Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

2014/2015

Annual Report and Accounts

Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 2014/15

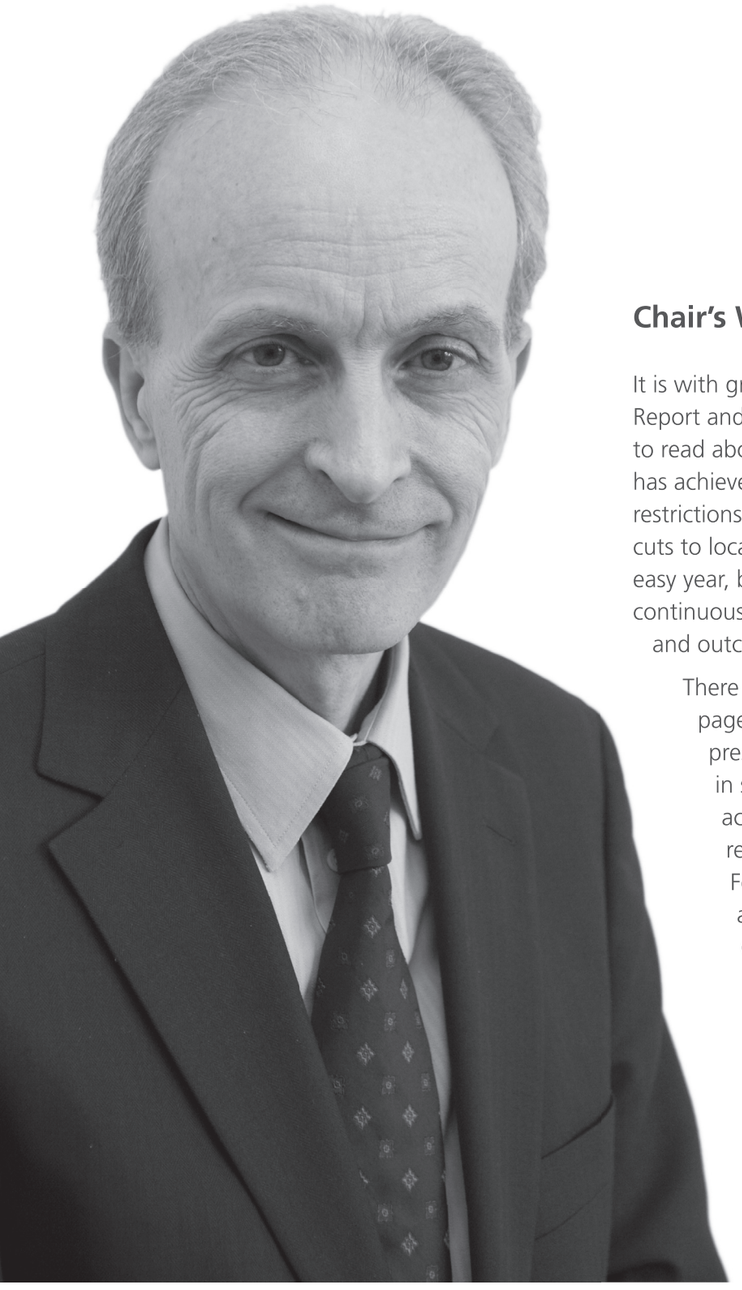
Presented to Parliament pursuant to Schedule 7, paragraph 25 (4)(a) of the National Health Service Act 2006

Contents

The front cover and art design of this report is inspired by the Recovery Tree tapestry created by the Trust's Sukoon Group which was established on acute adult mental health in-patient wards at the Longley Centre with the aim of encouraging black and ethnic minority service users to engage with therapeutic interventions on the ward. The Recovery Tree project was developed to explore different aspects of recovery and what it means to each service user.

Section 1

Introduction



Chair's Welcome

It is with great pleasure that I introduce this Annual Report and Accounts for 2014/15 and invite you to read about the Trust's objectives and what it has achieved over the past year. Due primarily to restrictions on NHS finances and the very heavy cuts to local authority budgets, it has not been an easy year, but our staff have worked hard to deliver continuous improvements in service user experience and outcomes.

There is plenty of evidence in the following pages to show that, despite the external pressure, the Trust has performed well and in some cases very well or exceptionally according to the criteria set by the NHS regulators. For example, the independent Foundation Trust regulator Monitor awarded a financial risk rating of green (the highest). Of particular importance are the many positive assessments made by service users themselves about the care and treatment they receive in many of our services. We are not complacent though: as I have written in every Annual Report and said at every Annual Members Meeting since becoming Chair, service quality improvement is a never-ending process, which means that advances in service user experience and in the positive outcomes of care are fundamental objectives every year.

During October 2014 the Care Quality Commission undertook a planned inspection of a range of our services. As of 31 March 2015 we have not yet received all the draft reports for the services inspected. Once these are received, we will review the findings with our Commissioners and Healthwatch and ensure any appropriate action is taken.

Some of the key service highlights in 2014/15 include:

- Building work began on the new Psychiatric Intensive Care Unit (due to open in the autumn);
- Establishment of the Community Enhancing Recovery Team (CERT) which among other things brings people back home from out of city placements and supports them to reintegrate in their communities and to learn new skills for independent living;
- Achievement of a remarkable turnaround in the use of acute in-patient beds so that bed occupancy levels have been brought down from over 100% to around 85%. This has been achieved by various improvement projects and investment in new community services. This is not only better for those requiring in-patient care but also means a significant reduction in the need to send people out of Sheffield for hospital care because of a lack of beds;
- The Trust bid successfully for Sheffield's non-opiate and opiate contracts, making us the sole NHS provider of drug and alcohol treatment in the city;
- The Practice Champions project between the Clover Group and Darnall Wellbeing has proved to be hugely successful in reducing unnecessary hospital admissions and building healthier and more empowered communities. This has led to further funding and joint working with Sheffield City Council to introduce a full enhanced primary care service over the next 12-18 months;
- The Longley Meadows respite unit has been refurbished, improving facilities and the environment and installing wireless internet facilities;

- The Learning Disability Service celebrated the 40th anniversary of the Case Register, which pioneered the collection of detailed information about everyone with a learning disability in the city. The Case Register's data on changes in life expectancy and morbidity among people with learning disabilities not only provides vital information to service Commissioners and providers in Sheffield, but also contributes to national strategic planning and research. Sheffield is one of only 2 cities in the country to maintain such a register and the Trust is proud to support it;
- We adopted the national living wage for directly employed staff, the only Trust in the city to do so.

There are many more new developments described later in this report. It is important to note that some of those service improvements, such as CERT, would not have been possible without the surplus we generate as a Foundation Trust. There were also some great disappointments in 2014/15 and, none more so, than the loss of the supported living learning disability contracts for Handsworth, Cottam Road and East Bank Road. Under Sheffield City Council's new contract culture there are likely to be further threats to Trust services in the coming year.

Our staff have continued to win prestigious awards. These include Mark Thorpe and Kim Parker, who won the 'Making a Difference' prize and the 'Reducing Stigma' one in the National Positive Practice in Mental Health Awards. Kim was also awarded the Barbara Burford Memorial Prize at the Annual Making Diversity Interventions Count Conference. Also the Health Service Journal named us as one of the top 100 places to work in the NHS.

The Trust's Council of Governors plays a vital role in the governance of the organisation and its support is highly valued. In 2014/15 we welcomed 6 new Governors: Angela Barney, Dani Hydes, Dean Chambers, Dr Debjani Chatterjee MBE, Sarah Burke and Toby Morgan, and welcomed back 1, Jules Jones, who was re-elected. The membership of the Trust in 2014/15 was maintained at 12,615 (excluding staff members). Two highly successful members events were held in the year – one focusing on nutrition and the other on anxiety and depression.

The record for 2014/15 shows many important improvements in services but, as noted above, achieving our aspiration to be the first choice for service users, carers and Commissioners is getting more and more difficult in the face of cuts to NHS funding and draconian cuts to local authority budgets. At the same time, due to demographic changes and the economic recession, the need for our services is increasing all the time. 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. We are 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.

As I write this introduction we are in the middle of a General Election campaign, the outcome of which is impossible to predict. None of the main political parties are promising the huge injection of money needed by the NHS and justified by the UK's relatively low spending on health services compared to other countries, which means that we will increasingly have to rely on generating more of our own resources. I am confident that we will be able to achieve this and continue to improve service quality despite resource restrictions. 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. 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 our 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.

So, let's look forward to next year with some confidence, regardless of what happens nationally. We have been successful because of the hard work and dedication of our staff and the support of our key stakeholders, especially service users and carers. There is a unique spirit that binds us together in the NHS and, although it is often severely tested, it survives and is passed from generation to generation of staff. Long may it continue!

Professor Alan Walker CBE
Chair

We introduced PARO Seal (an interactive robot with tactile sensors) on our dementia ward, G1.

We celebrated our annual Staff Awards for Excellence at our Annual Members meeting. Two of our staff also won individual awards in the national Positive Practice in Mental Health Awards.

We introduced the Living Wage for all directly employed staff on substantive or temporary contracts.

We successfully piloted 'enhancing primary care' through our GP services in partnership with Darnall Well-being, providing targeted support to patients identified as being at risk of needing hospital care and effectively reducing hospital admissions.

We refurbished the facilities at Longley Meadows which provides respite for people with a learning disability and complex needs.

We launched the Community Enhanced Recovery Team (CERT) who provide intensive support to bring people back from out of city placements in hospital to return to live independently in Sheffield.

On World Mental Health Day we broke ground on our new Psychiatric Intensive Care Unit – due to open Autumn 2015.

We became the sole provider in the city for drug and alcohol services and aim to provide a seamless, cohesive service for people affected by alcohol or drug problems.

At a glance the highlights of the year

Section 2

Strategic Report

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.

2.1 Our Trust

We provide mental health, learning disability, specialist and primary care services for the people of Sheffield. We also provide some services on a wider regional, or national basis.

We serve a population of over 500,000, across a geography of over 368 square kilometers with around 3,000 staff. Our turnover will be around £131,824,000 million.

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).

We are a membership-based organisation and our Board of Directors is directly accountable to the communities we serve through our Council of Governors and our members.

Our Council of Governors consists of people who use our services, their carers, representatives of members of the general public and our staff in addition to appointed Governors from our partner organisation (for example, NHS Sheffield Clinical Commissioning Group, Sheffield African and Caribbean Mental Health Association (SACHMA), MENCAP Sheffield). The diversity of our Council's membership ensures that our services are shaped by the people who live in the communities we serve.

As a Foundation Trust we have certain freedoms to develop and improve services and offer more choice to service users. Being a Foundation Trust enables us to:

- Build on and improve positive relationships with service users, carers, staff, partners and local communities while being more accountable to the communities we serve;
- Strengthen our internal processes and systems to meet the challenges of modern health services;
- Develop locally based specialist services (such as the Sheffield Adult Autism and Neurodevelopment Service);
- Continue to invest in capital development (such as our new Psychiatric Intensive Care Unit).

Our core values form the guiding principles and behaviours for the way we do our work:

Respect – We listen to others, valuing their views and contributions. We treat others as we would like to be treated, with dignity and consideration and challenge others when they do not. We are polite, courteous and non-judgemental, we are aware that how we behave can affect others and appreciate and recognise others' qualities and contributions;

Compassion – We show empathy and kindness to others so they feel supported, understood and safe. We engage with others in a warm, approachable manner, give the time and attention to others that they need, are sensitive to the needs of others and listen so as to understand others' points of view;

Partnership – We engage with others on the basis of equality and collaboration. We work to build trust, we work flexibly with others to identify and achieve the best outcomes, we value and acknowledge the contribution made by others and we share our knowledge, skills and offer practical support to others;

Accountability – We are open and transparent, acting with honesty and integrity, accepting responsibility for outcomes. We do what we say we are going to do, we encourage staff and service users to speak up if they think something is not right, we admit when we make mistakes and we accept and respond to constructive challenge and feedback from others;

Fairness – We ensure equal access to opportunity, support and services. We ensure our services are accessible for everyone, we appreciate people's differences and pay attention to meeting different needs, we actively try to help others to get what they need and we consult with and include others in decisions which affect them;

Ambition – We will make a difference and help to fulfil the aspirations and hopes of our service users and staff. We do this by encouraging staff to look for ways to continuously improve services, we work collaboratively with others to achieve excellence, we support service users and colleagues to achieve their potential and we share and celebrate achievements and successes.

Our vision is for Sheffield Health & 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 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.

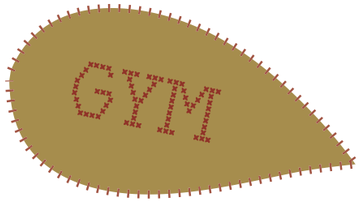
For more information visit our website: **www.shsc.nhs.uk**

Our services

With an annual income of approximately £131,824,000 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 3 years the Trust has grown by 7.6% with an extra income of £9.350 million as we have developed the way we provide mental health and substance misuse services.

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, assertive outreach services for homeless people and members of



the traveller community, perinatal mental health services, and gender dysphoria services;

- Services for adults with drug and alcohol misuse problems;
- Primary care services for people of all ages delivered 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 to help them to maintain their independence and continue 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 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 staff. Others attend our clinics to see nurses, social workers, therapists or doctors. We give treatment, care and help 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.

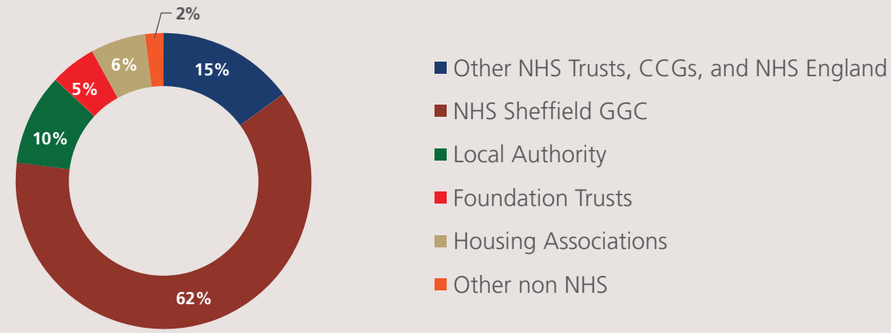
Our Commissioners

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

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

NHS England and CCGs commission education, training, research and development from us.

Total income by Commissioner



2.2 Our Strategy and Business Model

We have a 5 year strategy which aligns our aspirations through 5 strategic aims, 6 values and 1 vision. This reflects our ambition to be the first choice for service users, their families and Commissioners. Our strategic aims are:

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.

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 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 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.

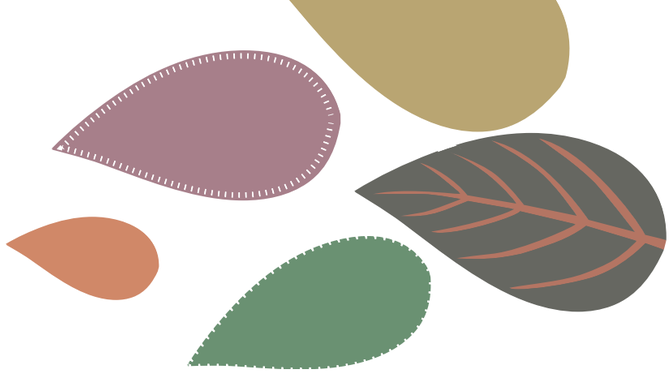
We recognise our shared humanity. The quality of our relationships and the way we treat each other matter, to both service users and staff. We recognise the importance of maintaining a compassionate workforce and of treating our staff and each other with the same respect and support with which we expect our staff to treat service users and their families. This requires leadership and leaders who recognise, understand and take a stand for humanity in healthcare and 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 CCG and Sheffield City Council. This allows us to understand the health and social care needs in the wider population, to influence the commissioning approach taken and to develop new services for the benefit of the 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.

The focus of our plans is to ensure we deliver our strategic aims and sustainable services and to support this we have developed:

- A quality improvement programme to ensure we continue to improve the quality and efficiency of our services in terms of safety, outcomes and experience;
- A service transformation programme that focuses on early intervention, delivering services in liaison and partnership with primary care and exploring investment in new community services to reduce the need for hospital-based care, particularly out of city care for people with a learning disability or serious or enduring mental health need;
- A programme to enhance our primary care services, exploring and developing new partnerships with other GP Practices to deliver effective primary care and support which will result in reduced health inequalities over the longer term;
- New models and partnerships to ensure the delivery of high quality and cost effective social care support for the people of Sheffield.



Next year

There is a strong determination within Sheffield to change the way services are provided. Together with our partners we are adopting citywide approaches to developing solutions for the future needs of our local population. NHS Sheffield CCG and Sheffield City Council are committed to the delivery of integrated community care which reduces the need for hospital care, which is led by primary care and which is focused on prevention and re-ablement.

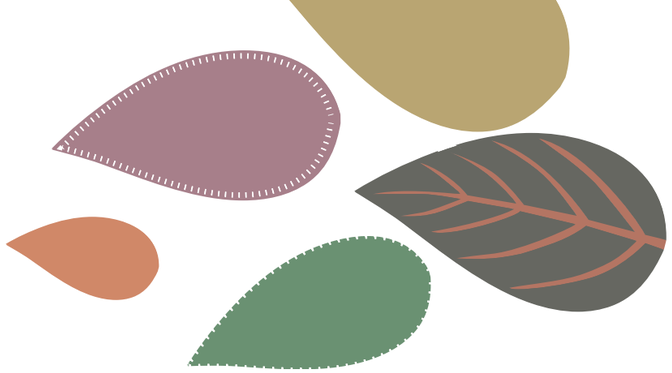
Together we are exploring how best to deliver community-based support to improve the health and wellbeing of our local population. The current direction of travel is outlined in a range of commissioning strategies and plans.

In Sheffield we have a history of working in partnership with Commissioners and providers of health and social care services to develop services in a co-ordinated manner. This partnership has been strengthened with the development and growing involvement of GP organisations and third sector representation. While much change is needed to transform services in Sheffield, the approach will continue to be delivered on a whole system basis which supports an incremental approach to the necessary developments and change required.

These changes within Sheffield will impact on our stability and how we provide services in the future. The move to integrated commissioning will see a change in our commissioning arrangements. We will continue to work with the joint Commissioners to ensure the developing strategies for the Trust's services are progressed during the period of change. 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 citywide health and social care economy.

The financial environment continues to be challenging and we will experience significant challenges delivering our services in the current financial environment. However, our assessments indicate that there are no significant changes expected in service activities that will result in increased risks to our income and expenditure profile. We continue to have a strong financial position which will continue to support our plans to deliver the required efficiencies over the medium term. The focus of our cost improvement programme aims to deliver efficiencies at the system wide level by taking on broader responsibilities for care pathways and delivering changes, a continued re-design and modernisation programme for our existing services and an efficiency programme focused on improving productivity and processes.

Currently competition within the local economy for our health services is stable and we perform well in our service delivery. We have performed well in reducing Commissioner expenditure with the private sector for hospital-based care and in growing our income base at the same time. Some of our services operate in a more competitive landscape. As the way social care services are provided changes, our provider 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 continue to have a higher impact on some of our services, particularly those we provide for people with a learning disability.



Through our joint work with our Commissioners we are well placed to identify new models of service delivery which provide improved outcomes for service users at reduced cost. Our joint service development approach ensures we have stability over the short term as we continue to develop plans for the longer term. We have an evolving 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 focused on delivering quick access to short-to-medium term packages of recovery-oriented support and treatment. Our aim 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 our income and operating stability. Some services are vulnerable to procurement changes and we have identified plans to mitigate against any adverse risk 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.

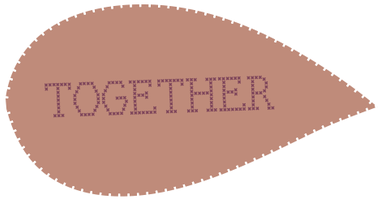
Our plans for the next year have been published and are available here:
www.shsc.nhs.uk/about-us/publications

2.3 A review of the last year

2.3.1 Progress against our plans and key service changes

Detailed information regarding the range and scope of the changes we have introduced to improve and develop our services is outlined in our Quality Report in **Section 9** *(page 96)*. Overall, the more significant changes that have been made to our services are summarised as follows:

- We have extended the range of substance misuse services we provide for the people of Sheffield. We were awarded new contracts to provide opiate and non-opiate services. The award of these contracts means we are now expanding the drug and harm reduction services that we previously provided and alongside the alcohol services that we also offer, we are now able to offer truly integrated support for people seeking to address their drug or alcohol use as part of their journey towards sustained recovery. This has resulted in the transfer of services previously provided by other NHS and third sector providers and increased the Trust's income by £903,700 this year (the increase will be £1,633,900 in 2015/16). We are extremely pleased to have secured this additional business and we are looking forward to providing seamless services to people in Sheffield who experience problems as a result of their drug or alcohol use;
- We have continued to successfully reduce demands for our acute in-patient care services as a result of a range of improvement projects and investment in new community services over the past few years. As a result of this, the need to send people out of Sheffield for hospital care when they are acutely ill has significantly reduced. This is a clear improvement for them, their families and loved ones. We are now in a position to reduce the size of our wards while increasing the number of staff working on our wards as well as further investing in new community services to ensure the right support is available to support people at home. These changes, which are due to be implemented during 2015/16, will bring about real improvements in service user experience, outcomes and safety;
- We have made real and positive progress in changing how care is delivered for people with long term rehabilitation needs. Due to the absence of the right services locally, a small but significant group of people have been cared for in long-term secure hospital settings, often far away from their home. This has delivered poor outcomes for service users, resulted in people being isolated away from family and friends for a very long time and has been very expensive. In agreement with our Commissioners, we have assumed responsibility for these service users' ongoing care and treatment. We have been able to develop intensive community support services, with the assistance and input of South Yorkshire Housing Association and have begun to deliver real change for people over the last year. 12 people have now been supported to return to Sheffield with a personalised community care package;
- We have successfully piloted 'enhancing primary care' provided through our GP services in partnership with Darnall Well-being (a third sector organisation). The aim of this development has been to provide targeted and more holistic support to those patients identified as being at risk of needing hospital care in an attempt to reduce hospital admissions and provide more care locally and this has proved to be very successful. Patient experience and feedback has been very positive, with patients achieving more independence and control over their day-to-day lives and interacting more with their local community, GP Practice and services. Their need for hospital care has reduced over the year, with Accident & Emergency attendances and admissions down by 25% for these patients, resulting in savings of up to 40%. We are already a provider of managed GP services through the Clover Group, and this year we were asked to provide additional GP services in Barnsley when an existing GP Practice was no longer able to continue. We are pleased that we were able to respond quickly and ensure that local people in Barnsley were able to continue with access to GP services;
- Social care support services for people with a learning disability have been re-designed as part of a citywide strategy. This has resulted in a number of community support services, which provide people with day-to-day help with their social care needs, being re-commissioned over the last year. This has impacted on 3 of the services that we currently provide and our proposals for providing support in the future were not successful. As a result of this, we will no longer be providing support for people resident in supported living facilities at Cottam Road, East Bank Road and the Handsworth Development. This will result in a loss of income to the Trust of £11.7 million in the next year. While the financial impact of this loss of business to the Trust is manageable at this stage, we are clearly disappointed at the outcome. We will continue to review and consider the implications of this for the other social care services that we provide.



2.3.2 Quality and regulatory performance

Our Quality Report in **Section 9** *(page 96)* describes our performance in delivering quality services over the last year. 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 of Foundation Trusts and by the Department Health, with the exception of 7 day follow up for people discharged from hospital under the Care Programme Approach (CPA). We failed to achieve the required targets during the 2nd quarter of the year. We put plans in place to address this and achieved the target for the rest of the year;
- All targets to improve access to psychological therapies for common mental health problems within primary care;
- All national targets relating to our GP 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.

The Care Quality Commission (CQC) registers and, therefore, licences us as a provider of care services as long as we meet essential standards of quality and safety. The CQC monitors us to ensure we continue to meet these standards. During October 2014 the CQC undertook a planned inspection of a range of our services. As of 31 March 2015 we have not received all the draft reports for the services inspected. We will review their findings with our Commissioners and Healthwatch and take any appropriate actions. The CQC reports and our action plan will be available on our website www.shsc.nhs.uk

Our performance during 2014/15, 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, based on our performance against the national indicators (positive). This is summarised in our Quality Report in **Section 9** *(page 96)*.

2014/15	Annual Plan	Actual Performance			
		Q1	Q2	Q3	Q4
Continuity of Service Rating	4	4	4	4	4
Governance Rating	Green	Green	Green	Green	Green

2013/14	Annual Plan	Actual Performance			
		Q1	Q2	Q3	Q4
Financial Risk Rating	5	5	5	n/a	n/a
Continuity of Service Rating	n/a	n/a	n/a	4	4
Governance Risk Rating	Green	Green	Green	Green	Green

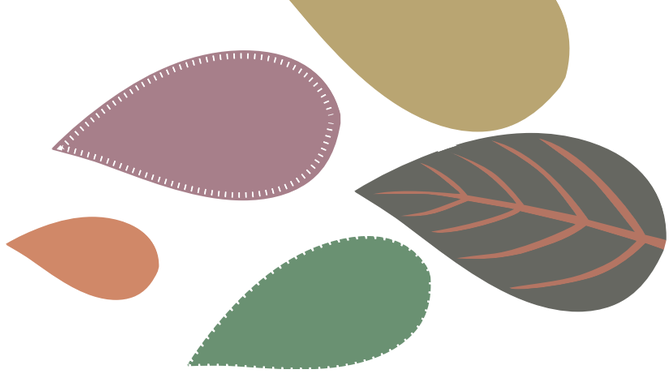
Note: *During 2013/14 Monitor's assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial Risk Rating was replaced by a Continuing of Service Rating. A rating of 4 under the Continuity of Service Rating is the equivalent of a 5 under the previous Financial Risk Rating.*

2.3.3 Our services

Over the year our services have undergone many positive changes, some of the highlights are outlined below.

We have invested £4.5million to build our new Psychiatric Intensive Care Unit (PICU) which is due to open in Autumn 2015. The new building will improve the care and experience of service users who have an admission to the PICU and reduce the need for out of town PICU admissions. As well as building the new PICU, we are also investing £2million to create a new welcoming and modern entrance to the Longley Centre and to undertake an external refurbishment of the façade elevation.

We launched the Community Enhanced Recovery Team, or CERT, which provides intensive support which is designed jointly between staff and individual service users. CERT's primary objective is to support people to be discharged from out of city placements in hospital so that they can return to live independently in Sheffield. The emotional impact of being in hospital far away from family and friends is significant and we want to bring as many people back to Sheffield as quickly and as safely as we can. The focus of the team is on recovery and as such, the interventions provided are wide ranging and somewhat wider than the usual boundaries of health and social care. We are working collaboratively with South Yorkshire Housing Association to help service users manage their own tenancies and support them to make a



successful transition to independent living in their home city.

We used £300,000 of our cost improvement savings to refurbish the environment at Longley Meadows which provides respite for people with a learning disability and complex needs – a project we identified in last year's Annual Report. Staff, service users and carers had raised concerns about the quality of the environment and this work has gone a long way to addressing these concerns. We have also introduced free wireless internet access onsite for service users and visitors to improve the facilities available.

Respite facilities at Warminster Road have benefited from new beds and a new kitchen. Buckwood View Nursing Home has established partnerships with local community organisations as part of its garden restoration project. This offers people the opportunity to gain work experience in garden design and maintenance and participants include horticulture students from Sheffield College and ex-offenders supported by the Probation Service.

We are investing over £500,000 in our Early Intervention Service to create 20 new posts (including 8 Care Co-ordinators and 8 Recovery Workers). Our pilot Street Triage service, working alongside South Yorkshire Police, is proving to be very successful. In the Street Triage scheme mental health nurses join officers on 999 calls to help those needing urgent mental health treatment.

We secured contracts from NHS England to run the Brierley Medical Centre (GP practice) in Barnsley and from Sheffield City Council to provide opiate and non-opiate drug services for Sheffield. We are now the sole provider in the city for drug and alcohol services and aim to provide a seamless, cohesive service for people affected by alcohol or drug problems. Our services are now supporting an additional 1,100 service users and our staff within these services has almost doubled. We have welcomed new colleagues who have considerable experience of working in primary care, early interventions and prescribing services.

Our Alternative Provider of Medical Services (APMS) contract has been extended until 31 March 2016. This relates to our GP Practices in the Clover Group: Darnall Primary Care Centre, Highgate Surgery, Jordanthorpe Health Centre and the Mulberry Practice. We have introduced the Friends and Family Test in these Practices to provide regular feedback to enable us to develop the services to meet the needs of our patients and to address any gaps in provision. We have continued to engage patients in patient participation groups to support the Practices in raising awareness of patients' needs and to improve health outcome for hard to reach, Black and Minority Ethnic (BME) and vulnerable groups.

In our social care services we implemented an ambitious reorganisation to create a single recovery focused pathway for service users with a single point of entry. The Community Recovery Service was created which consists of SPACES, Community Support Services and the Home Environment Service. The service works with service users to build social confidence as well as delivering a bespoke range of educational programmes designed to support health and social care needs and the facilitation of peer support networks to assist service users to enhance their recovery. Our growing number of experts by experience and volunteers work in partnership with the service to provide support which assists service users to take active steps towards recovery.

We piloted a personal recovery model in our adult Community Mental Health Teams (CMHTs) in which peer and professional experts work together to develop person-centred care. As part of the pilot, staff in the CMHTs develop collaboratively written care plans which incorporate best practice in order to assist service users to reach their individual recovery goals.

We have significantly cut waiting times for psychotherapy for service users with Post Traumatic Stress Disorder while strengthening staff support and supervision.

We have seen a consistent reduction in average waiting times to access treatment in our Improving Access to Psychological Therapies (IAPT) Service. The average waiting times have reduced from 4.46 weeks to 4.2 weeks and this has been achieved while also increasing the number people accessing the service. We are working to fulfil the ambition of valuing mental health equally with physical health by supporting dual trained practitioners to work with service users with long-term conditions and medically unexplained symptoms.

We have moved forward in our plans for a Recovery College as outlined in last year's Annual Report. The project has been renamed the Sheffield Education Exchange and we have created a prospectus which details all the short courses already offered by the Trust. We have an agreement in place with the Workers Educational Association to provide courses to our service users and have also developed a sharper focus among the project group to establish links with community learning providers. We are working with Sheffield City Council and a range of third sector providers to bid for funding in order to establish a community learning pilot which we hope will form the start of a citywide Recovery College in years to come.

