from the perspective of our staff. Sheffield Health and Social Care Trust 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.

We intend to continue with our 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.

### 3.4 Staff experience

#### National NHS staff survey results

The experience of our staff indicates that they feel positive about the quality of care they are able to deliver. This is a positive position for us to be in, and it helps us to move forward in partnership with our staff and deliver further improvements.

#### Staff Survey

What percentage of staff would recommend the Trust as a provider of care to their family or friends	Lowest 20% score	Top 20% score	Average score	Our score
2011 Staff Survey	3.30	3.56	3.42	3.60
2012 Staff Survey	3.36	3.68	3.54	3.63
2013 Staff Survey	3.40	3.68	3.55	3.80

Overall Engagement and Care	Previous year		This year 2013/14		
	2011/12	2012/13	Our score	National averages	Comparisons
Overall staff engagement	3.69 out of 5	3.73	3.81	3.71	Top 20%
Recommend Trust as place to work or receive treatment	3.59 out of 5	3.63	3.80	3.55	Top 20%
Care of service users is my organisation's top priority	n/a	71%	73%	63%	
Staff feel able to contribute to improvements	70%	73%	74%	71%	Above average
<b>Top 5 Rankings– the areas we compare most favourably in with other mental health and learning disability Trusts</b>					
% of staff who feel satisfied with the quality of work and service user care they are able to deliver	77%	78%	83%	77%	Top 20%
% receiving job related training and learning	n/a	85%	88%	82%	Top 20%
% of staff working extra hours (low is good)	53%	64%	62%	71%	Top 20%
% of staff feeling harassment, bullying or abuse from other members of staff (low is good)	21%	19%	16%	20%	Top 20%
% of staff believing the Trust provides equal opportunities for career progression and promotion	88%	90%	93%	89%	Top 20%
<b>Other best scores - We were also in the best 20% of mental health and learning disability Trusts in the following areas</b>					
Job satisfaction	3.6 out of 5	3.72	3.76	3.66	Top 20%
Fairness and effectiveness of our incident procedures	3.49 out of 5	3.54	3.60	3.52	Top 20%
Feeling pressure in last 3 months to attend work when unwell	19%	20%	19%	22%	Top 20%
<b>WORSE 5 – the areas we compare least favourably in with other mental health and learning disability Trusts</b>					
% of staff receiving health and safety training	70%	50%	48%	75%	Worse 20%
% of staff receiving equality and diversity training	32%	38%	35%	67%	Worse 20%
% of staff having an appraisal	78%	79%	76%	87%	Worse 20%
% of staff experiencing physical violence from service users, relatives or members of the public	20%	21%	26%	19%	Worse 20%
% of staff feeling motivated at work	3.73 out of 5	3.77	3.73	3.85	Worse 20%

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.

Overall we are encouraged with the results overleaf. The positive feedback around engagement continues to support our on-going 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 with job satisfaction from work, and the worse 20% for staff feeling motivated at work.

The areas we have prioritised for on-going and further development work are as follows:

### **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 simpler arrangements and

procedures to ensure this can happen. Next year we will adopt an approach to appraisals that ensures everyone will receive their appraisal between April and July. This will help us to ensure all staff benefit from an appraisal on an annual basis.

### **Training**

We have an extensive training programme in place. We have put a lot of emphasis on developing local priorities about the development needs of our staff, that will support the improvements in quality we want to make and ensuring these are delivered effectively. Overall this is reflected in the positive feedback from staff in respect of engagement, satisfaction with the care they deliver and staff believing they can make improvements locally. We compare very well for staff who believe they have received job related learning and development opportunities (top 20%).

Overall, over 80% of staff have received training in diversity and health and safety issues. However, our existing training programme does not ensure that this is repeated for all staff every year.

During 2014/15 we will further review our training provision alongside the needs analysis we have undertaken of the skills our staff need to deliver high quality care. We will aim to develop more targeted approaches in respect of key training areas where these will be beneficial. Through the next year we will continue to monitor how this is being delivered.

### **Violence against staff from service users, relatives or the public**

This important area has been a key improvement priority for the Trust for the last 2 years. The Quality Objective section of this report provides a detailed account of the work we have done (see page 79).

The evidence indicates that there has been a significant improvement in awareness and reporting among staff. Through the extensive training we have provided we have been actively encouraging staff to report all incidents, no matter how insignificant, to ensure we have as full and informed a picture as possible.

What our incident data shows us is that there has been a significant increase in reported incidents, but no associated increase in harm to staff. In fact the severity of harm experienced by staff as a consequence of assaults in the workplace has decreased.

We will continue with our existing development plans which we believe are resulting in clear improvements in service user and staff experience in relation to violent, aggressive and threatening behaviour.

# Annexe A

## Statements from local networks, overview and scrutiny committees and Clinical Commissioning Groups

### Healthwatch

Healthwatch Sheffield acknowledges the work done by Sheffield Health and Social Care Trust in 2013/14 and welcomes the opportunity to provide feedback on their Quality Account.

The document is clearly laid out and there appears to have been a genuine attempt to make it as understandable as possible, which is to be commended. We have asked that the Trust consider a summary or easy read version to accompany the report so that more people can read and understand the contents.

The progress made against the 5 priorities for improvement is important, and we note that there have been tangible outcomes for service users in most areas. We have spoken to the Trust about the large increase in seclusion of patients (Objective 2) and understand the reasons behind this and the processes that are being followed to address this. We look forward to seeing significant change in this area in 2014/15. We are pleased that the Trust has chosen to take forward improving people's physical health as a priority for 2014/15 and hope to see some quantifiable data showing improvement next year. Healthwatch recognises and praises the prioritisation of reduction in waiting times both in this year and the forthcoming year. We understand that good progress has been made in some areas, most notably those with the longest waiting times, but are concerned that the waiting times for memory clinic services are growing and would like to see evidence of targets and action planning to address this.

We are pleased to note that the Quality Objectives for the next 2 years include a recognition of the importance of quality improvement through service user experience, and commend the Trust for this.

Healthwatch notes that where reports and audits have led to results and actions (p.98) these do appear to have been used as a basis for formulating the Quality Objectives.

We recognise that there are some issues with some areas of performance with the Clover Group of GPs, and expect that the Trust will wish to keep this under review.

We note the low PLACE score for some of the Trust's settings, and have raised the particular issue of Longley Meadows directly with the Trust, to which we received a sufficient response. We will continue to monitor this and other settings and hope to work with the Trust to provide PLACE volunteers next year.

In conclusion, we welcome this report which is clear, and written in an open and honest style. We commend the Trust for their acknowledgement of where things could be done better and look forward to working with them to achieve this in 2014/15.

Professor Pam Enderby,

Chair, Healthwatch Sheffield

### Our response

We welcome the helpful feedback from Healthwatch.

We look forward to reporting in the future on the progress we continue to make with this year's quality priorities. Our planned investment in new facilities for our Intensive Treatment Service will support real improvements in the way we deliver care, and we look forward to that service opening in 2015/16. With NHS Sheffield Clinical Commissioning Group we share the concerns regarding long waits to access Memory Services. We have outlined the plans we have agreed with the Clinical Commissioning Group, to make progress on this during 2014/15, and deliver improvements (See Quality Objective 5). We will report on this in next year's Report.

We will continue to monitor progress in performance across all our services. We expect to see further improvements within the Clover Group, which overall is performing very well across most indicators.

We look forward to ongoing joint work in respect of PLACE assessments and value the contribution and perspective that Healthwatch can provide.

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

As in previous years, the Committee welcomes the opportunity to comment on the Health and Social Care Foundation Trust's draft Quality Accounts

The Committee feel that the quality priorities selected by the Trust reflect the needs of the people of Sheffield. In particular, the Committee welcomes the continued prioritisation of dementia services through Quality Objective 5: "To improve access to the right care for people with a dementia". The Committee support the focus on reducing waiting times in terms of diagnosing people with dementia and the Trust's efforts to look at interim solutions to addressing this issue. Dementia and memory management services are areas that the Committee have given particular consideration over the past 2 years and we look forward to seeing improvements in due course.

The Committee have spoken with the Trust regarding the significant increase in the use of seclusion of patients (Objective 2) over the last 12 months. The Committee understand the reasons for this and were satisfied with the response given by the Trust which confirmed that this was being monitored regularly by the Trust Board's Quality Sub Committee.

The Committee also supports the Trust's plans to construct a new Psychiatric Intensive Care Unit (PICU) on the former Oakwood site at the Northern General Hospital which will result in a larger unit with improved facilities for patients.

In terms of physical wellbeing the Committee is pleased to see that the Trust continues to demonstrate a commitment to the physical wellbeing of patients. Both through its Physical Health Strategy and the prioritisation of Quality Objective 3: "To improve the identification and assessment of physical health problems in at-risk client groups". The Committee welcome the progress that has been made to date and looks forward to seeing continued improvements in the future.

The Committee believes strongly that involving service users is a key factor in successful service development and quality improvement and so commends the fact that a number of the Trust's Governors are also people who access the Trust's Services. In addition in the interests of accessible information, the Committee supports Healthwatch Sheffield's request that the Trust consider producing a summary or easy read version to accompany the Quality Report.

