Sheffield City Council

Sheffield Health and Social Care NHS
NHS Foundation Trust

Our Operational Plan

for the period 2017-19

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Public version

Contents

Strategic and Local Context

With an annual projected income of approximately £112 million and 2,687 members of staff, we provide mental health, learning disability, substance misuse 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.

Our plans to deliver on our vision, supported by clear strategic aims and service plans are summarised in our Five Year Strategic plan for 2014-2019 which, at the time of writing, is being refreshed owing to significant challenges in our internal and external operating environment.

This final plan has been arrived at following a challenging round of financial and business planning. On 4 November 2016, our lead commissioner, NHS Sheffield CCG requested an additional QIPP challenge of £6m over the next two years. Our Board is clear that we are not accepting their request against a backdrop of an already challenging CIP target, the achievement of the control total, disinvestments across our social care services and high levels of risk associated with redeployment of staff and an on-going HMRC case. The Trust is keen to work in partnership with our lead commissioner and across the wider STP to develop QIPP schemes to meet the system challenges but is only willing to accept reduced income once plans are fully developed, quality impact assessed and when costs are removed from the organisation.

Section 1: The Sustainability and Transformation Plan

The South Yorkshire and Bassetlaw area, through the development of the STP, has agreed that "*Our goal is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer*."

The key strategic plans are focussed on –

- Putting prevention at the heart of what we do
- Reshaping primary and community based care
- Standardising hospital care

The Plan is delivered through localised Place based plans and a smaller number of STP wide plans were additional co-ordinated efforts across the STP network will support the successful delivery of the necessary change. The STP is published separately and it describes how the health and social care system will –

- Prevent illness, empower people to look at their own health to avoid hospital stays
- Strengthen and invest in primary care in line with General Practice Forward View
- Make tangible improvements to mental health and Learning disabilities services
- Simplify the Urgent and Emergency Care system, making it more accessible
- Deliver the A&E and Ambulance Standards
- Make tangible improvements to cancer services
- Improve the quality of hospital services
- Create a financially sustainable health system for the future

The Sheffield Plan delivers the local element of the South Yorkshire and Bassetlaw Plan. It responds to the STP wide agreed development priorities for implementation at local level in respect of –

- Radical upgrade in prevention
- A complete primary care offer
- Development of out of hospital care services
- Neighbourhood models of delivery, targeting the most vulnerable in communities
- Developing models of integration and accountable care

Our role in this is to work collaboratively with stakeholders locally and across South Yorkshire and Bassetlaw to deliver new models of care in respect of –

- Effective community services within Sheffield, based on neighbourhood models, primary care led and integrated approaches with the third sector
- Effective, affordable and quality mental health and learning disability services across the South Yorkshire and Bassetlaw area, working collaboratively to deliver sustainable specialist services.

Our plans
STP Priority: Healthy Lives, Living Well and Prevention

The Plan's focus over the next two years are to –

- Deliver a step-change in employment and employability across the footprint
- Transform, invest and broaden our interpretation of primary care, with a focus on investing in social prescribing
- Invest significant levels of resource in an 'SYB Healthy Lives' programme, aimed at tackling the main causes of ill health, early death and reducing health inequalities.

In support of these plans we will -

- Ensure accessible health promotion interventions underpin our approach, adopting an 'every contact counts' approach targeting smoking, alcohol, diabetes, social isolation, employment and other key areas of health
- Work with partners to promote and support the delivery of city wide initiatives to improve employment outcomes for people across Sheffield
- Our workforce plans will ensure we embed the right skills and knowledge across our workforce

Sheffield Plan Priority: Primary Care For Now and For The Future
The Sheffield Plan's focus over the next two years, in respect of Primary Care, is to -

- Strengthen Primary Care to meet today's needs and future needs
- Help more people to stay at home through self-care, support in the community, and pathway coordination

In support of these plans we will –

- Develop a new model of care for the delivery of mental health care and support within primary care settings, teams and neighbourhood level services.
- Develop, through our partnership with Primary Care Sheffield, options to support General Practice to remain sustainable and introduce enhanced services.

STP Priority: Mental Health & Learning Disabilities
The Plan's focus over the next two years is to –

- To ensure that people facing a crisis have access to mental health care 24/7, supported by a review of urgent care and hospital based psychiatric liaison services and planned reductions in out of area placements
- To deliver against our commitments to the transforming care agenda to support people with learning disabilities in receiving care as close to home as possible
- To develop alternative models of service delivery outside of specialist mental health providers, building capacity and capabilities with social prescribing models
- To ensure that people with severe mental illness also have their physical health needs met

In support of these plans we will –

- Continue to work with commissioners locally to ensure that current services remain as effective as they can be while exploring opportunities to develop and make improvements in line with national guidance and investment plans.
- Extend current CERT service model to reduce long term hospital care for people with rehabilitation needs to a minimum through the provision of intensive 'hospital at home' care and treatment. Test

the application of the CERT model to develop new community services to reduce need for secure care
- Deliver a community mental health team model that effectively delivers treatment and support across the age range with clear single points of access supported by specialist psychotherapy services and the broader access to social prescribing models of support

Develop and introduce initiatives to reduce bed usage for people with a learning disability and transform care into a more community facing model. As part of the development programme we will explore and test the suitability of building city wide approaches to Positive Behavioural Support, enhancing the provision of community forensic services and increased capacity within the community team to support and provide rapid response and intensive support at times of need.

Section 2: Quality Planning

Approach to Quality Improvement

Our approach is set out within our Quality Improvement and Assurance Strategy 2016 - 2022 and the accompanying implementation plan which is in the process of being refreshed to accommodate the Trust's overall Quality Improvement Plan. The purpose of the strategy is to develop a culture of continuous quality improvement by -

- Delivering quality by creating the conditions for all our staff and every team to engage successfully in quality improvement underpinned by effective team governance;
- Ensuring measurable quality objectives are agreed across the organisation;
- Ensuring effective, supportive and responsive Trust governance and assurance systems;
- Having clear arrangements to support delivery and accountability;
- Ensuring we have accurate and appropriate information available about the quality of care provided at all levels;
- Enhancing quality improvement capacity and capability through ensuring maximum numbers of staff are coached in Microsystems quality improvement methodology.