We cared for over 700 people in our adult acute in-patient facilities. We improved the acute care pathway which resulted in service users having shorter stays in hospital and being actively supported to return home. This work has supported the reduction in the number of beds being used on the wards which has meant that staff have more time to spend therapeutically with service users.

We launched a training package for all staff in in-patient services which is focused on collaborative working with service users to design care plans which are jointly written and owned. This builds on our RESPECT training which supports staff to manage difficult situations which can occur on acute wards. These training packages support staff to work compassionately with service users.

We appointed a Reader in Residence on a 1 year contract to extend our programme of small reading groups on the acute wards. The programme is a collaborative initiative between occupational therapy staff and volunteers and provides a space, reading material and a trained reader to spend time with service users.

Our Community Learning Disability Team introduced assessment clinics which reduced waiting times considerably from an average wait across all professions of 47 weeks (as of October 2014) to just 15 weeks by January 2015.

We celebrated Learning Disabilities Week in June 2014 and held a Big Health Event which gave our staff the opportunity to work with partner organisations to raise the profile of health and wellbeing. The Big Health Event was just one part of our commitment to improve the physical health needs of service users and to raise awareness of and tackle the city's health inequalities. We also held a very successful physical health improvement event in April 2014 which focused on the physical health inequalities for people with mental health problems. We will continue this work to improve both the physical and mental health of our service users and staff with the aim of positively impacting the statistic that people with severe mental illness or a learning disability die 20 years sooner than the national average.

We celebrated the 40th anniversary of Sheffield Case Register. The Case Register's data on changes to life expectancy, morbidity and mortality of people with a learning disability contributes to national strategic planning, policy and research as well as providing information directly to service users about service developments in the city. We have begun a project to modernise the way in which we capture this information to ensure that the Register works in a more intuitive way and we are planning to use mobile technology to improve efficiency.

We undertook a comprehensive review of our Memory Service which resulted in an improved way of providing assessment and follow-up. The redesign will reduce waiting times for initial appointments, continue to increase Sheffield's diagnostic rates to 75% over the next 2 years and provide a central, specialist diagnosis hub supported by routine follow-up through outreach into primary care (GP surgeries). The redesign also offers us the opportunity to review the way in which we use transport to support the service, making cost improvements and reducing our environmental impact.

We began a review of our Older Adults Community Mental Health Teams with a focus on needs-led care. We relocated all 4 teams to a single citywide base with outreach into the local community which allowed us to look at how we make best use of citywide resources while reducing expenditure on buildings and increasing spending on frontline service provision. Winter resilience money allowed us to test the demand for 7 day community services for older people and will inform the service redesign in 2015/16.

We implemented the reconfiguration of our Long-Term Neurological Conditions services to create streamlined care pathways, a better use of skill and grade mix of staff and to strengthen clinical and managerial leadership. This will benefit our position to consider options for business expansion in this area in future years.

We led a whole system review of Liaison Psychiatry Services for both for working age and older adults who present to Sheffield Teaching Hospitals NHS Foundation Trust. This has informed an intention to reconfigure the services. Additional winter resilience investment is being used to evidence the need for ongoing increased investment to respond to demand both in the community and in hospital, both in and out of hours, 7 days a week.

Working in partnership with the University of Sheffield we became the first Trust in the country to introduce the services of a companion robot on our dementia ward (G1). PARO Seal is an advanced interactive robot with tactile sensors which responds to sounds and can show emotions such as surprise and happiness. PARO Seal is proving to calm and relax service users as well as providing distraction and reassurance.

We established Sheffield Dementia Involvement Group (SHINDIG) with Sheffield Alzheimer's Society. SHINDIG is a citywide forum which meets 4 times a year and aims to provide opportunities for people living with dementia (and their family carers) to share ideas, views and opinions on local services and developments.

Two of our staff won individual awards at the national Positive Practice in Mental Health Awards held in Sheffield in October. Mark Thorpe, Community Recovery Worker, won the Making a Difference award and Kim Parker, Senior Nurse, won the Time to Change Anti-Stigma award. Kim was also awarded the Barbara Burford Memorial Prize at the Annual Bradford University Conference, Making Diversity Interventions Count.

Our RESPECT training programme was shortlisted for the Health Service Journal's Patient Safety and Care Awards in the mental health category. Our Director of Therapy Services, Julie Edwards, was a finalist in the regional NHS Leadership Awards in the category of Inclusivity Leader of the Year. The Ward Team on G1 were shortlisted as finalists for the UK Royal College of Psychiatrist's mental health team of the year in the old age category.

We adopted the Living Wage for directly employed staff on substantive or temporary contracts. Employers choose to pay the Living Wage on a voluntary basis and it is significantly more than the national minimum wage. This is part of our commitment to ensuring that our lowest paid workers receive sufficient income to provide themselves and their families with the essentials of life.

We celebrated our Awards for Excellence at our Annual Members Meeting in September which was a wonderful opportunity to thank our volunteers and staff for the excellent work they do. The volunteer and service user category was won by Steph Grant, a service user and volunteer with our Sheffield Community Brain Injury Rehabilitation Team. The clinical individual category was won by Jayne Grayson who is based at Woodland View Nursing Home while the non-clinical individual category was won by Amy Levick from our IT Department. Respite services at Wainwright Crescent won the clinical team category and a truly multi-disciplinary team comprising staff from the Specialist Directorate, the IT Department, Facilities, and other central services won the non-clinical team award for their work on the relocation of the Older Adults Community Mental Health Teams, Older Adults Functional Intensive Care Service and the Dementia Rapid Response and Home Treatment Teams to a single location at Edmund Road.

Our Chair, Professor Alan Walker, was awarded the CBE (Commander of the British Empire) in the Queen's Birthday Honours List for services to social sciences. This is a great testament to his tireless work over many years and his deep commitment to improving care for the elderly.

2.4 Financial performance

Through continued strong financial performance, we have successfully maintained a Continuity of Service Rating of a 4 with Monitor, our independent regulator.

In respect of the year 2014/15, we exceeded our planned forecast of a £2,550,170 surplus and achieved a surplus of £2,596,000 with Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £6,644,000 (against a plan of £6,501,000).

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 including funding the capital investments planned for 2015/16 highlighted on the next page. 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 2014/15, some of this delivery (approximately £1.762 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 01 April 2014 to 31 March 2015 are included in full under **Section 13** *(page 174)* of this Annual Report.

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 this has been via the 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; and

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.

Our income and expenditure position

In the 12 months covered by this report, the Trust generated an income totalling £131,824,000. A summary of the position is provided overleaf:

	Total 01 April 2014 – 31 March 2015 (£000s)	Total 01 April 2013 – 31 March 2014 (000's)
Income from activities	100,792	97,849
Other operating income	31,032	32,181
Total income	**131,824**	**130,030**
Operating expenses	(127,568)	(125,985)
Profit on disposal of property, plant and equipment	-	-
Interest received and other financial costs	47	56
Movement in fair value of investment property	-	20
Public dividend payable	(1,707)	(1,608)
Surplus for the year	**2,596**	**2,513**

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** *(page 174)* of this report.

Income disclosures: Non – NHS income

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's income from the provision of goods and services for the purpose of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

In 2014/15, the Trust met this requirement, with significantly more than 50% of the Trust's income generated by activities for the purposes of the health service in England.

As the vast majority of Trust income is categorised as generated by activities for the purpose of health service in England, carrying on with the activities to generate non principal purpose income would not to any significant extent interfere with fulfilment by the Trust of its principal purpose.

Cash flow management

We continue to review our Treasury Management Policy and cash and working capital management.

Our cash balance at the end of March 2015 was £28.933 million. The Trust has reviewed its working capital requirements and due to the continued 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 at present.

Capital expenditure

The Trust's investment in capital expenditure for 2014/15 was £2.716 million. The commencement of the new Psychiatric Intensive Care Unit was the main capital investment in 2014/15 at £2.335 million in year.

Work on the new Psychiatric Intensive Care Unit commenced in September 2014 and is due to be completed in October 2016 with a total project capital cost of £6.52 million over the period. Further work on Phase 2 of the Acute Care Reconfiguration is planned to start in October 2015 with the development of the adult wards. £2.65 million is set aside for this project in 2015/16, and a further £6.97 million in 2016/17.

Capital spend on IM&T, Transport and Equipment totalled £0.381 million in 2014/15. Plans continue to fund capital equipment renewal in these areas and we have additionally set aside an uplift of £0.11 million capital investment in these areas for 2015/16 to develop our capital infrastructure and maintain technological advances.

The Trust is presently not seeking to obtain loans to fund capital projects during 2015/16 and will utilise in year depreciation and capital slippage from previous years to fund the requirement for 2015/16 and 2016/17. Cash holdings from I&E surplus will be utilised for future periods.

Key financial risks and challenges for 2015/16 onwards

The Trust's on-going financial planning continues with detailed financial modelling and downside/ scenario planning underpinning the details provided in this report, only a summary of the base plan 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:

iii). Salary costs are the single biggest component of our costs; our staff are predominantly on national terms and conditions of service. The majority of Trust staff will receive minimal increases to salary of up to 1% and associated increments at certain levels. The cost of this inflationary rise is funded within the national Tariff for 2015/16;

iv). 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 2015/16, there is a national efficiency requirement of 3.5%, with pay and price inflation uplifts at 1.9%. The application of this formula gives a net reduction for NHS commissioned services of 1.6%. 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.

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 19** to the Annual Accounts in **Section 13** *(page 174)*).

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 19** to the Annual Accounts in **Section 13** *(page 174)*).

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 £28.933 million at 31 March 2015. 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.

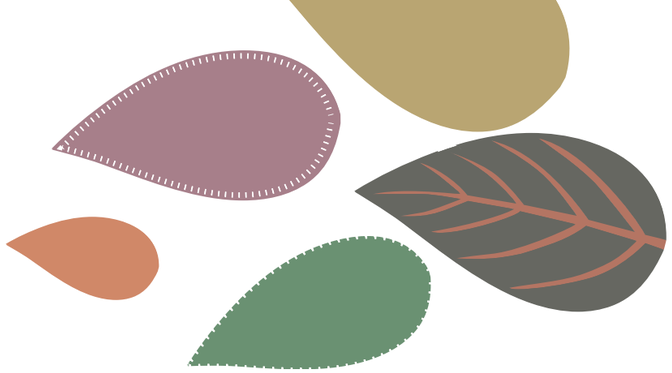
Other financial risks/challenges

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 the level of CIP's (£4.514 million) and Disinvestments required (£5.806 million) is the major challenge especially as the majority of income is from block contracts and 80% of operating expenditure relates to staffing;
- Loss of business through procurement plans for some Trust services by external government bodies. Services being disinvested in during 2015/16 following tendering exercises include Learning Disabilities registered care c£2.434 million and the Sheffield Community Equipment Loan Service c£1.951 million from 01 July 2015 (£2.601 million FYE). Although these are considered delivered to a good standard of care, financial challenges exist when competing with the private and charitable sector with regards to ensuring we recover our costs aligned to national terms and conditions as an NHS body;
- Going forward in 2015/16 there is potentially further learning disability services being disinvested in, in relation to supported living services. While the Trust has clear plans and strategies in place to inform the direction and a positive track record of managing our existing service, plans have been put in place to manage the risk and ensure the costs are removed in line with the loss of income and meet the disinvestment requirements;
- General risks around tariff and the wider impact of Mental Health Clustering will continue throughout 2015/16. However, the Trust is investing in this area to help support and minimise this risk. 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. A risk share approach for 2015/16 has been agreed;
- On-going CQUIN achievement remains a key risk and an area of uncertainty from quarter to quarter, however a specific reserve is available to invest and ensure we minimise the potential shortfall on delivery in line with previous years;
- •The Trust has taken on the management of the full CHC and IFR detained patient budgets from NHS Sheffield CCG c£7.9 million on a recurrent basis. Although this is a positive outcome, the risk of increased demand has now transferred to the Trust.

Risk Issues – Other

- Robust contracting arrangements are in place with Commissioners and all contracts are filtered through the Director of Commercial Relations and the Trust's Contracting Team. The outlook for future years is challenging but equally has opportunities not least of which is the development of our specialist services and exploring new business opportunities and furthermore, the options for these opportunities will have a robust business case to satisfy the Board of Directors that service quality will be maintained, even if volume of service diminishes. Investments are on the table for consideration, and would support the strategic aims of the Trust;
- The Trust is aware of the challenges in the forthcoming year and is taking necessary actions to ensure sustainable financial balance. In addition the robust process of Directorate Service Reviews, the Accountability Framework enables the Trust to manage risks and to identify and implement mitigating actions.



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.

Additional pension liabilities incurred

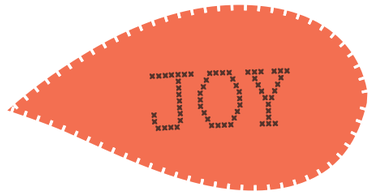
It is considered best practice for NHS Foundation Trusts to disclose the number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year. These disclosures are made in **note 5.5** in the Annual Accounts based on figures supplied by NHS Pensions.

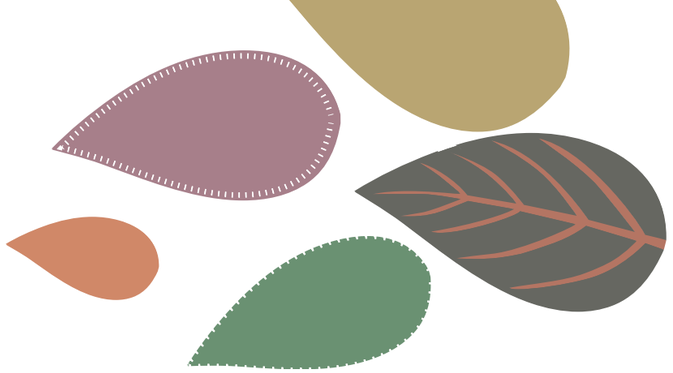
Better payment practice code

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 93.23% (last year 91%) in terms of the number of invoices paid and 95.25% (last year 92%) in terms of the value of invoices paid.

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.





2.4.1 Countering fraud and corruption

Local Counter Fraud services were provided by 360 Assurance. The role of the Local Counter Fraud Service assists in creating an antifraud 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.

2.5 How we go about our business

2.5.1 An overview of our arrangements for quality governance

We produce an Annual Governance Statement (see **Section 11** *(page 158)*) which describes our arrangements for quality governance.

2.5.2 Monitoring improvements in service quality

We use our governance systems and a range of reports to monitor quality and improvements in service quality. The Board of Directors and the Quality Assurance Committee receive regular reports on service quality and improvements. We also report on the quality of our services 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 share ideas for innovation and best practice.

We 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 them and, our performance in the additional arrangements that they use to incentivise us to make quality improvements in areas that they prioritise.

2.5.3 Monitoring improvements towards meeting national and local targets

We identify a range of areas in which we wish to improve. 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 (CQUINS).

During the year the Board of Directors reviewed its performance reporting arrangements and has approved a number of changes that will improve how we monitor and improve our performance in respect of service quality. These will be implemented during the early part of 2015/16 and will be supported by investment in improved and more flexible information reporting systems.

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 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 ongoing 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 that 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.

2.5.4 Improving services from complaints and concerns

We are committed to ensuring that all concerns and complaints are dealt with promptly and investigated thoroughly and fairly. We value the feedback we receive from service users and carers and recognise the importance of using this feedback to develop and improve our services.

Service users, carers, or members of the public who raise concerns can be confident that their feedback will be taken seriously and that any recommendations 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 protocols, thus raising standards.

A number of service improvements were made as a result of complaints this year. For example:

- Since November 2014, there is now an extra member of staff on duty every night to cover A&E attendances. There is now a twilight approved mental health professional and a twilight nurse who begin their shifts at 4pm and work until midnight. Since this increase in staffing level, attendance rates at A&E have been reduced from an average wait of 4 hours to 1 1/2 hours.
- The Specialist Psychotherapy Service took action to ensure that there is clear and up-to-date information available about the range of services they offer which is accessible to all referrers;
- The Manager reviewed the duty system at Argyll House and put measures in place to ensure that if both duty workers have to leave the building, any crisis calls taken by administrative staff can be immediately transferred to professionals within the team;
- The number of Band 6 qualified nurses was doubled and the number of qualified nurses and support workers on every shift was increased at Woodland View Nursing Home;
- A new drainage system was installed at Lightwood House incorporating a new manhole and increasing the pipe sizes to 150mm and 225mm. A road gulley was installed across the full width of the car park to prevent overspill in the direction of the houses on Lightwood Lane.
- All remaining bedroom carpets were replaced with more appropriate floor coverings at Hurlfield View Resource Centre.

We consider the learning from complaints a valuable opportunity to improve standards of service delivery and to share good working practice. We produce regular reports, giving details of complaints made and resultant actions plans on a quarterly basis. These reports are discussed at the Quality Assurance Committee and are available to all staff.

This year we saw an 17% increase in formal complaints compared with the previous year and a 29% decrease in the number of informal complaints received. The majority of formal complaints were received in relation to clinical treatment and care, with attitude of staff and communication to services users featuring in the top 3 main categories. These cases have been analysed to look for trends or themes and where these have been identified, these have been shared with the relevant senior managers.

Of those cases where the investigation has been completed we responded to 86% of the formal complaints within the timescales agreed with complainants. 21% of formal complaints were upheld, 31% were partially upheld and 48% were not upheld. At the time of finalising this report, 10 complaints were still under investigation.

This year the Parliamentary and Health Service

Ombudsman notified us that 10 complaints had been referred to them. One complaint referred to the PHSO in 2013/14 was still under investigation. No further action was required in 3 of the cases, 5 cases required remedial action (for example, apologies, reassessment and/or financial compensation) and, at the time writing this report, the outcome of 3 cases is still awaited.

More information is provided in our comprehensive Annual Complaints report (which includes the complainant survey) and is available at: **www.shsc.nhs.uk/about-us/complaints**

2.5.5 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. We aim to involve service users, carers and the public in the production of our information.

Throughout this year 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;
- Regular involvement of service users in the development of information for the in-patient services, 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 Cognitive Behavioural Therapy Courses.

2.5.6 How we use our Foundation Trust status to improve service user care

Our 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** *(page 96)* 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.

As a Foundation Trust, we are able to use our money more flexibly to support the priorities we have identified. For example, we have built up our cash reserves in order to improve our estate and in-patient services. In last year's Annual Report we reported on the real improvements made to the services we provide to people with a learning disability with the opening of Firshill Rise. This year the Board approved a major capital investment programme to improve our psychiatric intensive care services and other in-patient services.

2.5.7 Consultations

We have not undertaken any formal consultations this year about proposed service changes. At the time of confirming this Annual Report there were no formal consultations in progress. In line with our established Annual Plan for 2015/16 we may consult on the development of new acute care services across community and in-patient settings supported by an estate improvement and re-design programme. We will consider the need and requirements for consultation once the options have been reviewed during the year.

2.5.8 How we work with our partners

With service users

We fully acknowledge that if we are to be successful in achieving quality improvement, we need to have a better understanding of the people who use our services. Learning about the service user experience and acting on the information received ensures that the improvements we prioritise are important and meaningful to our service users.

We involve service users in helping us to continuously improve our services and we have a variety of different mechanisms to assist us with this. Service user feedback is provided through a range of surveys including the Friends and Family Test and the Quality and Dignity survey. Service users are also involved in staff training either as service user trainers or by sharing their own experiences of care.

We have a range of different methods we use to self-inspect and service users and carers are valued members of the teams which carry out the 15 Steps Challenge, mock Care Quality Commission inspections and Patient-Led Assessments of the Care Environment (PLACE).

We have produced and the Board of Directors has agreed, a 3 year development plan to build on existing involvement activities and to ensure that service user involvement is further embedded through our services and in every aspect of our work. The plan is available on our website: **www.shsc.nhs.uk/about-us/corporate-information/DP**

With Commissioners

We work in partnership with the organisations that commission our services, namely NHS Sheffield CCG 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.

With partners

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 a proven track record of 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 citywide 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 better collaborative working between us. We use these opportunities to promote the needs and interests of the people that we serve and to reduce

some of the barriers people can often encounter when 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 which provide seamless care pathways across health and social care.

We have developed new ways of delivering much needed services in partnership with the third sector. In last year's Annual Report we reported on our partnership with Rethink Mental Illness who deliver our Crisis House service. We have built on this development by entering into a new partnership this year with South Yorkshire Housing Association, for the delivery of housing support services for people with serious mental health problems. This has allowed us to develop effective community support packages combining health and social care support alongside support for day-to-day living within the community and intensive tenancy support. As a result of this people are now accessing support locally rather than requiring long-term hospital care away from Sheffield. This has allowed us bring some service users back to Sheffield and to reduce the number of services users placed in long-term hospital care outside Sheffield delivering improved outcomes for the service users concerned.

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

2.6 Valuing our staff and volunteers

2.6.1 Supporting staff through change

Once again this has been a year of considerable uncertainty and change. The pressures facing Commissioners impact upon our various provider services as well as the ongoing internal challenges relating to improving quality and reducing cost. Despite these pressures, we were delighted to be awarded the new opiate and non-opiate contracts for Sheffield which commenced from October. This involved the transfer of over 50 staff from previous providers to the Trust and considerable efforts were made to ensure that the transition took place as smoothly as possible for service users, new staff and existing Trust staff. The work on the service model and staffing model has continued throughout the year to ensure it fully meets service user needs.

A major element this year, which will continue throughout the next year, is the process for deregistration of our 5 Registered Care Homes. The deregistration process is being accompanied by a tender process with each Care Home establishment being a separate entity under the tender process. The process has been a much extended one which has in itself placed additional demands upon staff. The outcome of the bids considered so far has resulted in alternative providers being identified. We are committed to engaging fully with the transition to the new arrangements to ensure that appropriate support is provided to staff, including consultation requirements in respect of the Transfer of Undertakings Regulations (TUPE).

In order to promote staff engagement in our approach to developing service improvements, we have organised training in Microsystems coaching (a service improvement methodology which enables frontline staff to undertake quality improvement). We are now putting in place the means to disseminate this approach to change management more widely across the Trust. At the same time, we are working with Meridian Productivity to analyse where service provision could be enhanced through redesigning systems and processes in order to improve quality, for example, freeing up more time for face-to-face contact with service users and reducing waiting times. Both of these approaches have demonstrated positive results. Other areas of development have included a pilot enabling more direct access to Consultant staff over the weekend to assist with assessment and discharge. The results of this pilot will be considered and taken forward in the forthcoming year.

We have also focused on improving the Personal Development Review (PDR)/appraisal completion rates by successfully introducing a PDR focal point between April and June 2014. The first phase concentrated on those employees whose PDRs were significantly out of date. Over the next year this focal point approach will be developed across the Trust. We have undertaken a review of supervision arrangements and devised an action plan to improve any identified shortfalls in this area. We have also re-launched, for next year, our Additional Annual Leave Scheme which enables staff to apply to 'buy' additional leave where this is consistent with service requirements, both helping with the work/life balance of staff and reducing our costs.

We have invested in technological developments to improve how staff adapt to changing requirements. During Phase 1 of our mobile working project over 500 tablet devices were issued to staff working in the community. We are also reviewing how our e-rostering provision can be improved and we are implementing an electronic expenses system.

Our approach to redeployment continues to be successful, reducing the need for any compulsory redundancies. This works in conjunction with a further round of our Mutually Agreed Redundancy Scheme (MARS) which enables posts to be available, where practicable, for staff on redeployment. We operate the scheme in conjunction with Staff Side representative through our MARS Vacancy Panel and 18 employees have had their applications approved under this scheme.

We have also established a Staffing Capability and Capacity Group to ensure that we can identify where teams are experiencing significant shortfalls in their fill rates in order for remedial action to be taken. Forthcoming change programmes will include the further development of our Acute Care Reconfiguration Programme on a whole-system basis and the development of our involvement in primary care, building on our community-based teams including the IAPT Service and our GP provision including the Clover Group.

2.6.2 Equal Opportunity Statement

We have maintained our 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.

2.6.3 Equality and Diversity

We produce a separate Equality and Human Rights Report each year. This contains information about our Equality Objectives and detailed information about the actions we have taken to support its duty 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 actions that we take are set using the framework of the NHS Equality Delivery System 2. The 2014/15 report will be published in July 2015.

Each year we also publish a range of information about staff and service user diversity this can be found in the Trust Equality and Human Rights Supplementary Information Report. The current report contains information to 31 March 2014; reports are published annually in July. www.shsc.nhs.uk/about-us/publications

2.6.4 Staff engagement

We have undertaken a range of initiatives aimed at increasing staff engagement by supporting staff to feel connected to the organisation, to be committed to and absorbed in their work, to experience positive relationships and to be physically and emotionally healthy. These include relatively informal activities such as senior managers undertaking 'walk rounds' and working on shifts, to more structured interventions (both specific to teams and across teams) to surveys of staff (within the Trust and nationally).

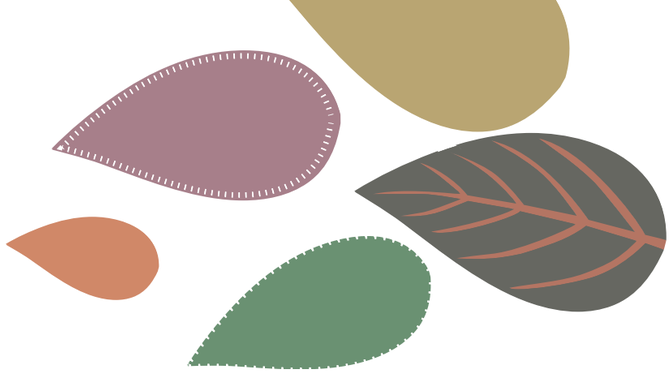
We continue to score positively in the national Staff Survey and the more recently introduced Staff Friends and Family Test. The Staff Survey results indicate that the Trust is again within the top 20% of mental health/learning disability Trusts in the country for overall staff engagement. This is a positive position for us to be in, and it helps us to move forward in partnership with our staff and deliver further improvements. For further information on the survey results see **Section 9**, Quality Account *(page 96)*.

We engage with Staff Side on a continuing basis. This includes the established mechanisms such as the Joint Consultative Forum, Joint Policy Group and, for medical staff, the Joint Local Negotiating Committee. In addition there are specific arrangements put in place in relation to particular issues or topics, for example, the Joint Sickness Working Party. The unprecedented organisational change agenda has also required close working between the ourselves and Staff Side in order to assist staff as much as possible. We have also co-operated successfully with Staff Side to ensure that safe minimum staffing levels have been achieved during the periods of national strike action which have occurred a different points during the year.

We have also worked successfully with Staff Side in implementing the decision of the Board of Directors to adopt the Living Wage with effect from January 2015. This has raised the lowest level of pay for substantive staff.

Staff engagement and associated support mechanisms are already well established within the Trust. These include:

- A monthly letter from the Chief Executive which updates staff on key developments and challenges facing the Trust, including financial and economic factors affecting the Trust's performance, and invites staff to feedback and engage with him directly;
- Visits to teams from Non-Executive Directors and Executive Directors of the Board, including the Chief Executive;
- Our Awards for Excellence Scheme which recognises staff and teams (both clinical and non-clinical) who have gone above and beyond expectations in the performance of their work. We also have a dedicated award category for volunteers;
- Regular team briefings.



This year we have introduced additional initiatives to strengthen staff engagement which include:

- Schwartz Rounds;
- Mindfulness and Mindful Leadership training;
- Microsystems coaching;
- A monthly newsletter from the Board of Directors which updates staff on issues discussed at each Board of Directors' meeting.

2.6.5 Sickness absence

We held 2 Promoting Attendance Conferences this year to help ensure our staff have an improved understanding of the causes of sickness and the actions which are available and appropriate to improve attendance. These have been developed through the work of our Joint Staff Working Party on sickness absence. The most recent Conference in February highlighted the importance of engagement in promoting attendance and involved presentations by an external academic and a Trust manager who set out the actions which can be undertaken to support engagement and promote attendance.

The level of sickness absence remains a focus for action as they are above our target of 5.1%. Our actions have involved raising awareness of the importance of the issue (our Conferences), improving the guidance available to staff and revising the documentation relating to the Return to Work form. It also encompasses measures to improve health and wellbeing and the prevention of ill health. This year, we have committed to a No Smoking Strategy for service users and staff which we will be taking forward in conjunction with stakeholders. We are also actively pursuing signing up to the Public Health Responsibility Deal which includes actions relating to diet and physical activity.

More detailed information on sickness absence is given below:

Staff Sickness Absence	2014/15	Restated 2013/14	2013/14
Total Days Lost	31,578	29,940	57,971
Total Staff Years	2,386	2,383	2,300
Average Working Days Lost	**13.2**	**12.6**	**25.2**

Note: Sickness data is reported on a calendar year basis (from January to December). The data originates from Sheffield Health and Social Care NHS Foundation Trust's Electronic Staff Record System. We are obliged to use only the published statistics. The latest publication, which covers up to December 2014, can be found on the website of the Health and Social Care Information Centre. Although in previous years the Trust calculated staff sickness days lost using actual data at the point of 31 of March 2015, the nationally published data uses average whole time equivalents and average sickness rates over the year from the published quarterly reports to calculate proxy figures for average days lost to sickness absence and therefore average days per whole time equivalent. This is a slightly different presentation from the total uplifted figures previously reported in the Annual Report. Prior year figures are restated using the revised required methodology. Data provided by the Health and Social Care Information Centre and reproduced here.

2.6.6 Occupational health

Our approach to occupational health involves the following strands:

Occupational Health Service – this is provided via a contract with Sheffield Teaching Hospitals NHS Foundation Trust. Our Occupational Health provider has representation on the Joint Sickness Working Party and presented at our recent Conference on Promoting Attendance at Work;

Workplace Wellbeing – this is our own free, confidential staff counselling and consultation service which is available to both individuals and groups of staff;

Health and wellbeing – we provide a dedicated page on our staff 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 flu immunisation campaign as well as special initiatives such as the introduction of the No Smoking Strategy and the future implementation of the Public Health Responsibility Deal.

2.6.7 Volunteers

Volunteering is managed within the Patient and Public Involvement office and this year the number of people who expressed an interest in volunteering for the Trust significantly increased. The active list now has over 300 volunteers and approximately 20 new volunteers are welcomed each month. All volunteers attend a specifically tailored volunteer induction during which they have an opportunity to meet other volunteers and take part in mandatory training.

Our volunteers are highly valued colleagues and we are committed to offering them opportunities which promote personal and professional development. Further information about volunteering at the Trust, along with contact details, can be found at **www.shsc.nhs.uk/about-us/get-involved/volunteering**

2.6.8 Education, training and development

We have a dedicated Education, Training and Development department which commissions and delivers core mandatory, clinical skills and specialist training for our staff to ensure that they meet the essential training requirements for their roles. Our aim is to ensure we always have the staff with the right skills at the right time to provide high quality, safe care to our services users.

