Sheffield City Council

Sheffield Health and Social Care NHS

NHS Foundation Trust

Our Operational Plan

for the period 2016-17

29 June 2016

Public

(Re-submitted plan following agreement of control total)

Contents

Section 1: Strategic and Local Context

Who We Are

With an annual projected income of approximately £119 million and 2,731 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.

Our vision for the Trust 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 way in which the Trust's operates is underpinned by our values (enclosed at **Appendix 1**).

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 and against a challenging financial context. The focus of our plans is to ensure we deliver sustainable services and can be summarised below: -

- 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 will focus on early intervention, delivering services in liaison and partnership with primary care and see investment in new community services to reduce the need for hospital based care, particularly out of town care for people with learning disabilities or serious mental health needs;
- Enhancing our primary care services, exploring and developing new partnerships to deliver effective primary care and support that will result in reduced health inequalities over the longer term;
- Developing new models and partnerships to ensure the delivery of high quality and cost effective health and social care support for the people of Sheffield.

Our National and Local Context

The people of Sheffield are living for longer with their last years of life in generally poorer health. The health and care system needs to work together across Sheffield and across the wider footprint in order to develop sustainable health and care services for our combined population, within our financial resources. The strong track record of partnership working across commissioners and the health and social care providers puts the city in a positive position. We collectively face very significant financial challenges over the next five years and these will only be met by working together with local people to transform services. With this significant financial challenge there is also a real opportunity to deliver transformative change to the way services are provided to deliver positive outcomes for the people of Sheffield.

This will feature four key elements:

1. The Sustainability and Transformation Plan;
2. The Sheffield Strategy;
3. The Sheffield Integrated Commissioning Programme;
4. The Sheffield one year Operational Plan and Five Year Sustainability and Transformation Plan.

The Sustainability and Transformation Plan (STP)

This is a five year plan across the combined population of the South Yorkshire and Bassetlaw CCGs, including working in association particularly on acute services with Wakefield, North East Derbyshire and probably Hull and North East Lincolnshire. This will use the already established governance arrangements of the Commissioner's Working Together Programme.

The STP is at a very early stage of development and by June 2016 a plan for delivery will be in place. Some initial modelling has been undertaken looking at the scale of provider and commissioner financial

challenges and using the Right Care and other data available, the opportunities for improving outcomes for patients at the same time as making financial efficiencies.

Early discussions suggest that key areas of focus will include:

- Workforce planning and resilience;
- Urgent and emergency care services;
- Cancer Services;
- Children's Surgery and Anaesthesia;
- Crisis Mental Health Services;
- Collaboration on out of hospital care.

The Sheffield Strategy

The developing Sheffield strategy for health and social care services will refresh the vision and the goals for the CCG and Council over the next 5 years.

The city's 2020 Vision engagement work is being used to develop the strategy alongside the Joint Strategic Needs Assessment (including relevant intelligence from more recent Health Needs Assessments), the Commissioning for Value pack. Integration of services on three levels will be an important feature:

1. Integrated Health and Social Care;
2. Integrated Physical and Mental Health;
3. Integrated Primary and Secondary Care.

The strategy will seek to –

- Strengthen the resilience of primary and out of hospital care.
- Describe the future approach for the providers we work with, which will be collaborative and integrated.
- Address parity of esteem for the Sheffield population.
- Set out ambitions for improving the health and wellbeing of children and young people.
- Consider workforce, estate and governance.
- Set out its ambitions for reducing inequalities and premature mortality

The Sheffield Integrated Commissioning Programme

As the developing strategy for Sheffield is developed and implemented a clear focus will continue on the established transformational programmes which are focussed to:

- Keep people well in the communities,
- Develop out of hospital care and a neighbourhood approach,
- Progress work on services for those currently requiring long term care and support.

Commissioning Plans for 2016-17

The Sheffield Strategy once finalised will articulate delivery expectations across years one to five. The commissioning key intentions for 2016-17, in respect of the Trust's services include:

- The NHS Constitution and access commitments in respect of A&E, Referral to Treatment, Cancer and Mental Health;
- Procuring an enhanced mental health liaison service, alongside the continued development of the crisis care pathway;
- Emphasis on developing out of hospital care including piloting neighbourhood hubs and enhancing third sector provision and social prescribing. Alongside this there is a commitment to the development of primary care mental health services;
- Review of the provision of specialist nursing home services;
- Transformation of CAHMS, children and young people's emotional wellbeing and mental health.

Trust Objective 1: Developing Our Approach to Delivering Outstanding Quality Care & Support

Quality is everyone's business. From the support worker in our community teams to the principal accountant in our finance team, all our staff have a responsibility to deliver outstanding services and strive to continually improve them. The Trust's learning from the recent CQC inspection has created an environment in which to critically evaluate the quality of services we currently provide, and particularly, the ways in which we keep service users safe from harm. We need to be clear on how we will seek to improve services and we must do this by learning from other Trusts and the CQC themselves so we can work towards becoming an outstanding provider of care at a future CQC inspection.