In order to ensure high quality care and support, the Trust's quality governance arrangements are summarised as follows:

Board of Directors: Sets the Trust's strategic aims and ensures the necessary supporting strategies, operational plans, policy frameworks and financial and human resources are in place for the Trust to meet its objectives and review its performance. Receives assurance reports on compliance with CQC standards as well as the improvements necessary to achieve quality services.

Quality Assurance Committee: Brings together the governance and performance systems of the Trust in respect of quality. The Committee provides oversight of Trust systems in respect of quality and risk management arrangements. The Committee is informed by the work of a range of committees that oversees Trust systems and performance in respect of key matters relating to quality and safety. Receives assurance reports on compliance with CQC standards as well as the improvements necessary to achieve quality services.

Audit Committee: Reviews the existence and maintenance of an effective system of integrated governance, risk management and internal control Trust-wide.

Executive Management Team: Oversees the operational functioning and delivery of services and programme management oversight of key transformation and improvement projects. The Medical Director is the Trust's executive lead for quality improvement. Oversees the development and implementation of Trust wide compliance plans.

Service User Safety Group: Monitors the Trust's performance around incident management including serious incidents, learning from incidents, Trust mortality, the patent safety thermometer, infection prevention and control, falls, restrictive practices and all matters of patient safety.

Clinical Effectiveness Group: Establishes our annual clinical audit programme (which includes national and locally agreed clinical audits), oversees the implementation of NICE guidance and embeds the routine use of outcome measures in clinical services.

Service User Engagement Group: Improves the quality of service user quality and experience, ensures that service user experience drives quality improvement and enables the clinical directorates to enhance how they engage with service users.

Systems of Internal Control: A range of policy and performance management frameworks (at individual and team level) as well as internal controls are in place to protect and assure the safety of care and treatment and the delivery of quality care in line with national policy and legislation.

Following the plans put in place for 2016/17, we are continuing to build on these into 2017/18 and beyond. We identified the areas below as key areas to enable us to improve our quality governance arrangements and these continue to be our focus from 2017/18 onwards: -

- Peer Review and Self Inspection – Continue to build capacity and capability across the Trust by which to self-inspect our services and ensure compliance with quality standards (CQC, MHA,MCA,EMSA)
- Enabling service user engagement in our quality improvement projects – Ensuring that service users are enabled and supported to contribute to Microsystems projects within teams
- Team Level Information Needs – Implementation of a business intelligence system to provide real-time quality information to front line teams

To deliver our strategy, it is essential that staff have the ability to engage with improvement techniques. Whilst we will use a range of quality improvement techniques as appropriate, the core Trust wide approach that we will use will be Microsystems improvement methodology.

Following the Trust's previous provider inspection (report published in June 2015 and assessed the Trust as 'Requires Improvement'), the Trust developed and implemented a plan to ensure there was targeted investment to improve our care environment, monitoring systems and staffing capacity within our crisis care services. Following our most recent inspection in November 2016, Executives have considered and agreed a further action plan to improve some of our seclusion rooms and to further reduce ligature risks on our inpatient areas. This will include the creation of a number of ligature reduced rooms on each of our in-patient wards. Our plans will be further considered once detailed feedback from the CQC has been received. We are expecting this feedback in February 2017 and we have planned to achieve a 'good rating'.

<u>Our Quality Improvement Plan</u>

We have maintained a Green risk rating for quality governance since we became an NHS Foundation Trust and when the Single Oversight Framework comes into operation we will ensure that we have high standards of financial, corporate and clinical governance.

We continue to exceed the national access standard for IAPT services and will achieve the access standard for people experiencing a first episode of psychosis. Rates of diagnosis for people with dementia remain positive. Our local CCG agreed for us to take the lead role in Sheffield in delivering care and treatment reviews for people with a learning disability, ensuring that care is delivered in the community as the preferred and first choice. However, we recognise that there are some challenging waiting times standards to meet and, where we can, exceed, particularly in relation to crisis, liaison and eating disorders services. When changes to services are required, we will work proactively with operational colleagues and those within the Project Management Office to ensure that when services engage with improvement or transformation that our obligations in respect of waiting times are met.

Commissioning plans are moving forward as part of the city wide STP and the Forward View's for Mental Health and Primary Care. The main focus of these plans, as they relate to the Trust, will be the development of sustainable community care systems that deliver quality care and experiences, positive outcomes and significantly reduced demand on acute hospital based services. As part of this programme there will be a focus on mental health and ensuring urgent and crisis care pathways and provision are accessible and effective over the full 7 day period. Commissioning priorities in respect of quality

improvement are defined through the agreed CQUIN programme and within the Quality Schedule. This forms part of our contractual relationship with NHS Sheffield CCG. The agreed areas of focus remain on improving physical health and developing improved outcome measures which link directly to our emerging Quality Objectives Framework within our Strategic Plan.

At the time of submitting this plan, we are engaging with our clinical directorates in the Trust's business planning processes. One such related process is the development of future plans for the Trust's approach to infection prevention and control and microbial resistance. We have requested that the directorates agree with Executives a series of stretch targets and key milestones within their business plans that align the delivery of strategic, business and quality objectives over the next two years. On conclusion of business planning, a Trust wide implementation plan will be developed and agreed at Trust Board so to ensure a robust and comprehensive approach to monitoring and managing our performance against agreed Quality Objectives.

The Trust has engaged with a number of mental health organisations working, with Mazars, to look at standardising the way we define mortality to improve learning and enable benchmarking across similar organisations. Over the next two years, we will align this work to recommendations to be made by the CQC, following their national mortality review. We have established a mortality surveillance group which we will continue to develop our reporting to maximise our learning and sharing of good practice.

The Trust has a range of development priorities and actions in place that are focussed on maintaining and improving the quality of care provided. These are defined elsewhere and within our Quality Account. These address our transformation priorities and a range of quality improvement programmes that focus on particular aspects of quality and safety, or build our capacity to deliver high standards of quality care.