Essential core mandatory training is an organisational priority and during this year we made considerable progress on actions to streamline the provision of this training and increase the uptake. This includes the development of bespoke 1 day training for specific staff groups and service areas, a review of life support training in conjunction with the Postgraduate Medical Education department, a service-based approach to clinical risk updates and a revised Mandatory Training Policy.

In addition, e-learning is now much more widely available across the Trust. Since November 2014 over 1,100 e-learning packages have been completed. E-learning offers our staff the opportunity to complete mandatory training at a time convenient to them and replaces the requirement to attend specific timed sessions which may not fit with shift patterns.

Over the past 12 months, the Recovery Education Unit has built on its commitment to bring the lived experience of people with mental health problems

to the centre of our work. Our teaching and practice development initiatives are strongly influenced by this expertise and this is supported by our recovery tutors and senior service user lecturer. Our recovery courses are popular, evolving and the feedback we receive demonstrates that they are useful and inspirational to people working in mental health related practice.

We currently accommodate 120 nursing students each year in 34 adult mental health and 8 learning disability placements. This equates to 40% of all the mental health nursing placements at Sheffield Hallam University. Placements range from both in-patient and community settings to day care, respite and specialist services. We have launched a new Practice-Based Learning Support Programme to provide dedicated support to student nurses on placement with us.

We continue to develop and train our support staff through apprenticeship opportunities and Quality and Credit Framework (QCF) qualifications. The introduction of the care certificate provides an opportunity to embed recovery principles, our values and effective supervision into practice.

2.6.9 External communication

We produced a large amount of proactive publicity this year and achieved good media coverage across a range of services. We were featured in The Guardian and local television in relation to the use of PARO Seal on our in-patient dementia ward at Grenoside Grange and the Mulberry Practice featured in a documentary about asylum seeker health on Radio 4. Staff from our substance misuse service were also interviewed on Sky News in relation to the growing use of steroids.

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 to build on our reputation, however, we will be open and honest in all our communications with the media (within the constraints of confidentiality).

We launched our new website in July and received a great deal of positive feedback about the new clearer layout, design and usability features. We regularly review the website to ensure that the information within is accurate and up-to-date.

We have maintained our social media presence during the year via our Facebook and Twitter accounts. These are regularly updated with news, events and photographs and are growing in popularity.

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

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

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

2.6.10 Environmental impact and Sustainability Report

We pride ourselves on maintaining a clean environment for service users, visitors and staff.

Patient-led assessments of the care environment (PLACE) is the measure we use to monitor our cleanliness, food, privacy, dignity, wellbeing and condition, appearance and maintenance. The action plan arising from the latest PLACE assessments is available on our website.

We are developing a Sustainable Development Management Plan which will outline our longer-term strategic approach to sustainability and ensure the involvement of the entire organisation. For more information see **Section 8**, Sustainability Report *(page 92)*.

2.6.11 Health and Safety performance

We place a strong focus on health, safety and wellbeing to maintain an environment that is safe and supportive for staff, service users and visitors.

The Health and Safety Committee's role is to monitor and maintain effective health and safety management systems that are proportionate to the risks and compliant to legislation, codes and practice. The Committee has overseen the completion of several areas of work including the development or updating of the Fire Safety Policy, Water Quality Policy, Management of Asbestos Policy, Assessment and Management of Ligature Points Policy, Control of Substances Hazardous to Health Policy, Management of Contractors Policy and Waste Management Policy.

In response to new legislation aimed at all healthcare organisations to reduce medical sharps injuries and to prevent the transmission of blood borne viruses, we have introduced syringes with retractable syringe needles to prevent needle stick injuries. Our number of needle stick injuries has always been very low in comparison to other Trusts, however, the new retractable needles have reduced the risk to staff and service users even further.

We prioritise training and competence to ensure that staff have the appropriate skills, experience and knowledge to undertake their work in a safe and caring manner. A significant amount of mandatory health and safety related training is now accessible to staff via e-learning from all workplace computers. Increasing the ease of access has already made a significant contribution towards meeting our training targets.

The Estates Department compliance/'Red Box' system is now firmly embedded within all our premises. This is a proven tool for local managers to establish the roles and responsibilities for all arrangements of estates, health and safety and fire prevention related matters in accordance with our policies and procedures.

Health and safety inspections are undertaken regularly at all sites by local staff. Inspections are also completed by our Health and Safety Advisor to measure health and safety performance both at a local level and Trustwide.

The Trust employs competent people to provide specialist advice in managing health and safety and related matters, including our Health and Safety Advisor, Risk Management and Clinical Governance staff, Senior Infection Prevention and Control Nurse, Fire and Security Officers, Local Security Management Specialist and designated Estates managers with specific responsibilities for estates related issues, for example, water quality, legionella, electrical safety.

This strategic report has been approved by the Directors of Sheffield Health & Social Care NHS Foundation Trust.

Kevan Taylor

Kevan Taylor
Chief Executive
22 May 2015

Section 3

Directors' Report

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 fulfil its ambition.

At the end of 2014/15, 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 CBE (Chair)

Susan Rogers MBE (Vice-Chair)

Councillor Mick Rooney (Senior Independent Director)

Anthony Clayton

Ann Stanley

Mervyn Thomas

3.1.2 The Executive Team

Kevan Taylor (Chief Executive)

Clive Clarke (Deputy Chief Executive)

Professor Tim Kendall (Executive Medical Director)

Liz Lightbown (Chief Nurse/Chief Operating Officer)

Phillip Easthope (Acting 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 (note 1)** *(page 168)* of this report and details of senior employees' remuneration can be found in the Remuneration Report in **Section 4** *(page 60)* 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. Arrangements will have been made to confirm our external auditor for the year 2015/16 onwards.

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:

- 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;
- Promoting the success of the organisation so as to maximise the benefits for the members as a whole and for the public.

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 2014/15, the Board met every month 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 Directors

The Board comprises 6 Non-Executive Directors (including the Trust Chair). During 2014 the terms of Martin Rosling and Councillor Mick Rooney came to an end. The Nomination and Remuneration Committee proposed to the Council of Governors and they agreed to extend Councillor Rooney's appointment for a further 6 months pending the outcome of discussions between the Trust and the Local Authority on the future of their Section 75 agreement. A formal process was undertaken to replace Mr Rosling which is detailed in **Section 6** *(page 78)* of this report. Ann Stanley was formally approved by the Council of Governors and was appointed with effect from 01 November 2014.

It is the responsibility of the Council of Governors to both appoint and remove Non-Executive Directors. Termination requires a formal process involving a number of rigorous elements and culminating in a vote requiring the approval of three-quarters of the members of the whole Council of Governors.

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 has been one change within the Executive Team during 2014/15. Paul Robinson, Executive Director of Finance, left the Trust on 20 March 2015 and Phillip Easthope was appointed Executive Director of Finance (Acting) for a period of 6 months.

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 2014/15, including their attendance at the Board's meetings, is set out below.

Name	Position	Term	Attendance
Professor Alan Walker CBE	Chair	Second 3 year appointment from 01/07/13	10/12
Kevan Taylor	Chief Executive	N/A	10/12
Clive Clarke	Deputy Chief Executive	N/A	11/12
Liz Lightbown	Chief Nurse/Chief Operating Officer	N/A	11/12
Professor Tim Kendall	Medical Director	N/A	8/12
Paul Robinson	Executive Director of Finance	N/A	12/12
Councillor Mick Rooney	Non-Executive Director and Senior Independent Director	Second 3 year appointment from 01/11/11 – extended for 6 months	10/12
Susan Rogers MBE	Non-Executive Director and Vice Chair	Second 3 year appointment from 01/12/12	12/12
Martin Rosling	Non-Executive Director	Second 3 year appointment from 01/11/11	5/7
Anthony Clayton	Non-Executive Director	Second 3 year appointment from 01/12/12	12/12
Mervyn Thomas	Non-Executive Director	Second 3 year appointment from 01/12/12	12/12
Ann Stanley	Non-Executive Director	3 year appointment from 01/11/14	5/5

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 work of the Audit and Assurance Committee also includes:

- Review the establishment and maintenance of an effective overall system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives;
- Ensure that there is an effective Internal Audit function that provides appropriate independent assurance to the Audit and Assurance Committee and Board;
- Ensure that there are effective counter-fraud arrangements established by management that provide appropriate independent assurance to the Audit and Assurance Committee and Board;
- Consider and make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor and to oversee the relationship with the External Auditor;
- Monitor the integrity of the financial statements of the Trust, reviewing significant financial reporting issues and judgements which they contain and review significant returns to regulators and any financial information contained in other official documents including the Annual Governance Statement.

The Audit and Assurance Committee takes assurance from the work of the wider Trust and the Quality Assurance Committee which ensures processes are reviewed and exist which allow staff of the NHS Foundation Trust and other individuals, where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. This includes a suite of policies and procedures covering the following:

- Grievance Procedure;
- Bullying and Harassment Procedure;
- Incident Reporting and Investigation Policy;
- Complaints Policy (including the Fastrack process – see Section 6.8 of the Complaints Policy);
- Safeguarding Adults Policy;
- Safeguarding Children Policy;
- Resolving Differences of Opinion between Practitioners;
- Fraud Policy and Response Plan.

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 Chair of the Committee was Martin Rosling up until the end of his term. The current Chair Ann Stanley came into post on 01 November 2014 and will chair the meeting going forward.

The Committee has met on 5 occasions during 2014/15 and discharged its responsibilities as set out in the terms of reference. 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	3/4
Ann Stanley	Committee Chair and Non-Executive Director (with effect from 01 November 2014)	1/1
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	4/5
Susan Rogers MBE	Committee Member and Non-Executive Director	5/5

Also in attendance at the Committee's meetings are the Executive Director of Finance, the Chief Nurse/ Chief Operating Officer, the Board Secretary/Director of Organisation Development, 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 effectiveness and on-going compliance.

The Audit and Assurance Committee met on 22 April 2015 in part to consider the financial statements for the period 2014/15 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 2014/15 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 and Corporate Risk Register;
- Due consideration of the annual Internal Audit report and opinion, and, elements of risk and audit emphasis identified in the External Audit plan, such as the Trust's income;
- 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 prior to submission to Monitor.

In relation to the risks and areas of emphasis in the External Audit Plan, KPMG consider the key areas of accounting judgement and disclosure. For each of these areas, the Committee critically reviews and assesses the judgements that have been applied, the consistency of application from year to year and the appropriateness of the relevant disclosures made, together with the compliance with applicable accounting standards. The key area of accounting judgement and disclosure that has been considered by KPMG was income recognition. How this was assessed by the Committee is set out below.

The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS Commissioners. These contracts make up 69% of the Trust's income from activities. The Trust also receives 15% of its income from non-patient care services to other bodies. In order to satisfy itself as to the validity of the income, the Committee has confirmed that the Agreement of Balances exercise and the confirmation of non-patient care income have been undertaken on a diligent and comprehensive basis. The Committee has also confirmed that effective income cut-off procedures were applied around the year end.

In relation to the Trust's income the Committee has been able to place reliance on work undertaken by the External Auditors as part of the work that they have undertaken to enable them to develop their Audit Opinion.

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

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

External Audit

The Trust's External Audit function is carried out by KPMG.

A full competitive tender process has been carried out during 2014/15 to ensure compliance with regulatory requirements. The outcome of the tender process, following a detailed review process was the recommendation to the Council of Governors for the reappointment of KPMG as the Trust's External Auditors. This decision was approved on 13 March 2015. This is for an initial period of 3 years with an option to extend for a further 2 years.

The statutory audit fee for the 2014/15 audit was £51,400 plus VAT. A separate fee is charged in relation to the External Assurance on the quality report of £11,500 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. For 2014/15 this was carried out as part of the External Audit tender process.

Provision of non-audit services by the external auditor; KPMG have carried out no other services for the Trust during the financial year 2014/15.

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 and the Trust 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 antifraud 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 Nurse/Chief Operating Officer, 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 10 occasions in the course of 2014/15 and details of members' attendance at its meetings are shown in the table below:

Name	Position	Attendance
Mervyn Thomas	Committee Chair and Non-Executive Director	10/10
Martin Rosling	Committee Member and Non-Executive Director	5/6
Anthony Clayton	Committee Member and Non-Executive Director	10/10
Councillor Mick Rooney	Committee Member and Non-Executive Director	8/10
Susan Rogers MBE	Committee Member and Non-Executive Director	10/10
Ann Stanley	Committee Member and Non-Executive Director	4/4
Professor Tim Kendall	Committee Member and Executive Medical Director	1/10
Liz Lightbown	Committee Member and Chief Nurse/Chief Operating Officer	7/10
Clive Clarke	Committee Member and Deputy Chief Executive	9/10
Paul Robinson	Committee Member and Executive Director of Finance	8/9
Phillip Easthope	Committee Member and Executive Director of Finance (Acting) (with effect from 23 March 2015)	1/1

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 2014/15 and Committee members' attendances at its meetings are as shown in the table below:

Name	Position	Attendance
Anthony Clayton	Committee Chair and Non-Executive Director	10/11
Mervyn Thomas	Committee Member and Non-Executive Director	10/11
Susan Rogers MBE	Committee Member and Non-Executive Director	11/11
Ann Stanley	Committee Member and Non-Executive Director (with effect from 01 November 2014)	4/4
Clive Clarke	Committee Member and Deputy Chief Executive	10/11
Liz Lightbown	Committee Member and Chief Nurse/Chief Operating Officer	2/11
Paul Robinson	Committee Member and Executive Director of Finance	8/10
Phillip Easthope	Committee Member and Executive Director of Finance (Acting) (with effect from 23 March 2015)	1/1

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 CBE, 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.

Full details of the Remuneration and Nominations Committee are provided within the Remuneration Report contained in **Section 4** *(page 60)* of this report.

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 Susan Rogers MBE, 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.

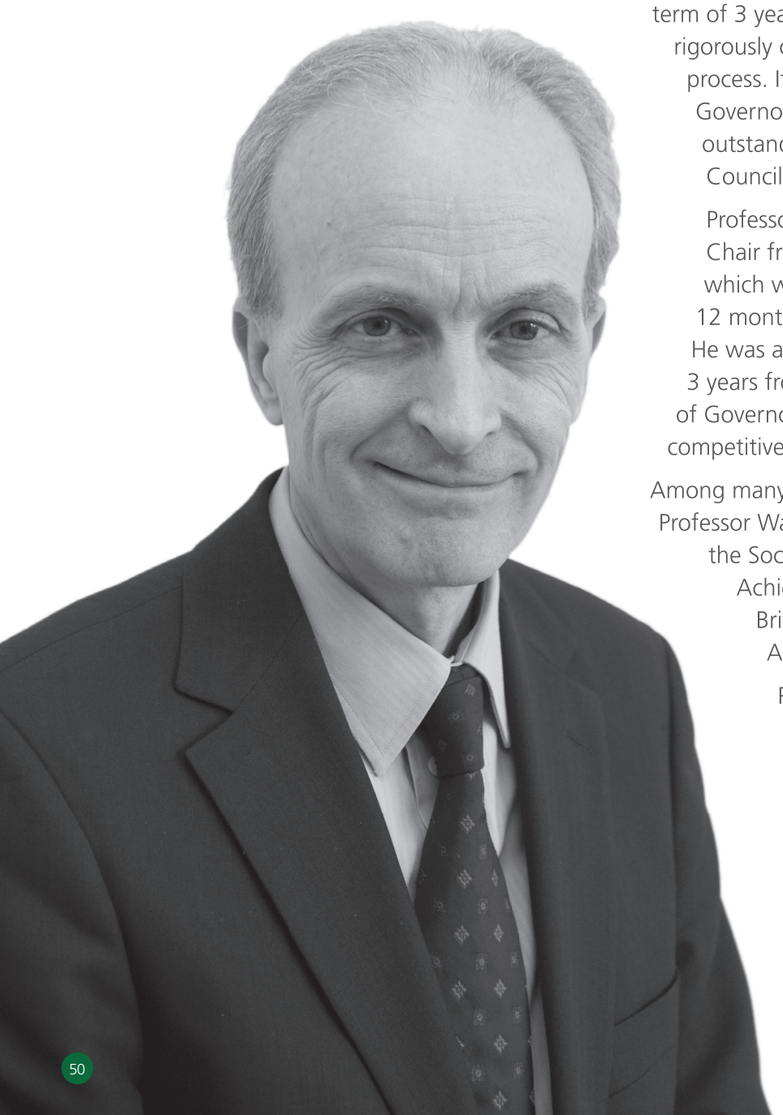
The Committee met on 7 occasions during 2014/15 and Committee members' attendance at its meetings are as shown in the table below:

Name	Position	Attendance
Susan Rogers MBE	Committee Chair	7/7
Martin Rosling	Committee Member and Non-Executive Director	3/4
Councillor Mick Rooney	Committee Member and Non-Executive Director	7/7
Ann Stanley	Committee Member and Non-Executive Director	2/2
Clive Clarke	Committee Member and Non-Executive Director	5/7
Liz Lightbown	Committee Member and Chief Nurse/Chief Operating Officer	5/7
Paul Robinson	Committee Member and Executive Director of Finance	6/7
Professor Tim Kendall	Committee Member and Executive Medical Director	1/7

3.5 Executive and Non-Executive Directors' qualifications and experience

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

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 01 July 2008 (for a term of 1 year which was extended for another period of 12 months).

He was appointed for a first full term of 3 years from 01 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).

Professor Walker was awarded the Commander of the British Empire (CBE) by the Queen in 2014 for his services to social science.

Tenure of office

01 July 2013 to 30 June 2016.

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

Appointed as the Trust's initial Chief Executive with effect from 01 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

Clive Clarke was appointed as an initial Executive Director of the Trust with effect from 01 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

Professor Tim Kendall was appointed as the Trust's initial Executive Medical Director with effect from 01 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 has chaired one of the pilot inspections of NHS Trusts. He is on the Mental Health Payment System Steering Group for the Department of Health and also the Expert Reference Group for Common Mental Health Disorders. He is also a member of the Royal College of Psychiatrists' Council. His clinical work is as Consultant Psychiatrist for homeless people in Sheffield.

Liz Lightbown Registered Mental Health Nurse (RMN), BSc (Hons) Behavioural Science, MSc Health Planning and Financing, Diploma in Public Health

Chief Nurse/Chief Operating Officer

Liz Lightbown joined the Trust on 21 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, Executive Lead for Health Professions (non-medical), 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 and in November 2012 became the Trust's Chief Operating Officer.

Paul Robinson ACMA, CGMA

Executive Director of Finance

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. Paul left the Trust in March 2015.

Phillip Easthope FCCA, BA (Hons) Accounting and Management Control

Executive Director of Finance (Acting)

Phillip was appointed as the Trust's Executive Director of Finance (Acting) on 23 March 2015. Prior to his appointment, he was the Trust's Deputy Director of Finance since 2012 and has over 12 years' experience in NHS finance. Phillip is a Fellow of the Association of Chartered Certified Accountants and has completed the NHS Strategic Financial Leadership Programme.

Susan Rogers MBE, BA (Hons) History, Certificate of Education

Non-Executive Director

(Vice-Chair) (Chair of the Workforce and Organisation Development Committee)

Susan Rogers MBE had 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 01 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

01 December 2012 to 30 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 01 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 Area 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

01 November 2011 to 31 October 2014.
Extended to 30 April 2015.

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 01 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 01 December 2012.

Tenure of office

01 December 2012 to 30 November 2015.

Martin Rosling CPFA

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

A qualified accountant by profession, Martin Rosling was appointed as an initial Non-Executive Director of the Foundation Trust with effect from 01 July 2008 to 31 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 was invaluable to the Board, where he served as Chair of the Audit and Assurance Committee.

Tenure of office

01 November 2011 to 31 October 2014.

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

Appointed with effect from 01 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 01 December 2012.

Tenure of office

01 December 2012 to 30 November 2015.

Ann Stanley FCCA
Non-Executive Director (Chair of the Audit and Assurance Committee)

A qualified accountant by profession, Ann Stanley was appointed as a Non-Executive Director of the Foundation Trust with effect from 01 November 2014.

Ann has held a range of senior financial roles in the public, voluntary and commercial sectors and presently serves as a Non-Executive Director for a leading Housing Association based in Lincolnshire. Her strong career track record is supported by her Fellowship of the Chartered Institute of Certified Accountants (FCCA). Ann's financial expertise is invaluable to the Board, where she currently serves as Chair of the Audit and Assurance Committee.

Tenure of office

01 November 2014 to 31 October 2017

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**.

3.5.2 Board Evaluation

There were 7 Board development sessions this year which aimed to build the Board's strategic capability. Throughout the development sessions the Board considered the implications of key changes in many aspects of the external environment and how this will influence the Trust's future, its strategy and strategic planning process and how this will inform the future development needs of the Board. In addition, a development session focused on preparing the Board for a planned inspection by the Care Quality Commission.

The Board also went through a 360 degree feedback exercise at the end of 2013/14, gaining feedback on its performance from key stakeholder groups (Commissioners, Governors, staff and senior Directors). Following this a joint development session took place in 2014 with Service and Clinical Directors in order to review the feedback given, understand the nature of the relationship between the Board and Corporate, Service, Clinical and Professional Directors and identify any changes in behaviours or ways of working that could lead to improvements in quality and organisation effectiveness. As a result of this, Clinical and Service Directors are now invited to regularly attend the Quality Assurance Committee. The 360 degree feedback results were also considered and discussed in detail with the Council of Governors.

In addition, the Board held an annual development session with the Governors which included a presentation and Question and Answer session where the Governors held the Board to account for the year's performance. The views of Governors were also sought on values and behaviours being developed by the Board for implementation across the Trust.

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.

Non-Executive Directors' appraisals took place to which members of the Council of Governors were individually invited to comment on the performance of each Non-Executive Director. This information was fed into the appraisal process in which the Lead Governor played a key role.

The Chair appraisal process began at the end of 2014/15 which included a rigorous process of assessment by all Board members. In addition, all Council members were invited to individually comment on the Chair's performance. The process was led by the Senior Independent Director in collaboration with the Lead Governor.

The evaluation of the performance of the Executive Directors was carried out by the Chief Executive during his monthly one-to-one meetings and annual reviews with them.

As stated in Section 4 *(page 60)*, the evaluation of the Chief Executive's performance was 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 2014/15 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 22 in the Annual Accounts contained in Section 13 *(page 174)*.

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

This is disclosed in Section 2.2 *(page 11)* and 2.3 *(page 14)*.

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 2.6.3 *(page 34)*.

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 2.6.3 *(page 34)*.

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

This is disclosed in Section 2.6.3 *(page 34)*.

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 2.6 *(page 32)*.

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 2.6 *(page 32)*.

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 2.6 *(page 32)*.

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 2.6 *(page 32)*.

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 2.4 *(page 21)*.

Section 4

Remuneration Report

Executive Directors' remuneration

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

The Committee met on 3 occasions during 2014/15 and Committee members' attendance at its meetings are as shown in the table below:

Name	Position	Attendance
Professor Alan Walker CBE	Committee Chair	2/3
Anthony Clayton	Committee Member and Non-Executive Director	2/3
Ann Stanley	Committee Member and Non-Executive Director	3/3
Mervyn Thomas	Committee Member and Non-Executive Director	3/3
Susan Rogers MBE	Committee Member and Non-Executive Director	3/3
Councillor Mick Rooney	Committee Member and Non-Executive Director	1/3

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.

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:

Executive Director	Date of Contract	Unexpired terms (Years to age 65)
Kevan Taylor	February 2003	11
Clive Clarke	April 2003	14
Liz Lightbown	April 2011	17
Professor Tim Kendall	April 2003	8
Paul Robinson	February 2013	17

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 referenced to the Chief Executive's level of remuneration and any increases determined for the Chief Executive. Performance-related pay is not applied under current arrangements.

The major decision during the current year was taken when the Committee reviewed the salaries of the Executive Team. The review took into account the national position and, in particular, the pay award which had been implemented for Agenda for Change staff from 01 April 2014. It was determined that the same increase of 1% non-consolidated would be awarded to Executive Directors as had been awarded to those who were at the top of the relevant Agenda for Change pay band. As with Agenda for Change staff this would be operational until 31 March 2015. This decision also applied to the Medical Director who received a 1% increase on his total payment but taking into account the 1% non-consolidated increase which he had received under the national agreement in respect of the Consultant element of his Medical Director remuneration.

The decision was taken in the context of the financial climate, the current levels of remuneration applicable to senior managers and the national awards applicable to other members of staff.

The salary component for Executives supports the short and long term strategic objectives of the Trust as it assist the Trust in attracting and retaining senior managers who have the necessary skills and experience to lead the Trust and take forward the identified objectives. The salary is paid through our normal payroll processes. There is no specified

maximum on the level of remuneration which could be paid but account would be taken of available benchmarking information and the relationship with the salaries available to other staff. There is provision, on termination of the contract, for the non-payment of salary in lieu of outstanding leave.

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** *(page 78)* of this report.

Details of the remuneration paid to all of the Directors during 2014/15 are shown in Table A on the following page. The Non-Executive Directors' duration of office is reported in **Section 3** *(page 40)* of this report. Information on appointment of a new Non-Executive Director is reported in **Section 6** *(page 78)* 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 C provides details of the current pension and lump sum position for each Director.

Table A: Salaries and Allowances

Name and title	Period 1.4.14 to 31.3.15			Period 1.4.14 to 31.3.15			
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long-Term Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
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	5-10	0					5-10
P. A. Stanley Non-Executive Director	0-5	0					0-5
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

Name and title	Period 1.4.13 to 31.3.14			Period 1.4.13 to 31.3.14			
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long-Term Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
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
P. A. Stanley Non-Executive Director	0	0					0
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

Name and title	Period 1.4.14 to 31.3.15			Period 1.4.14 to 31.3.15			
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long-Term Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
K. Taylor, Chief Executive	140-145	0				50-52.5	195-200
C. Clarke, Deputy Chief Executive and Social Care Lead	122-125	0				62.5-65	185-190
P. Robinson, Executive Director of Finance	105-110	0				0	105-110
P. Easthope, Acting Executive Director of Finance	0-5	0				12.5-15	10-15
Prof. T. Kendall, Executive Medical Director	105-110	85-90	5-10			(0-2.5)	200-205
E. Lightbown, Chief Nurse/ Chief Operating Officer	105-110	0				72.5-75	180-185

Name and title	Period 1.4.13 to 31.3.14			Period 1.4.13 to 31.3.14			
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long-Term Performance Related Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
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
P. Robinson, Executive Director of Finance	105-110	0				0	105-100
P. Easthope, Acting Executive Director of Finance	0	0				0	0
Prof. T. Kendall, Executive Medical Director	60-65	125-130				10-12.5	200-205
E. Lightbown, Chief Nurse/ Chief Operating Officer	105-110	0				40-42.5	145-150

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.

P. Robinson and M. Rosling left the Trust in 2014/15.

Table B: **Senior Managers' Remuneration**

Component	Description
Salary and Fees	The salary component for Executives supports the short and long term strategic objectives of the Trust as it assists the Trust in attracting and retaining senior managers who have the necessary skills and experience to lead the Trust and take forward the identified objectives. The salary is paid through our normal payroll processes. There is no specified maximum on the level of remuneration which could be paid but account would be taken of available benchmarking information and the relationship with the salaries available to other staff. There is provision, on termination of the contract, for the non-payment of salary in lieu of outstanding leave.
Other Remuneration	Only 1 Executive receives payment under this component. This relates to payment for work undertaken for the Royal College of Psychiatrists. The other remuneration component supports the short and long term strategic objectives of the Trust as it assists the Trust in attracting and retaining senior managers who have the necessary skills and experience to lead the Trust and take forward the identified objectives while also undertaking work of national importance related to one of the key functions of the Trust (mental health treatment and care).
Taxable Benefits	Only 1 Executive receives payment under this component. This relates to the Trust's lease car scheme and all staff are eligible to apply for this. The taxable benefits component supports the short and long term strategic objectives of the Trust as it assists the Trust to attract and retain its workforce. The level of remuneration which could be paid is dependent on the terms and conditions of the lease car scheme.
Annual Performance Related Bonuses	Performance-related pay is not applied under current arrangements.
Long-Term Performance Related Bonuses	Performance-related pay is not applied under current arrangements.
Pension Related Benefits	There is nothing in addition to the normal NHS pension employer contributions for all staff.

Notes: There are no new components of the remuneration package. There have been no changes made to existing components of the remuneration package. The Executive Directors' remuneration levels are referenced to the Chief Executive's level of remuneration and any increases determined by the Remunerations and Nominations Committee. The remuneration levels for employees are set by Agenda for Change or other relevant agreed contractual arrangements.

The Hutton Disclosure

	1.4.14 to 31.3.15	1.4.13 to 31.03.14
Band of highest paid Director's total (remuneration £000)	200-205	190-195
Median total remuneration	19,268	19,268
Ratio of median remuneration to midpoint of the highest paid Director's Band	10.6	9.9

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 31 March 2015, 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.

Directors and Governors Expenses

Directors and Governors Expenses	**2014/15 £00**	**2013/14 £00**
Expenses shown in £00s		
Aggregate sum of expenses paid to Governors	**9**	6
Aggregate sum of expenses paid to Directors	**36**	31
Total	**45**	**37**

	Number in office		**Number receiving expenses**	
	2014/15	2013/14	**2014/15**	2013/14
Governors	**40**	42	**6**	6
Directors (excluding the Chair and Non-Executive Directors)	**5**	5	**5**	5

Table C: **Pension Benefits**

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

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2015 £000	Cash equivalent transfer value at 31 March 2014 £000	Real increase in cash equivalent transfer value £000
K. Taylor, Chief Executive	2.5-5	7.5-10	50-55	160-165	1,082	964	92
C. Clarke, Deputy Chief Executive and Social Care Lead	2.5-5	10-12.5	20-25	70-75	436	351	75
P. Robinson, Executive Director of Finance	-	-	-	-	-	-	-
P Easthope, Acting Executive Director of Finance	0-2.5	2.5-5	10-15	30-35	130	112	15
Prof. T. Kendall, Executive Medical Director	0-2.5	2.5-5	55-60	170-175	1,273	1,184	57
E. Lightbown, Chief Nurse/ Chief Operating Officer	2.5-5	10-12.5	30-35	100-105	577	602	(41)

Service contract obligations

There is a requirement to notify of any outside business interests and/or contracts/proposed contracts where there is a financial interest. Prior written consent is required for engaging in any other business, profession, trade or occupation.