The Committee commends the Trust for presenting an honest and balanced picture of performance and looks forward to engaging with the Trust on both the Quality Accounts and a broader range of issues over the coming year.

### Our response

We welcome the feedback from the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

We all acknowledge the 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 NHS Sheffield Clinical Commissioning Group. We have outlined the plans we have agreed with the Clinical Commissioning Group, to make progress on this during 2014/15, and deliver improvements (See Quality Objective 5). We will report on this in next years Report.

## NHS Sheffield Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group (CCG) has had the opportunity to review and comment on the information contained within this quality account prior to its publication. Sheffield Health and Social Care NHS Foundation Trust have considered our comments and have made amendments where necessary. The CCG is therefore 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 2013 – March 2014.



The CCG commissions Sheffield Health and Social Care NHS Foundation Trust to provide a range of general and specialised mental health and learning disability services. We aspire to continually improve the quality of services provided by the Trust and the experience of those people who use them. We do this by reviewing and assessing the Trust's performance against a series of key performance indicators as well as evaluating contractual performance. We also work closely with the Care Quality Commission, who are the independent regulator of all health and social care services in England, as well as Monitor who are the sector regulator for health services in England, to ensure that care provided by the Trust meets the regulators requisite standards and that the Trust is well led and is run efficiently.

Our overarching view is that Sheffield Health and Social Care NHS Foundation Trust continues to provide services to a good standard, which is underpinned by strong contractual performance. This quality account evidences that the Trust has achieved positive results against the majority of its key objectives for 2013/14. Where issues relating to clinical quality have been identified, we have worked closely with the Trust to ensure that improvements are made.

During 2014/15 we will continue to work closely with the Trust and will build on existing good clinical and managerial working relationships. Our aim is to proactively address issues relating to clinical quality so that standards of care and clinical governance are upheld whilst services continue to evolve to ensure they meet the changing needs of our local population. We will continue to set the Trust challenging targets whilst at the same time incentivise them to deliver high quality, innovative services.

Kevin Clifford  
Chief Nurse

### **Our response**

We welcome the comments and response from NHS Sheffield Clinical Commissioning Group.

We look forward to delivering further benefits and improved outcomes for the people of Sheffield with the support of our main health Commissioner.

# Annexe B

## 2013/14 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 2013 to May 2014;
  - Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
  - Feedback from the Commissioners dated 2 May 2014;
  - Feedback from Governors dated 8 May 2014;
  - Feedback from Healthwatch dated 29 April 2014;
  - Feedback from the Scrutiny Committee dated 9 May 2014;
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
  - The [latest] national patient survey issued in 2013;
  - The national staff survey issued February 2014;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 28 May 2014; and
  - Care Quality Commission quality and risk profiles issued monthly during 2013/14;

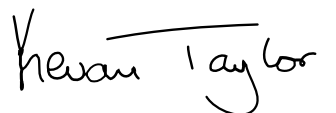
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance 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](http://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](http://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  
28 May 2014



Chief Executive  
28 May 2014

# Annexe C

## Independent Auditors' 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 2014 (the 'Quality Report') and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients received follow-up contact within seven days of discharge from hospital; and
- Admissions to in-patient services had access to crisis resolution home treatment teams.

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 the 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 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

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 2014, 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 2014:

- 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 above; 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

Chartered Accountants

1 The Embankment  
Leeds

LS1 4DW

28 May 2014

# SECTION 10.0

## 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 the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Sheffield Health & 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 & Social Care NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

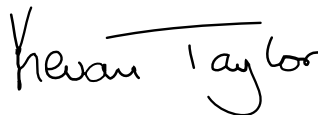
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable 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;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- Prepare the financial statements on a going concern basis.

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

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



Kevan Taylor, Chief Executive  
28 May 2014



Memory Service



Transport Services



Pharmacy Department

# SECTION 11.0

## Annual Governance Statement

### 11.1 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, while 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.

### 11.2 The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can, therefore, only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Health and Social Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sheffield Health and Social Care NHS Foundation Trust for the year ended 31st March 2014 and up to the date of approval of the Annual Report and Accounts.

### 11.3 Capacity to Handle Risk

#### 11.3.1 Risk management leadership and structure

Risk management and governance leadership is provided jointly through the Deputy Chief Executive and the Medical Director. Underneath this Board level leadership is the Director for Planning, Performance and Governance and the Associate Medical Director for Clinical Governance and Quality. The Integrated Governance Team provides leadership, support, guidance and advice for all

matters relating to risk management and clinical governance. Specific roles and responsibilities for risk management are detailed within the Trust's Risk Management Strategy, and 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.

#### 11.3.2 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. Development for the Board of Directors during 2013/14 has included workshops on quality governance, annual planning, service user experience, and Board effectiveness.

Staff receive appropriate training, relevant to their post requirements. All staff receive an introduction to the organisation and core training (risk management, health and safety, equality and human rights, information governance, safeguarding, infection control etc.). More specific training is provided, dependent upon the individual's job role, and includes incident reporting and investigation (including root cause analysis), Mental Health Act, Mental Capacity Act, first aid and life support (including resuscitation), clinical risk assessment and management, medicines management and RESPECT (managing violence and aggression).

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, safeguarding, human resources, data protection and financial.

### 11.3.3 Learning from good practice

The Trust uses a variety of mechanisms for ensuring that good practice and lessons learned are shared across the services. These include:

- Quality Assurance Committee reports;
- Quality Improvement Group presentations and reports;
- Clinical audit and clinical effectiveness reports;
- Serious incident briefings;
- Compliment and complaint reports;
- Quality improvement and sharing good practice events;
- Team /Directorate governance reports and events;
- In-patient Forum;
- Community Care Forum;
- Service User Safety Group;
- Risk register links forums.

## 11.4 The Risk and Control Framework

### 11.4.1 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 service improvements. The Trust's Risk Management Strategy describes the Trust's vision, values, attitude and strategic approach to safety and risk management; sets out the Trust's structure and governance arrangements, together with defining levels of authority, accountability and responsibility for risk management.

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. Risks that are categorised as moderate or high (scoring 12 or above) are entered onto the Corporate Risk Register, together with risks described as trustwide, for example an information risk affecting more than one Directorate. Risks are recorded on an electronic risk management database (Ulysses Safeguard system), which is separated into teams, departments and Directorates. All recorded risks have an accountable individual and are reviewed and monitored by the appropriate operational governance group. Risk registers are held at corporate, Directorate and team/local level. Each Directorate has a risk register lead responsible for managing and maintaining their risk register. The Corporate Risk Register is administered by the Governance Facilitator, who also provides advice, support and guidance for the Directorate risk register leads.

High level risks which are recorded on the Corporate Risk Register are reported to the Executive Directors' Group and the Board of Directors every monthly using a Board Risk Profile. The full Corporate Risk Register is reviewed and reported to the Executive Directors' Group, the Quality Assurance Committee and the Audit and Assurance Committee quarterly. During the year the Trust identified 8 new risks, which were recorded on the Corporate Risk Register. These risks related to changes in social care provision, our learning disabilities service, commissioning contracts and quality of care provision. All of which were managed and regularly monitored as described above. Some risks were completely mitigated through the course of the year, others remain on the Corporate Risk Register.

Risks are also highlighted via incidents, including serious incidents, complaints, concerns, safeguarding issues, claims and other queries. The Quality Assurance Committee of the Board of Directors receives quarterly reports on incidents, complaints, infection prevention and control, safeguarding, service user experience and clinical audit, among others.

The Trust has a strong incident reporting culture and staff are actively encouraged to report all incidents and near misses to enable the Trust to learn from such events and improve service user safety. The Trust is currently rolling out electronic incident reporting which enables staff, managers and the Trust to respond more efficiently and effectively to incidents.

#### **11.4.2 Board Assurance Framework**

The Board of Directors has an approved Board Assurance Framework for the period 1st April 2013 to 31st March 2014, which was last approved by the Board in April 2014. 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 Framework is updated and reviewed quarterly by the Executive Directors' Group and the Audit and Assurance Committee and bi-annually by the Board.

As at 1st April 2014, 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 2014/2015 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 Trust'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 2013/14 that is consistent with Department of Health guidance and that it continues to make progress in strengthening the underlying processes which underpin it. The Framework is considered to be reflective of the principal risks that could impact on the achievement of the Trust's strategic objectives, and the arrangements within which the Assurance Framework operates are deemed to be satisfactory.

#### **11.4.3 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 has this year formed relationships with Healthwatch Sheffield, who has also been involved with the development of the Trust's Quality Report, together with Governors.

Service users and carers, who are part of the Partners in Improving Quality Group, have undertaken various site visits across the Trust in relation to checking compliance against the Care Quality Commission's Essential Standards of Quality and Safety, as well as being involved in Patient-Led Assessments of the Care Environment (PLACE).