The Trust acknowledges the immense effort that this will take from front line teams, to corporate departments and from our Board, Governors and Commissioners. We must therefore galvanise everyone towards creating outstanding services that deliver positive experiences and are safe, effective, caring, responsive and well led. We have reviewed and updated our Quality Improvement and Assurance Strategy to ensure we continue to develop a culture of continuous quality improvement. This is summarised in **Section 2**. Alongside the new Strategy we have agreed the following.

1.1 That all services, both clinical and corporate, will produce and deliver an annual quality improvement programme;
1.2 The Trust becomes fully compliant with the CQC's recommendations;
1.3 The Trust will review the safety of its services through the establishment of a peer review group;
1.4 That each service will define service standards, based on CQC domains of care and those locally determined, and publish these in service areas in order to strengthen local accountability;
1.5 We will meet national minimum waiting times for access to evidence based treatment and where we can, further reduce waiting times;
1.6 That the Trust's principal approach to quality improvement, Microsystems[1], is embedded within clinical and corporate teams;
1.7 Ensure we are providing appropriate physical health care to meet service user needs;
1.8 We will develop therapeutic teams that deliver NICE guidance approved treatments with a skill mix which recognises the needs of our service users

Trust Objective 2: Involving Service Users In Designing and Delivering Care and Support

Service user leadership has become increasingly important for social care and health, emphasised by the Department of Health's 'No Decision About Me, Without Me' consultation. Service users can often be experts in their own symptoms and support needs, meaning shared decision-making can lead to more effective treatment and improved patient outcomes, while involvement in making decisions is essential to protecting people's dignity and autonomy. As a result, working side-by-side with service users, their families and carers is key to developing and delivering services fit for the needs of current and future users.

2.1 All services will seek feedback from service users, their families and carers and use this to inform their quality improvement plans;
2.2 Continue to develop the Service User Experience and Monitoring Unit (SUEMU) to collect information on patient experience and refresh the strategy for service user involvement;
2.3 That the Trust will explore involving service users in the delivery of services eg. peer support and management of service pathways[2].

Trust Objective 3: Transforming the Services We Deliver

The Trust will reduce its reliance on restrictive and institutional ways of providing care such as in-patient wards and develop services which deliver care closer to home - in community and primary care settings. To achieve this, we have a number of programmes involving service redesign as well as changing

[1] Microsystems is the Trust's preferred Quality Improvement technique. It supports front line staff to identify and implement changes to the ways in which services are designed and delivered.
[2] A pathway is an agreed way of organising services around the needs of a service user to ensure they receive a quality service.

professional practices. A key principle of service redesign in this context is to reduce our reliance on less efficient ways of delivering care and place greater emphasis on community based alternatives. At the same time, the Trust has a series of options in which to progress opportunities to deliver services outside Sheffield.

3.1 We will provide effective alternatives to hospital admission and better approaches to rehabilitation in order to further reduce admissions, lengths of stay and to cease out of town placements;
3.2 All care pathways are improved to offer access to evidence based treatments;
3.3 Opportunities to deliver new services are explored, where possible;
3.4 Where appropriate, all teams will implement collaborative care planning by the end of 2016-17;
3.5 We will continue our work to reduce all forms of chemical, physical and mechanical restraint;
3.6 Urgent care pathways are enhanced, offering 24/7 access to high quality care, across the entire age range;
3.7 Work in partnership with Seven Hills Care and Support Ltd[3] in line with the first year of the company's agreed two year business plan.

Trust Objective 4: Maintaining Our Financial Sustainability

Times are incredibly tough for the NHS and Social Care services, and the care economy in Sheffield is not exempt from these challenges. Achieving quality care and financial balance becomes more challenging year on year, particularly when our income is at risk, expectations from our service users increases and inflation, cost pressures and investments increase our expenditure. With this in mind, the Trust needs to make difficult decisions and prioritise spending according to these decisions.

4.1 That all services review their productivity and ensure appropriate action is undertaken to increase it;
4.2 That all services have an agreed plan to reduce costs over the next three year period;
4.3 That plans are implemented to reduce the Trust's estate.

Trust Objective 5: Workforce Engagement

The commitment and motivation of our staff underpins everything that the Trust achieves both now, and in the future. As a result, we must seek to actively develop and engage our workforce. By providing opportunities for clinical and corporate staff to directly contribute towards the ways in which services are designed and delivered, we can ensure that our staff have an active role in the ways in which the organisation operates.

5.1 That all services involve their staff in the design and delivery of services.

Enabling Objectives: How the Trust Will Deliver Trust Objectives

In order to ensure that the plans above are delivered, the following priorities will enable the Trust to deliver great services now, and in the future.

6.1 Review the HR/workforce development and training, information technology, estates strategy and the research and development strategy (and where any of these does not exist, one is developed and implemented) to ensure alignment with these Trust objectives;
6.2 That the leadership of corporate and clinical teams is improved in order to meet the future challenges faced by delivering services in an environment with ever-reducing resources;
6.3 That supervision occurs regularly within teams and, where necessary, it reinforces the value of collaborative care planning and service user involvement in their care;
6.4 Pro-actively understand and manage sickness absence across the Trust to ensure a reduction in sickness absence rates.