The intellectual property created during the course of employment belongs to the Trust and there is provision for payment to Trust for any remuneration which arises from such intellectual property.

Policy on payment for loss of office

There is a requirement on each side to provide 6 months' written notice. The principles for approaching payment for loss of office will be those arising from the legal obligations of the Trust under normal contractual or statutory provisions.

The Trust reserves the right to terminate the contract forthwith for offences of gross misconduct and other similar situations such as serious breach of the contract, becoming bankrupt, being convicted of a criminal offence, becoming permanently incapacitated and/or becoming disqualified from holding office as an Executive Director.

Statement of consideration of employment conditions elsewhere in the Trust

The Committee took explicit account of the Agenda for Change pay award which was effective from 01 April 2014 and, this year, applied the same increase to Executive Directors. There was no consultation with staff regarding this increase.

Off-payroll arrangements

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

The Trust's procurement policy 'Engaging Individual Self-Employed Contractors' seeks to provide a framework and clear guidance for budget holders and managers to follow when making a decision to recruit an individual to provide a service for the Trust. The order of consideration would generally be: employment, agency, self-employed contractor (off-payroll). Any engagement of a self-employed contractor must be requisitioned in advance of engagement as per usual procurement processes and require the directorate's Executive Director approval to confirm that he or she is assured that other avenues (employment or agency) have been explored. The Trust assures itself of the tax status of the contractor via issue of a Tax Declaration at the commencement of the contract. A register of engagements of contractors earning over £220 per day is maintained by the directorate. All such engagements will be reviewed and re-authorised after 12 weeks with advice sought from procurement and Human Resources.

Table 1: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than 6 months

Number of existing engagements as of 31 March 2015	**1**
Of which:	
Number that have existed for less than 1 year at time of reporting	1
Number that have existed between 1 and 2 years at time of reporting	0
Number that have existed between 2 and 3 years at time of reporting	0
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, as 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.

Table 2: For all new off-payroll engagements, or those that reached 6 months in duration, between 01 April 2014 and 31 March 2015, for more than £220 per day and that last longer than 6 months.

Number of new engagements, or those that reached 6 months in duration, between 1 April 2014 and 31 March 2015	**1**
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	1
Number for whom assurance has been requested	1
Of which:	
Number for whom assurance has been received	1
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

Table 3: For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 01 April 2014 and 31 March 2015.

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 figures should include both off-payroll and on-payroll engagements.	**6**

Notes

The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. A small number of staff are, however, members of South Yorkshire Pensions scheme. Further details can be found in the Annual Accounts at **note 1.6**.

Paul Robinson opted out of the scheme in 2013/14.

Chief Executive

22 May 2015

Section 5

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.

Sheffield Health & Social Care NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Code issues in 2012.

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 2014/15 the Trust complied with all relevant requirements of the Code with the exception of provision A.1.9 on having a single code of conduct for Board members. Although the Trust does not have a single code, the conduct of Board members is governed by their terms and conditions of office and contract of employment as appropriate. In addition, the Constitution, Standing Financial Instructions and Declaration of Interests & Standards of Business Conduct Policy including Potential Conflicts of Interest, Ethical Standards, Hospitality, Gifts, Research and Commercial Sponsorship all specify the standards of conduct to which all Board members adhere.

Disclosure of corporate governance arrangements

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

A.1.1 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. A statement describing how any disagreements between the Council of Governors and the Board of Directors will be resolved is contained in **Section 6** *(page 78)*.

A.1.2 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** *(page 40)* of this report.

A.5.3 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** *(page 78)* of this report. The number of meetings of the Council of Governors and the individual attendance by Governors and Directors is also contained in **Section 6** *(page 78)*.

B.1.1 The Board considers the following Non-Executive Directors to be independent in character and judgement:

i. Professor Alan Walker CBE;

ii. Martin Rosling;

iii. Anthony Clayton;

iv. Mervyn Thomas;

v. Susan Rogers MBE;

vi. Councillor Mick Rooney;

vii. Ann Stanley.

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.

B.1.4 Contained in **Section 3** *(page 40)* of this report is a description of each Director's expertise and experience and a statement on the Board of Directors' balance, completeness and appropriateness. In addition, it also contains information about the length of appointments of the Non-Executive Directors and how they may be terminated.

B.2.10 An explanation of the work of the Remuneration and Nomination Committee which oversees the appointment process of Executive members of the Board can be found in **Section 4** *(page 60)* 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** *(page 78)* of this report.

B.3.1 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** *(page 40)* of this report.

B.5.6 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** *(page 78)* of this report.

B.6.1 A statement on how the performance of the Board, its Committees and individual Directors was evaluated is contained in **Section 3** *(page 40)* of this report.

B.6.2 At the beginning of 2015 preparations began for an external evaluation which will be conducted in 2015/16 in line with Monitor's Well Led Framework for Governance Reviews.

C.1.1 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 and the approach taken to quality governance is detailed in the Annual Governance Statement (**Section 11)** *(page 158)* .

C.2.1 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** *(page 158)* of this report.

C.2.2 The Trust has an Internal Audit function. Information on how the function is structured and what role it performs is included in **Section 3** *(page 40)* of this report.

C.3.5 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.

E.1.5 Board members and in particular Non-Executive Directors develop an understanding of the views of Governors and members through their attendance at meetings of the Council of Governors. They are further informed of the Governors' views at their monthly board meetings as updates on the affairs of the Council of Governors and the Trust's members are a standing item on the Board's agenda. Further details on how the Board canvass the views of Governors and members can be found in **Sections 6** *(page 78)* and 7 *(page 88)* of this report.

E.1.4 Members who wish to communicate with Governors or Directors may do so by contacting the Deputy Board Secretary.

E.1.6 Information on monitoring how representative the Trust's membership is and the level and effectiveness of member engagement is contained in **Section 7** *(page 88)* of this report.

Detailed information regarding the Trust's membership constituencies and their eligibility, membership numbers, the membership strategy and steps taken in the year to ensure a representative membership are outlined in **Section 7** *(page 88)*.

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.

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** *(page 8)* of this report.

Section 6

Council of Governors

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 2014/15. 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 Health and Social Care Act 2012 and the Trust's Constitution. These include:

- Holding the Non-Executive Directors both individually and collectively to account for the performance of the Board of Directors;
- Holding the Board of Directors to account for the effective management and delivery of the organisation's strategic aims and objectives;
- To be consulted by Directors on future plans, including any significant changes to the delivery of the Trust's business plan, and offer comment on those plans;
- Receiving the annual accounts, any report of the auditor on them, and the annual report;
- Deciding whether any private patient work undertaken by the Trust would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England, or performing the Trust's other functions;
- Approving any proposed increases in non-NHS income of 5% or more in any financial year. Approval means that at least half of the Governors participating in the vote agree with the increase;
- Approving 'significant transactions';
- Approving an application by the Trust to enter into a merger, acquisition, separation or dissolution. In this case, approval means at least half the Governors participating in the vote agree with the amendments;
- Approving amendments to the Constitution.

In 2014/15, the Council of Governors appointed Ann Stanley as a Non-Executive Director and set her remuneration, terms and conditions (see section 6.5). It also appointed the Trust's External Auditors **(see section 3.4.1)**.

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;
- Representing the interests of members and partner organisations;
- Providing feedback to members;
- Developing the Trust's membership strategy;
- Contributing to constructive debate regarding the strategic development of the Trust and any other material and significant issues facing the organisation;
- Building and maintaining close relations between the Trust's constituencies and stakeholder groups to promote the effective operation of the Trust's activities.

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

The Engagement Policy which defines the relationship between the Board of Directors and the Council of Governors clearly sets out the roles and responsibilities of each including that of the Chair, Chief Executive, Lead Governor, Senior Independent Director as well as the Governors. Any disputes are resolved in accordance with the Trust's Constitution, where it is the Vice Chair's role to mediate and resolve the issue. The Engagement Policy provides further guidance on action to take depending on the type of dispute.

6.2 Composition of the Council of Governors

The Council of Governors comprises 44 seats, 33 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 CBE who is also the Chair of the Board of Directors. It is his responsibility to ensure that the views of Governors are represented at the Board of Directors and that information from the Board is fed back to the Council. He fulfils this responsibility through a monthly letter to Governors as well as providing updates at each Council meeting. The Chair also gives Governors the opportunity to meet with him 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 Lead Governor on 13 June 2013 for a 2 year term.

6 Council meetings took place during 2014/15. The individual attendance of each Governor is shown in Table 1, which also shows a breakdown of seats on the Council and associated Governors as at 31 March 2015, including their term of office.

Number of Seats	Name	Constituency	Date Appointed From	Date Term of Office Ends	Meetings attended over total number of meetings eligible to attend
9 Public seats (Elected)	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 01.07.2014	30.06.2014 30.06.2017	6/6
	Brandon Ashworth	Public South West	01.07.2010 10.12.2014	30.06.2013 30.06.2016	3/3
	Tina Levitt	Public South West	01.07.2013	23.07.2014	2/2
	Tamsin Ryder	Public South West	01.07.2013	09.12.2014	2/3
	Rosemary De Ville	Public South West	07.08.2014	30.06.2016	4/4
	Dave Jones	Public North East	01.07.2011	30.06.2014	1/1
	Trudie Smallwood	Public North East	01.07.2011	30.06.2014	0/1
	Paul Harvey	Public North West	01.07.2011	30.06.2014	0/1
	Sylvia Hartley	Public North West	01.07.2014	30.06.2017	3/5
	John Buston	Public North West	22.09.2014	30.06.2016	4/4
	Afrah Alkheili	Public North East	01.07.2014	30.06.2017	4/5
	Lorraine Ricketts	Public North East	01.07.2014	30.06.2017	0/5
	Susan Wood	Public North West	01.07.2010 01.07.2013	30.06.2013 08.07.2014	0/1

Number of Seats	Name	Constituency	Date Appointed From	Date Term of Office Ends	Meetings attended over total number of meetings eligible to attend
10 Service User seats (Elected)	Dean Chambers	Service User	11.08.2014	10.08.2017	3/4
	Tyrone Colley	Service User	01.07.2011 01.07.2014	30.06.2014 30.06.2017	4/6
	Shamshad Hussain	Service User	01.07.2011	30.06.2014	0/1
	John Kay	Service User	01.07.2013	30.06.2016	5/6
	Neel Khan	Service User	24.04.2014	30.06.2014	0/1
	Pat Molloy	Service User	01.07.2013	30.06.2016	3/6
	Russell Shepherd	Service User	22.04.2013 01.07.2014	30.06.2014 30.06.2017	5/6
	Kate Steele	Service User	01.07.2011 01.07.2014	30.06.2014 03.03.2015	3/6
	Nev Wheeler OBE	Service User	01.07.2013	30.06.2016	4/6
	Myra Wilson	Service User	01.07.2011	30.06.2014	0/1
	Debjanji Chatterjee	Service User	11.08.2014	10.08.2017	2/4
	Andrew South	Service User	01.07.2014	26.02.2015	2/4
	Doug McCallum	Service User	12.02.2014	20.03.2015	1/6
	Sarah Burke	Service User	24.03.2015	23.03.2018	0/0
	Toby Morgan	Service User	24.03.2015	23.03.2018	0/0
2 Young Service User/ Carer seats (Elected)	Abbey George	Young Service User/Carer	27.07.2012 01.07.2014	30.06.2014 30.06.2017	4/6
	Jean-Michel Bellas	Young Service User/Carer	01.04.2013	25.09.2014	1/2

Number of Seats	Name	Constituency	Date Appointed From	Date Term of Office Ends	Meetings attended over total number of meetings eligible to attend
4 Carer Seats (Elected)	Leon Ballin	Carer	01.07.2011	05.08.2014	0/2
	Ian Downing	Carer	01.07.2013	30.06.2016	4/6
	Jean Nicholson	Carer	01.07.2011	30.06.2014	0/1
	Susan Roe	Carer	01.07.2013	30.06.2016	6/6
	Gill Holt	Carer	01.07.2014	30.06.2017	4/5
	Angela Barney	Carer	24.03.2015	23.03.2018	0/0
8 Staff Seats (Elected)	Dan Creber	Social Work	01.07.2014	30.06.2017	2/5
	Joan Davies	Psychology Staff	11.11.2013	10.11.2016	4/6
	Elaine Hall	Allied Health Professionals	01.07.2011 01.07.2014	30.06.2014 30.06.2017	6/6
	Elliott Hall	Central Support Staff	01.07.2011	30.06.2014	0/1
	Diane Highfield	Clinical Support Staff	11.11.2013	10.11.2016	3/6
	Dani Hydes	Central Support	08.07.2014	07.07.2017	4/4
	Enos Mahachi	Support Work Staff	01.07.2014	30.06.2017	3/5
	Paul Miller	Medical & Clinical Staff	01.07.2011 01.07.2014	30.06.2014 30.06.2017	5/6
	Stephanie Pursehouse	Support Work Staff	01.07.2011	30.06.2014	0/1
	Vin Lewin	Nursing Staff	01.04.2013	31.03.2016	3/6

Number of Seats	Name	Constituency	Date Appointed From	Date Term of Office Ends	Meetings attended over total number of meetings eligible to attend
11 Appointed Governors (Stakeholders)	Professor Peter Woodruff	University of Sheffield	24.08.2011	13.03.2015	4/6
	Joan Healey	Sheffield Hallam University	29.09.2011 29.09.2014	28.09.2014 28.09.2017	5/6
	Sue Highton	Staffside (Unions)	01.07.2011 01.07.2014	30.06.2014 30.06.2017	3/6
	Teresa Barker	Age UK Sheffield	26.11.2013	25.11.2016	0/6
	Janet Sullivan	Sheffield MENCAP	01.07.2011 01.07.2014	30.06.2014 30.06.2017	5/6
	Dr Abdul Rob	Pakistan Muslim Centre	24.01.2011 24.01.2014	23.01.2014 23.01.2017	4/6
	David Bussue	SACMHA	30.07.2012	23.02.2015	1/6
	Celia-Jackson Chambers	SACMHA	23.02.2015	22.02.2018	1/1
	Cllr Roger Davidson	Sheffield City Council	14.11.2012	13.11.2015	6/6
	Cllr Clive Skelton	Sheffield City Council	31.07.2012	22.05.2014	1/1
	Cllr Jenny Armstrong	Sheffield City Council	11.06.2013	29.04.2014	0/1
	Cllr Adam Hurst	Sheffield City Council	05.09.2014	04.09.2017	3/4
	Cllr Josie Paszek	Sheffield City Council	04.02.2015	03.02.2018	1/2
	Dr Leigh Sorsbie	Sheffield CCG	18.12.2014	17.12.2017	0/2

6.3 Changes to the Council of Governors

In 2014/15 3 elections took place. 3 constituencies were uncontested as detailed below.

Constituency	Number of candidates	Successful Candidate(s)
Public: South East	3	Jules Jones
Staff: Support	2	Enos Mahachi
Staff: Central Support	1	Dani Hydes (uncontested)
Service User	4	Debjani Chatterjee MBE Dean Chambers
Service User	2	Toby Morgan (uncontested) Sarah Burke (uncontested)
Carer	1	Angela Barney (uncontested)

In addition, the following Governors stood down from the Council during 2014/15

Name	Constituency	Replaced by
Cllr Clive Skelton	Sheffield City Council Local Authority	Cllr Jenny Armstrong
Cllr Jenny Armstrong	Sheffield City Council Local Authority	-
Susan Wood	Public North West	John Buston
Tina Levitt	Public South West	Rosemary de Ville
Leon Ballin	Carer	Angela Barney
Cllr Jayne Dunn	Appointed Local Authority	-
Jean-Michel Bellas	Young Service User/Carer	-
Tamsin Ryder	Public South West	Brandon Ashworth
David Bussue	Appointed, SACMHA	Celia Jackson-Chambers
Kate Steele	Service User	Toby Morgan
Andrew South	Service User	Sarah Burke
Professor Peter Woodruff	Appointed (University of Sheffield)	-

6.4 Governor Activities in 2014/15

6.4.1 Holding to Account

Throughout the year Governors have undertaken a number of activities which have enabled them to fulfil their statutory duties, represent members and the public and hold the Trust to account. The foundation of their success is dependent upon their relationship with the Board of Directors. 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 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.

An additional mechanism by which Governors can scrutinise the Trust's performance is through the Performance Overview Group. This provides an opportunity for Governors to spend more time with key Board members scrutinising aspects of human resources and workforce, finance, quality and governance. Detailed information is provided which is then analysed and discussed with Executive Directors. The Performance Overview Group met 4 times in 2014/15.

To further strengthen the Board of Director's accountability and increase its scrutiny, Governors are invited to ask questions of the Board at each meeting. The responses to these questions are formalised in the minutes of Council meetings. Governors have used this mechanism to question the Trust on RESPECT training, the smoking policy, financial legacy risks, young carers, governance processes, food banks, detox beds, learning disabilities consultation, Governor training, support for service users discharged from the Crisis House, suicide prevention strategies, evidence based psychiatry and liaison psychiatry into the local Accident & Emergency Department.

6.4.2 The Forward Plans

The Board of Directors holds an annual session with Governors to discuss the Trust's forward plans. This is undertaken prior to firm objectives being set so that the views of Governors can help shape objectives. In addition, Governors then seek the views of their members so that objectives can be fully informed by the membership. Governors do this via the membership magazine and an electronic and paper survey. This method resulted in over 400 members' responses. Governors presented the outcome of the survey to the Board of Directors in February 2015.

6.4.3 Other Activities

Governors were provided with training during 2014/15 which enabled them to understand their role and duties, the national context in which NHS Foundation Trusts operate and how to hold the Trust and Non-Executive Directors to account.

In addition, the Council of Governors undertook an appraisal of its performance. Overall, it appraised itself as having sufficient knowledge to carry out its duties, but identified that it would like to strengthen its own internal communications processes.

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

- CAST;
- Carers Centre Mental Health Carers Group;
- Children Young People and Family Support Scrutiny Committee (SCC);
- Clover Group Patient Participation Group;
- Community Mental Health Team Review;
- Crisis House Governance;
- Families Lobbying and Advising Sheffield (FLASH);
- Health and Wellbeing Event;
- Healthwatch;
- Learning Disabilities Case Register;
- Membership Engagement;
- Mental Health Partnership Board;
- New Connections;
- Nomination & Remuneration Committee;
- Partnership First;
- Patient Participation Group for Primary Care Services;
- PLACE visits;
- Psychological Therapies Governance Committee;
- Quality Improvement Group;
- Recovery College;
- Roshni Asian Women's Resource Centre;
- Service User Safety Group;
- Sheffield Anglican Diocese;
- Sheffield Health and Wellbeing Board;
- Sheffield Women's Counselling Services;
- SUN:RISE (service user involvement network);
- Thornsett Road Focus Group;
- Wellbeing Festival;
- World Mental Health Day.

Through their wider interests, the Governors were 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 email **karen.jones@shsc.nhs.uk** or telephone **(0114) 271 6747**.

6.5 The Nominations and Remuneration Committee of the Council of Governors

While the appointment of the Trust's 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's Chair and the Non-Executive Directors.

The Trust's Chair presides over the meetings of the Committee, except in circumstances where there would be a conflict of interest in which case the Reserve Chair (who is a member of the Council and Lead Governor) presides.

In 2014/15 a recruitment process was held for 1 Non-Executive Director whose term had come to an end. The process was formal and rigorous and is summarised below.

The role profile, person specification and appointment process were agreed and proposed to the Council of Governors for its approval. After advertisement, undertaken by both an external resourcing company and via local links, a long list of candidates was considered by the Nominations and Remuneration Committee. The candidates were then invited to a stakeholder event with Governors (who were not members of the selection panel). This was followed by a formal interview by the panel drawn from the Nominations and Remuneration Committee which selected a candidate and recommended their appointment to the Council of Governors. This was duly accepted and Ann Stanley was appointed as a Non-Executive Director with effect from 01 November 2014 for a period of 3 years.

The attendance of Committee members is shown below.

Name	Position	Attendance
Professor Alan Walker	Chair	3/3
John Kay	Reserve Chair/Lead Governor	3/3
Russell Shepherd	Committee Member	2/3
Paul Harvey	Committee Member Left 30/6/14	2/2
Dave Jones	Committee Member Left 30/6/14	0/2
Abbey George	Committee Member	3/3
Ian Downing	Committee Member	3/3
Elaine Hall	Committee Member	3/3
Jules Jones	Committee Member Commenced 16/12/14	1/1
Sylvia Hartley	Committee Member Commenced 16/12/14	1/1
Professor Peter Woodruff	Committee Member Left 13/3/15	2/3

Section 7

Membership

Foundation Trust status gives us the advantage of being closely influenced by the people who live in the communities which we serve. This is reflected in the diversity of the constituencies in 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 class and its eligibility criteria and, where applicable, the number of members in the class as at 31 March 2015.

Constituency	Class	Number of Members	Criteria
Public	South West	3118	Must live in the following electoral wards: Gleadless Valley, Dore & Totley, Fulwood, Graves Park, Nether Edge, Ecclesall, Beauchief & Greenhill, Crookes
	South East	2562	Must live in the following electoral wards: Darnall, Manor Castle, Arbourthorne, Richmond, Birley, Mosborough, Beighton, Woodhouse
	North West	2277	Must live in the following electoral wards: Stocksbridge & Upper Don, Stannington, Hillsborough, Walkley, Broomhill, Central
	North East	2459	Must live in the following electoral wards: West Ecclesfield, East Ecclesfield, Southey, Firth Park, Burngreave, Shiregreen & Brightside
	Out of Sheffield	447	Any area within England outside of the Sheffield electoral wards
Service User	Service User	1008	Must have received a service or services from the Trust within the last 5 years
	Carer	649	Must have cared for someone who has received a service from the Trust in the last 5 years
	Young Service User or Carer	95	A service user and carer, but must be 35 years old or younger
Staff	Allied Health Professionals	166	Must have either worked for the Trust continuously for at least 12 months or have a contract of no fixed term
	Central Support Staff	315	
	Clinical Support Staff	594	
	Medical & Clinical	225	
	Nursing	581	
	Psychology	244	
	Social Work	61	
	Support Work	1010	
Appointed	Voluntary, Community & Faith Sector Organisations	Not applicable	Not applicable
	University of Sheffield		
	Sheffield Hallam University		
	Staffside (unions)		
	Local Councillors		
	NHS Sheffield		

At the end of March 2015 there were 12,615 members (excluding staff).

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

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

Some of the actions identified to achieve these 4 points are:

- Widely publicising the opportunities and benefits of membership;
- Recruiting members from across the whole community;
- Specifically targeting hard to reach groups;
- Developing and supporting effective channels of communication and engagement between Governors and members;
- Ensuring membership is a worthwhile experience for individuals by engaging them in a manner of their choice.

7.3 Membership Recruitment & 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 ethnically diverse areas of the city as well as people with a learning disability. The events included:

- Sheffield Consumers In Research;
- Darnall Health Centre Information Day;
- Learning Disabilities Week;
- Sharrow Festival;
- Sheffield EID Festival;
- Wellbeing Festival;
- World Mental Health Day Celebrations;
- Recruitment events at the Royal Hallamshire Hospital and Northern General Hospital.

The Trust held a very successful Annual Members' Meeting in 2014 which over 250 staff and members attended. The event celebrated the excellence of staff and volunteers as well as providing an opportunity for members to learn more about the Trust and its services. Governors presented a report on their activities to members. In addition, the membership was asked to approve an amendment to the Trust's Constitution in the form of a new public membership category for people who live outside Sheffield's electoral wards. This was approved by a majority vote.

The Trust continued to respond to and engage with members' issues by holding 2 successful membership events: the event on depression and anxiety (which coincided with World Mental Health Week) was attended by over 100 people; the other event focused on the importance of nutrition. A programme of events will continue throughout 2015/16 which will reflect the issues members have told us are important to them.

As well as maintaining 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 maintains its focus on the issues that are important to members. The editorial group also ensure 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 should they wish to do so.

If you want to contact your Governor, you can telephone (0114) 2718768, email **governors@shsc.nhs.uk** or write to

The Council of Governors

FREEPOST

SHSC NHS FOUNDATION TRUST

Section 8

Sustainability Report

Our approach to sustainability is reflected in our Sustainable Development Policy. The objectives of the policy are for the Trust to continually improve upon and manage its environmental impacts wherever possible, while taking value for money into account. This will include:

- Conservation of water, energy and other resources;
- Appropriate waste disposal;
- Monitoring discharges and emissions with the aim of reducing pollution and greenhouse gases;
- Promoting recycling;
- Training and educating staff, involving them in developing new ideas and initiatives.

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

We have taken a range of actions during 2014/15 to improve our sustainability performance.

In last year's Annual Report we mentioned we had successfully obtained Department of Health Energy Efficiency Fund money for 2 schemes. These were both completed successfully and on time:

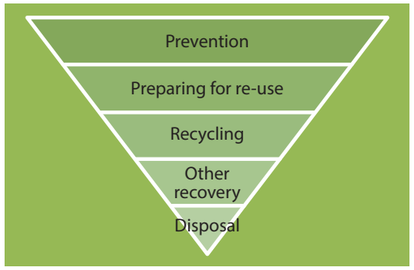
- The software system to shut down Personal Computers (PCs) when not in use was well received across the Trust and is fully implemented at all sites with some 1,500 PCs incorporated, although the savings are slightly less than anticipated at £9,000 per annum. This equates to 1,114,529 inactive hours/annum and just under 100 tonnes or reduced greenhouse gas emissions;
- The Combined Heat & Power (CHP) Unit at our Michael Carlisle Centre has generated 13,906 Kw of electricity in the first 6 months of operation giving a saving of £1,390. The associated replacement boiler plant at this site is proving to be at least 20% more efficient than the very old boilers previously in place. We will be able to fully assess the impact after the end of the winter period and when the systems have been operational for 12 months.

We have continued to self-fund a number of smaller schemes which have a beneficial impact. These include:

- Smaller boiler replacement schemes at our Lightwood House and Forest Lodge sites also saving on average 20% energy;
- The introduction of LED (light emitting diode) lighting in some areas via refurbishment schemes – this type of lighting typically uses 75% less energy and also has a much lower maintenance frequency due to the very long lifetime of the lamps;
- Supplying our estates craftsmen with Personal Digital Assistants (PDAs) which enable them to receive job requests in real time via our office computers - this is beginning to save on mileage travelled;
- The introduction of Smart metering and targeting which enable the demonstration of energy use across our sites. We will aim to use this data to target inappropriate or high use sites;
- Replacement of out of date Building Management System (BMS) controls which optimise heating control and enable heating levels to be amended from our estates office.

One of the main actions we have taken during 2014/15 is to significantly revise and improve our approach to waste management. This commenced around 15 months ago with the appointment of a new member of staff in the Facilities Directorate, part of whose job role it is to specifically manage waste disposal. The initiatives taken so far are outlined below:

- Wherever possible the Trust implements the Waste Hierarchy tool (see below). Preventing the creation of waste in the first instance is key to developing a sustainable organisation and environment while reducing the lifecycle costs of products and services;



(Source: Defra, 2011)

- Revised Waste Management Policy ratified on 23 October 2014 providing relevant and up to date advice and information;
- 100% of our black bag waste continues to be diverted from landfill and is incinerated at Veolia's Energy Recovery Facility, generating green heat and power, supplying city homes and businesses with heating and hot water;
- A full suite of recycling including plastics, aluminium and paper, is recognised by the Trust with a total of 26 premises implementing this disposal route. This is an increase of 44% based on 2013/14 figures;
- We have continued to improve our compliance with disposal of hazardous (non-clinical/ healthcare) materials such as fluorescent tubes, paints, batteries, WEEE (electrical) waste by ensuring safe and secure storage solutions are in place prior to collection by our approved waste contractors;
- A 2 yearly training tool has been developed and included within the our revised Waste Management Policy (Level 2 compliance with the Trust's Training Needs Analysis Tool) for completion by staff with higher levels of involvement/management with waste – this may include housekeepers, caretakers, tradesmen, gardeners and healthcare assistants;
- 6 monthly audits are undertaken by the Trust's Waste Lead, ensuring compliance and value for money across the Trust while delivering support and advice to Ward and Site Managers and Co-ordinators;
- A 6 monthly Audit Tool for all sites and wards has also been established and is included within our revised Waste Management Policy. This enhances local ownership and encourages each site or ward to ask 'are we compliant?', 'could we do more?';
- Waste Management Roadshows were held across the Trust in November, December and February. These were incredibly successful with a total of 112 staff attaining Level 1 Waste Management Training (which is mandatory under the Trust's Training Needs Analysis Matrix);
- Expectation of savings in the region of 20% from waste contractors Healthcare Environmental Services with reduced prices from 01 January 2015 for the offensive (tiger bags) and clinical (orange bags, sharps bins and pharmaceutical waste) waste streams. This has been brought about through the anticipated reclassification and utilisation of floc waste (a by-product of incineration) as an energy source.

Reporting Table/Metrics

Area	Type	Non-financial information	Financial information
Greenhouse Gas Emissions	Direct Greenhouse Gas Emissions	In 2014/15 the Trust consumed 11,493,590 kWh of Gas which equates to 2126 tonnes of Co2e*	In 2014/15 the Trust spent £371,043 kWh purchasing Gas
	Indirect Energy Emissions	In 2014/15 the Trust consumed 3,327,125 kWh of Electricity which equates to 1740 tonnes of Co2e*	In 2014/15 the Trust spent £356,597 purchasing Electricity
	Official Business Travel Emissions	Grey Fleet (including Lease Car Mileage)** In 2014/15 mileage travelled by the Grey Fleet amounted to 1,381,188	Grey Fleet (inc. Lease Cars): In 2014/15 the Trust spent £774,718 on mileage for the Grey Fleet
Waste Minimisation and Management	Domestic Waste (Including Recycling and Offensive Waste)	For 2014/15 the figures for Domestic Waste are as follows: Total Waste Arising: - 449,036 kg Waste to Landfill: - 51,008 kg Waste Recovered/Recycled: - 398,028 kg Waste Incinerated: - 0 kg	Domestic Waste: In 2014/15 the cost of disposing of Domestic Waste was £82,895.67
	Healthcare Waste (orange bags, sharps, mattresses and Pharmaceutical Waste)	For 2014/15 the figures for Healthcare Waste are as follows: Total Waste Arising: - 16,723 kg Waste incinerated: - 9,562 kg Waste to Deep Landfill: - 7,161 kg	Healthcare Waste: In 2014/15 the cost of disposing of Healthcare Waste was £21,748.91
Finite Resources		In 2014/15 the Trust consumed 42,890 m3 of water and sent away 40,745 m3 in the form of sewage	In 2014/15 the total water and sewage cost was £126,372

* Co2e = Carbon Dioxide Equivalent which is a way of reporting all greenhouse gas emissions or reductions as 1 standard unit

** Grey Fleet = employee-owned (or lease) vehicles used for Trust business purposes (home visits, meetings, conferences etc)

Future Priorities and Targets

We have been working with a specialist consultancy (ECOVATE) to develop a range of proposals to continue increasing both our energy efficiency and our overall approach to sustainability. Subject to agreement we will plan to procure delivery of a strategic programme of energy efficiency measures including additional LED lighting, more CHP units, improved insulation, better zone control and different heating circuit pumps, as well as more new boilers.