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

#### **11.4.4 Quality governance arrangements**

Quality Impact Assessments are undertaken on all cost improvement plans contained within the Trust's Annual Plan, directorate level business plans and business case development, production and implementation. The vast majority of plans during 2013/14 were assessed as very low or low risk in respect of their impact on the quality of service. The Trust has arrangements in place to ensure that assessments of the impact on service quality is integral in the production of its forward and future plans. Ongoing and routine monitoring of quality impact assessments takes place, which provides assurance through the Trust's Quality Assurance Committee to the Board of Directors.



The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

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

- Hurlfield View;
- Mansfield View;
- Longley Meadows;
- Wainwright Crescent;
- 136 Warminster Road;
- Grenoside Grange;
- Intensive Support Service.

From these inspections, all locations with the exception of Mansfield View, were deemed to be fully compliant against the Essential Standards of Quality and Safety that were reviewed. Mansfield View received 2 compliance actions against outcome 14 (supporting staff) and outcome 21 (records). This inspection took place in February 2014 and the Trust is currently implementing actions to ensure full compliance with these outcomes is restored.

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 Partners in Improving Quality Group, together with various staff members, also carry out 'mock' inspections, using a template devised to assess compliance against the CQC's standards, at various locations throughout the year. Where contractual arrangements are in place stakeholders also assess compliance with CQC standards and monitor progress where improvements are identified. The Trust's Non-Executive Directors also have an established programme of site visits to further assure the Trust of the quality of care provision.

The Trust assesses itself against Monitor's Quality Governance Framework on a quarterly basis. This is reported through the Quality Assurance Committee to the Board of Directors. The assurances that this self-assessment provides has been tested and challenged at a Board development session held during the year.

Sheffield Health and Social Care NHS Foundation Trust 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 Clinical Commissioning Group.

The Executive Directors Group commissioned a service review into Learning Disability Provider Services in September 2013, following a number of serious incidents and complaints within the service. In carrying out the Review, the Review Team worked closely with the directorate management team which enabled the service to proactively respond to areas of concerns raised throughout the Review. The Review was completed in April 2014 and the findings have been reported to the Board of Directors, the Care Quality Commission, Monitor and NHS Sheffield Clinical Commissioning Group.

#### **11.4.5 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. 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 2014 and has met the required level on all items. A work programme is in place to ensure further progress over the following year.

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. Between 1st April 2013 and 31st March 2014 the Trust had 1 incident reportable to the Information Commissioners Office, as classified by the Department of Health Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents, (Gateway Ref. 13177). This incident involved the disclosure of 1 service user's confidential information in an incorrectly addressed letter. The Information Commissioner was satisfied with the actions the Trust took following this incident. A summary of the lower level data security incidents reported through the year is provided within Section 2.7.1 of the Trust's Annual Report.

#### **11.4.6 Foundation Trust compliance**

During the year the Trust has undertaken a number of measures to ensure its compliance with its Provider Licence and Code of Governance. These have included an initial assessment by KPMG on its Provider Licence G and an audit undertaken by Internal Audit on the effectiveness of the Trust's quality governance framework. Neither of which exercises flagged any significant gaps or concerns for the Trust.

The Board of Directors receives regular information on various aspects of the Trust's performance, to assure itself that it is fulfilling the requirements and responsibilities as established within the Provider Licence, Code of Governance and Quality Governance Framework. Further information on this is provided within Section 5 of the Trust's Annual Report.

#### **11.4.7 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 updated in accordance with the timescales detailed in the Regulations.

#### **11.4.8 Equality, diversity and human rights**

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

#### **11.4.9 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 the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

### **11.5 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 6 monthly basis and a financial sign off for current year budgets is performance managed by the respective Executive Directors.

## 11.6 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 provided 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 service user 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 Quality Assurance Committee, the 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 300 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 9 of the Annual Report.

## 11.7 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 Workforce and Organisation Development 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 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 provided that there is a generally sound system of internal control, designed to meet the Trust's objectives and that controls are generally being applied consistently. Any actions resulting from internal or external audits are closely monitored by the Audit and Assurance Committee, and any gaps are recorded and progressed through the Assurance Framework.

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 CQC, including Mental Health Act Commissioners;
- Full registration with the CQC across all locations;
- Clinical Audit Programme;
- Patient-Led Assessments of the Care Environment (PLACE);
- Service User Surveys;
- Information Governance Toolkit assessment.

### **11.7.1 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. The Board of Directors receives and scrutinises detailed information and assurances on all aspects of the Trust's performance and business. It assesses its own performance and effectiveness, ensuring that it complies fully with its statutory and regulatory functions and duties. Further information on the Board of Directors can be found in Sections 3.3.2, 3.5.2 and Section 5 in the Trust's Annual Report. Further information on the Board of Directors' sub-committees (as given below) can be found in Section 3.4 of the Trust's Annual Report.

### **11.7.2 Audit and Assurance Committee**

The Audit and Assurance Committee provides assurance to the Board of Directors 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.

### **11.7.3 Quality Assurance Committee**

The Quality Assurance Committee provides assurance to the Board of Directors 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.

### **11.7.4 Finance and Investment Committee**

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

### **11.7.5 Remuneration and Nominations Committee**

The Remuneration and Nominations Committee makes recommendations to the Board of Directors 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 Directors and Directors.

### **11.7.6 Workforce and Organisation Development Committee**

The Board of Directors established the Workforce and Organisation Development Committee, as a Board level sub committee, in September 2013. This Committee provides assurance to the Board of Directors on the human resource structures, systems and processes that support employees in the delivery of high quality, safe service user and patient care and to ensure the Trust meets its legal and regulatory duties in relation to its employees.

### **11.7.7 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.

### **11.7.8 Operational Governance Groups**

A number of operational governance groups are established across the Trust, together with a series of professional advisory groups and committees, which report to the Executive Directors' Group. These groups provide operational, clinical and professional advice and assurance on the Trust's business.

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, while safeguarding the public funds and departmental assets.

## **Conclusion**

In my opinion, no significant control issues have been identified for the period 1st April 2013 to 31st March 2014.



Kevan Taylor  
Chief Executive  
28 May 2014

# SECTION 12.0

## Auditors' Report

# 12.0

### **Independent auditors' 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 2014 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and Notes to the Accounts. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. 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 2014 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 2013/14.

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

In our opinion the information given in the Strategic Report and 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.

Clare Partridge, for and on behalf of KPMG LLP  
Statutory Auditor

Chartered Accountants  
1 The Embankment  
Neville Street  
Leeds  
LS1 4DW

28 May 2014

# SECTION 13.0

## Annual Accounts

# 13.0

### Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts for the year ended 31 March 2014 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.

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



Kevan Taylor

Chief Executive (as Accounting Officer)


28 May 2014



The Accounts of Sheffield Health and Social Care NHS Foundation Trust for the period ending 31st March 2014 follow. The 4 primary statements; the Statement of Comprehensive Income (SOCl), 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 4 primary statements and are cross referenced accordingly.

The financial statements (Accounts) were approved by the Board on 28th May 2014 and signed on its behalf by:

Signed:  (Chief Executive)

Date: 28th May 2014

### Statement of comprehensive income for the year ended 31 March 2014

	Note	2013/14 £000	2012/13 £000
Operating income from continuing operations	3	<b>130,030</b>	128,382
Operating expenses of continuing operations	4	<b>(125,985)</b>	(122,994)
<b>Operating surplus</b>		<b>4,045</b>	5,388
<b>Finance costs:</b>			
Finance income	6	<b>89</b>	234
Finance expense – financial liabilities	7	<b>(19)</b>	(87)
Finance expense - unwinding of discount on provisions	16	<b>(14)</b>	(17)
Public Dividend Capital (PDC) dividend payable		<b>(1,608)</b>	(1,986)
<b>Net finance costs</b>		<b>(1,552)</b>	(1,856)
<b>Movement in fair value of investment property</b>	10	<b>20</b>	(20)
<b>SURPLUS FOR THE YEAR FROM CONTINUED OPERATIONS</b>		<b>2,513</b>	3,512
<b>Other comprehensive income and expenses</b>			
Gain/(loss) from transfer by absorption from demising bodies		<b>625</b>	0
Impairment losses on property, plant and equipment		<b>(2,249)</b>	(1,587)
Revaluation gains on property, plant and equipment		<b>4,730</b>	416
Other recognised gains and losses		<b>(766)</b>	987
Remeasurements assets/(liabilities) on defined benefit pension schemes		<b>871</b>	(1,122)
<b>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</b>		<b>5,724</b>	2,206