[3] Seven Hills Care and Support Ltd is the Trust's separate operating company of which Sheffield Health and Social Care NHS FT is the 100% shareholder of.

Section 2: Quality Planning

The CQC published the findings from its inspection of Trust services in June 2015. The Trust's overall rating was *Requires Improvement*. Following the CQC inspection, the Board approved and targeted investment towards improving our care environment, monitoring systems and improved staffing capacity within our crisis care services. Progress in delivering the plan is reviewed by the Executive Team (the Executive Lead for Quality is the Medical Director, Professor Tim Kendall), the Board's Quality and Assurance committee and the Board on a monthly basis. Our improvement plans for 2016-17 will ensure that we continue to improve the crisis care pathway in respect of health based place of safety and capacity out of hours to support people presenting in a mental health crisis. We aspire to be a good or outstanding provider at a future inspection.

National Standards and Priorities

We have maintained a Green risk rating for quality governance since we became an NHS Foundation Trust. We experienced in year challenges with rates of delayed transfers of care, but overall we deliver standards of care that consistently achieve the quality governance standards required of us.

We have exceeded the new national access standard for IAPT services during 2015-16 and have plans in place that will assure achievement of the access standard for people experiencing a first episode of psychosis during 2016-17. Rates of diagnosis for people with dementia remain positive, with Sheffield consistently rated in the top 5 performing areas within England. We have agreed with our local CCG 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.

The commissioning plans will move forward as part of the city wide STP. The main focus of this plan, as it relates to the Trust, will be the development of sustainable community care systems that deliver quality care and experiences, positive outcomes and significant 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. The agreed areas of focus remain on improving physical health and developing improved outcome measures.

Quality Improvement Goals

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 priorities 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.

Through this programme we continue to focus on our quality improvement goals in respect of

- Improving access;
- Improving physical health;
- Improving the experience of people who use our services;

Within this programme we have a specific focus on improving safety in respect of improved physical health outcomes and reducing restrictive interventions.

QUALITY GOAL 1: Improving access to services and treatment		
Directorate	Directorate specific goal	Measured by

Community	Achieving better access standards achieved	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 GOAL 2: Improving physical health 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 GOAL 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 Approach to Quality Improvement

The Trust has reviewed and updated its Quality Improvement and Assurance Strategy. 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

In order to ensure quality, the Trust's 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.

Quality Assurance Committee: Brings together the governance and performance systems of the Trust in respect of quality. The Committee provides oversight of the Trust systems in respect of quality, risk management arrangements. The Committee is informed by the work of a range of committees that oversee Trust systems and performance in respect of key matters relating to quality and safety.

Audit and Assurance 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.

Systems of Internal Control: A range of policy frameworks and 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. These range from Policy statements of the Trust.

We have identified and have put plans in place to improve our governance arrangements in 2016/17 and include –

- Peer Review and Self Inspection: Central to quality assurance will be the Peer Review process. This builds on our experience of being reviewed by the CQC and as CQC reviewers. The review process incorporates the CQC methodology and framework domains. Review outcomes are presented by the Chief Operating Officer to the Executive Team for scrutiny and management and to the Quality Assurance Committee for assurance.
- Service User Led Monitoring of Services: The Trust uses a range of information to monitor service quality and performance. Our approach is to work with service users so they gather feedback from service users about their experiences of services on our behalf.
- Team Level Information Needs: Alongside Trust wide information about quality, each team will have additional information needs that reflect the care they provide and deliver. Teams will be supported to establish their own information requirements so they have a balanced and informed understanding of the quality of care they are providing. As teams progress their quality improvement plans, being able to measure if improvements are being achieved will be key to the success of their quality improvement work.

We recognise that to deliver our quality improvement strategy, it is essential that staff have the ability to engage with improvement techniques. To support this strategy we have a programme to equip staff and teams with the time and the skills to deliver continuous quality improvement. While 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.

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 are to be made within 2016/17 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 are able to scrutinise and manage the operational performance of services and the Board to maintain 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. The Executive Team reviews with each operational directorate their performance against planned objectives.

Key Risks To Quality

The Trust is clear that cost improvements should not impact on quality. All plans relating to clinical and corporate services have been developed and approved by the appropriate clinical and service directors. Each cost improvement plan is accompanied by a Quality Impact Assessment (QIA). Each QIA is 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. Following agreement by the Clinical and Service Directors, all QIAs 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 Trust Board and commissioners, NHS Sheffield CCG to ensure that the Trust's cost improvement plan will not impact on quality. Monitoring of service quality is to be undertaken quarterly and, in exceptional circumstances e.g. if a plan is high risk, this could be more frequent.

Top Three Risks	Key Methods of Mitigation
Risk that the quality of care provided falls below expectations and/or standards	• Service user experience surveys • 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.

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 growth in line with service strategies. During 2016/17, there will be considerable efforts focussed towards the development of workforce plans across all Directorates but specifically, Community, Learning Disabilities and Primary Care as they embark on or continue with the delivery of significant change programmes. 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.