We will also plan to introduce a Sustainable Development Management Plan (SDMP). This will embody our longer term strategic approach and will ensure involvement of the whole organisation from top to bottom. The SDMP will address a suite of issues and will be measured by our progress against the Good Corporate Citizen initiative.

We have already held a series of events to engage staff with our sustainability agenda and a number have signed up to be volunteer 'Sustainability Champions' who will promote good practice in their own workplaces. We held events to mark NHS Sustainability Day on 26 March 2015.

We are building a new Psychiatric Intensive Care Unit (PICU) due to open in Autumn 2015 which has a wealth of sustainability features incorporated into its design, for example, air source heat pumps, photo voltaic panels, green roof and living green wall, modern insulation standards and LEDs

Section 9

Quality Account

Part 1: Quality Account 2014/15 Chief Executive's welcome

I am pleased to present the Sheffield Health and Social Care NHS Foundation Trust Quality Account for 2014/15.

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.

During this year we have continued to progress a number of important 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;
- Being clear about standards we want to deliver and working with people who use our services and our staff to deliver improvements;
- Ensuring staff within teams have access to better information about how they are performing in their aim to deliver high quality services.

In October and November of 2014 we had a planned inspection of our services by the Care Quality Commission. At the time of issuing this Quality Account and our Annual Report the findings from the Inspection have not been concluded or published. Therefore, we are unable to provide an account of the findings from the Inspection and our plans to respond at this stage. The findings of the Inspection will identify areas of concern about some services we provide, along with many examples of good practice. We are clear that the findings will help us focus on the issues that we need to improve and once they are available we will publish the reports and our development plan that shows how we will make the necessary improvements. More information about this is in section 2B of this report.

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 in many areas. However, we also know we can do better, and need to do better. Our ambition is to provide excellent services that deliver a really positive experience for the people who need them. We have much to do to ensure the quality of what we provide is of a consistently high standard for every person in respect of safety, effectiveness and experience. Our plans for quality improvement will ensure we make continued improvements.

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 2014/15 and our goals for 2015/16

In setting our plans for 2014/15 we reviewed our priorities for quality improvement. The people who use our services and the membership of our Foundation Trust have been instrumental in deciding what our priorities are.

In undertaking this review 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 Healthwatch.

Our Governors engaged with our members about our proposed priorities and we have received comments and feedback from over 400 of our members about our priorities we proposed for this year. From this review the Council of Governors have reviewed our plans and we have taken on board their feedback.

Through this year we 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 improvement during 2014/15 were:

Responsiveness

Quality Objective 1: We will improve access to our services so that people are seen quickly;

Safety

Quality Objective 2: We will improve the physical health care provided to our service users;

Experience

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

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

We chose this priority because

The evidence clearly demonstrates that prompt access to effective treatment has a significant impact on outcomes.

When we met with our Governors this was a key area of concern for them. They wanted us to ensure that people got seen quickly when they needed to. Improving access is an area prioritised by our Commissioners and they are supportive of improvement and service reconfigurations to help us achieve this. We had started to make some improvements in reducing waiting times but not as much as we wanted to.

We said we would

Reduce the time it took for people to get an assessment of their needs following a referral in our Improving Access to Psychological Therapies (IAPT) Service, adult Community Mental Health Teams (CMHTs)and our Memory Service.

How did we do?

We have made positive progress in some areas, but not within the Memory Service.

IAPT Service

The information below shows the positive progress made. This has been achieved through an on-going development programme focused on improving pathways and working relationships with each GP Practice. Through this we have reduced the numbers of inappropriate referrals which has meant we are able to see people more quickly than before. Over the last 2 years, we have introduced direct booking by GPs, which reduces the amount of time it takes to offer an appointment. This year we aimed to continue to reduce overall waiting times for the service. We also wanted to reduce waiting times in the 2nd half of the year for those GP Practices which had experienced the longest waits.

Measure	2013/14	2014/15
How many people started treatment	11,611	13,535
Average waiting time to start treatment	5.3 weeks	4.2 weeks
Average waiting time to start treatment for 8 GP Practices with longest waits.	9.6 weeks	2.3 weeks (Oct-March)

As well as monitoring performance based on average waiting times, we look to make sure as few people as

possible wait longer than the averages. The following information shows the proportion of people we saw within different time ranges.

Measure	2013/14	2014/15
Between 0-6 weeks	68%	79%
Between 6-12 weeks	22%	16%
Between 12-18 weeks	6%	3%
Longer than 18 weeks	3%	1%

The above information shows how long people have been waiting to access talking therapies within the IAPT Service. A small number of people once they have started treatment need to access counselling support, and they can wait around 14 weeks to start this. We plan to reduce waiting times for counselling over the next year.

CMHTs

The information below shows the position over the year. We have focussed on improving the way referrals are managed and triaged, appointments are made and assessment clinic slots are best utilised to meet demands. This work will continue and we expect to reduce the overall waiting time for the service.

Measure	2013/14	2014/15
Average waiting time for people to be assessed in our adult CMHTs for a routine appointment	36 days	40 days

As well as monitoring performance based on average waiting times, we look to make sure as few people as possible wait longer than the averages. The following information shows the proportion of people we saw within different time ranges.

Measure	2013/14	2014/15
Between 0-6 weeks	79%	82%
Between 6-12 weeks	16%	15%
Between 12-18 weeks	3%	2%
Longer than 18 weeks	2%	1%

Memory Service

We haven't made the progress we wanted to in reducing waiting times for this important service. During the year we agreed improvement plans with our Commissioners to provide more follow up support in community settings. This is more convenient for service users, and will free up resources in the specialist assessment clinic to see more new referrals. This should have a beneficial impact on reducing waiting times.

These changes were introduced during the autumn, and should have a more noticeable impact next year. However, during this year the number of referrals received by the service has increased by 41%.

Measure	2013/14	2014/15
No. of referrals	1,517	2,150
No. of initial assessments	1,396	1,700
Average waiting time for assessment	140 days	161 days

How will we keep moving forward?

We will continue to focus on waiting times to access services. During 2015/16 we plan to:

- Continue with the above improvement work for CMHTs;
- Review our capacity and resource plans for the Memory Service due to the increased levels of demand and agree a way forward with Commissioners and the Healthier Communities and Adult Social Care Scrutiny Committee;
- Define waiting time standards for all our services and publish information about how we are performing for each service;
- Ensure we deliver on the new national access targets for waiting times for IAPT Services and Early Intervention Psychosis services.

Quality Objective 2: We will improve the physical health care provided to our service users

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 have been 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.

The need to deliver continued improvements in this area is 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. As we have developed our plans our clinicians have told us this was a key area they wished to focus on to deliver improvements. We know from reviewing progress against our Physical Health strategy and national audits that we have further improvements still to make.

We said we would

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

- Smoking cessation - offering advice guidance and referrals to the Smoking Cessation Service to decrease smoking among service users, and develop our Trustwide plans to support smoking cessation;
- Alcohol – providing alcohol screening across services to ensure timely referral to appropriate services;
- Obesity - providing advice and support to address the issue of poor lifestyle choices, encouraging healthy diet and exercise;
- Diabetes - ensuring 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 - ensuring 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 – ensuring that all service users have appropriate physical health checks, whether completed by our services or within our partner organisations.

How did we do?

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

- Smoking cessation – we have improved the way we gather information about if people smoke and have encouraged staff to be more proactive about this. The Board has formally committed the whole of our organisation to going smoke-free. This programme will be formally launched early in 2015/16 and supported by a range of proactive initiatives to support service users and staff to stop smoking, while not allowing smoking anywhere within the Trust's premises;
- Alcohol - the Alcohol Screening Tool is incorporated into the city-wide 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 have begun to improve our standards of practice within our in-patient services for assessing alcohol use with service users, and have developed plans to extend this into community services. However, we need to continue to improve how we do this consistently, and ensure it informs on-going decisions about people's care and support;
- Obesity - an e-based version of the malnutrition universal screening (MUST) tool and associated training is in place across most of the in-patient areas and we have reviewed our weight management care pathway during the year. 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 and Diabetes Link Nurse roles. 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 implemented that contain diabetes related skills and knowledge, including Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS), Foot Care, Physical Assessment, Apprentice Programmes. We have introduced an audit programme regarding standards to reduce harm for people with diabetes;
- 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 in oral health care;
- Physical Health checks - the recording of physical health assessment on has improved across our in-patient services, with a plan to address shortfalls in place. Revised protocols for the use MUST Tool, falls, patient safety thermometer, and the introduction of local audits in the previous year, 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 service.

National Physical Health Audit

The Trust participated in the national audit programme to support improvements in how we assessed and planned for the physical health needs of people with serious mental health problems. This audit formed part of the CQUIN scheme we have with NHS Sheffield CCG (see Part 2B). The audit had 2 important elements.

Physical health screening for in-patients

To ensure patients with a psychosis had received an assessment and appropriate plans were in place in respect of:

- Smoking;
- Lifestyle (including exercise, diet, alcohol and drugs);
- Body Mass index;
- Blood pressure;
- Glucose regulation;
- Blood lipids.

We re-audited the care provided as part of the national audit programme in December 2014, and achieved the above standards for 74% of in-patients with a psychosis.

We are pleased that we have made the progress we have, however we will continue to focus on this important area. We need to improve the delivery of the standards and ensure the information from the assessments of people's physical health circumstances fully informs the on-going plans for people's care.

Communication with GPs

A key goal is to ensure that we have clear and shared information between our services and primary care about people's mental and physical health care needs. We audited how we were doing between July – August 2014, and we were not achieving the standards (see below). We developed clear guidance for services and repeated the audit in February – March 2015. We audited the records of 100 people on the Care Programme Approach to examine if we had shared information with their GPs about

- Their diagnosis in respect of the individual's mental and physical health conditions;
- Medications prescribed and arrangements for monitoring;
- The individual's physical health condition and on-going monitoring and treatment needs.

We achieved the standards for 94% of the records we audited.

How will we keep moving forward?

Overall, we continue to make progress, but we are clear that we have further work to do to ensure the best standards of care and support are being provided to people consistently. As part of our overall physical health strategy programme, we will be focussing on the following developments next year:

- Smoking cessation - ensuring nicotine replacement treatments/patches are available. Working with Pharmacy to ensure all in-patient areas have daily access to these options. Train staff to deliver smoking cessation advice and not be reliant on referral elsewhere;
- Evaluate a 'bespoke smoking cessation' service specifically tailored to individual service users with severe mental illness. A mental health nurse or allied health professional will be trained to deliver smoking cessation interventions, and to become the service user's mental health-smoking cessation practitioner;
- Continue working with GPs to ensure equity of access to primary care services for people with mental health problems, or a learning disability. Develop joint working initiatives/training plans with GPs to increase uptake by service users;
- Improve CMHT interventions in relation to physical health (assessing/screening) and continue to deliver the RAMPPS programme;
- Continue to audit compliance with physical health assessments for all our in-patient settings and oversee the quality and training standards required for Cardio Pulmonary Resuscitation (CPR) practice in settings that deliver mental healthcare.

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

We chose this priority because

Understanding the experiences of the people who use Trust services is essential if we are to be successful in achieving quality improvement. In November 2013 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 2014/15 and beyond 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.

The Board of Directors invested in the establishment of a service user monitoring unit within the Trust. This department was to be led by a service user and support the Trust's on-going strategies to improve our understanding of the experience of the people who use our services.

We said we would

- Establish a service user led unit to lead on work within the Trust to understand experience;
- Review our existing development plans to ensure they were focussed on the right issues.

How did we do?

We have started to review the approaches we use to understand service user experience across our different services. We will develop these next year, establishing best practice standards. We have implemented the Friends and Family Test to provide service users with simple ways to let us know about their experience.

Our plans for service user engagement

During the year we reviewed the progress being made on key development priorities. These were ensuring we provided recovery oriented services and care, and ensuring we engaged with service users in all aspects of how we provide care and deliver services.

Informed by this review we have established a Trustwide service user engagement group to lead on service user engagement and ensure a co-ordinated and effective approach is taken to delivering the improvements we need to make. This group is chaired

by a service user, supported by the Deputy Medical Director. The group has established the following objectives:

- To have in place effective and consistent approaches for the collection of Trustwide information about service user experience;
- To ensure service user involvement takes place at the most senior levels of decision making;
- To ensure that service users are partners in their own care and in supporting the recovery of others;
- To establish a performance framework for governing service user experience, ensuring regular feedback to Teams, the Board and Governors;
- To have in place a range of appropriate information technology based solutions to support the gathering and recording of service user feedback;
- To develop quality indicators for supporting recovery in appropriate service areas, based on and using the Implementation of Recovery Orientated Care (ImROC) 10 key challenges and the NICE Quality Standard for Service User Experience 2011.

How will we keep moving forward?

We will implement the above objectives, and report on progress next year.

How are we doing on our previous years Quality Objectives?

Introduction

In last year's Quality Account we reported on progress for the previous 2 year period 2012/13 to 2013/14. Because of the progress made we reported that we would no longer continue with some of our Quality Objectives. In doing this, we said that we would continue to report on progress in 2 important areas, even though they were no longer part of our formal Quality Objectives.

Reducing the incidence of violence and aggression and use of restraint and seclusion

Ensuring the safety of service users and our staff is of paramount importance to the Trust. As a result, one of our key areas of development continues to be the reduction of instances of violence and aggression and the subsequent use of restraint and seclusion.

The policy environment changed in 2014 following the publication of Positive and Proactive Care by the Department of Health and changes made to the Mental Health Act 1983 Code of Practice. Put together, the changes proposed in both documents are far reaching and extended beyond the remit of the Trust's original reduction programme. As a result, a project group was established, chaired by the Deputy Medical Director, to examine the changes proposed with a view to implementing them on a Trustwide basis.

These changes include:

- The creation of a Trustwide dashboard to capture all forms of restrictive intervention across all of our sites;
- The introduction of positive behavioural support or something similar in which to identify the root cause of behaviours that challenge;
- Increased access to meaningful activities across bed based services;
- Development of an environment and culture that supports service users' needs in a way that reduces to a minimum the need for restrictive interventions;
- Ending all face down physical restraint;
- Providing support to service users in a way that results in us no longer needing to use seclusion to keep people safe;
- Ensuring that staff have the resources and training to deliver care in an environment that feels safe and supportive.

Delivery of the programme is realising the following results:

- A single reported instance of face down restraint in 2014/15;
- Roll out of an e-reporting system in which to eradicate the current paperbased system and, by implication, increase instances of reporting;
- A much better and broader understanding of the way service users movements are being restrained and restricted as a result of better reporting. We have doubled our reported numbers of restraint related incidents.

Incident type	2012/13	2013/14	2014/15
Incident reported where **service users** had been:			
Secluded;	74	279	304
Restrained;	89	184	406
Assaulted;	387	384	420
Caused harm from assault.	72	75	217
Incidents reported where **staff** working in in-patient services:			
Had been assaulted;	606	595	489
Were harmed due to the assault.	99	108	157
Level of harm caused from the assault:			
Negligible harm;	68	87	117
Minor or moderate;	31	21	40
Major and above.	0	0	0

While our plan is ambitious and requires further development, the Trust has been encouraged by early successes. We believe that this plan achievable in the longer term and will promote our position as a caring and compassionate provider of choice.

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

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. For this reason, we continue to deliver a range of improvement programmes and monitor closely how we are doing.

In last year's Quality Account we reported that overall incidents of falls that resulted in harm had reduced by 25% over the three year period from 2011/12.

Over the last year the number of falls that resulted in harm increased, following a year on year decrease over the previous 3 years. A summary of the impact of the harm caused is provided in the table below:

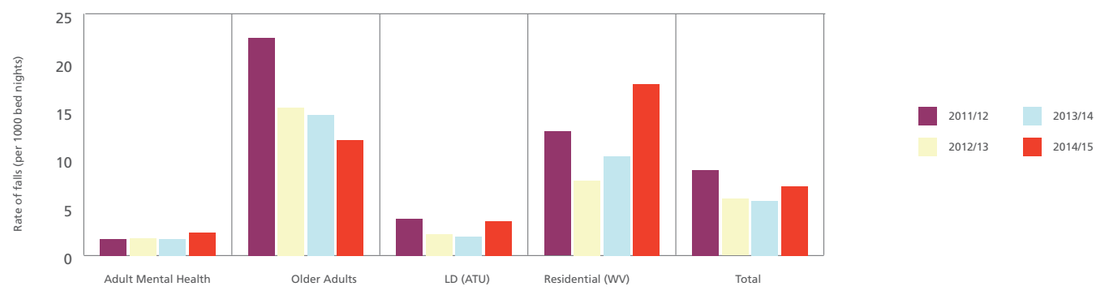
How many incidents of	2012/13	2013/14	2014/15
Falls resulting in harm	403	387	404
Needed to attend hospital or A&E	52	50	51
Experienced minor harm	90	68	77
Experienced moderate harm	17	13	16
Experienced major harm	0	1	1

As the total number of falls that resulted in harm had reduced over the last 3-4 years, we had also closed a number of our bed based services as more community based services and support was introduced. The graph below shows the rates of falls compared against bed days across different types of services provided. It shows that for all services rates of falls reduced over the 3 year period 2011/12- 2013/14, with some increases over the last year. The main area where increased rates of falls are reported is within our services at Woodland View Nursing Home. Over the year there has been a change in client group with the service caring for people with more complex needs.

Our improvement plans continue to focus on the following areas:

- Practice improvement – improving assessment and falls screening processes over the first 3 days of a person's admission, followed by effective falls management plans for those considered to be of risk of falling;
- Awareness and training – delivering targeted staff training programmes for key services, such as Woodland View Nursing Home;
- Assistive technologies – continuing to explore how further use of assistive technologies can support falls reduction plans;
- Monitoring of progress – through ensuring all services have access to a range of information to understand how they are performing.

Rate of falls (per 1000 bed nights) as calculated by the NPSA (April to March)



Our Quality Objectives for 2015/16

Overall, we perform well in delivering the national standards asked of us across our services for primary care, learning disabilities, substance misuse and mental health. We remain confident that we will continue to meet these standards.

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 in many areas. However, we also know that we can do better, and need to do better. Our ambition is to provide excellent services that deliver a really positive experience for the people who need them. 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. Our plans for quality improvement will ensure we make continued improvements.

In last year's report we outlined actions that we were taking following a review of culture and practice within our residential/supported living homes for people with a learning disability. We were committed to implementing a range of improvements to ensure personalised approaches were being taken to meet people's needs. Jointly with our Commissioners we have commissioned an external review of the progress made and the report confirms that we have made good progress in delivering the actions we set ourselves.

Significant development work will be progressed over the next year. The Sheffield-wide Crisis Concordat Action Plan will deliver much needed and important improvements in the way all services in Sheffield support people experiencing a mental health crisis. Our service development plans (see our Annual Plan) will improve primary care mental health provision, deliver more intensive community care and support integrated approaches to how peoples' care provided to meet their psychological and physical health care needs.

We will continue with our existing quality improvement programmes that focus on the following key areas:

- Recovery care planning;
- Service user engagement;
- Improving physical health care;
- Restrictive practices;
- Fall prevention and reduction;
- Support for carers;
- Improving access to evidence based treatments.

We will have clear plans in place to ensure we address the areas we need to improve from the findings of the CQC Inspection of our services. Key actions will focus on improvements in safety, effectiveness and staff training. These plans will be publicly available on our website.

Our quality objectives for 2015/16

We have reviewed progress over the last year and engaged with our Governors and members regarding about next year's priorities. Alongside the development plans noted above, during 2015/16 we have updated our quality objectives. For each of the objectives we will monitor progress through the year against clear measures of success and report on progress to the Council of Governors, and publicly in next year's Quality Account.

The quality objectives we have agreed are:

Our current 2 year improvement priorities:	During 2015/16 we will focus on:
1. Responsiveness: We will improve access to our services so that people have their needs assessed quickly.	We will ensure all our services have agreed waiting time targets and we will report on our achievements during the year.
2. Safety: We will improve the physical health care provided to our service users.	We will ensure service users receiving on-going care and treatment will have an assessment and plan to meet their assessed physical health needs.
3. Experience: We will establish the Service User Experience Monitoring Unit to drive improvements in service user experience across the Trust.	From April 2015 onwards, all services will seek service user feedback and show they have responded to the feedback provided.

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:

ENGAGE and LISTEN

Ensuring we understand the experience and views of those who use our services so we can make the right improvements

Our Governors and membership share their experiences and views and inform our plans for the future.

We have a range of forums where service users come together to help us develop our services (eg in-patient forum, SUNRISE, Physical Health Group, Service User Engagement Forum, user and carer forum across ISS, CLDTs and supported living).

We have prioritised the development of service users to survey other service users about their experiences as this will give us much more reliable feedback.

DELIVER BEST PRACTICE

Ensuring the care and support we provide is guided by what we know works

We have developed a range of care pathways across services so we are clear about what we expect to be provided.

We have an established Audit programme that evaluates how we deliver care against agreed standards.

Regular Quality Improvement Group forum brings clinicians and managers together to share best practice.

MONITOR and ASSESS

Ensuring we evaluate how we are doing

We have a team governance programme that supports each service to reflect on how they perform and agree plans for development.

We have prioritised the provision of information to teams so they can understand how they are doing, and we continue to improve our ability to provide them with the information they need.

We periodically self-assess our services against national care standards with service users, members, Governors and our Non-Executive Directors providing their views through visits and inspections.

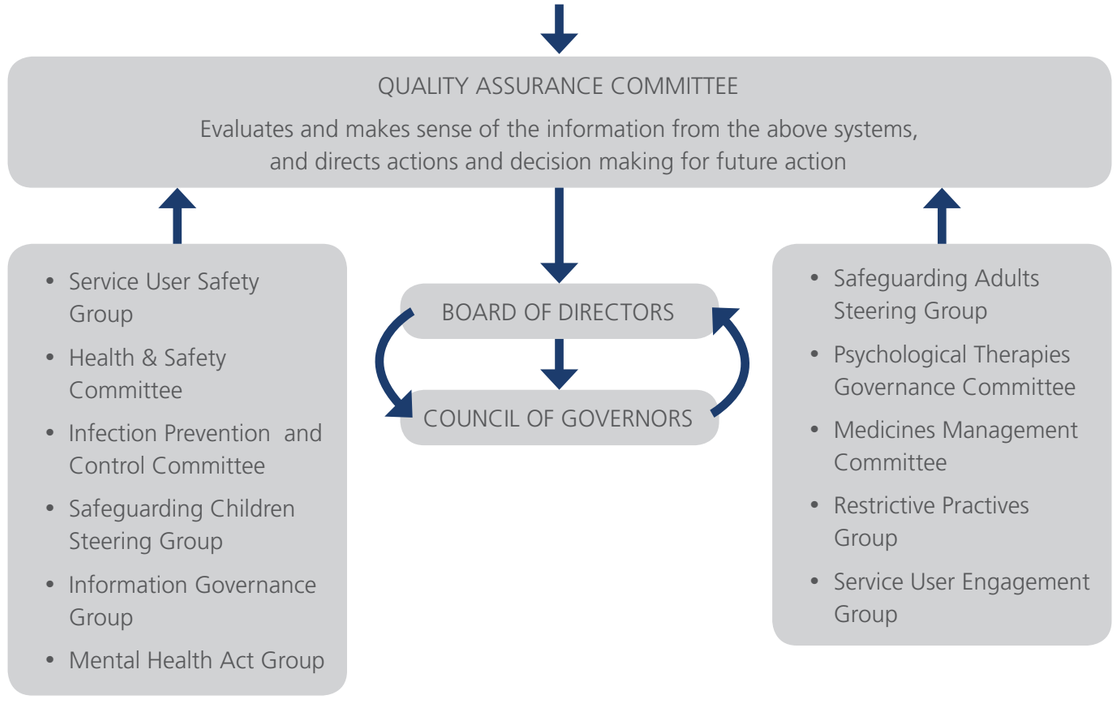
WORKFORCE DEVELOPMENT and LEADERSHIP

Supporting and developing our staff to deliver the best care

We have an established workforce training programme that aims to equip our staff with the skills, knowledge and values to deliver high quality care.

We have a well established culture and programme of developing our clinical and managerial leadership teams to support them to deliver improvements in care.

We use a range of service improvement and system improvement models to help us deliver the changes we wish to see, we continue to increase our ability to do this.



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 CQC registers, and 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.

The Care Quality Commission has not taken enforcement action against the Trust during 2014/15. The Trust has not participated in any special reviews or investigation by the CQC during the reporting period.

During 2014/15 we became the registered provider of the Brierley Medical Centre in Barnsley. We were asked to provide this service at short notice by the NHS Commissioner because the previous Practice was unable to continue to deliver appropriate services.

Planned Inspection

During 2014/15 the CQC undertook a planned inspection of some of the Trust's services. They inspected the following mental health and learning disability services that we are registered to provide:

- Acute wards for adults of working age and psychiatric intensive care unit;
- Long stay/rehabilitation mental health wards for working age adults;
- Forensic in-patient / secure wards;
- Wards for older people with mental health problems;
- Wards for people with a learning disability or autism;
- Community-based mental health services for adults of working age;
- Mental health crisis services and health based places of safety;
- Community-based mental health services for older people;
- Community mental health services for people with a learning disability or autism.

They inspected the following social care services that we are registered to provide:

- Longley Meadows respite service for people with learning disabilities;
- Hurlfield View community centre for older people with dementia;
- Woodland View Nursing Home;
- 136 Warminster Road respite service for people with learning disabilities;
- Supported living services for people with learning disabilities at Mansfield View;
- Supported living services for people with mental health problems at Wainwright Crescent respite service.

The Inspection took place during October - November 2014. At the time of producing this report the findings from the inspection have not been concluded or published. This is due to be finalised in June 2015.

There will be a range of issues that we will need to improve on in respect of safety and effectiveness. Along with the CQC we will publish the findings of the Inspection once they have been confirmed, along with our detailed action plan to respond to issues of concern identified. We will report publicly on the progress we have already made, and continue to make during 2015/16 to ensure we respond quickly and effectively to the feedback provided. The reports, our planned response and our progress reports will all be available on our website and formally reported in next year's Quality Account.

Mental Health Act reviews

During 2014/15 the CQC has undertaken 7 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
  Dovedale Wards 1 & 2, Burbage Ward
- Longley Centre
  Pinecroft Recovery Ward, Rowan Ward, Intensive Support Service
- Forest Close
  Bungalows 1, 1A, 2, 3
- Forest Lodge
  Assessment Ward
- Grenoside Grange Hospital
  Ward G1

2.2 Monitors' Assessment

Monitor reviews our performance and publishes a quarterly assessment on how we are doing. This information is available at **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 Monitors own assessment of how we are performing. In considering this, Monitor considers the following information:

- 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 overleaf feature our ratings for the last 2 years.

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 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 reorganise 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, and have continued to perform well during 2014/15.

2014/15

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 one of the national indicators during the year. We failed to achieve the standard of providing follow up care within 7 days of discharge from in-patient care for people under the Care programme Approach in the 2nd Quarter. Improvements were made to support communication and monitoring around discharge plans. We achieved the standards for the rest of the year.

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 Service Rating	n/a	n/a	4	4
Governance Risk Rating	Green	Green	Green	Green

Note: During 2013/14 Monitor's assessment framework changed to the Risk Assessment Framework in Quarter 3. The Financial Risk Rating was replaced by a Continuity of Service Rating. A rating of 4 under the Continuity of Service Rating is the equivalent of a 5 under the previous Financial Risk Rating.

A rating of 4 (which the Trust has) is a risk based rating used by monitor to assess the level of risk within the Trust based on its performance. A rating of 4 indicates that Monitor's assessment concludes there is no need to take any additional action in addition to routine monitoring of performance.

2014/15 Governance assessment of our performance

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Continuity of Service Rating	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green

2.3 Goals agreed with our NHS Commissioners

A proportion of our income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

For 2014/15 £1,780,537 of the Trust's contracted income was conditional on the achievement of these indicators. We achieved the majority of the targets and improvement goals that we agreed with our Commissioners. We received 83% of the income that was conditional on these indicators. For the previous year, 2013/14, the associated monetary payment received by the Trust was £1,814,117.

A summary of the indicators agreed with our main local health commissioner NHS Sheffield Clinical Commissioning Group for 2014/15 is shown below.