QUALITY OBJECTIVE 1: Improving access to services and treatment		
Directorate	Directorate specific goal	Measured by
Community	Achieving better access standards	Exceed national standards: IAPT standards of 75% accessing treatment in 6 weeks and 95% in 18 weeks Early psychosis standards of 50% accessing treatment in 2 weeks
	Improved access to urgent and crisis services ensuring effective access over the 7 day period	The number of people who receive a crisis assessment within 90 minutes of referral
Inpatient	Access to a health based place of safety for people detained under Section 136	The number of people unable to access the health based place of safety
Specialist	Improving access to memory services	Improve waiting times for assessment at memory service Waiting times to receive diagnosis following memory assessment
	Improved access and support for people with substance misuse problems	Number of people receiving alcohol support and completing treatment
Learning Disabilities	Care and Treatment reviews ensure community care is delivered where possible.	Number of people who have received a care and treatment review. Number & % of people who received a care and treatment review prior to admission. Number & % of people who received a care and treatment review within 2 weeks of admission.
	Reducing duration in inpatient care to a minimum	Length of stay for inpatients at the Firshill Rise Assessment and Treatment Unit

QUALITY OBJECTIVE 2: Improving physical, mental and social wellbeing outcomes		
Directorate	Directorate specific goal	Measured by
Community	Assessment of physical health needs of people receiving care	Number of community clients with a physical health assessment and plan shared with their GP Number of community clients assessed as at risk of problematic alcohol use who are referred to specialist alcohol support services
Inpatient	Comprehensive physical health assessments of all inpatients	Number of inpatients with an assessment of their physical health needs Number of inpatients with a treatment plan for their physical health needs where indicated.
Specialist	Assessment of physical health needs of people receiving care	Number of community clients with a physical health assessment and plan shared with their GP
Learning Disabilities	People with a learning disability will receive an annual health check with their GP and have a health action plan and a hospital passport in place.	Number of people with a health action plan in place who are known to SHSC. Number of people with a hospital passport in place who are known to SHSC.

QUALITY OBJECTIVE 3: Improving experience through service user engagement and feedback		
Directorate	Directorate specific goal	Measured by
Community	Develop approaches to regular monitoring of service users experience	Use of Friends and Family Test and outcome scores Self-assessment against NICE Service User Experience Quality Standards
Inpatient	Reduce restrictive practices	Rates of restrictive practices
	Embed collaborative care planning	Rates of inpatients reporting as engaged with their collaborative care plan
	Quality and dignity survey programme	Use of quality and dignity patient survey
Specialist	Develop approaches to regular monitoring of service users experience	Use of Friends and Family Test and outcome scores Self-assessment against NICE Service User Experience Quality Standards
Learning Disabilities	Reduce restrictive practices.	Rates of restrictive practices as benchmarked against other local and national services. Audit of % and quality of Alternatives to Restraint Care Plans in relation to people on a Deprivation of Liberty Safeguards.

Our Trust Board approved our Service User Engagement Strategy in July 2016. The commitments within this builds on existing work and assets, and directs future action in a coherent and planned way in order to extend and maximise impact, and foster a culture of excellence in service user engagement in which innovation, flexibility, and responsiveness are central. The aims within the strategy are ambitious, in line with the Trust's organisational values.

Our Quality Impact Assessment Process

The Trust is clear that cost improvements should not impact on quality. All plans relating to clinical and corporate services will be developed and approved by the appropriate clinical and service directors after comprehensive engagement with staff. Each cost improvement scheme is submitted for review to the CIP Working Group which is chaired by the Senior Finance Manager. The quality of the scheme and its

deliverability are reviewed and approved or otherwise. If there could be an impact on quality, then this triggers the completion of a Quality Impact Assessment (QIA).

Following completion, the QIA is reviewed and agreed by the Service and Clinical Directors to ensure that as a result of making the cost improvement, service quality will be managed in accordance with a series of quality metrics. The QIA is assessed against the three core quality domains of safety, effectiveness and experience which allows for a comprehensive assessment of the impact to be identified. Following agreement by the Clinical and Service Directors, all QIAs, including the ways in which the quality metrics will be monitored, are thoroughly scrutinised by the Clinical Executive Scrutiny Panel, Chaired by the Trust's Medical and Nursing Directors. Once their agreement has been sought, their assurance is provided to our Quality Assurance Committee, Trust Board and commissioners, NHS Sheffield CCG, to ensure that the Trust's cost improvement plan will appropriately manage its impact on quality.

Monitoring of all QIA processes is undertaken quarterly and, in exceptional circumstances e.g. if a plan is high risk, this would be more frequent. When undertaking quarterly monitoring, Directorates are advised to provide an honest appraisal of any quality impact which the cost improvement has had on service quality and are requested to refresh the risk rating, if appropriate, in accordance with changes to the quality metrics. These updates are provided to Executive Directors Group, Quality Assurance Committee and Trust Board for the purposes of monitoring and managing any risks to quality.

Top Three Risks	**Key Methods of Mitigation**
Risk that the quality of care provided falls below expectations and/or standards	• Service user experience surveys • Capability and Capacity Group to have oversight of safe staffing • CQC Action Plan delivery • Mandatory training programme in place • Staff supervised • Nurse revalidation system introduced • Acute and Scheduled Care Pathways fully implemented • Non-Executive Director and Executive Directors visit Trust services • In Year review of Quality Impact Assessments
Risk that service users will have to wait longer than expected to receive services	• Waiting times are monitored by service directorates • External liaison group with commissioners monitor progress and developments • Monitor's risk assessment framework monitors service access
Risk that the Trust will not continue to be financially viable and that strategic plan will not deliver required financial savings	• Clear plan and strategies in place to inform trust direction • Robust financial planning and control mechanisms in place • Finance and Investment Committee maintains an overview of the Trust's financial processes • Audit and Assurance Committee has responsibility for ensuring effective internal control.

How We Triangulate Quality, Workforce and Finance

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service, Directorate and Trust wide level. Further developments continue to be made to enhance our performance management frameworks through effective business information systems.