## Statement of financial position as at 31 March 2014

	Note	31 March 2014 £000	31 March 2013 £000
<b>Non-current assets</b>			
Intangible assets	8	12	16
Property, plant and equipment	9	55,847	54,528
Investment property	10	200	180
Trade and other receivables	11	3,188	3,751
<b>Total non-current assets</b>		<b>59,247</b>	<b>58,475</b>
<b>Current assets</b>			
Inventories	12	90	106
Trade and other receivables	11	4,464	3,465
Cash and cash equivalents	13	27,673	22,731
<b>Total current assets</b>		<b>32,227</b>	<b>26,301</b>
<b>Current liabilities</b>			
Trade and other payables	15	(7,592)	(5,776)
Taxes payable	15	(1,771)	(1,868)
Provisions	16	(915)	(1,131)
Other liabilities	17	(56)	(216)
<b>Total current liabilities</b>		<b>(10,334)</b>	<b>(8,991)</b>
<b>Total assets less current liabilities</b>		<b>81,140</b>	<b>75,786</b>
<b>Non-current liabilities</b>			
Provisions	16	(700)	(680)
Other liabilities	17	(3,223)	(3,867)
<b>Total non-current liabilities</b>		<b>(3,923)</b>	<b>(4,547)</b>
<b>Assets less liabilities</b>		<b>77,217</b>	<b>71,239</b>
<b>Financed by taxpayers' equity:</b>			
Public Dividend Capital		33,826	33,572
Revaluation reserve	9.3	19,804	17,191
Income and expenditure reserve		23,587	20,476
<b>Total taxpayers' equity</b>		<b>77,217</b>	<b>71,239</b>

## Statement of changes in taxpayers' equity for the year ending 31 March 2014

<b>Changes in taxpayers' equity for 2013/14</b>	<b>Public dividend capital £000</b>	<b>Revaluation reserve £000</b>	<b>Income &amp; Expenditure Reserve £000</b>	<b>Total £000</b>
<b>Taxpayers' equity at 1 April 2013</b>	33,572	17,191	20,476	<b>71,239</b>
Surplus for the year	-	-	2,513	<b>2,513</b>
Impairment losses on property, plant and equipment	-	(2,249)	-	<b>(2,249)</b>
Revaluations gain on property, plant and equipment	-	4,730	-	<b>4,730</b>
Other recognised gains and losses*	-	-	(766)	<b>(766)</b>
Remeasurements on defined benefits pension scheme	-	-	871	<b>871</b>
Transfers by modified absorption on 1 April transfers from demising bodies	-	-	625	<b>625</b>
Transfers by modified absorption: transfers between reserves	-	132	(132)	-
Public Dividend Capital received	296	-	-	<b>296</b>
PDC adjustment for cash impact of payables/receivables transferred from legacy PCTs	(42)	-	-	<b>(42)</b>
<b>Taxpayers' equity 31 March 2014</b>	<b>33,826</b>	<b>19,804</b>	<b>23,587</b>	<b>77,217</b>
<b>Changes in taxpayers' equity for 2012/13</b>				
<b>Taxpayers' equity at 1 April 2012</b>	33,572	18,523	16,938	<b>69,033</b>
Surplus for the year	-	-	3,512	<b>3,512</b>
Impairments on property, plant and equipment	-	(1,587)	-	<b>(1,587)</b>
Revaluations gains on property, plant and equipment	-	416	-	<b>416</b>
Actuarial loss on defined benefits pension scheme	-	-	(135)	<b>(135)</b>
Other reserve movements	-	(161)	161	-
<b>Taxpayers' equity at 31 March 2013</b>	<b>33,572</b>	<b>17,191</b>	<b>20,476</b>	<b>71,239</b>

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

\*766,000 relates to the back to back agreement with Sheffield City Council in respect of the Local Authority defined benefit pension scheme on - SOFP.

## Statement of cash flows for the year ended 31 March 2014

	Note	2013/14 £000	2012/13 £000
<b>Cash flows from operating activities</b>			
Operating surplus from continued operations	SOCI	<b>4,045</b>	5,388
<b>Non-Cash income and expense</b>			
Depreciation and amortisation	9	<b>2,127</b>	2,049
Impairments and reversals	9	<b>886</b>	172
(Gain)/loss on disposal	3	<b>157</b>	(318)
(Increase) in trade and other receivables	SOPF	<b>(1,015)</b>	(496)
Decrease in inventories	SOPF	<b>16</b>	57
Increase in trade and other payables	SOPF	<b>1,755</b>	721
Increase/(decrease) in other liabilities	SOPF	<b>(160)</b>	1,165
Increase/(decrease) in provisions	SOPF	<b>(210)</b>	1,218
Other movements in operating cash flows	SOPF	<b>9</b>	(245)
		<b>7,610</b>	9,711
<b>Cash flows from investing activities</b>			
Interest received	6	<b>91</b>	149
Payments for intangible assets	8	-	(4)
Purchase of property, plant and equipment	9	<b>(1,524)</b>	(2,741)
Receipts from disposal of property, plant and equipment	9	<b>5</b>	644
		<b>(1,428)</b>	(1,952)
<b>Cash flows from financing activities</b>			
PDC received		<b>296</b>	-
PDC dividends paid		<b>(1,494)</b>	(2,056)
PDC received - adjustment for modified absorption transfers of payables / receivables		<b>(42)</b>	-
		<b>(1,240)</b>	(2,056)
<b>Net cash generated used in financing activities</b>			
		<b>(1,240)</b>	(2,056)
<b>Net increase in cash and cash equivalents</b>			
		<b>4,942</b>	5,703
<b>Cash &amp; cash equivalents at 1 April</b>			
		<b>22,731</b>	17,028
<b>Cash &amp; cash equivalents at 31 March</b>			
	13	<b>27,673</b>	22,731

# SUPPORTING NOTES TO THE ACCOUNTS

## 1. Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 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.

### 1.1 Accounting Period

The accounts of the Trust have been drawn up for the year to 31 March 2014.

### 1.2 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.

### 1.3 Acquisitions and Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

### 1.4 Consolidation

The Trust is one of the related charities to Sheffield Hospitals Charitable Trust, under the umbrella registration of 1059043-3. It is not a corporate trustee. The Trust has assessed its relationship to the charitable fund and determined it not to be a subsidiary because the Trust does not have the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013/14 the FT Annual Reporting Manual permitted the NHS Foundation Trust not to

consolidate the charitable fund. From 2013/14 this dispensation does not apply and material charitable funds should be consolidated. Due to our assessment, the Trust will not be consolidating the Sheffield Hospitals Charitable Trust.

### 1.5 Income

The main source of income for the Trust is from Clinical Commissioning Groups, which are government funded Commissioners of NHS health and patient care.

Income is recognised in the period in which services are provided 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.

Interest income is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

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.

### 1.6 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**

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.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP Practices and other bodies, allowed under the direction of the 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.

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. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 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) has been used and replaced 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 VC'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 net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Re-measurements of the defined benefit plan 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. For further information see note 26.

### **1.7 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.

### **1.8 Property, Plant and Equipment**

#### **Recognition**

Property, Plant and Equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

## **Measurement**

### **Valuation**

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

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where a service could be provided in any part of the City, the Trust has used the alternative site valuation method.

A full revaluation was undertaken as at 31 March 2014 and is reflected in these financial statements.

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 re-valued 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 of the assets of the Trust are as follows:



	Minimum life years	Maximum life years
Assets held under finance lease: lower of lease term or useful economic life.		
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.

## **1.9 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, provided this exceeds £5,000.

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.

## **1.10 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.

### **1.11 Government and other grants**

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups 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 2013/14 no government grants or other grants were received.

### **1.12 Donated 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 imposes a condition that the future economic benefits embodied in the donation/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 the grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

During 2013/14 no donated assets were received.

### **1.13 Non-current assets held for sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their existing carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses. Depreciation ceases to be charged when assets are classified as 'held for sale'. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the income statement. On disposal, the balance for the asset on the revaluation reserve, donated asset reserve or government grant reserve is transferred to retained earnings.

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

During 2013/14 no assets were held for sale.

### **1.14 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.

### **1.15 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 cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

## 1.16 Leases

### Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is derecognised when the liability is discharged, cancelled or expires.

During 2013/14 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.

## 1.17 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 at the reporting date. Where the effect of the time value of money is significant, the estimated cashflows are discounted using the short- (-1.9%) (-1.8% 2012/13); medium- (-0.65%) (-1.0% 2012/13); and/or long-term (+2.2%) (+2.2% 2012/13) 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 1.8% (2.35% 2012/13) in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

### **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. The contribution is charged to operating expense. 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 16 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.

### **1.18 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the 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 2014 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.

As at 31st March 2014 the Trust has contingent liabilities of £41,000 related to litigation claims through the NHS Litigation Authority.

### **1.19 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. The Secretary of State can issue new PDC to, and require repayments of, PDC from the Foundation Trust. PDC is recorded at the value received. HM Treasury has determined that, as PDC is issued under legislation rather than under contract, it 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) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1st April 2013, and (iv) 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.

## 1.20 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.

## 1.21 Corporation Tax

The Finance Act 2004 amended Section 519A of the Income and Corporation Taxes Act 1998 to provide power to the Treasury to make certain non-core activities of the Trust, which are not related to, or ancillary to, the provision of healthcare and where profits exceed £50,000 per annum, are potentially subject to corporation tax and should be subject to a review.

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.