Incentivising improvements in the areas of safety, access, effectiveness and user experiences	
Implement the Friends and Family Test Survey We introduced the Friends and Family Test survey for service users and staff. By getting regular and consistent feedback from service users and our staff about the experience of receiving care, and providing care, we will be able to make better decisions about what we need to improve. We now need to continue to promote its use so everyone has the opportunity to provide feedback.	✔ FULLY ACHIEVED
NHS Safety Thermometer – reduce rates of falls that result in harm The target was to reduce the numbers of falls that resulted in harm within in-patient services, as measured by the NHS Safety Thermometer methodology. Incidents rates over a fixed 3 day period each month are reported. Between October 2013 - March 2014 there were 5 incidents of falls that resulted in harm to in-patients. Between October 2014 - March 2015 there were 2 incidents of falls that resulted in harm to inpatients. The median rate of falls has reduced within this timeframe from 0.5 to 0 (zero).	✔ FULLY ACHIEVED
Improving physical healthcare to reduce premature mortality in people with severe mental illness We wanted to improve our performance in 2 key areas: a) Undertaking comprehensive assessments of people's physical health needs when admitted to inpatient services	◗ PARTIALLY ACHIEVED
The aim was to achieve this standard for 90% of service users with achievements above 50% required as a minimum. We achieved the standard for 74% of service users. b) Ensuring comprehensive information about service users care under the care programme approach was communicated with their GP. The aim was to achieve this standard for 90% of service users, with achievement above 50% required as a minimum. We achieved the standard for 94% of service users.	✔ FULLY ACHIEVED

Incentivising improvements in the areas of safety, access, effectiveness and user experiences

Reducing variation in waiting times for patients referred to the IAPT Service We identified 8 GP Practices where people were experiencing very long waiting times to access our IAPT Service. We wanted to reduce the waiting times from an average of 9.6 weeks for the 8 Practices to below 5 weeks for the period October 2014 - March 2015 for each of the 8 Practices. We were very successful with this. Waiting times reduced overall for the 8 Practices to 1.9 weeks for the period October 2014 -March 2015. Each of the 8 Practices had an average waiting time of below 3 weeks. The city-wide average waiting times for the whole of the IAPT Service reduced from 5.4 weeks in 2013/14 to 3.8 weeks in 2014/15.	✔ FULLY ACHIEVED
People who are referred for a routine assessment will be assessed within 2 weeks of the referral We set a goal a goal for the number of people we would see for assessment within 2 weeks of the referral being made. We were successful in achieving the improvement targets over 3 of the 4 quarterly periods in the last year.	◗ PARTIALLY ACHIEVED
People using mental health services should have a care plan agreed with them and in place within 4 weeks of the assessment. We wanted to ensure that following an assessment, those who needed on-going support and treatment then had a plan of care in place quickly. We achieved the target set for this.	✔ FULLY ACHIEVED
Improved use of electronic discharge communications between in-patient services and GP's In the previous year we had piloted the introduction of electronic discharge communications to GPs for people discharged from in-patient care. This year we wanted to extend the e-discharge method of communicating discharge information to a community team as part of a continued roll-out programme. The aim behind this is to ensure GP's have immediate access to information about on-going care arrangements when someone is discharged. We continued to make progress on this, however, it did take longer than expected. We have made further changes to how this works and it will continue to be used next year.	◗ PARTIALLY ACHIEVED

The table above summarises the goals that we agreed with our Commissioners, and the progress that we made. Full details of the agreed goals for 2014/15 and for the following 12 month period are available electronically **www.shsc.nhs.uk/about-us/corporate-information/publications**.

The issues we have prioritised in next year's scheme are summarised as follows:

- Improving physical healthcare to reduce premature mortality in people with severe mental illness – continuing this year's work into next year;
- IAPT Service - continued focus on waiting times – for 80% of people to start treatment within 6 weeks of being referred;
- To improve access to dental care for people who need in-patient care for longer than a year;
- Smoking cessation support;
- Cluster reviews – 80% of reviews to be undertaken within the agreed timescales;
- To improve our screening and assessment of people's alcohol use;
- To improve the information we collect about if people have a copy of their care plan, the advice and support provided to carers and the use of recovery and relapse prevention plans;
- To continue to use of the e-discharge care plans, extending its use to other services in the Trust.

2.4 Review of services

During 2014/15 SHSC provided and/or subcontracted 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 2014/15 represents 100% of the total income generated from the provision of the relevant health services by the Trust for 2014/15.

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 CCG, other CCGs, Sheffield City Council and other NHS Commissioners.

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

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

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

Health and Safety Executive

There were no Health and Safety Executive visits to the Trust during 2014/15.

South Yorkshire Fire and Rescue

During 2014/15 the South Yorkshire Fire and Rescue Service did not undertake any visits or audits of the Trust's premises. In the previous year, 2013/14, 2 such visits were undertaken and 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 covered organisational, clinical, non-clinical and health and safety risks.

These factors create a 'RAG' rating which, in turn, determines the level of contribution the Trust makes to the NHSLA for insurance cover. The Trust's current RAG rating is red, which reflects a level of concern based on the cost incurred from negligence claims. This concern is based upon the previous claims history of the Trust, arising from incidents over 4-5 years ago.

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 2014/15 who were recruited during that period to participate in research approved by a research ethics committee was 843.

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 Yorkshire and Humber Collaboration for Leadership in Applied Health Research and the Yorkshire and Humber Local Research Network to improve our services and increase opportunities for our service users to participate in research, when they choose do so.

We have strong links with academic partners, including the Clinical Trials Research Unit and the School of Health and Related Research at the University of Sheffield, and the School of Health and Wellbeing at Sheffield Hallam University, to initiate research projects in the Trust.

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.

In 2015, SHSC will begin to use the Join Dementia Research tool designed by the National Institute for Health Research in association with Alzheimer's Research UK and the Alzheimer's Society to match service users who have expressed an interest in research with appropriate studies.

The Trust was involved in conducting 63 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;
- Stigma and discrimination experienced by mental health service users;
- Supporting for the families and carers of service users with dementia;
- Help to stop smoking for those with severe mental illness;
- Improving transition from children's to adult mental health services;
- Co-morbidities between physical health and mental health;
- New treatments for service users with dementia (including Alzheimer's disease).

2.8 Participation in Clinical Audits National Clinical Audits and National Confidential Enquiries

During 2014/15 4 national clinical audits and 3 national confidential inquiries covered relevant health services that Sheffield Health and Social Care NHS Foundation Trust provides.

During 2014/15 the Trust participated in 100% national clinical audits and 100% national confidential inquiries in which it was eligible to participate.

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 percentage of those asked for
Guideline Audits		
National Audit of Schizophrenia – to ensure that the cardio-metabolic parameters of in-patients with schizophrenia were recorded	100	100%
POMH UK		
Prescribing for Substance Misuse (Topic 14a) – to ensure that prescribing practices are in line with NICE guidance	49	100%
Prescribing for people with Personality Disorder (Topic 12b) – to ensure that prescribing practice are in line with NICE guidance	52	100%
Antipsychotic prescribing for people with Learning Disabilities (Topic 9c) – to ensure that prescribing practices are in line with NICE guidance (see note 1)	26	100%
National Confidential Inquiries		
Inquiry into Suicide and Homicide by people with mental illness	8	16% (see note 2)
Inquiry into Suicide and Homicide by people with mental illness Out of District Deaths	14	100%
Inquiry into Suicide and Homicide by people with mental illness Homicide data	3	10% (see note 2)

Note 1: This audit was undertaken and submitted in March 2015 and the results are not available at the time of completing this report.

Note 2: The percentage figure represents the numbers of people who we reported as having prior involvement with as a percentage of all Inquiries made to us under the National Confidential Inquiry programme, i.e. in 84% and 90% 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 2014/15 and Sheffield Health and Social Care NHS Foundation Trust intends to take the following actions to improve the quality of health care provided:

	National Audit results and actions
National Audit of Schizophrenia and recording of cardiometabolic parameters of in-patients	**Results** – the aim of the audit was to assess if service users with a psychosis had received an assessment and appropriate plans were in place in respect of: • Smoking; • Lifestyle (including exercise, diet, alcohol and drugs) • Body Mass index; • Blood pressure; • Glucose regulation; • Blood lipids. We achieved the above standards for 74% of the service users audited. This was an improvement on previous audits and assessments. We are pleased that we have made good progress in this important area, but are clear that we have more to do to deliver the necessary standards of care consistently. **The Actions we have taken are**: We will continue with our existing development plans to improve awareness and training and monitor practice across in-patient teams to support further improvements. We will continue to audit standards of practice and care.
Prescribing for Substance Misuse	**Results** – 84% of service users had their drinking history documented on admission. 86% of service users had been prescribed the recommended medication for managing acute withdrawal. 69% of service users had a physical health assessment on admission and 71% had a liver function test done on admission. In total only 53% of service users were assessed for Wernicke's encephalopathy. Thiamine was only being prescribed parentally for 57% of service users. **The Actions we have taken are**: Training and development will be provided to support an improvement in assessment and prescribing practices.
Prescribing for people with Personality Disorder	**Results** – 64% of service users had a reason documented for prescribing antipsychotics. Of the service users prescribed medication for more 4 four weeks, 68% had a review. **The Actions we have taken are**: We will continue to monitor prescribing practices, paying attention to the above issues. Significant development work is being progressed to review and improve care pathways and the treatment and support provided to people with a personality disorder.
Antipsychotic prescribing for people with Learning Disabilities	**Results** – the data for this audit was submitted in March 2015 and results from the national audit are not available for inclusion in this year's report.

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 CCG, also asks the Trust to complete a number of local clinical audits each year, to review local quality and safety priorities. On a quarterly basis the Board review the progress of other local audits.

Examples of the types of local audits we have undertaken over the last year are:

- Falls Audit – to ensure that service users are screened for risk of falls within 72 hours of admission and that there is a falls plan in place;
- NHS LA Care Records - to ensure risk assessment documentation is adhering to guidelines;
- Food and nutrition – to ensure that in-patients are being screened for nutrition on admission and discharge.

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 report our performance on the following indicators:

- 7 day follow up – people on CPA should receive support in the community within 7 days of being discharged from hospital;
- 'Gate keeping' - everyone admitted to hospital should be assessed and considered for home treatment;
- Waiting times for IAPT services – 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 2014/15 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 regarding data quality under the mental health minimum data set is for January 2015. The Trust's performance on data quality compares well to national averages and is summarised as follows:

Percentage of valid records	Data quality 2014/15	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 2015.		

As a NHS Foundation Trust delivering mental health services we are required to deliver the following standards in respect of data completeness.

Percentage of valid records	Target	2013/14	2014/15
Service user identifiers For example date of birth, gender.	97%	99.8%	99.8%
Service user outcomes For example employment status, HoNOS scores	50%	95.3%	90.3%

Clinical coding error rates

Sheffield Health and Social Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

2.10 Information governance

We aim to deliver 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 framework. Based on our self-assessment Sheffield Health and Social Care NHS Foundation Trust's Information Governance Assessment Report overall score for 2014/15 was 68% for the 45 standards and was graded satisfactory/ green. A summary of our performance is provided below:

	Achieved			
Criteria	2012/13	2013/14	2014/15	Current Grade
Information Governance Management	73%	73%	66%	Satisfactory
Confidentiality and Data Protection Assurance	74%	66%	66%	Satisfactory
Information Security Assurance	66%	66%	66%	Satisfactory
Clinical Information Assurance	73%	66%	66%	Satisfactory
Secondary Use Assurance	66%	76%	66%	Satisfactory
Corporate Information Assurance	66%	66%	66%	Satisfactory
Overall	69%	68%	66%	Satisfactory

Note: 'Satisfactory' means we are at Level 2 on all the assessment criteria, based on our self-assessment. There are 4 levels, with Level 0 being the lowest rating and Level 3 the highest.

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 a positive reflection of the safety culture within the Trust. It helps us to understand what the experience of care is like, spot trends and make better decisions about what we want to address and prioritise for improvement. NHS England assesses our performance using the data supplied through the National Reporting Learning System (NRLS). Our reporting rates are summarised in the table below:

Incident rates per 1,000 bed days	Our rates	National average
April 12 - September 12	36.1%	23.8%
October 12 - March 13	29.1%	25.2%
April 13 - September 13	27.1%	26.4%
October 13 - March 14	42.4%	26.7%
April 14 - September 14	55.3%	32.8%

Source: National Reporting Learning System

The above changes in reporting rates are due to errors in the reports published by the NRLS and reduced bed days within our services as we have developed better community services. During April 12-September 12 our reported incidents under the NRLS was 1,858. During April 14-September 14 it was 2,129. This represents an increase in reported incidents of 14.5%. The national rates of reported incidents for the same period increased by 21.6% from 110,360 to 134,187. Our reported rates of bed days over the same period reduced from 51,400 in April 12-September 12 to 38,489. This is the main reason our reported rates have increased.

Nationally, based on learning from incidents and errors across the NHS, NHS England 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 2014/15 the Trust received 99 non-emergency alert notices, of which 94% where acknowledged within 48 hours, 18 were applicable to the services provided by the Trust and all were acted upon within the required timescale. In addition a further 26 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 latest NRLS figures show 12.2% of all patient safety incidents reported by the Trust were related to self-harm, in comparison with 21% for mental health trusts nationally.

Proportion of incidents due to self-harm/suicide	Our rates	National average
April 12 - September 12	11.3%	18.1%
October 12 - March 13	13.9%	19.8%
April 13 - September 13	11.7%	20.4%
October 13 - March 14	13.0%	21.0%
April 14 - September 14	12.2%	20.0%

Source: National Reporting Learning System

Violence, aggression and verbal abuse experienced by service users

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 over the last 3 years as we have prioritised and progressed significant improvement work under our RESPECT programme. Our reported incidents are now comparable with the national averages. This is summarised in the table below:

Proportion of incidents due to disruptive behaviour	Our rates	National average
April 12 - September 12	20.6%	18.2%
October 12 - March 13	16.5%	16.6%
April 13 - September 13	19.3%	17.0%
October 13 - March 14	21.8%	16.1%
April 14 - September 14	20.9%	16.1%

Source: National Reporting Learning System

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. Overall, the proportion of patient incidents that relate to medication errors in the Trust is below the national averages. Reported incidents have increased during 2014/15 due to improved reporting of discrepancies in stock balances, missed administrations and unclear prescribing.

Proportion of incidents due to medication errors	Our rates	National average
April 12 - September 12	6.1%	8.4%
October 12 - March 13	5.1%	8.3%
April 13 - September 13	5.8%	8.8%
October 13 - March 14	6.0%	9.0%
April 14 - September 14	6.4%	9.2%

Source: National Reporting Learning System

Cleanliness and infection control

The Trust is committed to providing clean safe care for all our service users and ensuring that harm from infections is prevented. An annual programme of infection prevention and control details the methods and actions required to achieve these ends. This includes:

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

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 at **www.shsc.nhs.uk**

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 2014/15 we have reported no breaches of these guidelines. We reviewed arrangements to ensure mixed sex guidelines were adhered to within our services at Forest Close during the year. Following this, we made some changes to accommodation arrangements to ensure we remained compliant with the guidelines.

Safeguarding

The Trust 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:

- Systems and policies in place;
- 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 worked hard over the last 2 years to improve staff awareness and provide appropriate training so that staff are aware of the issues and know what to do if they have any concerns. While most staff are familiar with the appropriate safeguarding procedures we have experienced challenges in delivering on-going training for staff. We will continue with our training programme into the next year and will ensure improvements in training provision are delivered.

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 this.

Overview of incidents by type

The table below 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. During 2014/15 we introduced an on-line incident reporting tool to make it easier for staff to report incidents that have occurred. We believe this is the main reason why the number of 'all incidents' reported has increased significantly during 2014/15, noting that the number of patient safety incidents reported to NRLS has remained stable. We will closely monitor this during 2015/16.

Incident Type	2012/13	2013/14	2014/15
All incidents	6275 (a)	6477 (a)	7808
All incidents resulting in harm	1461 (a)	1423 (a)	1878
Serious incidents (investigation carried out)	33 (a)	34 (a)	20
Patient safety incidents reported to NRLS (d)	3372 (a)	3616 (a)	3251
Patient safety incidents reported as 'severe' or 'death'	38	35 (a)	19
Expressed as a percentage of all patient safety incidents reported to NRLS	1.1%	0.97% (a)	0.66%
Slips, Trips and Falls incidents	1181 (a)	1175 (a)	1260
Slips, Trips and Falls incidents resulting in harm	420 (a)	419 (a)	448
Self-harm incidents	425	444 (a)	668
Suicide incidents (in-patient or within 7 days of discharge)	1	0	0
Suicide incidents (community)	19	16 (b)	16 (c)
Violence, aggression, threatening behaviour and verbal abuse incidents	1934	2162 (a)	2302
Violence, aggression and verbal abuse incidents resulting in harm	237	269 (a)	395
Medication Errors	322 (a)	345 (a)	485
Medication Errors resulting in harm	1	1	0

Incident Type	2012/13	2013/14	2014/15
Infection Control			
Infection incidents			
MRSA Bacteraemia	1	0	0
Clostridium Difficile infections (new cases)	0	1	1
Periods of increased infection/outbreak			
• Norovirus & Rotavirus	3 (28)	1 (12)	7 (64)
• Influenza	1 (3)	0	0
Showing number of incidents, then people affected in brackets			
Preventative measures			
MRSA Screening – based on randomised sampling to identify expected range to target	39%	47%	50%
Staff Influenza Vaccinations	56%	50%	50.7%

(a) Incident numbers have increased/decreased from those reported in the 2013/14 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 increased from that reported in last year's Quality Account report due to the conclusion and judgements of 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 are within 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 large Practice (16,700+ patients) serves a majority multi-ethnic migrant population in areas of social deprivation within Sheffield, with over 60% of the registered population from ethnic minority backgrounds, including one of the city's highest Slovak Roma population . The Mulberry site provides specialist and GP healthcare services to Sheffield's asylum seeking population. These populations bring 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 often 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. The table below summarises the overall achievement of all the QoF standards. The reduction on 2013/14 was due to the introduction of many new standards and an increase in % thresholds making QOF harder to achieve, rather than a reduction against the previous year's performance.

Year	Clover
2012/13	98.3%
2013/14	94%
2014/15	88%

The following table summarises performance against national standards for GP services. With specific regard to the flu vaccinations below, the uptake was lower this year possibly due to a combination of mild winter weather and adverse media publicity regarding the efficacy of the vaccine.

Primary Care – Clover GPs	This year's target	How did we do?			
		2012/13	2013/14	This year 2014/15	
Flu vaccinations					
Vaccinate registered population aged 65 and over	75%	78%	75%	72%	✔
Vaccinate registered population aged 6 months to 64 year in an at risk population	70%	56%	58%	51.7%	✔
Vaccinate registered population who are currently pregnant	70%	51%	46%	33.6%	✖
Childhood immunisations					
2 year old immunisations	70-90%	90%	90%	90%	✔
5 year old immunisations	70-90%	85%	82%	82%	✔
Cervical Cytology	60-80%	66.4%	66.2%	66.5%	✔

Source: National Reporting Learning System

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 year's target	How did we do?			
		2012/13	2013/14	This year 2014/15	
Drugs					
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%	95%	96%	81%	✔
Alcohol Single Entry and Access					
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%	✔
Outcomes, Self Care					
Initial Treatment Outcome Profile (TOP) completed	80%	98%	83%		
Review TOP completed	80%	71%	89%	Unable to report at this time due to NDTMS reporting system issue	
Discharge TOP completed	80%	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	272	258	Discontinued as a measure due to service specification changes. New performance metrics in place for 2015-16	
% successful completions for the provision of treatment for injecting-related wounds and infections	75%	94%	94%		

Information source: National Drug Treatment Monitoring System

Learning Disability Services

The Intensive Support Service provides intensive support to people with complex learning disabilities, mental health problems and challenging behaviours. The focus over the last year has been to develop the service to ensure co-ordinated support is available to support people's needs within a community and in-patient setting.

The Community Learning Disability Teams (CLDT) aim to provide assessments of people's needs and co-ordinated support for people with complex needs. The CLDT service has prioritised improving access and reducing waiting times over the last year due to concerns that people were waiting for very long periods to access support. In the Autumn of 2014 there were 388 people on the waiting list for an assessment. By the end of March 2015 this had been reduced to 82 people. Waiting times over the same period had reduced from 40-46 weeks to 1-10 weeks, depending on which professional the person needed to see.

LEARNING DISABILITIES SERVICE	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
No-one should experience prolonged hospital care ('Campus beds')	Nil	Nil	Nil	Nil	✔
All clients receiving hospital care should have:					
• full health assessments	100%	100%	100%	100%	✔
• assessments and supporting plans for their communication needs	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 CPA 7 Day follow up and Gatekeeping indicators. While we have achieved the standards set for both measures, we compare above average for Gatekeeping and below average for CPA 7 Day follow up. We consider that this data is as described for the following reasons:

- Our development work to ensure effective and appropriate care pathways are in place;
- Failure to achieve the standards for CPA 7 day follow up in the 2nd Quarter of 2014/15.

The national average performance for CPA 7 Day follow up is 97.2% for the Q1-Q3 period. Our performance each quarter was 96.5% (Q1), 92.9% (Q2), 98.7% (Q3) and 98.6% (Q4). We have reviewed the circumstances behind the care provided for those who were not supported within the 7 day period after discharge. In the majority of cases the arrangements in place to deliver follow up care were appropriate and proactively implemented. NHS Sheffield CCG, our main Commissioner, has reviewed our performance under our contract with them, particularly in respect of the failure to achieve the standards over the 2nd Quarter. Informed by the reviews we have undertaken we have introduced measures to further improve communication between teams around discharge planning. We will review all future breaches with our Commissioner. We intend to ensure the above approaches continue to support effective delivery of standards in respect of Gatekeeping and CPA 7 day follow-up.

MENTAL HEALTH SERVICES	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
Improving Access to Psychological Therapies					
Number of people accessing services	10,008	10,735	11,611	13,535	
Number of people achieving recovery	50%	46%	47%	45%	✔
Early intervention					
People should have access to early intervention services when experiencing a first episode of psychosis	90 new clients per year	107 new clients accessing services	106 new clients accessing services	174 new clients accessing services	✔
Access to home treatment					
People should have access to home treatment when in a crisis as an alternative to hospital care	1,202 episodes to be provided	1,418 episodes provided	1,415 episodes provided	1,310 episodes provided	✔
Delayed transfers of care					
Delays in moving on from hospital care should be kept to a minimum	No more than 7.5%	4.7%	6.0%	4.4%	✔
Annual care reviews					
Everyone on CPA should have an annual review.	95%	98%	95.7%(a)	95.6%	✔
'Gate keeping'					
Everyone admitted to hospital is assessed and considered for home treatment	95% of admissions to be gate-kept	99.5%	99.8%	99.8%	
Comparators (b) National average		98.2%	98.3%	98.1%	✔
Best performing		100%	100%	100%	
Lowest performing		81.2%	85.7%	64.6%	

MENTAL HEALTH SERVICES	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
7 day follow up					
Everyone discharged from hospital on CPA should receive support at home within 7 days of being discharged	95% of patients to be followed up in 7 days	95%	96.1%	96.4% (c)	✔
Comparators (b) National average		97.5%	97.3%	97.2%	
Best performing		100%	100%	100%	
Lowest performing		92.7%	88.8%	91.9%	

Information source: Insight and Trust internal clinical information system

Note:

(a) The 95.7% figure represents the Trust's annual performance. The Trust failed to achieve the standard over the Quarter 2 period.

(b) Comparative information from Health and Social Care Information Centre.

(c) The 96.4% figure represents the Trust's performance at the end of the year. During the year the Trust failed to meet this target in Q2.

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. As we deliver better and more intensive community services the need for in-patient care has been gradually reducing.

We continue to explore ways to build on the excellent success of the Memory Service in improved access and improved diagnosis rates within Sheffield. Sheffield has the 2nd highest diagnostic rates in England, which means people in Sheffield are far more likely to access support with memory problems than elsewhere in the country. More people are receiving support and treatments than before as we get more referrals and see more people. As we see more people we have not reduced waiting times over the last year (see Part 2). We have introduced changes to the way we provide services, delivering more follow up support in local communities and we expect to deliver reductions in waiting times next year.

DEMENTIA SERVICES	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
Discharges from acute care (G1)	27	53	43	38	✔
Number of assessments for memory problems by memory management services	930	846	884	963	✔
Rapid response and access to home treatment	350	339	349	330	OK
Waiting times for memory assessment	N/A	15.4 weeks	15.8 weeks	23 weeks	▼ Getting Worse

Information source: Insight and Trust internal clinical information system

INDEPENDENT LIVING and CHOICE	This year's target	How did we do? 2012/13	2013/14	This year 2014/15	
Access to equipment Community equipment to be delivered within 7 days of assessment	95% of items to be delivered within 7 days	95.2%	96.7%	95.8%	✔
Choice and control People accessing direct payments to purchase their own social care packages	n/a	454 people with budgets agreed	635 people with budgets agreed	666 people with budgets agreed	✔

Information source: Insight and Trust internal clinical information system

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. 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.

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

Number of	2012/13	2013/14	2014/15
Formal Complaints	142	147	173
Informal Complaints	260	217	152
Compliments	1,396	1,196	1,150

This year the Parliamentary and Health Service Ombudsman notified us that 10 complaints had been referred to them by people who were dissatisfied with the Trust's response to their complaint. They were also still reviewing 1 case referred to them in 2013/14. No further action was required in 3 of the cases, 5 cases required remedial action (for example, apologies, reassessment and/or financial compensation) and, at the time writing this report, the outcome of 3 cases is still awaited.

A full picture of the complaints and compliments received by the Trust over the year is available on our website in the Annual Complaints and Compliments Report. This includes feedback from the complainants (the people who have made the complaint) about their experience of the complaints process and if they felt their concerns were appropriately addressed and taken seriously. We also publish information about the complaints and compliments we have received on a quarterly basis. The reports can be accessed via the following link:

www.shsc.nhs.uk/about-us/complaints

We use complaints as an opportunity to improve how we deliver and provide our services. A number of service improvements were made as a result of complaints this year. For example:

- Supported by investment from our Commissioners we have increased the numbers of staff working in A&E, Out of Hours and at weekends to provide quicker access to support people experiencing a mental health crisis;
- The Specialist Psychotherapy Service has improved the information available about the services they offer and how to access them;
- We improved the administrative arrangements to ensure quick responses were made to crisis referrals, ensuring professional staff were aware of the referral as it was received;
- We increased the nursing staffing levels at Woodland View Nursing Home to support improvements in service user experience and safety;
- We improved the drainage system at one of our premises to better protect neighbours should overspills occur;
- We improved the floor coverings at Hurlfield View Resource Centre.

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 have not been as good as we have wanted them to be.

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 has invested £6.4 million to 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 dedicate gardens and outdoor space. The building work started during 2014/15 and we look forward to the new ward opening towards the end of 2015.

Dovedale Ward – improving in-patient care for older people

Our wards for older people on the Longley and Michael Carlisle Centres were not as well designed as they needed to be. There was limited communal space and many of the bedroom areas were small and do not provide en-suite facilities for service users.

In response to this we opened a new ward in April on the Michael Carlisle Centre. Supported by an investment of over £320,000 Dovedale Ward now provides better access to en-suite facilities and an improved ward environment.

Woodland View Nursing Home – improving community care for older people

We have invested over £400,000 in a range of design and structural improvements to improve the environment and services provided at Woodland View Nursing Home.

General environment – external review and feedback

The last Patient Led Assessment of the Care Environment (PLACE) took place at the end of 2013/14. The conclusion of the review is summarised in the table below. Between 2013 and 2014 we improved our assessed scores in 19 of the 24 categories, and in 2014 the standards provided across the Trust's services were above the national average in 19 of the 28 categories (we had an extra site location in 2014, Firshill Rise).

Following a review of the last assessment the Board approved a development plan to address a range of improvements. Particular attention has been given to improving cleanliness and overall décor across the estate.

Site location	Year	Cleanliness	Food & Hydration	Privacy & Dignity	Condition & Appearance
Longley Centre	March 2013	89.4%	82.5%	89.7%	79.3%
	March 2014	96.4%	90.2%	89.6%	92.1%
Longley Meadows	March 2013	83.7%	87.4%	53.9%	65.6%
	March 2014	99.0%	90.1%	83.6%	95.7%
Michael Carlisle Centre	March 2013	95.5%	94.7%	94.2%	80.1%
	March 2014	99.2%	95.5%	89.0%	98.9%
Forest Close	March 2013	93.4%	88.6%	85.9%	77.1%
	March 2014	96.8%	92.6%	85.1%	94.5%
Forest Lodge	March 2013	83.4%	89.0%	96.2%	73.7%
	March 2014	98.0%	85.4%	82.9%	95.8%
Grenoside Grange	March 2013	84.9%	92.5%	87.7%	80.1%
	March 2014	99.7%	94.7%	83.3%	100.0%
Firshill Rise	March 2013	n/a	n/a	n/a	n/a
	March 2014	98.5%	87.7%	91.4%	98.4%
National average	March 2013	95%	84%	88%	88%
	March 2014	97.8%	88.8%	87.7%	92.0%

What do people tell us about their experiences?

The national patient survey for mental health Trusts highlights that the experience of our service users is comparable with other mental health Trusts.

The table overleaf summarises the overall results from the last national survey undertaken in 2014. The national patient survey was changed in 2014, and its new structure means that comparisons to previous years surveys cannot be readily undertaken. Therefore, we haven't reported in this report on the survey scores from previous years. However, this information is available in our Quality Account for the previous year 2013/14.

Mental Health Survey 2014 **Issue** – what did service users feel and experience regarding;	**Patient response**	**How did we compare with other Trusts?**
Their health and social care workers	7.5/10	About the same
The way their care was organised	8.4/10	About the same
The planning of their care	6.5/10	Worse
Reviewing their care	7.2/10	About the same
Changes in who they saw	5.9/10	About the same
Crisis care	5.9/10	About the same
Treatments	7.2/10	About the same
Other areas of life	4.8/10	About the same
Overall views and experiences	7.0/10	About the same

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

Patient Survey	**2014 Survey**		
	Lowest national score	**Highest national score**	**Our score**
How well did people who use our services comment on their overall experience of contact with a health or social care worker	7.3	8.4	7.5/10
Did they feel staff listened carefully to them?	7.7	8.9	8.2/10
Did they feel they were given enough time to discuss their needs and treatment?	7.2	8.4	7.4/10
Did they feel the member of staff had an understanding of how their mental health needs affect other areas of their life?	6.5	8.1	7.0/10

The table above highlights our comparative performance on service user experience in respect of contact with our staff and the support and care we have provided. In most of the areas covered in the survey, the experience of our service users is about the same as it is in other Trusts in the country. While this offers some assurance about the quality of the services we provide, we want to do better than this. We want the experience of our service users to be really positive and among the best in the country. We are concerned that the feedback highlights that service users have a poorer experience of the arrangements for planning their care than in other Trusts across the country, and we will ensure our current plans continue to deliver the necessary improvements..

We consider that this data (the survey scores in the table overleaf) is as described for the following reasons:

- We need to continue with our development programme to improve our approaches to care planning, ensuring recovery orientated care is based around the goals that individuals set for themselves. This programme has been successfully established within our in-patient services, and was introduced within our community services during the year. We plan to extend this approach to care planning to the rest of our community teams;
- We need to reduce the time staff in teams have to spend on administrative tasks that take them away from time with service users. We have introduced a range of productivity improvement and mobile working initiatives. The focus of this work is to ensure staff can spend the maximum amount of time directly with service users.

We will continue to take the above actions to maintain and improve our position regarding the quality of our services. Our on-going development programmes, our Quality Objectives, and our focus on supporting individual teams to understand their own performance and take decisions to improve the quality of care they provide locally are some of the key actions that will support this.

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**
2012 Staff Survey (score out of 5)	3.36	3.68	3.54	3.63
2013 Staff Survey (score out of 5)	3.40	3.68	3.55	3.80
2014 Staff Survey (percentage score)	n/a	n/a	60%	67%

The above table highlights how our staff view the quality of services provided by the Trust compared to staff in other mental health organisations.