The Board's monthly and annual performance reporting processes ensure that the Executive Management Team is able to scrutinise and manage the operational performance of services and the Board maintains overall oversight on the performance of the Trust. On an established quarterly cycle, the performance of all services are reviewed through Directorate-level Service Reviews. These reviews consider each directorate's performance, with particular reference to performance against strategic/business/quality objectives, cost improvement delivery and any over/under spending, clinical effectiveness, service user experience, staffing matters eg. vacancy control, sickness absence management and patient safety eg. Incident trends and themes and learning from serious incidents. The Board uses this information to achieve assurance that performance is on track to deliver Trust objectives or to direct improvements where this falls short of expectations.

Section 3: Workforce Planning

The Trust's approach to workforce planning is to work closely with Directorates to establish their workforce needs based, principally, on organisational change and alignment with service strategies. During 2017/19, there will be a continued focus and further development of workforce plans across all Directorates but specifically, Community, Learning Disabilities, Specialist and Primary Care as they manage the delivery of significant change programmes. Trust efficiency and cost reduction programmes will also mean changes in the workforce as there is a shift in workforce from inpatient to community services, supported by the shift in resources and development of new roles within community teams. A significant emerging theme is likely to be around mental health support for long term conditions and management within primary care. Mental health care pathway redesign will require increased home treatment capacity, drawing on the peer support worker role and more psychology based interventions.

New roles will be required in primary care services including Physician Associates and Advanced Nurse Practitioners as well as investment in the skills and training of the healthcare assistant workforce. Increased demand for roles such as Liaison Psychiatrists are anticipated to support the integration of physical and mental health and 7 day services, together with dual training across General Psychiatry and Specialist Psychotherapy as service delivery shifts into the community and away from hospital and secondary care. In order to achieve standards set as part of Achieving Better Access to Mental Health Services we will require additional investment in Psychological professionals such as IAPT staff and Clinical Psychologists. Our current workforce is shown below and we expect organisational change within this financial year and future financial years to change the composition of our establishment further, along with changes to WTE in line with the on-going CIP efficiency programmes.

Workforce planning is led by service needs and informed by workforce data, staff and commissioners and overseen by our Staffing Capacity and Capability Group (led by the Chief Nurse) and the Medical Workforce Planning Group (led by the Medical Director), Strategic Workforce Planning Group (led by HR), Executive Directors Group and Trust Board to ensure that workforce plans are rooted in clinical and operational strategy.

To ensure the successful implementation of our Workforce Plans; quality and safety metrics are considered on a regular basis by both Executive Director's Group and the Board to identify any improvements to staffing levels or the deployment of additional staffing.

Headcount Quarter 2 2016/17 (to 30/09/2016)	**HC**	**FTE**	**%**
Trust	2687	2327.51	
Community Directorate	508	435.71	18.9%
In-patient Directorate	513	466.26	19.1%
Learning Disabilities Service	304	274.69	11.3%
Medical	119	104.77	4.4%
Non Med Support Directorates	305	282.64	11.4%
Primary Care	70	49.97	2.6%
Specialist Directorate	868	713.48	32.3%

Staff Group Headcount Quarter 2, 2016/17	**HC**	**FTE**	**%**
Add Prof Scientific & Technical	168	133.54	6.3%
Add Clinical Services	899	782.40	33.5%
Admin & Clerical	566	491.77	21.1%
Allied Health Professionals	150	112.98	5.6%
Estates & Ancillary	173	144.32	6.4%
Medical & Dental	185	154.35	6.9%
Nursing & Midwifery	540	481.16	20.1%
Students	6	5.44	0.2%

Workforce Priorities 2017/19	Plans to Address Workforce Priority
Effective management of organisational change	Workforce Strategic Action Plan in development based on People Plan Priorities to enable proactive support for change activity (including the development of a manager's guide to further develop change management support and practice) Review of redeployment processes Review of the Vacancy Control Panel to ensure effective management of vacancies Enabling effective working relationships both internally and externally to support change activity Enable service improvements and ways of working through increased use of microsystems, reflective practice, qualitative supervision, Schwartz Round
Enabling workforce transformation	Strategic workforce planning group in place to co-ordinate the Trust's annual workforce planning process Expansion of Trust Bank staff to meet temporary cover needs (including Admin, OT, Housekeepers) Reduction in agency spend co-ordinated through agency task group Embed apprenticeships as part of the Trust Workforce Work collaboratively across the SY Sustainability and Transformation partnership to explore opportunities for maximising joint working on training programmes and ensure return on the apprenticeship levy for example Sheffield wide inclusive leadership programme Development of a recruitment and retention plan to attract and retain the right workforce with the right skills, and position as an employer of choice Further development of the widening participation agenda Development of new roles including Band 5 nurse (rotation), Band 4 Assistant Practitioner
Leadership and management development	Development of a leadership and management development programme based on Trust diagnostic data Embed a coaching culture to enable staff to achieve their full potential Strengthen management accountability and enable efficient management of performance (i.e. sickness, mandatory training) though training, improved planning and systems support Further work to embed Trust Values, and engage staff through significant change activity
Supporting the health and wellbeing of our workforce	Focussed action to support a reduction in sickness absence below Trust target through case manager role, updated policy and guidance, training and people plan actions to address specific needs Easy access wellbeing support available to staff Review of occupational health provision

The Trust has operated an e-rostering system for a number of years and invested substantially in upgrading its provision during 2015/16. This is being introduced across the Trust, as a cost effective system

which further supports the move towards minimal use of agency staffing. In addition, the Agency Task Group continue to review further opportunities to reduce agency costs; increasing the use of bank staff, transferring off payroll and agency staff to Trust contracts where possible and increased control of agency usage through the Vacancy Control Panel. This continues to feature as part of the planning for 2017/18 with the objective of the on-going compliance with the NHSi agency caps and cost effective interim solutions being in place where needed.

The Strategic Workforce Planning Group supports the collection of training priorities to Health Education England on an annual basis. This involves working together with the Lead for Education, Training and Development as well as the Deputy Chief Nurse and Directorates to understand their future needs. Our plan is to develop the remit of the group to continue cross Trust working; building on the framework for our People Plans to ensure we clearly understand workforce planning challenges, including recruitment, succession planning and talent management to enable effective use and planning of our staffing resource. This information underpins the Directorate business plans and compliments the Strategic Workforce Planning Group work to ensure a more informed cohesive and robust approach to planning at both an operational and strategic level.