## 1.22 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in foreign currency at the Statement of Financial Position date:

- Monetary items (other than financial instruments measured at 'fair value through income and expenditure) are translated at the spot exchange rate on 31 March;
- Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising from the settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

## 1.23 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.

## 1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks.

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

## 1.25 Accounting Standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

IFRS 9 - Financial Instruments: Financial Assets and Financial Liabilities (uncertain)

IFRS 10 - Consolidated Financial Statements (effective from 2014/15\*)

IFRS 11 - Joint Arrangements (effective from 2014/15\*)

IFRS 12 - Disclosure of Interest in Other Entities (effective from 2014/15\*)

IFRS 13 - Fair Value Measurement (effective from 2013/14) but not yet adopted by HM Treasury

IAS 27 - Separate Financial Statements (effective 2014/15\*)

IAS 28 - Associates and Joint Ventures  
(effective 2014/15\*)

IAS 32 – Financial Instruments: Presentation  
– Amendment (effective from 2014/15)

\*This reflects the EU-adopted effective date rather than the effective date in the standard.

The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures. This conforms with the FT ARM 2013/14, which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

### **1.26 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.

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.

### **1.27 Transfers of functions from other NHS Bodies**

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.

The net gain corresponding to the net assets transferred from Sheffield PCT on 1st April 2013 is recognised within the Trust's income and expenditure reserve.

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.

## 2. Operating Segments

The Trust considers that it has 1 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:

	2013/14 £000	2012/13 £000
<b>Income from activities</b>		
Cost & Volume income	3,726	3,046
Block contract income	83,935	83,242
Clinical partnerships providing mandatory services (including Section 31 agreements)	7,551	4,446
Other clinical income from mandatory services	2,637	2,542
<b>Total income from Commissioner-requested services</b>	<b>97,849</b>	<b>93,276</b>
<b>Other operating income</b>		
Research and development	693	570
Education and training	6,446	6,587
Non-patient care services to other bodies	20,243	22,760
Other income	746	712
Profit on disposal of land and buildings	-	313
Profit on disposal of other tangible fixed assets	-	5
Reversal of impairments of property, plant and equipment	-	23
Rental revenue from operating leases	42	34
Income in respect of staff costs	4,011	4,102
	<b>32,181</b>	<b>35,106</b>
<b>Total operating income</b>	<b>130,030</b>	<b>128,382</b>



### 3.2 Private patient income

The Trust has no private patient income. (2012/13 £nil)

### 3.3 Operating lease income

#### Rental income from operating leases:

	2013/14 £000	2012/13 £000
Rents recognised as income in period	42	34

#### Future minimum lease receipts due:

	2013/14 £000	2012/13 £000
<b>Receivable on leases of buildings expiring</b>		
Not later than 1 year	20	14
Later than 1 year and not later than 5 years	17	42
Later than 5 years	-	-
	37	56

### 3.4 Operating income by type comprises

	2013/14 £000	2012/13 £000
<b>Income from activities</b>		
NHS Foundation Trusts	3	16
NHS Trusts	3	-
Clinical Commissioning Groups/Primary Care Trusts	89,363	87,459
Local Authorities	7,554	4,446
Non-NHS: Other	926	1,355
	<u>97,849</u>	<u>93,276</u>
<b>Other operating income</b>		
Research and development	693	570
Education and training	6,446	6,587
Non-patient care services to other bodies	20,243	22,760
Income in respect of staff costs	4,011	4,102
Rental revenue from operating leases	42	34
Other income	746	712
	<u>32,181</u>	<u>34,765</u>
<b>Total operating income</b>	<u>130,030</u>	<u>128,041</u>
Profit on disposal of plant and equipment	-	5
Profit on disposal of land and buildings	-	313
Reversal of impairments of property, plant and equipment	-	23
<b>Total operating income*</b>	<u>130,030</u>	<u>128,382</u>

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

## 4. Operating expenses by type

### 4.1 Operating expenses by type comprise:

	2013/14 £000	2012/13 £000
Services from NHS Foundation Trusts	1,502	1,286
Services from NHS Trusts	64	68
Services from PCTs	-	1,288
Services from CCGs and NHS England	451	-
Services from other NHS bodies	56	-
Purchase of healthcare from non-NHS bodies	4,907	3,307
Employee expenses - Executive Directors	815	805
Employee expenses - Non-Executive Directors	97	97
Employee expenses - Staff	96,514	98,709
Drug costs	1,168	1,200
Supplies and services - clinical (excluding drug costs)	1,515	1,390
Supplies and services - general	1,295	1,176
Establishment	948	1,411
Research and development	16	64
Transport	1,307	1,600
Premises	8,357	4,933
Increase/(decrease) in provision for impairment of receivables	32	-
Change in provisions discount rate(s)	41	-
Inventories written down (net, including inventory drugs)	-	5
Rentals under operating leases	722	774
Depreciation on property, plant and equipment	2,123	2,046
Amortisation on intangible assets	4	3
Impairments of property, plant and equipment	886	195
Audit fees: statutory audit	71	69
Other auditors' remuneration: other services	20	1
Clinical negligence premium	208	233
Losses on disposal of property, plant & equipment	157	-
Legal fees	145	238
Consultancy costs	478	374
Training, courses and conferences	549	468
Patient travel	107	108
Car parking and security	54	92
Redundancy	70	320
Publishing	13	6
Insurance	288	167
Other Services	8	-
Losses, ex gratia and special payments	235	17
Other	762	544
	<b>125,985</b>	<b>122,994</b>

#### Limitation on Auditors liability

There is a £1,000,000 limit on the Trust's Auditors' liability. (2012/13 £1,000,000)

## 4.2 Operating leases

### 4.2.1 Payments recognised as an expense

	2013/14 £000	2012/13 £000
Minimum operating lease payments	<u>722</u>	<u>774</u>

### 4.2.2 Future minimum lease payments due:

	2013/14 £000	2012/13 £000
Payable:		
Not later than 1 year	631	646
Later than 1 year and not later than 5 years	1,077	1,261
Later than 5 years	<u>8,684</u>	<u>9,078</u>
	<u>10,392</u>	<u>10,985</u>

### 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 staff numbers

### 5.1 Employee expenses

	2013/14 £000	2012/13 £000
Salaries and wages	78,181	79,503
Social security costs	5,728	5,854
Employer contributions to NHS pension scheme	8,994	8,903
Employer contributions to Local Authority scheme	350	389
Termination benefits	248	1,603
Agency/contract staff	3,936	3,589
	<b>97,437</b>	99,841
Less costs capitalised	(32)	(7)
<b>Total employee expenses excluding capitalised staff</b>	<b>97,405</b>	99,834

### 5.2 Employee Benefits

There were no employee benefits, other than the benefits of the relevant pension schemes.

### 5.3 Directors' remuneration

	2013/14 £000	2012/13 £000
Fees to Non-Executive Directors	91	91
Executive Directors – Salaries*	662	643
Executive Directors – Benefits (NHS Pension scheme)	65	85
	<b>818</b>	819

Further information about the remuneration of individual Directors and details of their pension arrangements is provided in the Remuneration Report and note 5.4

## 5.4 Executive and Non-Executive Directors' Remuneration

Name and title	Period 1.4.13 to 31.3.14				Period 1.4.12 to 31.3.13			
	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	140-145	-	17	20	135-140	-	16	19
C Clarke, Deputy Chief Executive and Social Care Lead	115-120	-	14	16	100 - 105	-	12	14
M Rodgers, Deputy Chief Executive and Executive Director of Finance	-	-	-	-	95-100	-	12	14
P Robinson, Executive Director of Finance	105-110	-	14	0	-	-	2	3
Dr T Kendall, Executive Medical Director	60-65	125-130	24	21	60 - 65	125 - 130	23	21
E Lightbown, Chief Operating Officer/Chief Nurse	105-110	-	12	15	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 £662,000. 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 £65,000.

## 5.5 Average number of people employed (whole time equivalent basis)

	2013/14 Number	Restated* 2012/13 Number
Medical and dental	155	152
Administration and estates	535	526
Healthcare assistants and other support staff	157	166
Nursing, midwifery and health visiting staff	1,271	1,311
Scientific, therapeutic and technical staff	368	365
Social care staff	106	117
Other	1	-
Bank and agency staff	123	133
	<b>2,716</b>	<b>2,770</b>

\* Staff numbers are restated for agency nursing staff

## 5.6 Early retirements due to ill health

During 2013/14 there were 3 (2012/13 - 4) cases of early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £223,986 (2012/13 - £168,478). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

## 5.7 Staff Exit Packages

The table below summarises the total number of exit packages agreed during 2013/14. Included within these are compulsory 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	
	13/14	12/13	13/14	12/13	13/14	12/13
<£10,000	0	3	5	19	5	22
£10,000 – £25,000	0	2	2	38	2	40
£25,001 – £50,000	0	0	3	8	3	8
£50,001 – £100,000	1	0	0	4	1	4
£100,000 – £150,000	0	2	0	0	0	2
Total number of exit packages	1	7	10	69	11	76
<b>Total resource cost £000s</b>	<b>70</b>	320	<b>178</b>	1,283	<b>248</b>	1,603

## 6. Finance income - interest income

	2013/14 £000	Restated 2012/13 £000
Bank accounts	89	153
Finance income associated with the Local Authority pension scheme*	-	-
<b>Total</b>	<b>89</b>	<b>153</b>

## 7. Finance costs - interest expense

	2013/14 £000	2012/13 £000
Finance costs associated with the Local Authority pension scheme*	19	6

\*The Finance interest income associated with the Local Authority Pension Scheme is presented net as a finance cost in 13/14 in line with IAS19 changes. Refer to Accounting Policies note 1.6

No claims were arising or payments made during 2013/14 under The Late Payment of Commercial Debts (Interest) Act 1998 (year ended 31 March 2013 - £nil).