Directorate	Headcount	FTE	%
Community Services Directorate	529	441.94	19%
In-patient Directorate	547	500.22	20%
Learning Disabilities Service	328	295.78	12%
Medical	99	88.23	4%
Non Med Support Directorates	295	272.14	11%
Primary Care	75	52.63	3%
Specialist Directorate	858	695.68	31%
Grand Total	**2731**	**2346.61**	**100%**

Staff Group	Headcount	FTE	%
Add Prof Scientific and Technic	166	133.86	6%
Additional Clinical Services	914	791.72	33%
Administrative and Clerical	568	495.56	21%
Allied Health Professionals	157	120.23	6%
Estates and Ancillary	188	157.04	7%
Medical and Dental	176	145.90	6%
Nursing and Midwifery Registered	557	497.84	20%
Students	5	4.44	0%
Grand Total	**2731**	**2346.61**	**100%**

Workforce planning is led by service needs and informed by workforce data, staff and commissioners and overseen by our Capability and Capacity Group (led by the Chief Nurse) and the Medical Workforce Planning Group (led by the Medical Director), 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 such as the Incident Decision Tree are considered on a regular basis by both EDG and the Board to identify any improvements to staffing levels or the deployment of additional staffing.

Our key workforce priorities for 2016/17 are –

Workforce Priorities	Plans to Address Workforce Priority
Managing workforce and organisational change	Workforce Planning Group in place to co-ordinate the Trusts annual workforce planning process; Directorate People Plans in development to support more effective planning to support change activity (including succession planning, talent management).
Recruitment and Retention	Expansion of flexible staffing service to meet temporary

	cover needs (to include Admin, OT, Housekeepers); Implementation of values based recruitment; Continuous improvement to recruitment processes; Vacancy control panel.
Sickness Absence	Dedicated support and action plan in place to improve sickness management and reduce sickness absence levels; Review of occupational health contract.
Training and Development	Action plan and compliance targets in place to address gaps in mandatory training delivery; Continued roll out of training programmes, including e-learning programmes and online learning communities to ensure staff have the skills to carry out current and new roles; Continued investment in leadership and management development.
Management of discipline and grievance casework	Revised Disciplinary policy and procedure; Review of investigation process; Training and development for line managers,

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 a still being developed and rolled out as we move into 2016/17 but remains a cost effective system which further supports the move towards a minimal use of agency staffing, which we are looking towards expanding the scope of further in 2016/17. In addition, a project to examine the use of any agency staff is in place and a policy to refine the process for the engaging of agency and all other off-payroll and self-employed contractors was launched in 2015/16. This is being scrutinised in detail as part of the planning for 2016/17 with the objective of the continued compliance with the Monitor Agency caps and cost effective interim solutions being in place where needed.

The Workforce Planning Project Group supports the collection of training priorities to Health Education England on an annual basis. This involves specific iterations between our Education, Training and Development Lead and Deputy Chief Nurse with Directorates to understand their needs going forward. The framework for our People Plan is 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 workforce planning project group work to ensure a more informed cohesive and robust approach to planning at both an operational and strategic level.

Although we do not have a representative on the Local Education Training Board we do have representatives on the Partnership Council and work closely with the Deanery regularly. We also run an apprenticeship programme each year.

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, Joint Consultation Forum, HR and Workforce, Workforce and Organisational Development, Trust Board, Performance Overview Group with Governors and the Council of Governors, Nominations and Remuneration Committee and the BME Strategy Group. Workforce trends and analysis are reported to and discussed with the Board on a monthly basis.

Section 4: Activity Planning

At this stage, the commissioners contractual intentions for 2016/17 have been confirmed. The outcome of which, came a little too late to be fully incorporated into the draft annual plan submission. The impact of which has since been fed into the final annual plan enclosed here. This predominantly results in a further QIPP requirement of c£1.4m (Reduced to £1.2m PYE) and is detailed further within the financial section. Despite the national agenda of Parity of Esteem for Mental health, we have seen no growth or additional areas of investment but this is no doubt impacted on the wider sector pressure across our Primary Commissioner. It is envisaged that the 2016/17 activity plan with our commissioners will be agreed. The following table provides a high level summary of the main activity delivered across our services.

2015/16 Forecasts and Target Assumptions for 2016/17

Service Type	Activity Measure	2015/16 Forecast Out-turn	2016/17 Final Target Values
Inpatient Services	Bed Nights	68,760	55,372
IAPT	New Patients Seen	13,652	13,776
Learning Disability Community	Community Contacts	13,919	13,079
Specialist Services	Community Contacts	23,991	22,578
Mental Clusters	Assessment Contacts / Community Clusters	2,341,158	2,208,559

As per the activity table above, the Trust expects that capacity and demand to deliver services within the IAPT, LDS Community and Specialist services will remain static during 2016/17, with the targets showing a minimal differential in variance.

The predicted activity variances forecast for 2016/17 will be in the following areas:

- Inpatient services;
- Mental Health Cluster (0-21).