We consider this data is as described due to our continued efforts to engage with our staff and involve them in the plans and decisions regarding ho 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 decisions 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.

OVERALL ENGAGEMENT& CARE	Previous years			2014		
	2012 Score	2013/14 Score	Compare	Our score	National averages	Comparisons
Overall Staff Engagement	3.73	3.81	Best 20%	3.81	3.71	Best 20%
Care of service users is my organisation's top priority	71%	73% n	n/a	76%	65%	n/a
TOP 5 RANKINGS – The areas we compare most favourably in with other mental health and learning disability Trusts						
Recommend Trust as place to work or receive care and treatment	3.63	3.80	Best 20%	3.78	3.57	Best 20%
% of staff who feel able to contribute to improvements	73%	74%	Above average	75%	72%	Best 20%
% of staff agreeing that they would feel secure raising concerns about unsafe clinical practice	n/a	69% n/a	n/a	72%	69%	Best 20%
Fairness and effectiveness of our incident procedures (score out of 5)	3.54	3.60	Best 20%	3.61	3.52	Best 20%
% of staff working extra hours (lower score is good)	64%	62%	Best 20%	64%	71%	Best 20%
OTHER BEST SCORES – We were also in the best 20% of mental health and learning disability Trusts in the following areas						
Job satisfaction (score out of 5)	3.72	3.76	Best 20%	3.73	3.67	Best 20%
% of staff reporting good communication between senior management and staff	35%	36%	Above average	37%	30%	Best 20%
WORSE 5 – The areas we compare least favourably in with other mental health and learning disability Trusts (in this year's survey the Trust was assessed to be in the worse 20% for only 4 categories)						
% of staff receiving H&S Training	50%	48%	Worse 20%	62%	73%	Worse 20%
% of staff witnessing potentially harmful errors, near misses or incidents in the last month	26%	24%	Below average	32%	26%	Worse 20%
% of staff experiencing physical violence from staff in last 12 months	4%	3%	Below average	6%	3%	Worse 20%
% of staff feeling motivated at work	3.77	3.78%	Below average	3.77	3.84	Worse 20%

The Trust employs around 3,000 people and as part of our responsibility to ensure we provide good quality care we participate in the annual NHS Staff Survey programme. The NHS Staff Survey attempts to identify the major factors contributing to staff engagement and motivation. By focusing on these, we aim to enhance the quality of care provided to the people who use our services. The NHS Staff Survey provides us with feedback on the Trust's performance across a range of relevant areas.

Overall, we are encouraged with the above results. The positive feedback around engagement continues to support our on-going focus on improving quality and delivering our plans for service improvement. The full survey will be available via the CQC website. The survey provides a large amount of detail around complex issues. We look 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 job satisfaction, and the worse 20% for staff feeling motivated at work.

Last year's survey (2013) highlighted that we were in the worse 20% for staff appraisals, providing diversity training and providing health and safety training. Over the last year we have focussed on these areas and are pleased to report good progress.

Our performance, as assessed through the staff survey, shows that we are now above average in providing staff with appraisals, increasing from 78% in 2013 to 90% in 2014. While we still compare as below average for providing diversity training and health and safety training, we have made good progress in improving this. Staff reporting that they have received diversity training has increased by 19% and for health and safety training by 14%.

Informed by the 2014 survey feedback the areas we have prioritised for on-going and further development work are as follows:

Training

We have an established training programme in place. We have placed significant 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 well for staff who believe they have received job related learning and development opportunities (above average).

However, we continue to experience challenges in ensuring all staff remain up to date with some routine and important training needs. Areas we need to improve, for example, are safeguarding, mental capacity act, refresher training in RESPECT and basic life support. NHS Sheffield CCG has reviewed this area of concern with the Trust and have closely monitored progress against our development plan. The Trust is committed to delivering sustained improvements next year, building on the progress made during 2014/15. Last year we made a range of changes to make key training areas more accessible to staff, for example, introducing more on-line training resources for staff. These changes have had a positive impact as the results in the 2014 survey show. We will continue with them next year, ensuring we have a clear improvement programme in place to make sure staff remained equipped to deliver safe and effective care.

Staff witnessing harmful incidents and errors

This figure has increased from 24% to 32% since last year. It is the only score which the results have highlighted as an area where staff experience has deteriorated; the mental health Trust average is 26%. The 2013 survey reported the mental health Trust average as 26% so at that time the Trust rated better than average in this score. The reason for this increase is not clear and the data is not straightforward as the Trust has maintained its position on the reporting of near misses (91%) and is in the best 20% of comparable Trusts for the fairness and effectiveness of its reporting procedures. It is likely that the most credible explanation is that the score relates to the fact that while several people may have witnessed an incident, only 1 person would have reported it. It is also recognised that the Trust moved to electronic reporting last year and it is not known whether this could have had some form of impact on the apparent discrepancy. We will further review incident trends and consider if there is any correlation and develop an action plan accordingly.

Staff experiencing assaults from other staff

The percentage of staff reporting physical violence from other staff has moved from better than average to the bottom 20%. This result does not accord with any reports under our various procedures and the survey indicates no statistically significant change from last year. At the same time the report indicates that the percentage of staff experiencing harassment from staff is better (lower) than average.

Any level of violence against staff is a concern. This finding from the survey does not correlate with any reported incidents which would be regarded as gross misconduct and subject to a disciplinary process and potential dismissal. The report is being shared with Staff Side representatives and we will work together to understand the potential for such issues to be unreported. We will also review incident reports to establish if they involve any indications of this issue.

Staff motivation at work

This is part of the staff engagement category where the Trust scores highly. At this stage, we have not identified any specific action in response to this because of the imprecise nature of the category and its inconsistency with the other indicators such as staff satisfaction and recommending the Trust as a place to work or receive treatment. However, the Trust will explore whether further information can be obtained to inform further understanding, for example, a question in the Staff Friends and Family Test.

ANNEXE A

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

Healthwatch

Healthwatch Sheffield are pleased to be able to comment on this Quality Account produced by Sheffield Health and Social Care NHS Foundation Trust.

We note that they have maintained a similar style and layout to last year's document and we are encouraged to see that the language used is on the whole understandable. We would still like to see the production of an easier to read or summary version of the report, as has been done in other Trusts in Sheffield. We would be willing to work with the Trust to achieve this.

We would challenge the Trust's assertion in Quality Objective 1 that they have made positive progress in some areas, as in fact it appears they have only made progress in 1 of the 3 highlighted areas. We did note the growing waiting times for the memory clinic in our response last year and are disappointed that this has continued, though we note the increased demand for the service and that the Trust is going to define waiting time standards in the forthcoming year.

We are pleased that the planned Service User Experience Monitoring Unit has been established, but would have liked to see a little more information about what it has achieved in this year.

Healthwatch notes the continued rise in serious incidents for both patients and staff. We commented on a similar situation last year and were assured that this was in part due to better reporting, however, we would still hope to see the total number of incidents fall or level off.

We also note that the NHS staff survey shows a worse than average result for staff undergoing Health and Safety training. The accompanying narrative states that the Trust has implemented a range of changes to make training more accessible for staff, and we would therefore ask that the Trust looks again at these changes in light of the information contained in the staff survey. We also see that double the average percentage of staff to staff violence is being reported and are pleased to see in the narrative that the Trust are taking this issue very seriously and is looking into how this figure may have arisen.

We are also concerned that in last year's comments we mentioned performance issues with the Clover Group, and that the figures for this year were not available in the draft we received, so at the time of writing our concerns still stand. We will of course revisit this once this year's figures are available to us.

We would like to thank the Trust for providing us with this draft Quality Account, and are pleased to have been invited to participate in their Service User Experience Safety Group in 2015/16.

Our response

We welcome the helpful feedback from Healthwatch following a review of a draft of our Quality Account.

It is clear that we have not made the progress we wanted to in reducing waiting times for access to Memory Services. While the service has done well to increase the number of people it has been able to assess by 21%, we remain concerned that waiting times have increased. This concern is equally shared by the Scrutiny Committee and NHS Sheffield Clinical Commissioning Group. We will continue to develop plans with the support of our Commissioners and report on progress during 2015/16.

The final version of our Quality Account summarises the work progressed with in the Trust in respect of service user monitoring and engagement.

We continue to monitor and evaluate our incident data. The final report contains the annual position for the 2014/15 year with commentary on the changes and trends. Overall, patient safety incidents or serious incidents have not increased this year compared to the previous year, although it is the case that overall rates of reported incidents have increased. The Board's Quality Committee will continue to monitor trends during the year.

The CQC staff survey confirms that we made a significant level of improvement during 2014/15 in ensuring staff have received Health and Safety training, increasing by 14%, while remaining worse than the national average. We believe the changes we have introduced have had an impact during 2014/15, but it is clear we have more to do and our plans will ensure further progress is made. At this stage we cannot account for the feedback from the staff survey regarding staff reporting incidents of violence from other staff. It does not accord with any other information available to the Trust and we will continue to explore this through the next year.

The annual performance figures for Clover are reported in the final Account. Performance levels have decreased due to increased thresholds for the targets, and there has been a deterioration within rates of screening. We will continue to respond to the needs of the Practice population with a range of approaches and improvement actions.

We will be producing an easy read summary version of our Quality Account.

We look forward to on-going dialogue and meetings with Healthwatch during 2015/16 during which we will be able to review progress in more detail on the above issues and other areas of interest.

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

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

The Committee feels that the quality priorities are appropriate, and through its work this year has not been made aware of any concerns about the Trust's performance by members of the public. The Committee remains concerned at the waiting times for the Memory Clinic, and will continue to monitor this over the coming year. The Committee is pleased to see the continued focus on the physical health of patients, and looks forward to seeing improvements.

We are disappointed to see that the Trust is below average on service user satisfaction with their care planning according to the 2014 Mental Health Service. We hope to see evidence that the Trust's continued focus on service user experience through the quality priorities will drive improvement in this.

The Committee found the Quality Report well presented, and easy to follow, and would like to suggest that in future, the Trust engages earlier with Healthwatch Sheffield in the Quality Accounts process.

The Committee recognises that the mandatory timescales for production of the Quality Report can be problematic, and often requires Trusts to consult on the document before they have full year performance information. The Committee will raise this with the Department of Health and Monitor.

The Committee thanks the Trust for their co-

operation this year, and looks forward to discussions on the outcome of the recent Care Quality Commission inspection in the summer.

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 welcome the opportunity to review our plans and progress further with the Committee during 2015/16. We are concerned that the feedback from the national patient survey highlights services users have a poorer experience of the arrangements for planning their care than in other Trusts in the country. We will ensure our current plans continue to deliver the necessary improvements. We have established a number of review meetings with Healthwatch during 2015/16 to support on-going dialogue about the Trust's performance and progress against its quality priorities.

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 Report 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 2014 – March 2015.

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.

This Quality Report evidences that the Trust has achieved positive results against most of its key objectives for 2014/15. Where issues relating to clinical quality have been identified, we have worked closely with the Trust to ensure that improvements are made. During 2015/16 we will continue this work in what will potentially be a very challenging year, and will do this through building 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.

Our response

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

We look forward to working with the CCG during 2015/16 to ensure the plans in place to deliver the necessary improvements will result in real benefits and improved outcomes for the people of Sheffield.

ANNEXE B

2014/15 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:

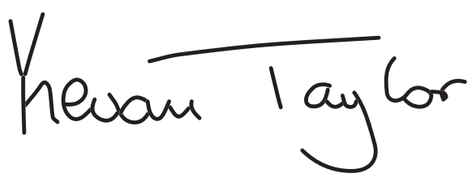
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to May 2015;
    - Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
    - Feedback from the Commissioners dated 19 May 2015;
    - Feedback from Governors in May 2015;
    - Feedback from Healthwatch dated 21 May 2015;
    - Feedback from the Scrutiny Committee dated 27 April 2015;
    - 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 2014;
    - The national staff survey issued February 2015;
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2015; and
    - Care Quality Commission intelligent monitoring reports issued during 2014/15;
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice; and

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

Chairman
22 May 2015



Chief Executive
22 May 2015

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 2015 (the Quality Report) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- 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 two 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 2014/15 (the Guidance); 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 Guidance.

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 2014 to May 2015;
- Papers relating to quality reported to the Board over the period April 2014 to May 2015;
- Feedback from Commissioners, dated May 2015;
- Feedback from Governors, dated May 2015;
- Feedback from Healthwatch Sheffield, dated April 2015;

- Feedback from Overview and Scrutiny Committee dated April 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2014;
- The 2014/15 national patient survey;
- The national staff survey, dated February 2015;
- The 2014/15 Care Quality Commission Intelligent Monitoring Report; and
- The Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2015.

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 the 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 2015, 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, except 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;
- Analytical procedures;
- 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; and
- 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.

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 affect 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 of these criteria, 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 2015:

- 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 Guidance; 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 and the six dimensions of data quality set out in the Guidance.

KPMG LLP,
Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

26 May 2015

Section 10

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 accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statements on a going concern basis.

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

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

Kevan Taylor

Chief Executive

22 May 2015

Section 11

Annual Governance Statement

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.

2 The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Sheffield Health and Social Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts.

3 Capacity to Handle Risk

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.

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 2014/15 has included Board effectiveness and 360° appraisal, workshops on Trust strategy, the external environment, Care Quality Commission Inspection preparation and stakeholder relationships.

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.

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;
- Service User Engagement Group;
- Risk register links forums.

4 The Risk and Control Framework

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 month 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 6 new risks, which were recorded on the Corporate Risk Register. These risks related to changes in social care provision, Woodland View Nursing Home, mandatory training, Brierley Medical Practice, the provision of services to non-Sheffield residents and non-payment of flexible staffing due to technical difficulties. 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.

Internal Audit has reviewed the Trust's risk management arrangements during the year and examined the effectiveness of the controls in place. Their opinion of this was that significant assurance could be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.

4.2 Board Assurance Framework

The Board of Directors has an approved Board Assurance Framework for the period 01 April 2014 to 31 March 2015, which was last approved by the Board in April 2015. 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 01 April 2015, 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 2015/2016 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 2014/15 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.

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 stronger 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 (CQC) 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.

4.4 Quality Governance Arrangements

The Trust had assessed itself against Monitor's Quality Governance Framework. This was reported through the Quality Assurance Committee to the Board of Directors. The assurances that this self-assessment provided was 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.

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 2014/15 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 Provider Review of Compliance at the following locations at the end of October 2014:

Longley Centre;
Michael Carlisle Centre;
Longley Meadows;
Grenoside Grange;
Warminster Road;
Wainwright Crescent;
Woodland View;
Forest Close;
Forest Lodge;
Intensive Support Service;
Hurlfield View;
Support Living Service;
A number of community team bases, including CMHT, Liaison, Out of Hours.

The Trust has received draft inspection reports from the CQC outlining their findings and a review process is underway.

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 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.

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 2015 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 01 April 2014 and 31 March 2015 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 unauthorised access of patient records, resulting in disciplinary action being taken.

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 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** *(page 74)* of the Trust's Annual Report.

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.

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.

4.9 Carbon Reduction Plans

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

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.

6 Annual Quality Report

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

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

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

In preparing the Quality Report, Directors satisfied themselves that the report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data taken from the Trust's systems for patient records (Insight) and risk management (Ulysses Safeguard) and public websites, e.g. the CQC. Service user feedback and information collected through team governance has also been used in the production of the report.

National reviews and guidance reports on Quality Accounts from Monitor were reviewed as well as the External Auditors' assurance report on Sheffield Health and Social Care NHS Foundation Trust's Quality Accounts from last year.

The Quality Report has been consulted upon with Sheffield City Council's Healthier Communities and Adult Social Care Scrutiny Committee, Healthwatch Sheffield and NHS Sheffield Clinical Commissioning Group. It has also been received and considered by the Board of Directors' Quality Assurance Committee, Audit and Assurance Committee and by the Board of Directors itself.

In reviewing and confirming its Quality objectives the Trust supported the Governors to undertake engagement with our Members on their opinions and thoughts on our planned improvement areas. Over 400 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** *(page 96)* of the Annual Report.

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 Workforce and Organisation Development Committee, the Finance and Investment Committee, the Information Governance Steering Group, the Human Resources and Workforce Group, the Business Planning Group, the Operational Delivery Group, the Strategic Leadership Group, the Quality Improvement Group and the Executive Directors' Group and a plan to address weaknesses and ensure continuous improvement of the system is in place.

These Committees/Groups and their accountability and reporting relationships are described more fully

below and in the Trust's Business Plan. I believe that they form an effective and robust system of governance for the Trust.

The Head of Internal Audit provides me with an opinion based on an assessment of the design and operation of the underpinning Assurance Framework and supporting processes and an assessment of the individual opinions arising from risk-based audit assignments contained within the Internal Audit risk based plan that have been reported throughout the year. This assessment has taken into account 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.

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** *(page 42)*, **3.5.2** *(page 57)* and **Section 5** *(page 74)* 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** *(page 43)* of the Trust's Annual Report.

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.

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.

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.

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.

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 patient care and to ensure the Trust meets its legal and regulatory duties in relation to its employees.

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.

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 01 April 2014 to 31 March 2015.

Kevan Taylor

Chief Executive

22 May 2015

Section 12

Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2015 set out on pages 174 to 227. In our opinion:

- The financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2015 and of the Trust's income and expenditure for the year then ended; and
- The financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risk of material misstatement that had the greatest effect on our audit was as follows:

Income Recognition - £131.8 million

Refer to Annual Report Section 3.4.1 (Page 43), Supporting notes to the accounts - 1.5 (accounting policy Page 182) and Supporting notes to the accounts - 3.4 (financial disclosures Page 197).

The risk. The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS Commissioners, which make up (69%) of income from activities. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Trust and its Commissioners, which will be resolved after the date of approval of these financial statements. For these financial statements the Trust identifies the specific cause and accounts for the expected future resolution of each individual difference. Mis-matches can occur for a number of reasons, but the most significant arise where:

- The Trust and Commissioners record different accruals for healthcare activities which have not yet been invoiced;
- Accruals for inter-Trust agreements are not matched by the amounts invoiced; or
- There is a lack of agreement over proposed contract penalties for sub-standard performance.

Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution.

The Trust also receives a significant proportion of its income from non-patient care services to other bodies (15%). This income is received under contract and certain elements of it are performance related and subject to variation.

We do not consider NHS income or income from non-patient care services to other bodies to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole, such income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- Agreeing the income recorded in the financial statements to signed contracts and contract variations with NHS Commissioners;
- Agreeing the income recorded in the financial statements to signed contracts and contract variations with non-patient care Commissioners;
- Using the results of the AoB exercise to match the Trust's NHS income with counterparty expenditure. We investigated differences by reconciling the initial contract value with the counterparty to the final income reported in the financial statements, determining the reasons for any differences and critically assessing the validity of recognising reconciling income items in the Trust's financial statements;
- For estimated accruals relating to healthcare or in relation to inter-Trust agreements, reviewing the Trust's calculation of the accrual, critically assessing the Trust's and the counterparty's correspondence in relation to disputed items and forming a view as to the accuracy of the balance recorded in the Trust's accounts.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £2.5m, determined with reference to a benchmark of income from operations (of which it represents 1.9%). We consider income from operations to be more stable than a surplus related benchmark.

We report to the Audit and Assurance Committee any corrected and uncorrected identified misstatements exceeding £130,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed at the Trust's headquarters in Sheffield.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- 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.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- We have identified material inconsistencies between the knowledge we acquired during our audit and the Directors' statement that they consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or
- Section 3.4.1 of the Annual Report does not appropriately address matters communicated by us to the Audit and Assurance Committee.

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 2014/15, 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;
- The Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above responsibilities.

Certificate of audit completion

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.

Respective responsibilities of the accounting officer and 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 UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, 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.

Clare Partridge

for and on behalf of

KPMG LLP, Statutory Auditor Chartered Accountants
1 The Embankment
Leeds
LS1 4DW
26 May 2015

Section 13

Annual Accounts

Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts for the year ended 31 March 2015 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)

22 May 2015

The Accounts of Sheffield Health and Social Care NHS Foundation Trust for the period ending 31 March 2015 follow. The 4 primary statements; the Statement of Comprehensive Income (SOCI), the Statement of Financial Position (SOFP), the Statement of Changes in Taxpayers' Equity (SOCITE), and the Statement of Cashflows (SCF) are presented first. These are followed by the supporting notes to the accounts.

Note 1 outlines the Foundation Trust's accounting policies. Subsequent notes provide further detail on lines in the 4 primary statements and are cross referenced accordingly.

The financial statements (Accounts) were approved by the Board on 22 May 2015 and signed on its behalf by:

(Chief Executive)

22 May 2015

Statement of comprehensive income for the year ended 31 March 2015

	Note	**2014/15** **£000**	2013/14 £000
Operating income from continuing operations	3	**131,824**	130,030
Operating expenses of continuing operations	4	**(127,568)**	(125,985)
Operating surplus		**4,256**	4,045
Finance costs:			
Finance income	6	**73**	89
Finance expense - financial liabilities	7	**(16)**	(19)
Finance expense - unwinding of discount on provisions	16.1	**(10)**	(14)
Public Dividend Capital (PDC) dividend payable		**(1,707)**	(1,608)
Net finance costs		**(1,660)**	(1,552)
Movement in fair value of investment property	10.1	**0**	20
SURPLUS FOR THE YEAR FROM CONTINUED OPERATIONS		**2,596**	2,513
Other comprehensive income and expenses			
Gain/(loss) from transfer by absorption from demising bodies		**0**	625
Impairment losses on property, plant and equipment		**0**	(2,249)
Revaluation gains on property, plant and equipment		**0**	4,730
Other recognised gains and (losses)		**1,693**	(766)
Remeasurements assets/(liabilities) on defined benefit pension schemes		**(1,925)**	871
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**2,364**	5,724

Statement of financial position as at 31 March 2015

	Note	**31 March 2015** **£000**	31 March 2014 £000
Non-current assets			
Intangible assets	8	**9**	12
Property, plant and equipment	9	**56,009**	55,847
Investment property	10	**200**	200
Trade and other receivables	12	**4,885**	3,188
Total non-current assets		**61,103**	59,247
Current assets			
Inventories	11	**130**	90
Trade and other receivables	12	**5,231**	4,464
Cash and cash equivalents	13	**28,933**	27,673
Non-current assets held for sale	14	**167**	-
Total current assets		**34,461**	32,227
Current liabilities			
Trade and other payables	15	**(7,334)**	(7,592)
Taxes payable	15	**(1,795)**	(1,771)
Provisions	16	**(831)**	(915)
Other liabilities	17	**(13)**	(56)
Total current liabilities		**(9,973)**	(10,334)
Total assets less current liabilities		**85,591**	81,140
Non-current liabilities			
Provisions	16	**(710)**	(700)
Other liabilities	17	**(5,200)**	(3,223)
Total non-current liabilities		**(5,910)**	(3,923)
Total assets employed		**79,681**	77,217

	Note	31 March 2015 £000	31 March 2014 £000
Financed by taxpayers' equity:			
Public Dividend Capital		**33,926**	33,826
Revaluation reserve	9.3	**19,804**	19,804
Income and expenditure reserve		**25,951**	23,587
Total taxpayers' equity		**79,681**	77,217

Kevan Taylor, Chief Executive

22 May 2015

Statement of changes in taxpayers' equity for the year ending 31 March 2015

Changes in taxpayers' equity for 2014/15	Public Dividend Capital £000	Revaluation Reserve £000	Income & Expenditure Reserve £000	Total **£000**
Taxpayers' equity at 1 April 2014	33,826	19,804	23,587	**77,217**
Surplus for the year	-	-	2,596	**2,596**
Other recognised gains and losses*	-	-	1,693	**1,693**
Remeasurements on defined benefits pension scheme	-	-	(1,925)	**(1,925)**
Public Dividend Capital received	100	-	-	**100**
Taxpayers' equity 31 March 2015	**33,926**	**19,804**	**25,951**	**79,681**
Changes in taxpayers' equity for 2013/14				
Taxpayers' equity at 1 April 2013	33,572	17,191	20,476	**71,239**
Surplus for the year	-	-	2,513	**2,513**
Impairment losses on property, plant and equipment	-	(2,249)	-	**(2,249)**
Revaluation gains on property, plant and equipment	-	4,730	-	**4,730**
Other recognised gains and losses*	-	-	(766)	**(766)**
Remeasurements on defined benefits pension scheme	-	-	871	**871**
Transfers by modified absorption on 1 April transfers from demising bodies.	-	-	625	**625**
Transfers by modified absorption: transfers between reserves	-	132	(132)	**-**
Public Dividend Capital received	296	-	-	**296**
PDC adjustment for cash impact of payables/ receivables transferred from legacy PCTs	(42)	-	-	**(42)**
Taxpayers' equity at 31 March 2014	**33,826**	**19,804**	**23,587**	**77,217**

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

*£1,693,000 (£766,000 at 31 March 2014) relates to the back to back agreement with Sheffield City Council in respect of the Local Authority defined benefit pension scheme on the Statement of Financial Position.

Statement of cash flows for the year ended 31 March 2015

	Note	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Operating surplus from continued operations	SOCI	**4,256**	4,045
Non-Cash income and expense			
Depreciation and amortisation	9	**2,236**	2,127
Impairments and reversals	9	**5**	886
Loss on disposal	3	**147**	157
(Increase) in trade and other receivables	SOFP	**(694)**	(1,015)
(Increase)/decrease in inventories	SOFP	**(40)**	16
Increase/(decrease) in trade and other payables	SOFP	**(1,038)**	1,755
Decrease in other liabilities	SOFP	**(43)**	(160)
(Decrease) in provisions	SOFP	**(84)**	(210)
Other movements in operating cash flows	SOFP	**(9)**	9
Net cash generated from operations		**4,736**	7,610
Cash flows from investing activities			
Interest received	6	**73**	91
Purchase of property, plant and equipment	9	**(1,863)**	(1,524)
Receipts from disposal of property, plant and equipment	9	**-**	5
Net cash outflow from investing activities		**(1,790)**	(1,428)
Cash flows from financing activities			
PDC received		**100**	296
PDC dividend paid		**(1,786)**	(1,494)
PDC received - adjustment for modified absorption transfers of payables / receivables		**-**	(42)
Net cash generated used in financing activities		**(1,686)**	(1,240)
Net increase in cash and cash equivalents		**1,260**	4,942
Cash & cash equivalents at 01 April		**27,673**	22,731
Cash & cash equivalents at 31 March	13	**28,933**	27,673

Supporting notes to the accounts

Note 1. Accounting Policies and other information

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 2014/15 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 01 July 2008.

1.1 Accounting Period

The accounts of the Trust have been drawn up for the year to 31 March 2015.

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. The Trust is not a corporate trustee of the charity. 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.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year (except

where a subsidiary's financial year end is before 01 January or after 01 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated). Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation. Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

During 2014/15 the Trust recognises no subsidiaries.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the Trust from the associate. Associates which are classified as held for sale are measured at the lower of their carrying amount and "fair value less costs to sell". During 2014/15 the Trust recognises no Associates.

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. During 2014/15 the Trust recognises no Joint ventures.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses. During 2014/15 the Trust recognises no Joint operations.

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.

1.6.1 NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.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 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 2012.

The Scheme Regulations 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.

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 3 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 01 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 12 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 5 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.

1.6.2 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 the 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 24**.

1.6.3 NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

1.7 Expenditure on 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

1.8.1 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.

1.8.2 Measurement

Initial 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 5 years with an interim valuation in the 3rd year. These valuations are carried out by professionally qualified valuers in accordance with Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Fair values are determined as follows:

Land and non-specialised buildings – market value taking into account existing use

Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where a service could be provided in any part of the City, the Trust has used the alternative site valuation method.

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 used by 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 as 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.

1.8.3 Impairments

In accordance with the FT Annual Reporting Manual, impairments that arise from a clear consumption of economic benefits or of 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 that arises from a clear consumption of economic benefit or of service potential is reversed when and to the extent that, the circumstance 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.

1.8.4 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 in that 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.

1.8.5 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

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

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 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.

1.9.2 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 2014/15 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 2014/15 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 1 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 2014/15 Brunswick House was reclassified as 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

1.15.1 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.

1.15.2 Measurement

Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other Financial liabilities'.

a) 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.

b) 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.

1.15.3 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.

1.15.4 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.16 Leases

1.16.1 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 2014/15 the Trust has no finance leases.

1.16.2 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.

1.16.3 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 cash flows are discounted using the short- (-1.5%) (-1.9% 2013/14); medium- (1.05%) (-0.65% 2013/14); and/or long-term (+2.2%) (+2.2% 2013/14) 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 1.3% (1.8% 2013/14) 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 16.1 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 31 March 2015 the Trust has no contingent assets.

Contingent liabilities are not recognised, but are disclosed in note 18, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.19 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 20 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 in to different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks.

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.25 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 13 – Fair Value Measurement (to be adopted from 2015/16)

IAS 36 (amendment) – recoverable amount disclosures (effective from 2015/16 aligned with IFRS 13 adoption)

Annual Improvements 2012 – (effective 2015/16, but not yet EU adopted)

Annual Improvements 2013 – (effective 2015/16, but not yet EU adopted))

IAS19 (amendment) – employer contributions to defined benefit pension scheme (effective 2015/16 , but not yet EU adopted)

IFRIC 21 – Levies (EU adopted June 2014 but not yet adopted by HM Treasury)

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 2014/15, 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 5 years with interim valuations every 3rd year. The revaluations are undertaken by professional valuers and significantly reduce the risk of material misstatement. Refer to **Paragraph 1.8** *(page 185)* for further details.

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. Refer to **Paragraph 1.17** *(page 191)* for further details.

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. Refer to **Paragraph 1.6.2** *(page 184)* and **note 24** for further details.

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.

In 2013/14 the net gain corresponding to the net assets transferred from Sheffield PCT is recognised within the Trust's income and expenditure reserve under the principles of modified absorption accounting which applied to transfers where the transferring body ceased to exist on 01 April 2013.

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** *(page 196)*.