Our Head of Education represents the Trust on the SY Excellence Centre (linked to the workforce stream of the local Workforce Advisory Board (LWAB)). We work closely with Health Education England (HEE) both regionally and nationally across the full range of medical and non-medical programmes. To support the Trust's Workforce Plan development, the Trust has in place a number of key forums where workforce planning can be triangulated with all aspects of the Trust's business. Those forums include the Business Planning Group, Workforce and Organisational Development Committee, Trust Board, Performance Overview Group with Governors and the Council of Governors, Nominations and Remuneration Committee, BME Strategy Group and the Strategic Workforce Planning Group. Workforce trends and analysis are reported to and discussed with the Board on a monthly basis.

The Trust continues to build on a positive working relationship with staff side through the Joint Consultation Committee and Joint Local Negotiating Committee, and seeks to engage fully with them on workforce transformation priorities.

Section 4: Activity Planning

Early contract negotiations have commenced with Commissioners, and although the Trust has had sight of their commissioning intentions, these are yet to be converted into their local "contractual intentions" which will form the basis of the contract particulars for the financial year 2017/18 and beyond. Therefore the outcome of those discussions cannot be fully incorporated into this draft annual plan submission.

From a provider and commissioner perspective we are currently not in a position to adopt the proposed capitation or episode of care payment approach by 2017/18 (although discussions continue). On this basis it's envisaged that the contract currencies, formerly used as our payment mechanism in 2016/17 i.e. Mental Health Clusters and non-clustered service specific currencies, such as diagnostic assessments, diagnostics follow up and community clinics, will remain static for 2017/18. A continued cost and volume contracting approach will ensure the Trust and Commissioners have a continued level of arrangement for over and under performance to be compensated for whilst working collectively to manage demand where needed.

This approach will be further supported by payment incentives linked to better outcome measures for service users, taking into consideration access and waiting time standards and supporting evidence based safe and effective care. In addition to this a full review of the contractual specifications will be undertaken to ensure these are prescriptive and transparent of service delivery, from both a commissioner and provider perspective.

The following table provides a high level summary and an early indication of the activity and targets across our services.

Draft Plan Indicative Target Assumptions for 2017/18

Service Type	Activity Measure	Indicative Target
Inpatient Services	Bed Nights	53,737
IAPT	New Patients Seen	13,238
Learning Disability Community	Community Contacts	15,542
Specialist Services	Community Contacts	23,764
Mental Health Clusters	Assessment Contacts / Community Clusters	2,199,090

The inpatient activity target has been based on the available bed capacity and taking into account the occupancy levels agreed between the Trust and the Commissioners. Occupancy levels vary dependent on the inpatient unit, clinical need and assumed lengths of stay.

The community and cluster targets denoted above are based on the forecast 2016/17 out-turns but are subject to change / variation. The modelling of the community activity is yet to be formally agreed with the commissioners, due to a number of service reconfigurations on-going within the Trust.

The predicted activity variances forecast for 2017/18 will be in the following areas:

- Acute Care Reconfiguration
- Learning Disability Inpatient and Community Services

The Trust continues with its Acute Care Reconfiguration, where a reduction in acute inpatient capacity will see a shift in funding to community based services for the remainder of 2016/17 and into 2017/18. The realignment of funding will respond to an increased need in home treatment, additional 136 place of safety provision and respond to demand in complex cases i.e. Personality Disorder. The outcome of this, once completed, will impact the proposed activity targets within the community settings, and therefore the mental health cluster target will need to be varied accordingly and the overall activity plan adjusted.

The Transforming Care Programme will look to reshape local need relative to inpatient and community provision for people with a Learning Disability and / or Autism. It terms of local context both the Trust and local commissioners, NHS Sheffield CCG, acknowledge that a number of actions will be enacted which will impact the current configuration of the Trusts Learning Disability inpatient and community services i.e. a reduction in inpatient capacity which will see funding realigned to community provision. This will have direct impact on the commissioned activity levels and therefore at the time of change the activity plan will need to be adjusted accordingly.

The capacity and activity levels are underpinned by robust contractual management processes (to monitor on-going performance against plan). Activity is to be monitored on a month by month basis, in order to review quarterly activity out-turns, demographic changes or demand and therefore inform any changes regards the sustainability of the activity plan, and the planned capacity to meet the activity requirements.

<u>Other factors which may influence / impact activity planning during 2017/19:</u>
Contractual Uncertainties – Due to increased financial pressures across the health and social care economy there are increased demands on providers to deliver savings or manage contracts within a reduced or static income allocation. This has caused a number of pressures on the Trusts contractual relationships with commissioners and created uncertainties surrounding the viability of a number of contracts moving into 2017/18 and beyond. Negotiations continue and risks have been identified from a financial perspective, within the plan, but the potential disinvestment of services will have an impact on activity targets, and the need to remodel / redesign capacity and services to meet service demand and pathway needs.

Procurement of Services – In testing the market and opening up the delivery of services to competition by commissioners the Trust is seeing an increase in local services, which have been historically provided by the Trust, put out to Tender. If the Trust doesn't retain this business then this will have a direct impact on the level of income the Trust receives and its viability to deliver some of its services. This will have a direct impact on the capacity to meet demand and the levels of activity which can be delivered.

Section 5: Our Governorship and Membership

Governors and Members play a vital role in the Trusts governance arrangements primarily through the meetings of the Council of Governors.

2016/17 was a very busy year for elections. There were 16 seats available in the following constituencies;

- 2 Public South West
- 1 Public North East
- 1 Public North West
- 1 Public South West
- 5 Service User
- 2 Carer
- 2 Young Service User/Carer
- 1 Nursing Staff
- 1 Psychology Staff

All seats were filled with the exception of two.

With a large Council of Governors (44 seats in total), elections are often large in size and 2017/18 will be no different with 16 seats to be contested.

Governors received a comprehensive Trust induction in 2016/17 which aligns with the good practice guidance from NHS Providers. In addition they were also provided with a bespoke training programme, delivered by NHS Providers as part of the GovernWell programme. Several Governors attended the Governor Focus Conference in London providing an opportunity to network with other governors and to hear from national bodies about key issues for Foundation Trusts.