The Trust continues with its reconfiguration of its Acute Inpatient services (Acute Care Reconfiguration ACR) which during 2014/15 and 2015/16 saw a planned reduction in its Adult and Older Adult inpatient beds, as part of an improved pathway into community services. In 2016/17, there is the intention to further reduce a number of Adult Inpatient beds which will see the closure of an 18 bedded acute inpatient ward and the reinvestment into community services, supporting the commissioner's intentions in the promotion and transition of care pathways in community settings. This realignment of funding will respond to an increased need in home treatment capacity and the need to respond to a demand in complex cases i.e. service users with a Personality Disorder, within the Adult Community Mental Health Teams.

In addition to this, and supporting strategy, work continues in the modernisation and reconfiguration of our rehabilitation services. This will see a relocation of the Trust rehab inpatient provision onto one site and as a result a reduction in the inpatient rehabilitation beds. In line with the ACR, funding is being reinvested in community capacity, for instance, the Community Enhanced Recovery Team (CERT), which currently supports services users to live well in the community and maintain their own tenancies to prevent hospital admission.

In is envisaged that the Mental Health Cluster targets will reduce; following agreement to set targets at a 2 year average out-turn, using an agreed methodology and with an assumption that targets should not be exceeded, unless there is an evidential and genuine increase in service demand. The out-turn in 16/17 is expected to be lower than 2015/16 (see table) as a result of adjusting targets to reflect the normalised activity levels based on the 2016/17 baseline contractual value and commissioned services. This adjustment takes account of the additional capacity in services which was delivered in 2015/16 as a result of non-recurrent funding investments made by commissioners in relation to System Resilience monies, Prime Minister's Challenge Fund, and allocations associated to projects as part of the Achieving Better Access to Mental Health Standards.

SHSC are not anticipating any significant investments from the commissioner, above the current contractual baseline, for 2016/17, and that the predicted shifts in activity, following review, won't change capacity or have an impact on the recurrent income projections for 2016/17.

The capacity and activity levels are underpinned by robust contractual management processes which will involve the following (to monitor on-going performance against plan):-

- Activity is to be monitored on a month by month basis, with quarterly freeze dates imposed 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;

- The contract value and associated activity plan is to be underpinned by a joint Risk Share arrangement with commissioners. This will be based on a cost and volume contract with tolerances built in to monitor activity out-turns and associated costs and therefore reduce any risk to the Trust and the Commissioner in year. SHSC don't envisage to deliver any activity outside of plan, and therefore should demand increase it will invoke discussions with commissioners regards how this will be managed going forward;
- Joint benchmarking work will continue in year to review the effectiveness of the current contract currencies as a means of counting activity, with also a review of the proposed "Year of Care / Episodic Care" currency as described in National guidance.

QIPP / Disinvestment

Following initial discussions with Commissioners it is envisaged that a QIPP programme will be imposed for 2016-17. Early indications have suggested that this will involve a review of a number of SHSC's core services. Therefore in the delivery of this we can anticipate that any adjustment or potential modernisation of services may require a change to the activity plan as developments are made in year

Section 5: Our Governorship and Membership

Governors and Members play a vital role in the Trust's governance arrangements primarily through the meetings of the Council of Governors. In 2015/16, there was 1 election for a public outside of Sheffield (Rest of England) position. 2016/17 is likely to be a busy year for elections with 15 seats available.

The Trust has an established training and development programme in place that ensure the Governors are equipped with the skills and knowledge they need to undertake their role. During the last financial year Training was provided to Governors in respect of Trust services, Financial governance and performance and the wider understanding of the organisations Foundation Trust annual accounts.

A training event have been delivered in partnership with 'GovernWell' and it provided Governors with training and development on the following areas –

- An awareness of the NHS
- Governance and the role of governors
- FT's and governor responsibilities to members
- Quality matters
- Effective questioning and challenge

SHSC NHS FT proactively works with community groups across the city and alongside Sheffield Teaching Hospitals to jointly organise events in which to raise awareness of strategic issues e.g. mental health awareness, food and nutrition, impact of brain injury and also to celebrate cultural diversity across the city e.g. annual presence at the Sheffield Eid event. In 2016/17, our membership strategy will be refreshed with a new focus on reaching out to young people and people from areas of deprivation with a view to engaging them in the work undertaken by the Trust.

Section 6: Financial Planning

In summary, the Trust is expecting to achieve plan for 2015/16 pre- technical adjustments and other one off restructuring costs. This is due to central specific investment reserves not being fully utilised in 2015/16. This is partly due to the delayed commencement of planned investments, due to delays in the governance sign off and reconfiguration change programme linked to various transformational and efficiency releasing schemes. As a result, the bulk of the costs will not be incurred in full until 2016/17.

The above delays have led to CIPs being delayed on a non-recurrent basis but these are still deemed viable plans. This is however, subject to the reconfiguration and investment planned associated with the above plans. This also addresses investments in relation to addressing previous CQC concerns for which no commissioner funding has been forthcoming or anticipated during 2016/17.

The bulk of unplanned in year expenditure has been funded by the non-recurrent profit £0.451m realised on the sale of one property. Without this technical profit, certain non-recurrent investments would not have

been possible, without under-achieving our planned surplus. There has also been some balance sheet flexibility released related to year end creditor and reversed unused provisions.