## 8. Intangible assets

### Computer software

	2013/14 £000	2012/13 £000
Gross cost at 1 April	27	23
Additions	-	4
Disposals	-	-
Gross cost at 31 March	<b>27</b>	<b>27</b>
Amortisation at 1 April	11	8
Provided during the year	4	3
Disposals	-	-
Amortisation at 31 March	<b>15</b>	<b>11</b>
<b>Net book value – closing</b>		
At 31 March	<b>12</b>	<b>16</b>



## 9. Property, plant and equipment

### 9.1 Current year movement

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
<b>2013/14:</b>								
<b>Cost or valuation</b>								
<b>At 1 April 2013</b>	8,669	43,513	2,968	1,128	489	2,165	146	59,078
Transfers by absorption -modified	45	430	-	122	-	169	32	798
Additions purchased	-	-	1,426	-	-	-	-	1,426
Impairments charged to operating expenses	(101)	(467)	(347)	-	-	-	-	(915)
Impairments charged to revaluation reserve	(545)	(2,488)	-	-	-	-	-	(3,033)
Reclassifications	189	3,336	(3,619)	14	-	80	-	-
Revaluations	35	2,233	-	-	-	-	-	2,268
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	(123)	(30)	(168)	(16)	(337)
<b>At 31 March 2014</b>	<b>8,292</b>	<b>46,557</b>	<b>428</b>	<b>1,141</b>	<b>459</b>	<b>2,246</b>	<b>162</b>	<b>59,285</b>
<b>Accumulated depreciation</b>								
At 1 April 2013	-	1,937	-	649	311	1,523	130	4,550
Transfers by absorption - modified	-	95	-	1	-	114	5	215
Provided during year	-	1,728	-	99	57	230	9	2,123
Reversal of impairments	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	-	(29)	-	-	-	-	-	(29)
Impairments charged to revaluation reserve	-	(784)	-	-	-	-	-	(784)
Revaluations	-	(2,462)	-	-	-	-	-	(2,462)
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	(16)	(19)	(138)	(2)	(175)
<b>At 31 March 2014</b>	<b>-</b>	<b>485</b>	<b>-</b>	<b>733</b>	<b>349</b>	<b>1,729</b>	<b>142</b>	<b>3,438</b>
<b>Opening Net book value</b>								
Owned	8,669	41,012	2,968	479	178	641	16	53,963
Donated	-	564	-	-	-	1	-	565
<b>Total at 1 April 2013</b>	<b>8,669</b>	<b>41,576</b>	<b>2,968</b>	<b>479</b>	<b>178</b>	<b>642</b>	<b>16</b>	<b>54,528</b>
<b>Closing Net book value</b>								
Owned	8,292	45,529	428	408	110	517	20	55,304
Donated	-	543	-	-	-	-	-	543
<b>Total at 31 March 2014</b>	<b>8,292</b>	<b>46,072</b>	<b>428</b>	<b>408</b>	<b>110</b>	<b>517</b>	<b>20</b>	<b>55,847</b>

No assets used in the provision of Commissioner-requested services have been disposed of during the year ending 31 March 2014.  
No assets were held under finance leases or hire purchase contracts as at 31 March 2014

## 9.2 Prior Year movements

Prior year	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
<b>2012/13</b>								
<b>Cost or valuation</b>								
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	-	(4,518)	-	-	-	-	-	(4,518)
Reclassified as held for sale	(100)	(230)	-	-	-	-	-	(330)
Disposals	-	-	-	-	(33)	-	(3)	(36)
<b>At 31 March 2013</b>	<b>8,669</b>	<b>43,513</b>	<b>2,968</b>	<b>1,128</b>	<b>489</b>	<b>2,165</b>	<b>146</b>	<b>59,078</b>
<b>Accumulated depreciation</b>								
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 SOCI	-	195	-	-	-	-	-	195
Revaluation surpluses	-	(4,934)	-	-	-	-	-	(4,934)
Reclassified as held for sale	-	(4)	-	-	-	-	-	(4)
Disposals	-	-	-	-	(33)	-	(3)	(36)
<b>At 31 March 2013</b>	<b>-</b>	<b>1,937</b>	<b>-</b>	<b>649</b>	<b>311</b>	<b>1,523</b>	<b>130</b>	<b>4,550</b>
<b>Opening Net book value</b>								
Owned	9,034	43,964	378	415	201	741	26	54,759
Donated	-	583	-	-	-	-	-	583
<b>Total at 1st April 2012</b>	<b>9,034</b>	<b>44,547</b>	<b>378</b>	<b>415</b>	<b>201</b>	<b>741</b>	<b>26</b>	<b>55,342</b>
<b>Closing Net book value</b>								
Owned	8,669	41,012	2,968	479	178	641	16	53,963
Donated	-	564	-	0	-	1	-	565
<b>Total at 31 March 2013</b>	<b>8,669</b>	<b>41,576</b>	<b>2,968</b>	<b>479</b>	<b>178</b>	<b>642</b>	<b>16</b>	<b>54,528</b>

No assets used in the provision of Commissioner-requested services were disposed of during the year ending 31 March 2013

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

### 9.3 Revaluation Reserve Movements

	<b>31 March 2014 £000</b>	31 March 2013 £000
<b>Relating to Property, Plant and Equipment</b>		
As at 1 April	<b>17,191</b>	18,523
Transfers by Absorption	<b>132</b>	-
Impairment losses	<b>(2,249)</b>	(1,587)
Revaluation gains	<b>4,730</b>	416
Transfers to other reserves	-	13
Asset disposals	-	(174)
<b>As at 31 March</b>	<b>19,804</b>	17,191

### 9.4 Contractual capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements are:

	<b>31 March 2014 £000</b>	31 March 2013 £000
Property, plant and equipment*	-	477

\*The Trust's Intensive Support Service development was completed in 2013/14 and there are no further capital commitments.

## 10. Investment property

### 10.1 Investment Property - Carrying Value

	<b>31 March 2014 £000</b>	31 March 2013 £000
As at 1 April	<b>180</b>	200
Acquisitions in year	-	-
Impairments recognised in expenses	-	(20)
Revaluation gains	<b>20</b>	-
<b>As at 31 March</b>	<b>200</b>	180

## 10.2 Investment property expenses

	2013/14 £000	2012/13 £000
Direct operating expense arising from investment property generating rental income in the year	<u>10</u>	<u>10</u>

## 10.3 Investment property income

	2013/14 £000	2012/13 £000
Investment property income	<u>42</u>	<u>34</u>

## 11. Trade and other receivables

### 11.1 Trade and other receivables

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
NHS receivables	2,241	1,645	-	-
Receivables due from NHS charities	-	3	-	-
Other receivables with related parties	196	878	2,837	3,403
Provision for impaired receivables	(41)	(18)	-	-
Prepayments	457	431	351	348
Accrued income	1,124	24	-	-
Interest Receivable	6	8	-	-
PDC receivable	-	66	-	-
VAT receivable	181	144	-	-
Other receivables	300	284	-	-
	<u>4,464</u>	<u>3,465</u>	<u>3,188</u>	<u>3,751</u>

The majority of trading is with Clinical Commissioning Groups, as Commissioners for NHS patient care services. As Clinical Commissioning Groups 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.