The Trust revised and updated the Membership Strategy for 2016/17 in partnership with its governors. The Trust takes membership engagement very seriously and also provides many opportunities to facilitate engagement between governors and members. As such the Trust attended and governors participated in a number of community events in 2016/17. The focus for this year has been specifically targeting ethnically diverse areas of the city and younger people. This has been achieved by attending a variety of community events throughout the city as well as holding and participating events at the University and local schools.

The Trust works closely and proactively with Sheffield Teaching Hospitals in its membership engagement and recruitment. Together we organise joint events to raise awareness of key health issues which have been identified by our members. In 2016 these have included topics on dementia and nutrition and physical health and activity. Not only do these events provide an opportunity for our members to learn more about health issues, they also provide an opportunity for governors to engage with members and the public.

The Trust holds regular recruitment sessions in partnership with Sheffield Teaching Hospitals where governors from both Trusts engage with patients and speak to them about the benefits of becoming a member. It is also an opportunity for governors to network with each other and learn about other Trusts.

The next year will focus on engaging governors in delivering the membership strategy, along with facilitating more Health Talks. We will respond to the interests of our current members when determining the subjects of the talks. A continued focus towards BME communities will be a priority.

Section 6: Financial Planning

2016/17 Outturn Assumptions

The Trust is expecting to achieve its control total for 2016/17. The month 7 forecast position anticipates an I&E surplus outturn on plan against the control total of £970,000.

Key risks to this position include the following:

- A number of services continue to operate at a loss. This is due to Local authority funding reductions being imposed in advance of plans being in place to reduce costs. Other services have benefited from investments being made to address quality and safety concerns on the back of CQC findings, but which have not been supported via additional commissioner funding. These issues will likely lead to further disinvestments as we approach 2017/18.

- Termination costs linked to the planned loss of contracts also remains a significant risk from April 2017. This includes numerous staff where Tupe doesn't apply. c280 staff are at risk and will be redeployed where possible but some termination costs may occur and the timing of which could impact 2016/17 or 2017/18.

- There has been a recent development in an on-going HMRC case where a potential HMRC liability has been flagged which could lead to a £1.2m charge pre interest and penalty charges. This is in relation to an interpreter service inherited under TCS being reviewed from a worker/employee perspective over the current self-employed status.

- Current forecasts assume CIP and disinvestment target delivery. This assumes a material improvement in CIP delivery in the second half of the year most notably in the Community Directorate, and that the Primary Care Services Directorate will be able to deliver services from October within its new funding envelope in line with the new tender submission following reorganisation.

- It is also assumed there is no adverse impact from any further losses of contractual income. The biggest risk to this is the continuing negotiations around the value and configuration of the Local Authority Section 75 agreement, which has still to be finalised and agreed. This poses a material risk to the Community Directorate's current forecast outturn position.

There is also a risk to the Trust's CQUIN income as it is likely that we will not achieve all of our CQUIN targets, (example being the national CQUIN around flu vaccines for 75% of front line staff). However some element of mitigation has been planned in line with previous delivery and expectations. The performance at quarter 2 is not satisfactory and improvement is needed throughout the remainder of the year. Continued under-performance at qtr. 3 and qtr. 4 would incur a loss of income in excess of any mitigation plan and previous financial years.

The Trust is also likely to need to consider creating a provision for a HMRC liability. This is in relation to a SCAIS interpreter service which the Trust inherited from the CCG under the Transferring Community Services arrangements. This is an on-going case linked to the status of self-employed interpreters recently being deemed workers by HMRC. This is under review as was previously only declared as a contingent liability in the Trusts accounts. The potential liability is in the form of tax, National Insurance and fines in respect of the SCAIS interpreter service. HMRC have now informed us of their computation of our PAYE tax and National Insurance liability of c. £1.2m (this figure doesn't include interest or penalties and covers both employee and employer liability.). The Trust is considering the initial findings and is taking legal advice and plans to challenge potentially the computation and certainly our liability for these charges. Whilst the value of any provision remains uncertain it is potentially substantial and poses a risk to our control total achievement either in 2016/17 or 2017/18 and beyond when this materialises.

CIP savings delivery in the six months to October was 100% of target and the current forecast outturn position is for a full-year CIP delivery level of 98%. The Trust is expecting to deliver and achieve the cost improvement target set for the period 2016/17. However, what is more of a concern is the CIP delivery which has been met only non-recurrently in 2016/17; c. £0.855 is expected to be carried forward into 2017/18.

The Trust also achieved the disinvestment target for the period; however £1.038m is expected to be achieved non-recurrently.

Disinvestments savings delivery in the period to October was 90% of target (unchanged from last month). Forecast delivery is 94% of target. At October there remains a disinvestment gap of £0.815m carried forward into 2017/18 which mainly relates to the Clover Group tender in Primary Care Services and Learning Disability Service Supported Living and Respite services disinvestment. These are simply timing delays and profile issues, and do not pose a material risk.

Cashflow
The Trust currently has a sound cash position and a month 7 forecasted balance at 31st March 2017 of £25.002m.

Use of Resources Rating
The forecasted Use of Resources Rating (UoRR) outturn for the year currently equates to a 2 (scale of 1-4, 1 being the best)

2017/19 Context
The Trust's financial strategy is shaped by the environment within which we are delivering our services and the direction of travel for our service developments and quality improvement.

Success in the wider FT sector has previously been to plan for and deliver a 1% surplus. Our historical strategy pre-2015/16 was aligned to this goal. Pre-2015/16 our surplus plans of 2% were set to generating cash surpluses to invest in future Acute Care reconfiguration services. In 2015/16, the Trust consciously reduced its planned surplus from 2% to 1%, to enable the Trust to respond to some arising CQC concerns and to continue investment in the quality of our services, e.g. forest close reconfiguration and refurbishment. 2015/16 also saw the new standard of capital facility possible from this previous hard work, with the new PICU opening in November 2015. Due to sector-wide financial pressure and an anticipated £2.2b deficit out-turn for Foundation Trusts at the close of 2015/16, which did in fact materialise, centrally-set control totals were introduced in 2016/17.