3 Operating income

3.1 Operating income by classification comprises:

	2014/15 £000	2013/14 £000
Income from activities		
Cost & Volume Income	**4,011**	3,726
Block contract income	**85,437**	83,935
Clinical partnerships providing mandatory services (including Section 31 agreements)	**8,164**	7,551
Other clinical income from mandatory services	**3,180**	2,637
Total income from Commissioner-requested services	**100,792**	97,849
Other operating income		
Research and development	**865**	693
Education and training	**6,396**	6,446
Non-patient care services to other bodies	**19,269**	20,243
Other income	**672**	746
Profit on disposal of other tangible fixed assets	**3**	-
Rental revenue from operating leases	**42**	42
Income in respect of staff costs	**3,785**	4,011
	31,032	32,181
Total operating income	**131,824**	130,030

3.2 Private patient income

The Trust has no private patient income.
(2013/14 £nil)

3.3 Operating lease income

Rental income from operating leases:	2014/15 £000	2013/14 £000
Rents recognised as income in the period	**42**	42

Future minimum lease receipts due:	2014/15 £000	2013/14 £000
Receivable on leases of buildings expiring:		
Not later than 1 year	**42**	20
Later than 1 year and not later than 5 years	**82**	17
Later than 5 years	**-**	-
	124	37

3.4 Operating income by type comprises:

	2014/15 £000	2013/14 £000
Income from activities		
NHS Foundation Trusts	**8**	3
NHS Trusts	**-**	3
Clinicial Commissioning Groups	**91,535**	89,363
Local Authorities	**8,164**	7,554
Non-NHS: Other	**1,085**	926
	100,792	97,849
Other operating income		
Research and development	**865**	693
Education and training	**6,396**	6,446
Non-patient care services to other bodies	**19,269**	20,243
Income in respect of staff costs	**3,785**	4,011
Rental revenue from operating leases	**42**	42
Other income	**672**	746
	31,029	32,181
Operating income before profits on disposal	**131,821**	130,030
Profit on disposal of plant and equipment	**3**	-
Total operating income*	**131,824**	130,030

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

3.5 Income from activities arising from Commissioner requested services

Under the terms of its Provider License, the Trust is required to analyse the level of income from activities that has arisen from Commissioner requested and non-Commissioner requested services. Commissioner requested services are defined in the provider license and are services that Commissioners believe would need to be protected in the event of provider failure. All services provided by NHS Foundation Trusts are automatically regarded as Commissioner requested services unless at some point prior to 01 April 2016 Commissioners decide they should not be so designated. Under condition 9 of the Provider License mandatory services were 'grandfathered' across on 01 April 2013 when licensing was introduced for Foundation Trusts. As at the reporting date no changes have been made.

	2014/15 £000	2013/14 £000
Income from services designated (or grandfathered) as Commissioner requested services	**100,792**	97,849
Other income from services not designated as Commissioner requested services	**31,032**	32,181
Total	**131,824**	130,030

4 Operating expenses by type

4.1 Operating expenses by type comprise:

	2014/15 £000	2013/14 £000
Services from NHS Foundation Trusts	**1,666**	1,502
Services from NHS Trusts	**91**	64
Services from CCGs and NHS England	**50**	451
Services from other NHS bodies	**72**	56
Purchase of healthcare from non-NHS bodies	**5,292**	4,907
Employee expenses - Executive Directors	**839**	815
Employee expenses - Non-Executive Directors	**97**	97
Employee expenses - Staff	**98,916**	96,045
Research and development - Staff	**411**	469
Research and development expenditure	**323**	344
Drug costs	**853**	1,168
Supplies and services - clinical (excluding drug costs)	**1,827**	1,515
Supplies and services - general	**1,195**	1,240
Establishment	**880**	948

	2014/15 £000	2013/14 £000
Transport	**1,346**	1,307
Premises	**5,839**	8,357
Increase / (decrease) in provision for impairment of receivables	**120**	32
Change in provisions discount rate(s)	**38**	41
Inventories written down (net, including inventory drugs)	**9**	-
Rentals under operating leases	**1,757**	722
Depreciation on property, plant and equipment	**2,233**	2,123
Amortisation on intangible assets	**3**	4
Impairments of property, plant and equipment	**5**	886
Audit fees: statutory audit	**76**	71
Other auditors' remuneration: other services	**-**	20
Clinical negligence premium	**228**	208
Losses on disposal of property, plant & equipment	**150**	157
Legal fees	**250**	145
Consultancy costs	**969**	478
Training, courses and conferences	**670**	549
Patient travel	**122**	107
Car parking and security	**106**	54
Hospitality	**75**	55
Redundancy	**220**	70
Publishing	**7**	13
Insurance	**263**	288
Other Services	**-**	8
Losses,ex gratia and special payments	**110**	235
Other	**460**	434
	127,568	125,985

Limitation on Auditors' liability

There is a £1,000,000 limit on the Trust's Auditors' liability. (2013/14 £1,000,000)

4.2 Operating leases

4.21 Payments recognised as an expense

	2014/15 £000	2013/14 £000
Minimum operating lease payments	1,757	722

4.22 Future minimum lease payments due:

	2014/15 £000	2013/14 £000
Payable:		
Not later than 1 year	**1,472**	631
Later than 1 year and not later than 5 years	**1,270**	1,077
Later than 5 years	**9,367**	8,684
	12,109	10,392

4.23 Significant Leasing Arrangement

The term of the operating lease for properties on the Northern General Hospital site is 125 years from 01 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

	2014/15 £000	2013/14 £000
Salaries and wages	**79,184**	78,181
Social security costs	**6,068**	5,728
Employer contributions to NHS pension scheme	**8,951**	8,994
Employer contributions to Local Authority scheme	**442**	350
Termination benefits	**220**	248
Agency / contract staff	**5,565**	3,936
	100,430	97,437
Less costs capitalised	**(43)**	(32)
Total employee expenses excluding capitalised staff	**100,387**	97,405

5.2 Employee Benefits

There were no employee benefits, other than the benefits of the relevant pension schemes.

5.3 Directors' and Non-Executive remuneration

	2014/15 £000	2013/14 £000
Fees to Non-Executive Directors*	**91**	91
Executive Directors - Salaries **	**677**	662
Executive Directors - Benefits (NHS Pension scheme)	**73**	65
	841	818

** Excludes National Insurance contributions.*

***Further information about the remuneration of individual Directors and details of their pension arrangements is provided in the Remuneration Report.*

5.4 Average number of people employed (whole time equivalent basis)

	2014/15 £000	2013/14 £000
Medical and dental	**145**	155
Administration and estates	**542**	535
Healthcare assistants and other support staff	**161**	157
Nursing, midwifery and health visiting staff	**1,251**	1,271
Scientific, therapeutic and technical staff	**376**	368
Social care staff	**100**	106
Other	**-**	1
Agency staff	**118**	123
	2,693	2,716

5.5 Early retirements due to ill health

During 2014/15 there were 5 (2013/14 - 3) 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 £463,692 (2013/14 - £223,986). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

5.6 Staff Exit Packages

The table below summarises the total number of exit packages agreed during 2014/15. 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**	
	2014/15	**2013/14**	**2014/15**	**2013/14**	**2014/15**	**2013/14**
<£10,000	**0**	0	**4**	5	**4**	5
£10,000 - £25,000	**0**	0	**6**	2	**6**	2
£25,001 - £50,000	**0**	0	**5**	3	**5**	3
£50,001 - £100,000	**1**	1	**1**	0	**2**	1
£100,000 -150,000	**0**	0	**0**	0	**0**	0
Total number of exit packages by type	**1**	1	**16**	10	**17**	11
Total resource cost £000s	**51**	70	**345**	178	**396**	248

6 Finance income - interest income

	2014/15 £000	2013/14 £000
Bank accounts	**73**	89

7 Finance costs - interest expense

	2014/15 £000	2013/14 £000
Finance costs associated with the Local Authority pension scheme*	**16**	19

*The Finance interest income associated with the Local Authority Pension Scheme is presented net as a finance cost in 2014/15 in line with IAS19 changes. Refer to Accounting Policies note 1.6

No claims were arising or payments made during 2014/15 under The Late Payment of Commercial Debts (Interest) Act 1998 (year ended 31 March 2014 - £nil).

8 Intangible assets

	2014/15 £000	2013/14 £000
Computer Software		
Gross cost at 1 April	**27**	27
Additions	**-**	-
Disposals		
Gross cost at 31 March	**27**	27
Amortisation at 1 April	**15**	11
Provided during the year	**3**	4
Disposals		
Amortisation at 31 March	**18**	15
Net book value - closing		
At 31 March	**9**	12

Intangible assets are all purchased. No intangible assets have been financed via government grants or leases in year.

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9 Property, plant and equipment

9.1 Current year movement

2014/15	Land £'000	Buildings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation								
At 01 April 2014	8,292	46,557	428	1,141	459	2,246	162	59,285
Additions purchased	-	-	2,715	-	-	-	-	2,715
Reclassifications	-	-	(326)	197	-	129	-	-
Reclassified as held for sale	(101)	(74)	-	-	-	-	-	(175)
Disposals	-	(158)	-	(72)	(49)	(74)	-	(353)
At 31 March 2015	**8,191**	**46,325**	**2,817**	**1,266**	**410**	**2,301**	**162**	**61,472**
Accumulated depreciation								
At 1 April 2014	-	485	-	733	349	1,729	142	3,438
Transfers by absorbtion - modified	-	-	-	-	-	-	-	-
Provided during year	-	1,899	-	89	49	190	6	2,233
Reclassified as held for sale	-	(3)	-	-	-	-	-	(3)
Disposals	-	(42)	-	(72)	(50)	(41)	-	(205)
At 31 March 2015	**-**	**2,339**	**-**	**750**	**348**	**1,878**	**148**	**5,463**
Opening Net book value								
Owned	8,292	45,529	428	408	110	517	20	55,304
Donated	-	543	-	-	-	-	-	543
Total at 01 April 2014	**8,292**	**46,072**	**428**	**408**	**110**	**517**	**20**	**55,847**
Closing Net book value								
Owned	8,191	43,208	2,817	516	62	423	14	55,231
Donated	-	778	-	-	-	-	-	778
Total at 31 March 2015	**8,191**	**43,986**	**2,817**	**516**	**62**	**423**	**14**	**56,009**

No assets used in the provision of Commissioner-requested services have been disposed of during the year ending 31 March 2015.

No assets were held under finance leases or hire purchase contracts as at 31 March 2015.

9.2 Prior Year movements

2013/14	Land £'000	Buildings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation								
At 01 April 2013	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)
At 31 March 2014	**8,292**	**46,557**	**428**	**1,141**	**459**	**2,246**	**162**	**59,285**
Accumulated depreciation								
At 01 April 2013	-	1,937	-	649	311	1,523	130	4,550
Transfers by absorbtion - modified	-	95	-	1	-	114	5	215
Provided during year	-	1,728	-	99	57	230	9	2,123
Impairments charged to operating expenses	-	(29)	-	-	-	-	-	(29)
Impariments charged to revaluation reserve	-	(784)	-	-	-	-	-	(784)
Revaluations	-	(2,462)	-	-	-	-	-	(2,462)
Reclassified as held for sale	-	-	-	-	-	-	-	-
Disposals	-	-	-	(16)	(19)	(138)	(2)	(175)
At 31 March 2014	**-**	**485**	**-**	**733**	**349**	**1,729**	**142**	**3,438**
Opening Net book value								
Owned	8,669	41,012	2,968	479	178	641	16	53,963
Donated	-	564	-	-	-	1	-	565
Total at 01 April 2013	**8,669**	**41,576**	**2,968**	**479**	**178**	**642**	**16**	**54,528**
Closing Net book value								
Owned	8,292	45,529	428	408	110	517	20	55,304
Donated	-	543	-	-	-	-	-	543
Total at 31 March 2014	**8,292**	**46,072**	**428**	**408**	**110**	**517**	**20**	**55,847**

No assets used in the provision of Commissioner-requested services were 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.

9.3 Revaluation Reserve Movements

	31 March 2015 £000	31 March 2014 £000
Relating to Property, Plant and Equipment		
As at 01 April	**19,804**	17,191
Transfers by Absorption	**-**	132
Impairment losses	**-**	(2,249)
Revaluation gains	**-**	4,730
As at 31 March*	**19,804**	19,804

*A full revaluation was undertaken as at 31 March 2014 and is reflected in these financial statements. An interim valuation will take place within 3 years, per our accounting policies. Refer to Note 1.8 for further details.

9.4 Contractual capital commitments

Contracted Capital Commitments at 31 March not otherwise included in these financial statements are:	**31 March 2015 £000**	31 March 2014 £000
Property, plant and equipment*	**3,054**	-

*The Trust's Capital scheme to build a new Psychiatric Intensive Care Unit is in progress. The Trust is committed to a contract with the developer to complete the build. Associated professional fees are included.

10 Investment Property

10.1 Investment Property - Carrying Value

	31 March 2015 £000	31 March 2014 £000
As at 01 April	**200**	180
Acquisitions in year	**-**	-
Revaluation gains	**-**	20
As at 31 March	**200**	200

10.2 Investment property expenses

	2014/15 £000	2013/14 £000
Direct operating expense arising from investment property	**8**	10

10.3 Investment property income

	2014/15 £000	2013/14 £000
Investment property income	**42**	42

10.4 Disclosure of Interests in other Entities

The Trust has reviewed its arrangements under IFRS10 Conslidated Financial Statements, IAS 28 Associates, IFRS11 Joint Arrangements and IFRS 12 Disclosure of interests in other entities. The Trust has no arrangements that require disclosure under these standards.

11 Inventories

11.1 Inventories analysis

	31 March 2015 £000	31 March 2014 £000
Drugs	**84**	68
Consumables	**46**	22
Total inventories	**130**	90

11.2 Inventories recognised in expenses

	2014/15 £000	2013/14 £000
Inventories recognised as an expense in the period*	**1,895**	1,925
Write-down of inventories (including losses)	**9**	8
	1,904	1,933

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

12 Trade and other receivables

12.1 Trade and other receivables

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £000
NHS receivables	**3,458**	2,241	**-**	-
Receivables due from NHS charities	**-**	-	**-**	-
Other receivables with related parties	**1,300**	196	**4,576**	2,837
Provision for impaired receivables	**(161)**	(41)	**-**	-
Prepayments	**380**	457	**309**	351
Accrued income	**(188)**	1,124	**-**	-
Interest Receivable	**6**	6	**-**	-
PDC receivable	**31**	-	**-**	-
VAT receivable	**156**	181	**-**	-
Other receivables	**249**	300	**-**	-
	5,231	4,464	**4,885**	3,188

The majority of trading is with Clinical Commissioning Groups, as Commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by the government to purchase NHS patient care services, no credit scoring of them is considered necessary. In addition, commissioning of social care is through public sector funded bodies, such as councils and housing associations. Again, no credit scoring is considered necessary.

12.2 Provision for impairment of receivables

	31 March 2015 £000	31 March 2014 £000
At 01 April	**41**	18
Increase in provision	**139**	41
Amounts utilised	**-**	(9)
Unused amounts reversed	**(19)**	(9)
At 31 March	**161**	41

12.3 Ageing of impaired receivables

	31 March 2015 £000	31 March 2014 £000
By 0 - 30 days (within term)	**-**	-
By 30 - 60 days	**-**	2
By 60 - 90 days	**-**	-
By 90 - 180 days	**46**	1
Over 180 days	**115**	38
Total	**161**	41

12.4 Receivables past their due date but not impaired

	31 March 2015 £000	31 March 2014 £000
By 0 - 30 days (within term)	**706**	746
By 30 - 60 days	**185**	202
By 60 - 90 days	**205**	126
By 90 - 180 days	**70**	171
Over 180 days	**456**	116
Total	**1,622**	1,361

13 Cash and cash equivalents

	31 March 2015 £000	31 March 2014 £000
At 01 April	**27,673**	22,731
Net change in year	**1,260**	4,942
At 31 March	**28,933**	27,673
Broken down into:		
Cash at commercial banks and in hand	**164**	253
Cash with the Government Banking Service	**28,769**	27,420
Cash and cash equivalents as in Statement of Financial Position	**28,933**	27,673

14 Non-current assets held for sale

Current year 2014/15	Property, plant and equipment £000	Other assets £000	Total £000
As at 01 April 2014	-	-	**-**
Assets classified as available for sale in the year	172	-	**172**
Assets sold in year	-	-	**-**
Impairment of assets held for sale	(5)	-	**(5)**
As at 31 March 2015	**167**	-	**167**
Prior year 2013/14			
As at 01 April 2013	-	-	**-**
Assets classified as available for sale in the year	226	100	**326**
Assets sold in year	(226)	(100)	**(326)**
Impairment of assets held for sale	-	-	**-**
As at 31 March 2014	**-**	**-**	**-**

15 Trade and other payables

	Current	
	31 March 2015 £000	31 March 2014 £000
Recipts in advance	**118**	-
NHS payables	**138**	144
Amounts due to other related parties	**1,219**	1,415
Trade payables - capital	**966**	114
Other trade payables	**1,223**	1,919
Social security costs	**1,795**	1,771
Accruals	**3,670**	3,952
PDC Dividend Payable	**-**	48
Total	**9,129**	9,363

16 Provisions

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Legal claims	**174**	130	**-**	-
Redundancy	**216**	518	**-**	-
Injury Benefits	**50**	50	**710**	700
Other	**391**	217	**-**	-
Total	**831**	915	**710**	700

16.1 Movement in Provisions

	Legal claims £000	Redundancy £000	Injury Benefits £000	Other £000	Total £000
At 01 April 2014	130	518	750	217	**1,615**
Arising during the year	155	-	13	191	**359**
Utilised during the year	(70)	(49)	(51)	(17)	**(187)**
Unwinding of discount	-	-	10	-	**10**
Change in discount rate	-	-	38	-	**38**
Reversed unused	(41)	(253)	-	-	**(294)**
At 31 March 2015	**174**	**216**	**760**	**391**	**1,541**
Expected timing of cash flows:					
Not later than 1 year	174	216	50	391	**831**
Between 1 and 5 years	-	-	197	-	**197**
Later than 5 years	-	-	513	-	**513**
	174	**216**	**760**	**391**	**1,541**

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 £760,000 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 2014 - £750,000).

£2,331,524 is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of Sheffield Health and Social Care NHS Foundation Trust (31 March 2014 - £2,561,898).

17 Other liabilities

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £000
Deferred Income	**13**	56	**-**	-
Net Pension Scheme Liability	**-**	-	**5,200**	3,223
	13	56	**5,200**	3,223

18 Contingent liabilities

	31 March 2015 £000	31 March 2014 £000
NHS Litigation Authority Legal claims	**43**	41
Other	**611**	-
	654	41

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. Other Contingent liabilities arise from unexpected events that give rise to the possibility of an outflow of resources embodying economic benefits.

In 2014/15 other contingent liabilities include potential costs of cessation of the provision of the Sheffield Community Equipment Loan Service, in terms of lease and reinstatement costs should the site become surplus to requirements, totalling £319,000. Also included is the potential cost to the Trust should an existing tribunal appeal not be successful, £292,000.

19 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.

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.

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 the end of the financial year is 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.

19.1 Financial assets

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.

	31 March 2015 £000	31 March 2014 £000
Denominated in £ Sterling - Floating interest rate*	**28,870**	27,605

*This excludes cash in hand of £63,352 (2013/14 £68,000).

19.2 All Financial assets by category

	31 March 2015 £000	31 March 2014 £000
Loans and Receivables		
NHS receivables and accruals	**3,584**	2,841
Other receivables with related parties	**5,876**	3,032
Provision for irrecoverable debts	**(161)**	(41)
Other accrued income	**(308)**	530
Other receivables	**249**	300
Cash at bank and in hand	**28,933**	27,673
Total at 31 March	**38,173**	34,335

19.3 Financial liabilities

The Trust has no financial liabilities with floating or fixed rates of interest. They are all non interest bearing.

19.4 All Financial assets by category

	31 March 2015 £000	31 March 2014 £000
Other financial liabilities		
NHS payables and accruals	**683**	816
Other payables with related parties	**1,219**	1,415
Trade payables - capital	**966**	114
Other trade payables	**1,223**	1,919
Other Accruals	**3,125**	3,280
Total at 31 March	**7,216**	7,544

19.5 Fair values of financial assets and liabilities at 31 March 2015

The fair value of the Trust's financial assets and financial liabilities at 31 March 2015 equates to the book value.

20 Third Party Assets

The Trust held cash of £2,777,000 at bank and in hand at 31 March 2015 (31 March 2014 - £3,116,000) 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.

21 Losses and Special Payments

The number of cases has increased in year due to the abandonment of credits held with Suppliers who have ceased trading.

There were no individual losses or special payment cases exceeding £300,000.

Losses and Special Payments shown below are reported on an accruals basis, exclude provisions for future losses, and include in year utilised provisions on a cash basis.

21.1 Losses by Category

	31 March 2015		31 March 2014	
	Number	**£000**	Number	£000
1. Cash losses	**2**	**3**	-	-
2. Fruitless payments and constructive losses	**-**	**-**	-	-
3. Bad debts and claims abandoned	**16**	**9**	4	4
4. Stores losses	**4**	**17**	4	15
Total at 31 March	**22**	**29**	8	19

21.2 Special Payments by Category

	31 March 2015		31 March 2014	
	Number	**£000**	Number	£000
5. Compensation payments	**1**	**68**	-	-
6. Extra-contractual payments	**-**	**-**	-	-
7. Ex gratia payments	**26**	**13**	25	14
8. Special severance payments	**-**	**-**	-	-
9. Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
Total at 31 March	**27**	**81**	25	14

22 Events after the reporting period

There have been no significant events after the reporting period date.

23 Related party transactions

23.1 Register of Interests

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:

	Receipts from Related Party £000	**Payments to Related Party £000**	**Amounts due from Related Party £000**	**Amounts owed to Related Party £000**
Sheffield Teaching Hospitals NHS FT	3,378	1,697	423	210
University of Sheffield	259	639	60	168
Royal College of Psychiatrists	10	15	-	-
Turning Point	-	476	-	9
Sheffield City Council	13,513	1,350	5,704	203
Age UK Sheffield	1	-	-	-
University College of London	5	-	5	-

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, Sheffield;
- One of the Non-Executive Directors receives a pension from Turning Point and is an appointed Trustee of the Turning Point Pension Scheme;
- 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. Provisions for doubtful debts have been raised against amounts outstanding in respect of Self Directed Support charges managed by Sheffield Council on behalf of individual service users totalling £60,975 but no other expenses are recognised in year in respect of bad or doubtful debts due from related parties.

23.2 Other related parties

The value of the Trust's transactions with other related parties during the year is given below:

	2014/15		2013/14	
	Income £000	**Expenditure £000**	Income £000	Expenditure £000
Department of Health	**512**	**-**	329	-
Other NHS bodies	**107,182**	**4,016**	105,686	4,321
Other bodies (including WGA)	**13,728**	**16,376**	13,547	16,190
	121,422	**20,392**	119,562	20,511

The value of transactions with Board members and key staff members in 2014/15 is £nil (2013/14 £nil). Details of Directors' remuneration and pensions can be found in the Remuneration Report of the accounts. Disclosures relating to salaries of Board members are given in Note 5.3 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 2015		31 March 2014	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000
Department of Health	**31**	**-**	19	48
Other NHS bodies	**3,582**	**793**	2,821	784
Other bodies (including WGA)	**5,961**	**3,225**	3,359	3,270
	9,574	**4,018**	6,199	4,102

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2015 is £60,975 (31 March 2014 £6,801).

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:

- Sheffield CCG;
- Health Education England;
- South Yorkshire and Bassetlaw Area Team of the National Commissioning Board;
- Barnsley CCG;
- North Derbyshire CCG;
- Rotherham CCG;
- Derbyshire Healthcare NHS Foundation Trust;
- Nottinghamshire Healthcare NHS Trust;
- Rotherham Doncaster and South Humber NHS Foundation Trust;
- Leeds Partnership NHS FT;
- Sheffield Children's NHS Foundation Trust;
- Sheffield Teaching Hospitals 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.

24 South Yorkshire Pensions Fund - Retirement Benefit Obligations

The total defined benefit pension loss for 2014/15 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £494,000 (the year ended 31 March 2014 a loss of £577,000). A pension deficit of £5,200,000 is included in the Statement of Financial Position as at 31 March 2015 (31 March 2014 - £3,223,000 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 2015, the deficit on the scheme was £5,200,000 (31 March 2014 - £3,223,000 deficit), the majority of which is offset by a non-current receivable of £4,576,000 (31 March 2014 - £2,837,000).

Estimation of the net liability to pay pensions depends on a number of complex judgements. A firm of consulting actuaries is engaged by South Yorkshire Pensions Authority to provide expert advice about the assumptions made, such as mortality rates and expected returns on pension fund assets.

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:

	31 March 2015 %	31 March 2014 %
Rate of inflation	**2.00**	2.4
Rate of increase in salaries	**3.75**	4.15
Rate of increase in pensions and deferred pensions	**2.00**	2.4
Discount rate	**3.30**	4.5
The current life expectancies at age 65 underlying the accrued liabilities for the scheme are:		
Non retired member - Male (aged 65 in 20 years time)	**25.3**	25.2
Non retired member - Female (aged 65 in 20 years time)	**28.4**	28.3
Retired member - Male	**23.0**	22.9
Retired member - Female	**25.6**	25.5

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	Scheme assets %	**31 March 2015 £000**	Scheme assets %	31 March 2014 £000
Equities	**59.55**	**10,105**	61.74	9,100
Government Bonds	**12.77**	**2,167**	10.41	1,534
Other Bonds	**8.34**	**1,416**	9.25	1,364
Property	**10.91**	**1,852**	9.82	1,447
Cash / Liquidity/Other	**8.43**	**1,430**	8.78	1,294
Total fair value of assets	**100.00**	**16,970**	**100.00**	14,739
Present value of defined benefit obligation		**(22,170)**		(17,962)
Net retirement benefit deficit		(5,200)		(3,223)

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:

	2014/15 £000	2013/14 £000
At 01 April	**(17,962)**	(17,557)
Current service cost	**(352)**	(414)
Interest on pension liabilities	**(802)**	(734)
Member contributions	**(109)**	(114)
Actuarial (losses) / gains on liabilities	**(3,319)**	517
Benefits paid	**374**	340
At 31 March	**(22,170)**	(17,962)

Movements in the present value of the defined benefit obligations are:

	2014/15 £000	2013/14 £000
At 01 April	**14,739**	13,690
Interest on plan assets	**660**	578
Remeasurements (assets)	**1,401**	354
Administration expenses	**(7)**	(7)
Employer contributions	**442**	350
Member contributions	**109**	114
Benefits paid	**(374)**	(340)
At 31 March	**16,970**	14,739

The net pension expense recognised in operating expenses in respect of the scheme is:

	Year ended 31 March 2015 £000	Year ended 31 March 2014 £000
Current service cost	**(352)**	(414)
Pension expense to operating surplus	**(352)**	(414)
Net interest cost	**(135)**	(156)
Administration expenses	**(7)**	(7)
Pension expense	**(142)**	(163)
Net pension charge	**(494)**	(577)

The reconciliation of the opening and closing statement of financial position is as follows:

	2014/15 £000	2013/14 £000
At 01 April	**(3,223)**	(3,867)
Expenses recognised	**(494)**	(577)
Remeasurements (liabilities and assets)	**(1,925)**	871
Contributions paid	**442**	350
At 31 March	**(5,200)**	(3,223)

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 2015, a cumulative amount of £583,000 was recorded in the Income and Expenditure Reserve (31 March 2014 £352,000).

The history of the scheme for the current and prior year is:

	2014/15 £000	2013/14 £000
Present value of defined benefit obligation	**(22,170)**	(17,962)
Fair value of scheme assets	**16,970**	14,739
Net retirement obligation	**(5,200)**	(3,223)

Experience losses on scheme liabilities in remeasurement for 2014/15 are £nil (year ended 31 March 2014 £875,000) and experience gains on scheme assets are £nil (year ended 31 March 2014 £nil).

Section 14

Glossary

Annual Accounts
Documents prepared by the Trust to show its financial position.

Annual Governance Statement
A statement about the controls the Trust has in place to manage risk.

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.

Annual Report
A document produced by the Trust which summarises the Trust's performance during the year, including the annual accounts.

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.

Audit Opinion
The auditor's opinion of whether the Trust's accounts show a true and fair view of its financial affairs. If the auditors are satisfied with the accounts, they will issue an unqualified audit opinion.

Available for sale
Assets are classed as available for sale if they are held neither for trading nor to maturity. An example of this would be an investment without a maturity date such as an ordinary share.

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 and cash equivalents
Cash includes cash in hand and cash at the bank. Cash equivalents are any other deposits that can be converted to cash straight away.

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.

Corporation tax
A tax payable on a company's profits. Foundation Trusts may have to pay corporation tax in the future. The legislation introducing corporation tax to Foundation Trust has been deferred and 2011/2012 was the first year that government introduced corporation tax to Foundation Trusts.

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.

External Auditor
The independent professional auditor who reviews the accounts and issues an opinion on whether the accounts present a true and fair view.

Finance lease
An arrangement whereby the party leasing the asset has most or all of the use of an asset, and the lease payments are akin to repayments on a loan.

Financial statements
Another term for the annual accounts.

Foundation Trust Financial Reporting Manual
The key document, published annually by Monitor, setting out the framework for the Trust's accounts. Now called the Annual Reporting Manual.

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.

Liquidity ratio
Liquidity is a measure of how easily an asset can be converted into cash. Bank deposits are very liquid, debtors less so. The liquidity ratio is a measure of an entity's ability to meet its obligations, in other words how well it can pay its bills from what it owns.

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.

Operating lease
An arrangement whereby the party leasing the asset is paying for the provision of a service (the use of the asset) rather than exclusive use of the asset.

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.

Primary statements
The 4 main statements that make up the accounts: the Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Taxpayers' Equity; and Statement of Cash Flows.

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.

Third Sector Organisations
This is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

True and fair
It is the aim of the accounts to show a true and fair view of the Trust's financial position, that is they should faithfully represent what has happened in practice.

UK GAPP (Generally Accepted Accounting Practice)
The standard basis of accounting in the UK before international standards were adopted.

Unrealised gains and losses
Gains and losses may be realised or unrealised. Unrealised gains and losses are gains or losses that the Trust has recognised in its accounts but which are potential as they have not been realised. An example of a gain that is recognised but unrealised is where the value of the assets has increased. This gain is realised when the assets are sold or otherwise used.

Section 15

Contacts

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Old Fulwood Road
Sheffield
S10 3TH
Tel: 0114 2716310 (24 hour switch board)
www.shsc.nhs.uk

Human Resources
If you are interested in a career with Sheffield Health and Social Care NHS Foundation Trust, visit the Trust website (**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
Tel: 0114 2716706

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 and Governor Officer on 0114 2718768.

Contacting members of the Council of Governors
The Governors can be contacted by emailing governors@shsc.nhs.uk or by phoning 0114 2718768.


nature
LIKE
FREE
CURE
LIGHT
LOVE
SUPPORT
TEA
JOY
FREEDOM
LOVE
LIFE
HOPE
HAPPY
HOPE
UNITY
SWIM
TEAM