## 11.2 Provision for impairment of receivables

	<b>31 March 2014 £000</b>	31 March 2013 £000
<b>As at 1 April</b>	<b>18</b>	18
Increase in provision	<b>41</b>	-
Amounts utilised	<b>(9)</b>	-
Unused amounts reversed	<b>(9)</b>	-
<b>At 31 March</b>	<b>41</b>	18

## 11.3 Ageing of impaired receivables

	<b>31 March 2014 £000</b>	31 March 2013 £000
By 0 - 30 days (within term)	-	-
By 30 - 60 days	<b>2</b>	-
By 60 - 90 days	-	2
By 90 - 180 days	<b>1</b>	3
Over 180 days	<b>38</b>	13
<b>Total</b>	<b>41</b>	18

## 11.4 Receivables past their due date but not impaired

	<b>31 March 2014 £000</b>	31 March 2013 £000
By 0 - 30 days	<b>746</b>	359
By 30 - 60 days	<b>202</b>	223
By 60 - 90 days	<b>126</b>	51
By 90 - 180 days	<b>171</b>	53
Over 180 days	<b>116</b>	186
<b>Total</b>	<b>1,361</b>	872

## 12. Inventories

### 12.1 Inventories analysis

	<b>31 March 2014 £000</b>	31 March 2013 £000
Drugs	<b>68</b>	72
Consumables	<b>22</b>	34
<b>Total inventories</b>	<b>90</b>	106

### 12.2 Inventories recognised in expenses

	<b>2013/14 £000</b>	2012/13 £000
Inventories recognised as an expense in the period*	<b>1,925</b>	1,862
Write-down of inventories (including losses)	<b>8</b>	5
	<b>1,933</b>	1,867

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

## 13. Cash and cash equivalents

	<b>31 March 2014 £000</b>	31 March 2013 £000
<b>At 1 April</b>	<b>22,731</b>	17,028
Net change in year	<b>4,942</b>	5,703
<b>At 31 March</b>	<b>27,673</b>	22,731
<b>Broken down into:</b>		
Cash at commercial banks and in hand	<b>253</b>	181
Cash with the Government Banking Service	<b>27,420</b>	22,447
Other current investments	-	103
<b>Cash and cash equivalents as in Statement of Financial Position</b>	<b>27,673</b>	22,731

## 14. Non-current assets held for sale

<b>Current year: 2013/14</b>			
	Property, plant and equipment £000	Other assets £000	Total £000
<b>As at 1 April 2013</b>	-	-	-
Assets classified as available for sale in the year	-	-	-
Assets sold in year	-	-	-
Impairment of assets held for sale	-	-	-
<b>As at 31 March 2014</b>	-	-	-
<b>Prior year: 2012/13</b>			
	Property, plant and equipment £000	Other assets £000	Total £000
<b>As at 1 April 2012</b>	-	-	-
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	-	-	-
<b>As at 31 March 2013</b>	-	-	-

At 31 March 2014 there were no properties declared surplus to operational requirements.

## 15. Trade and other payables

	<b>Current</b>	
	<b>31 March 2014 £000</b>	31 March 2013 £000
NHS payables	144	33
Amounts due to other related parties	1,415	1,160
Trade payables – capital	114	212
Other trade payables	1,919	931
Social security costs	1,771	1,868
Accruals	3,952	3,440
PDC Dividend Payable	48	-
<b>Total</b>	<b>9,363</b>	<b>7,644</b>

## 16. Provisions

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Legal claims	130	81	-	-
Redundancy	518	926	-	-
Injury Benefits	50	49	700	680
Other	217	75	-	-
<b>Total</b>	<b>915</b>	<b>1,131</b>	<b>700</b>	<b>680</b>

### 16.1 Movement in Provisions

	Legal claims £000	Redundancy £000	Injury Benefits £000	Other £000	Total £000
<b>At 1 April 2013</b>	81	926	729	75	<b>1,811</b>
Arising during the year	260	166	16	217	<b>659</b>
Utilised during the year	(62)	(256)	(49)	-	<b>(367)</b>
Unwinding of discount	-	-	14	-	<b>14</b>
Change in discount rate	-	-	40	-	<b>40</b>
Reversed unused	(149)	(318)	-	(75)	<b>(542)</b>
<b>At 31 March 2014</b>	<b>130</b>	<b>518</b>	<b>750</b>	<b>217</b>	<b>1,615</b>
<b>Expected timing of cash flows:</b>					
Not later than 1 year	130	518	50	217	<b>915</b>
Later than 1 year and not later than 5 years	-	-	190	-	<b>190</b>
Later than 5 years	-	-	510	-	<b>510</b>
	<b>130</b>	<b>518</b>	<b>750</b>	<b>217</b>	<b>1,615</b>

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. The eventual settlement costs and legal costs may be higher or lower than provided. Costs in excess of £10,000 per case are covered by the NHSLA and are not included above.

A provision of £750,000 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 2013 - £729,000).



£2,561,898 is included in the provisions of the NHS Litigation Authority at 31 March 2014 in respect of clinical negligence liabilities of Sheffield Health and Social Care NHS Foundation Trust (31 March 2013 - £3,585,000).

## 17. Other liabilities

	Current		Non-current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Deferred Income	56	216	-	-
Net Pension Scheme Liability	-	-	3,223	3,867
	<b>56</b>	216	<b>3,223</b>	3,867

## 18. Prudential Borrowing Limit

The Prudential Borrowing Limit disclosures are no longer required as the Prudential Borrowing Code was repealed by the Health and Social Care Act 2012.

## 19. Contingent liabilities

	31 March 2014 £000	31 March 2013 £000
Legal claims	(41)	(66)
Redundancy	-	(412)
	<b>(41)</b>	(478)

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 Clinical Commissioning Groups and the way those Clinical Commissioning Groups 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.

### 20.1 Financial assets

	<b>31 March 2014 £000</b>	31 March 2013 £000
Denominated in £ Sterling - Floating interest rate*	<b>27,605</b>	22,664
<i>*This excludes cash in hand of £68,000 (2012/13 £67,000)</i>		

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.

### 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 2014 are in receivables from customers, as disclosed in the receivables note.

### Liquidity risk

The Trust's net operating costs are incurred under contract with Clinical Commissioning Groups, Local Authorities, and other government bodies which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from funds from cash reserves or loans. The Trust is therefore not exposed to significant liquidity risks.

## 20.2 Financial assets by category

	<b>31 March 2014 £000</b>	31 March 2013 £000
<b>Loans and Receivables</b>		
NHS receivables and accruals	<b>2,841</b>	1,666
Other receivables with related parties	<b>3,032</b>	4,284
Provision for irrecoverable debts	<b>(41)</b>	(18)
Other accrued income	<b>530</b>	11
Other receivables	<b>300</b>	247
Cash at bank and in hand	<b>27,673</b>	22,731
<b>Total at 31 March</b>	<b>34,335</b>	28,921

## 20.3 Financial liabilities

The Trust has no financial liabilities with floating or fixed rates of interest. They are all non interest bearing.

## 20.4 Financial liabilities by category

	<b>31 March 2014 £000</b>	31 March 2013 £000
<b>Other financial liabilities</b>		
NHS payables and accruals	<b>816</b>	33
Other payables with related parties	<b>1,415</b>	1,160
Trade payables - capital	<b>114</b>	212
Other trade payables	<b>1,919</b>	921
Other Accruals	<b>3,280</b>	3,450
<b>Total at 31 March</b>	<b>7,544</b>	5,776

## 20.5 Fair values of financial assets and liabilities at 31 March 2014

The fair value of the Trust's financial assets and financial liabilities at 31 March 2014 equates to the book value.

## 21. Third Party Assets

The Trust held cash of £3,116,000 at bank and in hand at 31 March 2014 (31 March 2013 - £4,342,736) 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

The number of cases has reduced as a result of changes in the guidance concerning the aggregation of instances of the same debtor or type of loss.

There were no individual losses or special payment cases exceeding £250,000.

Losses and Special Payments shown below are reported on an accruals basis and exclude provisions for future losses.

### 22.1 Losses by Category

	31 March 2014		31 March 2013	
	Number	£000	Number	£000
Cash losses	-	-	4	1
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	4	4	14	10
Stores losses	4	15	35	5
<b>Total as of 31 March</b>	<b>8</b>	<b>19</b>	<b>53</b>	<b>15</b>

### 22.2 Special Payments by Category

	31 March 2014		31 March 2013	
	Number	£000	Number	£000
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	28	33
Special severance payments	-	-	-	-
Ex gratia payments	25	14	16	2
	<b>25</b>	<b>14</b>	<b>44</b>	<b>35</b>

## 23. Events after the reporting period

There have been no significant events after the reporting period date.

## 24. Related party transactions

Sheffield Health and Social Care NHS Foundation Trust is a corporate body 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:

	<b>Payments to Related Party £000</b>	<b>Receipts from Related Party £000</b>	<b>Amounts owed to Related Party £000</b>	<b>Amounts due from Related Party £000</b>
Sheffield Teaching Hospitals NHS FT	1,792	3,685	279	716
University of Sheffield	692	185	204	25
Royal College of Psychiatrists	21	94	-	-
Turning Point	210	-	37	-
Sheffield City Council	1,611	13,355	279	3,082
Age UK Sheffield	-	1	-	-
University College of London	-	2	-	-

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 and visiting Professor at University College London;
- The Chair is Professor of Social Policy at the University of Sheffield and Vice-President at Age UK;
- 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:

	2013/14		2012/13	
	Income £000	Expenditure £000	Income £000	Expenditure £000
Department of Health	329	-	123	-
Other NHS bodies	105,686	4,321	105,010	3,664
Other bodies (including WGA)	13,547	16,190	12,028	16,662
	<b>119,562</b>	<b>20,511</b>	117,161	20,326

The value of transactions with Board members and key staff members in 2013/14 is £nil (2012/13 £nil). Details of Directors' remuneration and pensions can be found in the Remuneration Report. Disclosures relating to salaries of Board members are given in note 5.4 and details of exit packages in note 5.7. 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 2014		31 March 2013	
	Receivables £000	Payables £000	Receivables £000	Payables £000
Department of Health	19	48	66	-
Other NHS bodies	2,821	784	1,666	644
Other bodies (including WGA)	3,359	3,270	4,456	3,285
	<b>6,199</b>	<b>4,102</b>	6,188	3,929

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2014 is £6,801 (31 March 2013 £9,223).