Historically the Trust has performed well financially but the organisation is experiencing unprecedented levels of risks and pressure not only from the local health economy but our close relationship with the Local Authority and pressure within the social care funding system in particular. The Trust continues to have to manage numerous disinvestments linked to the loss of business via national tendering processes where under NHS T & C's the Trust fails to compete on price. The timescales of required disinvestments and the need to remove the associated overheads all add to the risks of exit costs being a concern on a non-recurrent basis in the short term.

Our initial risk related to lost business is modelled at a reduction in income of c£11.4m which equates to c10% of our organisation. This is a fundamental challenge, particularly re deliver of reduced overheads and corporate functions, at a time where control totals have been mandated without due consideration to this arising challenge and significant reduction in turnover anticipated for 2017/18. Furthermore exit costs also propose a further risk given c280 staff being affected by potential lost roles and lack of TUPE opportunities.

Having reviewed the pre-commitments and requirements for 2017/19, our current final financial plan is built on the expectation of achieving the designated control totals of £1.529m in 2017/18 and £2,139m in 2018/19.

The proposed 2017/18 control total represents 1.50% of our anticipated turnover, rising to 2.07% in year 2.This is also 1.6 times this year's control total. In order to achieve a surplus of this level in the context of having aimed for a breakeven (£1) position in 2015/16 and a much smaller control total in 2016/17 will require significant cost improvements above the level anticipated in the national tariff proposals.

The Trust will need to fully review its strategy and achieve cost improvements via service redesign and consideration of options such as outsourcing for back-office functions, as recommended in the Carter report and subsequent planning guidance, both to meet its own control total and the wider Sustainability and Transformation footprint control total for Yorkshire and Humber of £48m.

Financial Strategy
Our strategy remains broadly similar to previous years as follows:

- To maintain a Use of Resources rating of at least a 2 and to meet our agreed target I & E surplus set.

- To effectively plan capital expenditure and asset disposals in line with a clear Estates Strategy that aims to reduce and rationalise total non-current assets, to reduce capital charges impact and improve the Use of Resources Metric score

- To effectively and robustly manage our financial ratios over the medium term as we expect to diminish the liquidity ratio as we start to expend our cash holdings in support of our capital expenditure programme. Our reducing income levels will also impact on our capital service cover ratio if our Estates Strategy; to rationalise our estate; is not met.

- Realistic assumptions underpin our strategy in respect of growth, adopting a measured approach to the future. This measured approach to what underpins the financial plan does not detract from our objective of maximising growth opportunities.

- Service improvements will be delivered through efficiency and change as opposed to additional investment to the Trust from outside. Our CIP programme is unlikely to provide for additional resource and funds to support internal investment plans due to the challenging scale of CIPs required to balance our financial position.

- Maintaining a sound awareness of our cost base across our service and business units as to support our understanding of the services and products we deliver and identify future improvement opportunities. The associated development programmes to progress the implementation of service line reporting and payment by results within mental health services will complement this approach.

- To undertake a thorough viability appraisal of all contracts to deliver cost improvements, ensuring the relative contribution of all service lines is transparent and that full cost recovery and surplus is achieved unless directed otherwise from the Board.

Modelling – Inflation Impact
Pay inflation within our financial plan has been modelled and funded in line with expected increases in costs, in line with the national agreements expected regarding pay awards and increments.

With the Trust being a predominantly mental health provider, the percentage of our cost base that is pay related is significantly higher (80:20) pay/non pay split than the typical acute sector Trust (60:40). Simplistically under the net Tariff inflator for 2017/18 the Trust has an added burden to manage in that significant transformational change is required including consultation periods to redesign services with lower level and fewer staff. The speed to which CIP schemes will deliver is therefore slower. We also have numerous people at risk and need to redeploy resources where possible to mitigate potential exit costs where Tupe doesn't apply.

The Trust also implemented the "Foundation living wage" during 2015/16 and continues to honour and uplift our minimum salaries for non-bank staff in line with the annual recommendations.

Modelling - Non Pay Inflation/Cost Pressures
Routine non pay inflation is not distributed and uplifted across all non-pay budgets. The Trusts only funds non pay inflation where clearly evidenced based inflation needs and cost pressures have been identified. Procurement and contracting processes aim to keep these required uplifts to a minimum.

The Lord Carter findings and recommendations although Acute focused are being adopted and areas under focus and Trust consideration re non pay efficiency schemes. Facilities and Estates remains an area of predominant focus and procurement has a large role to play in helping drive savings in non-pay and service provision areas of expenditure.

The Trust is progressing with its Estate strategy refresh and continues to work on a plan to rationalise our estate in line with our future needs. Numerous sites have been identified for disposal but primarily in year 3

– 5. At the same time, the Trust is conscious it needs to protect itself from long standing leases in light of the increasing tendering of services, in order to ensure itself is protected from on-going overheads and difficulties in removing overheads and managing exist costs on lost business.

Efficiency / Disinvestment Requirements
The Trust 2017/18 financial plan passes on both the required efficiency of 2% in relation to health funded services included within the net tariff uplift and an additional 2.5% efficiency requirement to enable the trust to hold minimal risk reserves and meet the target control total.

The total CIP requirement for 2017/18 is therefore projected and modelled at £5.5m (4.9% of turnover).

In previous years a higher efficiency target has been levied on corporate functions. However, increased disinvestments and CIP requirements have placed all departments under pressure to make savings, the Sustainability and Transformation Fund requires a pound for pound return on the STP payments. Therefore the Trust plans to use a blanket rate across all directorates.

Unidentified 2016/17 CIPs are carried forward within the Directorates within which they relate as per previous years. Directorates are required to identify plans to deliver any carry forward CIP recurrently. This continues the approach taken in 2016/17.

The CIP requirement for 2017/18 stands at £5.5m (excluding 2016/17 carry forwards).
The disinvestment plan for 2017/18 stands at £10.02m (excluding 2016/17 carry forwards).

Disinvestments are anticipated predominantly in local authority funded services such as Respite, Hurlfield View, Mental Health floating support, and LD Supported Living Services. Some commercial services such as SCAIS have also been lost to national providers. The current assumption is that these are deliverable with costs being managed out of the organisation in line with the loss of the service and any TUPE impact etc. However, there is a risk of exit costs to manage going forward where TUPE doesn't apply and c280 staff have initially been identified as at risk.