2015/16 CIP and disinvestment outturn and performance

The Trust is expecting to deliver and achieve the cost improvement target set for the period 2015/16; however £2.329m is currently projected to be achieved non-recurrently. The Trust also achieved the disinvestment target for the period; however £1.038m is expected to be achieved non-recurrently.

Large elements of this shortfall are purely a timing delay linked to the above delays in transformation changes and ward closure programmes and not considered a cause for major concern.

Of the £3.367m non-recurrent CIP/Disinvestment achievement, the directorates have covered c£1.3m with the balance being covered from the release of centrally held reserves. Of this central mitigation, £0.750m was covered by contingency reserves earmarked at the APR stage in the areas of Inpatients and Community. In addition, a further £0.594m has been offset in year through the release of further reserves to mitigate timing delays, resulting in reduced investments and call on planned reserves in year.

Cashflow

The Trust currently has a sound cash position and a forecasted balance at 31st March of £27.201m.

Financial Sustainability Ratio

The forecasted FSRR outturn for the year currently equates to a Financial Sustainability ratio of a 3.

2016/17 Context

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 in the short term.

Having reviewed the pre-commitments and requirements for 2016/17, our current final financial plan for 2016/17 is built on the expectation of achieving a breakeven plan for 2016/17. Whilst this maybe better than most, the level of risks underpinning this are still in need of effective management and full delivery of the efficiency and disinvestment programme is required.

In order to plan for a surplus, there would need to be a significant change of direction, with regards to our strategic plans for the Organisation or an increased level of CIPs imposed across the organisation. These are both considered unviable at this time and would simple lead to a higher level of risk, with no clear mitigation plan. It is deemed appropriate for this trust to continue to hold a contingency reserve and risk reserve to ensure sustainability and resilience.

Financial Strategy Remains Predominantly Similar to Previous Years. This Includes:-

- To maintain a Financial Sustainability Risk rating of a 3 and to maintain a breakeven position or nominal I & E surplus.

- The Trust's financial objective is to ensure our financial strategy and plan ensures the Trust is well placed to ensure we can continue to be sustainable in the long term and yet resilient in these immediate and challenging times. This includes maximising and making improvements in our level of productivity.

- 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.

- 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 provides for an additional resource and funds to support internal investment plans and our capacity to develop and expand our business in response to developing commissioning strategies.

- 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.

Financial Modelling – Inflation and Efficiency Requirements

Pay Inflation Requirements

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).

As a result, under the net Tariff inflator for 2016/17 the Trust has an added burden to manage. This is related to issues such as the increase in NI for employers.

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 announced and recently uplifted again during 2015/16 for the second time. This is slightly higher than the proposed new government living wage rate proposed.

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.

As expected, costs increases anticipated during 2016/17 are primarily linked to increases in capital costs and increases in CNST costs. Diagnostic tests and drug expenditure costs are two further pressures. These pressures have had to be managed accordingly as has the risk of increases in CNST premiums. The latter is of particular concern for non-tariff based services and Mental Health Trusts in particular. The CNST cost pressure has been quantified for 2016/17 and has been funded by our commissioners. A similar pressure occurred in the previous financial year and this has been managed internally, with no retrospective allocation been forthcoming from commissioners.

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. 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 Requirements and Plans

On a positive note, the Trust Financial plan has passed on the required reduced efficiency of 2% in relation to health funded services included within the net tariff uplift. This should help ensure the CIP requirements of the organisation are delivered recurrently in year, whilst addressing the brought forward backlog in efficiency requirements caused via some delays and some minor un-identification in certain isolated areas. This is expected to deliver a positive outcome and reduced level of carried forward efficiencies into future years 2017/18 and beyond. The reduced CIP imposed on directorates should enable some level of internal self-funded finance to progress without the need for additional resources.

CIPs and Disinvestments

The general approach to CIPs is consistent with previous years. The Trust has continued the previous approach of imposing a higher efficiency requirement on the corporate functions to continually drive down the organisations overhead cost. For 2016/17 this is currently at 2.75% for corporate directorates compared to the tariff requirement of 2%, and thus slightly lowed CIPs for clinical directorates. Unidentified 2015/16 CIPs are carried forward within the Directorates within which they relate. Furthermore, Directorates are required to identify plans to deliver any carry forward CIP recurrently from 1/4/16. This continues the approach taken in 2015/16.

The CIP requirement for 2016/17 stands at £4.672m including those brought forward from 2015/16. Plans have been identified and the CIP gap at the final planning stage stands at £0.73m

The disinvestment plan for 2016/17 stands at £8.037m including those brought forward from 2015/16 (This is post the impact of the recent commissioner intensions request for a further £1.4m QIPP. (This has been reduced as part of the contract negotiations down to £1.2m PYE for 2016/17 in recognition of the timescales involved in one of the schemes. This is predominantly linked to FYE loss of contracts in Learning Disabilities and SCELS. New for 2016/17 are further disinvestments re Woodland View Dementia Care, Acute Care, Detained patients, Clover, Hurlfield View, Mental Health floating support, SCAIS and FMP services. 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.