The Department of Health (“the Department”) 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:

- South Yorkshire and Bassetlaw Area Team of the National Commissioning Board;
- Health Education England;
- Sheffield CCG;
- Barnsley CCG;
- North Derbyshire CCG;
- Rotherham CCG;
- Derbyshire Healthcare NHS Foundation Trust;
- Nottinghamshire Healthcare NHS Trust;
- Rotherham Doncaster and South Humber NHS Foundation Trust;
- Sheffield Children’s NHS Foundation Trust;
- Sheffield Teaching Hospitals NHS Foundation Trust;
- Leeds Partnership NHS Foundation Trust;
- NHS Litigation Authority;
- NHS Business Services Authority.

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. Most of these transactions have been with HM Revenue and Customs (including National Insurance Funds), the NHS Pension Scheme as well as with Sheffield City Council in respect of joint enterprises and the South Yorkshire Pension Scheme.

## 25. South Yorkshire Pensions Fund - Retirement Benefit Obligations

The total defined benefit pension loss for 2013/14 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £577,000 (the year ended 31 March 2013 a loss of £420,000). A pension deficit of £3,223,000 is included in the Statement of Financial Position as at 31 March 2014 (31 March 2013 - £3,867,000 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 2014, the deficit on the scheme was £3,223,000 (31 March 2013 - £3,867,000 deficit), the majority of which is offset by a non-current receivable of £2,836,000 (31 March 2013 - £3,402,960).

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.

Pension increases or revaluations for public sector schemes are based on the Consumer Prices Index (“CPI”) 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:

	<b>31 March 2014 %</b>	31 March 2013 %
Rate of inflation	<b>2.4</b>	2.4
Rate of increase in salaries	<b>4.15</b>	4.15
Rate of increase in pensions and deferred pensions	<b>2.4</b>	2.4
Discount rate	<b>4.5</b>	4.2

The current life expectancies at age 65 underlying the accrued liabilities for the scheme are:

	<b>31 March 2014 Years</b>	31 March 2013 Years
Non retired member – Male (aged 65 in 20 years time)	<b>25.2</b>	23.7
Non retired member – Female (aged 65 in 20 years time)	<b>28.3</b>	26.6
Retired member – Male	<b>22.9</b>	21.8
Retired member – Female	<b>25.5</b>	24.7

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	<b>Scheme assets %</b>	<b>31 March 2014 £000</b>	Scheme assets %	31 March 2013 £000
Equities	<b>61.7</b>	<b>9,100</b>	61.4	8,405
Government Bonds	<b>10.4</b>	<b>1,534</b>	11.1	1,520
Other Bonds	<b>9.3</b>	<b>1,364</b>	10.2	1,396
Property	<b>9.8</b>	<b>1,447</b>	9.3	1,273
Cash/Liquidity/Other	<b>8.8</b>	<b>1,294</b>	8.0	1,096
Total fair value of assets	<b>100.0</b>	<b>14,739</b>	100.0	13,690
Present value of defined benefit obligation		<b>(17,962)</b>		(17,557)
<b>Net retirement benefit deficit</b>		<b>(3,223)</b>		(3,867)



Updates to IAS19 mean that rather than recognising the expected gain during the year from scheme assets in finance income and the interest cost during the year arising from the unwinding of the discount on the scheme liabilities recognised in finance costs; we now present the net interest cost during the year within finance costs. Actuarial gains and losses are not presented; rather the Re-measurements of the defined benefit plan are disclosed and recognised in the income and expenditure reserve. To provide comparative data last years figures are restated and presented under new IAS19 guidance.

Movements in the present value of the defined benefit obligations are:

	<b>2013/2014 £000</b>	Restated 2012/2013 £000
At 1 April	<b>17,557</b>	14,828
Current service cost	<b>414</b>	381
Interest on pension liabilities	<b>734</b>	714
Member contributions	<b>114</b>	126
Actuarial (losses)/gains on liabilities	<b>(517)</b>	2,146
Benefits paid	<b>(340)</b>	(638)
<b>At 31 March</b>	<b><u>17,962</u></b>	<u>17,557</u>

Movements in the fair value of the scheme's assets were:

	<b>2013/2014 £000</b>	Restated 2012/2013 £000
At 1 April	<b>(13,690)</b>	(12,114)
Interest on plan assets	<b>(578)</b>	(591)
Remeasurements (assets)	<b>(354)</b>	(1,116)
Administration expenses	<b>7</b>	8
Employer contributions	<b>(350)</b>	(389)
Member contributions	<b>(114)</b>	(126)
Benefits paid	<b>340</b>	638
<b>At 31 March</b>	<b><u>(14,739)</u></b>	<u>(13,690)</u>

The net pension expense recognised in operating expenses in respect of the scheme is:

	Year Ended 31 March 2014 £000	Restated 31 March 2013 £000
Current service cost	<b>(414)</b>	(381)
<b>Pension expense to operating surplus</b>	<b>(414)</b>	(381)
Expected return on plan assets	n/a	n/a
Interest on pension liabilities	n/a	n/a
Net interest cost	<b>(156)</b>	(123)
Administration expenses	<b>(7)</b>	(8)
<b>Pension expense</b>	<b>(163)</b>	(131)
<b>Net pension charge</b>	<b>(577)</b>	(512)

The reconciliation of the opening and closing statement of financial position is as follows:

	2013/2014 £000	Restated 2012/2013 £000
At 1 April	<b>(3,867)</b>	(2,714)
Expenses recognised	<b>(577)</b>	(512)
Remeasurements (liabilities and assets)	<b>871</b>	(1,030)
Contributions paid	<b>350</b>	389
<b>At 31 March</b>	<b>(3,223)</b>	(3,867)

Remeasurement 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 2014, a cumulative amount of £352,000 was recorded in the Income and Expenditure Reserve (31 March 2013 £463,000).

The history of the scheme for the current and prior year is:

	<b>2013/2014</b> <b>£000</b>	2012/2013 £000
Present value of defined benefit obligation	<b>17,692</b>	17,557
Fair value of scheme assets	<b>(14,739)</b>	(13,690)
<b>Net retirement obligation</b>	<b><u>3,223</u></b>	<u>3,867</u>

Experience losses on scheme liabilities in remeasurement for 2013/14 are £875,000 (2012/13 are £nil) and experience gains on scheme assets are £nil (year ended 31 March 2013- £1,699).

# SECTION 14.0

## Glossary

# 14.0

### **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 Foundation Trust 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.

### **Continuity of Service (COS) Risk Rating**

The new approach replacing the previous financial Risk Rating. Previously a basket of 5 financial metrics were used: EBITDA(%), % Plan delivered, I&E Margin (%), Net return of the financing (%) and liquidity (days). The new COS rating incorporates 2

metrics, namely liquidity (days) and capital service capacity ratio (time) which monitor the financial stability of the Trust.

### **CQC**

Care Quality Commission. The independent regulator of all health and social care services in England.

### **CQUINs**

Commissioning for Quality and Innovation payments framework were set up in 2009/10 to encourage care providers to continually improve how care is delivered.

### **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.

### **EBITDA**

Earnings Before Interest, Tax Depreciation and Amortisation – this is an 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.

### **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 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 is the sector regulator for health services in England.

**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).

**NICE**

National Institute for Health and Care Excellence. NICE provide independent, evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

**NIHR**

National Institute for Health Research. The NIHR is a large, multi-faceted and nationally distributed organisation, funded through the Department of Health to improve the health and wealth of the nation through research.

**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 1 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.

**NPSA**

National Patient Safety Agency. Their key functions transferred to the NHS Commissioning Board Specialist Health Authority in June 2012.

**Payment by Result/Payment by Outcomes**

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.

**POMH**

The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice.

**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 annual amount paid to the Government for funds made available to the Trust.

**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.

**Right First Time**

A Sheffield programme formed to achieve a vision of working in partnership across Health and Social Care to transform services and deliver better outcomes for people.

**Risk Assessment Framework (RAF)**

From 1st October 2013 the RAF replaces the compliance framework previously used by Monitor to regulate Foundation Trusts. The new RAF generates 2 risk ratings, the Continuity of Service (COS) rating and the NHS Foundation Trust governance rating.

**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.

# SECTION 15.0

## Contacts

# 15.0

### **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](http://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 website ([www.shsc.nhs.uk](http://www.shsc.nhs.uk)) and click on 'Working for the Trust'.

### **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](mailto: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 2718825.

### **Contacting members of the Council of Governors**

The Governors can be contacted by emailing [governors@shsc.nhs.uk](mailto:governors@shsc.nhs.uk) or by phoning 0114 2718825.



**Sheffield Health and Social Care** 

NHS Foundation Trust

Sheffield Health and Social Care NHS Foundation Trust  
Fulwood House  
Old Fulwood Road  
Sheffield S10 3TH

PRINTER TO PLACE  
FSC LOGO TO BE  
POSITIONED HERE