Procurement
A change in procurement focus from transactional support to adding value is helping to change the area of focus. We are also contacting all suppliers re cost control and exploring further areas for savings. Agency spend is also a key area of focus and we have expanded this work stream to all off-payroll arrangements to drive value for money and more cost effective recruitment.

HR processes have also been reviewed to streamline recruitment processes and help convert needed agency resources onto payroll timely where practical and required in the longer term.

Although Acute focused we will look to comply and contribute to all requirements related to reporting and sharing data re procurement purchases

A more focused CIP process is planned for building on the Lord Carter findings (although often acute evidenced based and focused). The area of facilities and estates remains a key area for the Trust to target and our plans include further estate rationalisation. This will be a key area of focus to ensure we close the gap on our CIP plan requirements for 2017/18 and contribute significantly over the next 5 years as outline in our revised estate strategy.

The Trust is continuing to look at benchmarking data to inform Trust wide saving schemes and areas for focus re on-going and future savings.

Investments in Quality and Transformation
The required disinvestments and need to meet the Trust's control total remove opportunities to invest in services. There is not currently expected to be enough flexibility within the financial position to invest unless supported by the commissioners or other external funding sources. It is proposed that internal investments are only considered where the proposal both meets strategic objectives and is an invest-to-save proposal on this basis, with a return on investment within 1 year.

Additionally, where the proposal meets strategic objects and is supported by Commissioner funding, new investment will be agreed to meet the national requirements outlined in the 5 year forward view.

Financial Risks
The primary risk for 2017/18 and financial challenge remains around CIP and Disinvestment delivery and the recurrent nature and the speed of commencement of any plans.

Risks around disinvestment largely relate to potential redundancy and/or Mars costs should TUPE not apply, or redeployment not be possible. Work is on-going to manage the risks involved but c280 staff are affected.

An overview of the risks currently acknowledged within the financial plan are documented below.

Risk Detail	Notes
Risk of failure to meet 2017/18 Control total and resulting loss of STP funding and potentially 0.5%+0.5% CQUIN	The investments have drawn down our historical surplus, and there are less central reserves to mitigate under-performance in year. CIP and disinvestment delivery will be key, as will the performance management and monitoring processes.
Funding for future investment needs of a revenue nature.	Current approved investments within Investment funding available via non-current historical commitments. The investments made are drawing down on our historical surplus and utilising our inflation funding. The level of investment is limited to investment where the proposal meets strategic objects and is supported by Commissioner funding and/or contains a return on investment within a year. Investments will largely be STP linked, requiring pound for pound return. The Trust has no more uncommitted reserves, unless a clear external funding source is received via a commissioning or charitable route.
CIP Plan Gap & Non Achievement	CIP planning for 2017/18 is underway. This is being pursued with the objective to not require use of the contingency reserve.
DIS Plan Gap & Non Achievement	The required disinvestments are currently anticipated to be delivered in the main linked to strong past performance. A Risk Reserve of 0.5% total income will be held to offset all risks
CQUIN Achievement (Partial failure)	20% of income held to invest re achievement and re failure risk
CQUIN Additional Risk Reserve Requirement	20% of income held in a risk reserve per national requirements until confirmation of system-wide achievement in 2017/18 confirmed. Unavailable to commit.
Risk that requirements exceed contingency fund.	A risk reserve for unknowns is factored into current plans and drives CIP target requirements.

Capital Planning
Our capital strategy is aligned to moving more appropriate care out of an inpatient and ward bed base setting and into the community. As a result the MH and acute care reconfiguration and capital investment requirements have reduced in recent years and the planned investment has been scaled back accordingly.

Capital remains directed to our primary MH and Acute Care reconfiguration plans. The rest is aligned to an IM&T focus and a key driver for automation and further efficiencies continuing to being realised during 2017/18.

Our refreshed estate strategy includes the disposal of our current Trust headquarters site in year 3 (2019/20) and an further, accelerated rationalisation of our estate is planned. At present, there are multiple sites logged for disposal but primarily in years 3 - 5. This remains an area of focus and will be developed further over the remainder of 2016/17 with a view to further accelerating disposals where possible.

The Trust is presently not seeking to obtain loans to fund capital projects during 2017/18 - 2018/19 and will utilise in year depreciation and capital slippage from previous years to fund the requirements for 2017/18. The Trust currently has a sound cash position with a forecasted balance of £24.997m at 31st March 2017. The Trust has no debt to service other than Public Dividend Capital as a result of no external borrowings or PFIs schemes in place or anticipated within the next 5 years.

The Capital plan has been refreshed in line with the Estates Strategy which was completed at by the end of October 2016 and is in the process of being signed off via the usual governance process.

The current baseline Capital programme for the 2-year Annual Plan is as follows. It incorporates the planned MH reconfiguration developments at the Longley Centre. Increases to capital spend will also increase the depreciation and capital charges figures within the I&E plan, and therefore will require equivalent additional CIPs from the directorates involved in the project.

Capital Expenditure	**2017/18 Plan £000s**	**2018/19 Plan £000s**	**2019/20 Plan £000s**	**2020/21 Plan £000s**	**2021/22 Plan £000s**
New Build	4,750	12,534	6,720	5,235	840
Equipment	79	56	63	71	80
IT	1,509	2,207	1,728	1,796	1,720
Other	65	39	43	52	62
Total	**6,403**	**14,837**	**8,555**	**7,154**	**2,702**

The plan assumes a baseline increase and growth in IT investment as a key enabler of efficiency and automation. The plan incorporates some increases in IT investment to support organisational transformation and modernisation (development of a data warehouse and a new patient record system).

Efficiency schemes are already in place ensuring efficient boilers, lighting etc. and these review routinely form part of any on-going maintenance plans. The initial focus has been on the feasibility of the plans to dispose of our HQ and the wider move to an agile working approach for our corporate functions. The next steps include the wider review and estate rationalisation of some of our Community bases. A full assessment of all sites; owned and leased forms part of our estate refresh plans and this will be a key area of our future efficiency programme going forward.