The area of most risk remains the Clover contract retained on a reduced contract value and this is a primary area identified within our risk reserve.

The current CIP and disinvestment gap combined is £0.799m. These plans continue to be developed and are reviewed monthly as part of internal governance arrangements to ensure deliverability.

Investments in Quality and Transformation

The following investments are seeing through the 2015/16 financial plan which included the 1% planned reduction in surplus planned for 2015/16. The financial plan allocated an investment to support improvement priorities across the following:

- Change management and project delivery.
- Quality improvement capacity and system improvement reviews, governance, business information.
- Staffing capacity & capability.
- Delivering on CQC action plans
- Information technology solutions, in particular, continued mobile working, in addition to new continued investments in a business Intelligence system to support reporting and e-rostering.

Addressing the CQC findings and delivering on the action plans remain a priority for the organisation. As does the wider work associated with crisis care concordat and the safe staffing levels under staffing capacity and capability. The wider MH reconfiguration is also key to the delivery on the objectives of the Trust and the wider efficiency savings linked to ward closures in particular. Some significant investment decisions of importance were approved during 2015/16 and are highlighted below.

A) Mental Health Reconfiguration
Investments sanctioned and planned with support from our lead commissioner includes:-

Investment is required to improve the community provision and facilitate the closure of an acute ward. This covers:-

- Increased home treatment capacity to provide intensive, responsive, high quality home treatment consistently across the city;
- Increased ability to manage complex cases in the community / CMHT investment to effectively work with complex cases to reduce crisis;
- Service development of for those with complex mental health needs that will deliver high quality talking treatments in line with NICE guidelines;
- Investment in the Introducing a new ward leadership model to more effectively manage the acute care system with a focus on responsiveness and quality – the right care in the right place at the right time – supporting productivity.
- Safe inpatient staffing including
    - Investment in safe staffing for PICU to provide safe staffing levels. This is vital for the new larger unit and to allow the unit to progress most effectively with the least restrictive interventions programme.
    - Investment re level of cover for nursing staff on acute wards.
- CQC Investments
    - Investment in an additional place of safety (136) – CQC compliance. Increased 136 place of safety provision in order to meet the current demand. This is in line with the crisis care concordat.
    - Pharmacy staffing investment and a temperature control system re medicines linked to CQC requirements and actions.

B) <u>CQUIN Income & Investment</u>

With the above investments, we are no longer holding large reserves centrally uncommitted in relation to CQUIN income. This has in the main been recurrently invested and is within baseline budgets.

The total CQUIN income modelled within the plan is c£1.889m and current financial plan assumes 80% achievement. The reserve to enable the delivery of the achieved schemes and manage any potential loss of income re failure is set at 20% of this value.

C) <u>Other new investments</u>

Some other investments have been approved in principle which are deemed essential and/or support the strategic aims of the Trust. These include:-

Service Transformation, productivity and growth

- Enhanced service user engagement.
- Microsystems and PMO resource to underpin and help deliver change projects and service redesign.
- Project management to support operationalising and supporting new service provision following winning new business via successful tenders and preparing to take on new services.

Other strategic investments

- Impact of the good governance review on Executive roles and responsibilities, and the associated impact on wider senior management roles.
- New subsidiary company's nominal operating costs for initial 2 year period following initial creation and dormant period in 2015/16 (purpose of retaining and winning business no longer viable in price terms as an NHS provider and particularly related LD services and social care).

Legislative and other mandatory changes in requirements

- Smoking cessation requirements which are a significant challenge for the Trust given aging client base, without a contribution being made available under contract negotiations. The longer term impact re prescribing costs of alternatives to cigarettes for service users is still unknown at this time but will continue to be a focus of future contracting rounds.
- E & T resources linked to various new requirements e.g. resuscitation officer.

Contingency Reserve & Resilience

£0.75m has historically been set aside each year as contingency. However, in utilising this to offset planned shortfalls in CIP plans, there is in fact little contingency. It is entirely appropriate to hold a level of contingency for resilience and this reserve therefore needs to be retained. If this was truly uncommitted, this could be used to offset unexpected and in year pressures. Progress on the CIP position has materialised as expected over the last month and is expected to continue. This reserve will enable the Trust to remains resilient and sustainable on its own footing throughout 2016/17. This will be available for addressing in year unexpected pressures and/or delays in CIP delivery. In the event of this not being required, this will carry to the bottom line and lead to the Trust delivering a surplus ahead of plan.

A new CIP working group has been set up to facilitate the monitoring and performance of directorates CIP delivery and this will work to the Monitor categorisations. A first review of the Trust-wide CIP plans and the associated gap, was included within the draft annual plan submission and the progress to date has been modelled accordingly in this revised version.

Based on the CIP and disinvestment plans at the reduced efficiency requirement of 2% across health funded services, the current overall CIP and disinvestment gap is currently £0.548m.

This will ensure the Trust can remain resilient, with the ability to offset unplanned and unexpected pressures from the contingency reserve.

Capital Expenditure

The Trust is presently not seeking to obtain loans to fund capital projects during 2016/17. The current 5 year capital programme from 2016/17 through to 2021/22 is detailed below.

This new build investment below includes the long standing strategic investment that is essential as part of our wider Acute Care reconfiguration strategy. The phase 2 design works have been instigated and the procurement is underway. This will continue over the next 4 years.

The Capital plan has also been reworked to reflect the month 11 forecast outturn cash and capital levels. This includes the assumption that the Fulwood House site will be disposed of during 2019/20. This includes a baseline increase and growth in IT investment as a key enabler of efficiency and automation. This will support further efficiencies and refinement across the organisation.

This includes reflection of an impairment in the value of the Fulwood site and the Longley site; the first due to plans to dispose of in 4 years, the latter due to costs to build the new PICU not fully reflected in the new valuation.

The capital planning model now, therefore, reflects adjusted depreciation charges for those assets, and corresponding impact on PDC charges (a reduction) due to a lower overall PPE value on the trust's Statement of Financial Position. These changes impact upon expected depreciation and capital charge costs within our final annual plan.

Capital Expenditure	**2016/17 Plan £000's**	**2017/18 Plan £000's**	**2018/19 Plan £000's**	**2019/20 Plan £000's**	**2020/21 Plan £000's**	**Total Plan £000's**
New Build	2,746	10,873	6,462	5,878	0	**25,959**
Equipment	54	62	71	81	92	**360**
IT	497	461	557	545	530	**2,590**
Other	41	50	61	50	53	**255**
Total	**3,338**	**11,446**	**7,151**	**6,554**	**675**	**29,164**
Disposal				(6,330)		**(6,330)**
Net CAPEX	**3,338**	**11,446**	**7,151**	**224**	**675**	**22,834**

Key Forecast Summary Financials	**2015/16 Plan £m**	**2016/17 Plan £m**
Turnover £m	£124.0m	£119.8m
I & E Surplus £m	£1.23m	£1.002m
I & E Surplus Margin %	0.99%	0.81%
CoSR / Financial Sustainability Risk Rating	4	4

Continuity of Service Rating / Financial Sustainability Risk Rating	**Plan - 2015/16**	**Plan - 2016/17**	**2016/17 Plan Ratio 1 - 4**
Debt Service Cover	3.9	2.9	4
Liquidity Ratio	69.6	69.2	4
I & E – Margin	N/A	0.8	3
I & E – Variance from plan	N/A	0 (No variation in plan)	3
Risk Rating	**4**	**3**	**4**

Liquidity

The Trust currently has a sound cash position with a forecasted balance of £27.201m at 31st March 2016 and a forecast cash balance of £24.484m 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.

Other Areas of Focus for 2016/17 In Addressing The Financial Challenge

Procurement

New procurement policies have been developed during 2015/16. These include a new procurement strategy, procurement policy and sustainability policy.

A tighter and more regimented mandated PO process is in place and breaches tracked and reported in via our Audit and Assurance Committee. These all underpin tighter control and understanding of our non-pay costs and are aligned to ensuring we achieve the best value for money possible.

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. e.g. delivery consolidation. The Monitor work on Agency is also a key area of focus and we have expanded this work stream to all off-payroll arrangements.

Although Acute focused we will look to comply and contribute to all requirements related to reporting and sharing data on what we are paying for the top 100 most common non pay items.

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 2016/17 and contribute significantly over the next 5 years.

Agency - Impact and Use of The New Frameworks and Agency Price Caps

The introduction of mandated frameworks and price caps will help the Trust reduce its agency usage. The Trust already operates an internal bank for nursing and support workers and is planning to expand this further. This will be a key component in reducing our agency bill. A working group has been setup to manage the pockets of isolated concern. Various initiatives are planned to drive down expenditure. The problem within the Trust is primarily linked to two isolated nursing homes and is being addressed. A number of solutions are expected to be in place with some improvements occurring from April. One of our lead commissioners QIPP disinvestment requirements relates to our dementia bed provision. This will also reduce agency usage associated in one of the two primary nursing agency areas of concern, resulting in an improved performance anticipated from quarter 2.

At the same time the Trust is tackling all off payroll and contractors under the same principle too. The Trust has a new process in place with a vacancy control Exec sign off required in relation to all off payroll agreements in place over 12 weeks. These are continually being assessed for the appropriate nature and moved on payroll on a cost effective basis where appropriate.

Having been issued with an agency ceiling of £3.024m, the Trust is confident that it has the processes in place to ensure that agency expenditure is reduced in line with expectations despite the challenging reduction of c35% based on 2015/16 outturn.

Capital

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 being realised during 2016/17.

Our estate strategy includes the disposal of our current Trust headquarters and the disposal of the site in year 4. Further estate rationalisation plans are planned and under review as part of the estate strategy refresh. This remains an area of focus and will be developed further over the next year. Although the Lord Carter findings are acute focused, we will look to implement and follow the recommendations re utilisation where appropriate.

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 plans for 2016/17 and this will be a key area of our future efficiency programme.

Appendix 1: Trust Values