Sheffield Children's NHS
NHS Foundation Trust

Operational Plan Document for 2016/17

Sheffield Children's NHS Foundation Trust

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For publication

SHEFFIELD CHILDREN'S FOUNDATION TRUST OPERATIONAL PLAN 2016/17

1. STRATEGIC CONTEXT

1.1 Trust Strategy

Sheffield Children's NHS Foundation Trust is a specialist children's healthcare provider with a strong reputation for delivering high quality, safe and effective care to children and young people in the north of England. The Trust provides a comprehensive range of care for children and young people including highly specialised hospital services, general hospital services including A&E, and a full range of community and mental health services. Our purpose is:

'To provide care and treatment of the highest standard to the children and young people of Sheffield, South Yorkshire and beyond, working closely with children and their families, other partners, and our staff to improve the health, wellbeing and life chances of the younger population.'

The Trust's five primary strategic objectives remain as follows:

OUR FIVE STRATEGIC AIMS

- **Provide healthcare to children of the highest standards available in the UK**
- **Develop and expand our role as a provider of specialist services for children**
- **Work in partnership with others to reshape healthcare for children in Sheffield**
- **Expand the Trust's role as an expert provider of specialist pathology services**
- **Be a national leader in research and education in children's healthcare**

The Trust's underpinning objectives support the effective delivery of this strategy:

Underpinning Strategies – are to:

a) Have robust arrangements are in place to ensure financial stability and the delivery of key financial targets to support high quality and efficient clinical services;

b) Ensure that the Trust has an appropriately trained, skilled and supported workforce;

c) Implement improvements to the Trust's estates to support the delivery of our clinical strategies and implement key Information Management and Technology strategies

d) Ensure that the Trust is well governed and works effectively in partnership with others to drive transformation in the delivery of healthcare.

1.2 Future Strategic Direction

The Trust is currently undertaking a revision of its existing strategy. This is not expected to lead to a substantial change in direction for the trust. It will however, refocus the organisation in terms of a number of the more significant changes that will be made in the delivery of our services over the next few years, taking into account the following:

- The Five Year Forward View and key national policy directives
- Local priorities – including those of local commissioners, and work being undertaken in partnership with other providers within both Sheffield and in the sub-region, including work being undertaken through the Working Together Vanguard, and via the South Yorkshire and Bassetlaw STP
- The financial context in which we are operating
- The need to transform the delivery of care

We recognise the Trust will increasingly work with other NHS and local authority partners in the planning and delivery of healthcare in the future. In this context, the Trust would not expect to develop plans independently. However, the direction we take the organisation will need to be articulated, and it is important we set out the direction of travel for the organisation going forwards. The work we are undertaking on future strategy will be used as a vehicle for engaging our staff, our Governors, patients and other partners in considering some the changes that Sheffield Children's and the wider health system might make in the delivery of children's services in the future. This work takes into account some of the main changes we are discussing with our partners which will feed into the system-wide STP which will be developed over the next few months.

The six key themes for consideration in this work are:

- Keeping children healthy
- Reshaping care for children in Sheffield
- Leading healthcare for children in the sub-region
- Improving the lives of children with disabilities
- Digital healthcare

We will also consider how the organisation needs to change in order to succeed in achieving the ambitions we have to improve services and to work with others to achieve the transformation necessary in healthcare in the future.

1.3 Key priorities in 2016/17

There are a number of key priorities for the Trust in 2016/17, as follows:

Strategic Objective	Major priorities in 2016/17
1. Provide healthcare of the highest quality in UK	• Improve quality in line with agreed Quality Improvement plans/priorities • Complete capital scheme and commission new ward block, new outpatient department and new main reception by year-end. • Meet all key access targets, including new mental health targets • Achieve four clinical standards for Seven Day Working
2. Develop & expand our role as a specialist provider	• Develop role within sub-region by setting up a Managed Clinical Network for children's surgery & anaesthetics as part of the Working Together Vanguard • Set up a partnership with The Rotherham Trust with a Managed Clinical Network for Paediatric Services as part of the Working Together Vanguard • Develop Trust role as Paediatric Trauma Centre by setting up Interventional Radiology Service and strengthening leadership • Ensure capacity in place to meet higher levels of contracted activity
3. Reshape services for children in Sheffield	• Develop mental health services in line with local Transformation plans to meet national *Future in Mind* priorities • Work with partners to redesign community and general paediatric services to provide integrated locally delivered services • Redesign Health Visiting & School Nursing Services to create a single Public Health nursing service, linked to local authority and GP provision
4. Expand and develop specialist pathology services	• Progress through partnership with LTH & STH on delivery of Genomic Medicine Centre and plan • With LTH & STH, develop plan for integrated Genetic Laboratory Service and take forward implementation
5. Be a national leader in research & education in children's healthcare	• Increase numbers of research studies undertaken by Trust, including meeting higher targets on recruitment to studies • Increase numbers of research active professionals • Collaborate with others on opportunities to take forward services for patients with long term conditions through the Test Bed

In addition to the service and clinical priorities identified above, the Trust will also take forward a number of key organisational imperatives:

- Deliver a significant cost-efficiency programme to achieve cost reduction across a number of areas, including implementing relevant recommendations from the Carter review;
- Undertake a review of future workforce requirements and develop a workforce strategy which will support the delivery of the Trust's future clinical and organisational strategies
- Implement electronic document management of clinical records and develop the Trust's IM&T services in order to progress opportunities for digital healthcare, and maximise the benefits of technology
- Develop an effective Estates Strategy to ensure most cost effective use of our estate.
- Develop the organisation to support the delivery of transformational change
- Through the Working Together Vanguard and the STP planning process, we will work in close partnership with other providers and commissioners to develop increasingly integrated health care solutions, with an emphasis on developing approaches which focus prevention and early intervention and systems-wide networked services.

2. APPROACH TO ACTIVITY PLANNING

2.1 Overview

The Trust has taken an open approach to activity planning with commissioners and shared our methodology early in October 2015 to gain agreement in principle. We have revised the methodology in agreement with commissioners and have shared workings transparently at CCG level. We submitted the latest position to commissioners on 29th January 2016.

The commissioners have accepted our methodology, and acknowledge the challenge in terms of achivieving national waiting time standards where demand is growing. However the resulting activity projection does leave a significant financial gap for commissioners and shows a need for a significant level of non-recurrent activity. The amount of non-recurrent activity reflects the growth in queues and overdue follow-up activity arising from growth in demand coupled with underperformance in 2015/16 which arose as a result of recruitment delays/challenges.

Overall our proposed change in activity plan to plan by POD from 2015/16 to 2016/17 is as follows:

Activity Growth											
	2015/16		2016/17 Total					2016/17 Non Recurrent (included within total)		
POD	FOT 15/16 based on M11	Plan 15/16	Plan 2016/17	Over 15/16 FOT	% over 15/16 FOT	Over 15/16 Plan	% over 15/16 plan	NR Total	% over 15/16 FOT	% over 15/16 plan
EL	4,947	5,782	5,634	687	13.9%	(148)	-2.6%	242	4.9%	4.2%
DC	13,514	13,633	15,454	1,940	14.4%	1,821	13.4%	829	6.2%	6.1%
NEL	6,711	6,498	6,407	(305)	-4.5%	(91)	-1.4%	0	0.0%	0.0%
OP1st	48,110	49,220	50,475	2,365	4.9%	1,255	2.6%	2,187	4.8%	4.4%
OPFU	95,159	101,693	101,691	6,532	6.9%	(2)	0.0%	4,221	4.9%	4.2%
A&E	55,383	55,197	55,656	273	0.5%	459	0.8%	0	0.0%	0.0%

2.2 Non-elective activity

Non-elective activity has been particularly high during 2015/16, although still within normal fluctuations across years. We have therefore agreed with commissioners that initially we would use a multi-year average to set the plan for 2016/17, thereby a reducing the plan against expected full year out-turn for 2015/16. This continues to be reviewed jointly with commissioners

2.3 Elective activity

Elective activity is planned at local specialty level and aggregated because:

- Numbers are often small so can fluctuate significantly and we need to avoid 'over' planning
- Delivery has to be planned at local specialty as there are often a very limited number of staff to deliver the activity particularly in highly specialist areas
- Clinical teams need to understand their demand and plans to deliver against these KPIs that are built into our internal processes
- We have a number of specialties which we have agreed with commissioners are better reviewed against 5 year averages rather than against a 12 month previous activity. These are specialties which are effectively driven by disease rather than by referral behaviour, for example where we see 'clustering' of diagnoses, and there are relatively low numbers of patients. They are also specialties with low numbers of new diagnoses: Bone Marrow Transplant; Clinical Haematology; Haemophilia; Burns; Oncology. For these areas we look at five years of actual activity and referral and ensure we are within reasonable boundaries of upper and lower statistical norms. Where we are outside these norms we would approach commissioners, but where we are within the norms we use previous years plan as our position for planning.

When applying growth we use the following methodology:

Outpatients: Growth applied to baseline (recurrent) at sub-specialty level and aggregated to main specialty
N:FU ratio based on 2015/16 actual ratio in the majority of cases except where there are known distortionary factors in the current year performance

Inpatients: Growth applied to baseline(recurrent) at sub-specialty level and aggregated to main specialty

Over the past five years our planning for growth has, in the main, proved correct. The model we used for growth calculation has not changed and in 2015/16 if we had seen all the patients in our existing queues, we would have shown a direct match between our predictions and activity. Once we have calculated growth we share this with commissioners and review deliverabilty at local specialty level to ensure the plan is realistic and reflects patient need.We review the demand for services as follows:

- Review of 5 year referral data at local specialty level at year and month level
- FOT referrals at Mth 6, repeated and Mth 9 and review at month and week level
- Divisional sense check i.e. if areas of 'special cause' variation (e.g. additional funding in year for a specific purpose, temporary lack of capacity at another provider)
- Confirm and challenge by Corporate Planning team

For 2016/17 the specialties where we are predicting material growth are:

Allergy	Rheumatology	ENT
Immunology	Audiology	Neurosurgery
Community Paediatrics	Neurodisability	Orthopaedics
Dermatology	Respiratory and Sleep	Paediatric Surgery
Gastroenterology		Dentistry/Exodontia

2.4 Non-recurrent activity/backlog calculation

The plan has a significant level of non-recurrent activity within it. We review our queue, referrals and waiting lists and use these to identify patients who require new appointments or elective treatment. For follow ups we have used those patients overdue by more than four weeks on our review lists and potentially at clinical risk, and model this through plus the 2015/16 actual ratio conversion from the new

patients expected. Our backlog prediction for 2016/17 is significantly higher due to the underperformance in delivery against plan in 2015/16. At the same time we have experienced continuing growth in referrals, and in some specialties higher than predicted.

The combination of underperformance and increasing referrals has resulted in a large proportion of backlog clearance required in early 2016/17 and we are in discussion with commissioners around the clearance level required to sustain 18 weeks and the corresponding backlog clearance plan.

2.5 Mental Health and community activity planning

Planning for Tier 3 CAMHs has taken into account the activity needed to achieve the new waiting times targets for mental health from April 2016 namely:

- Treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks;
- Treatment within 2 weeks for more than 50% of people experiencing a first episode of psychosis
- Appointment within 4 weeks of referral for Eating Disorder services

Although the first target applies only to Adult IAPT our local commissioners have asked us to plan for childrens services to meet a target of 18 weeks for all CAMHS Tier 3 patients.

Tier 4 plans will be based on the same methodology as previous years; i.e.based on bed numbers and occupancy rate.

Community activity planning, for services within the block contract, is based on FOT and the same methodology applied as to acute activity for follow up.

2.6 Resiliance, Winter and unplanned changes in demand

NHS Sheffield have agreed to commission an OPAT (Outpatient Parenteral Antibiotic Therapy) scheme from 1st April 2016, which moves activity into the community to release capacity for inpatient care. We expect this scheme to therefore provide internal capacity to manage some of the pressure on in-patient beds which we have experienced in recent years. We are also opening our new ward block in 2017 which will improve the configuration of beds without increasing capacity.

NHSE have indicated that they plan to commission the same critical care enhancements in 2016/17 as they did in 2015/16 at equivalent value.

3. APPROACH TO QUALITY PLANNING

3.1 Executive responsibility

Executive lead: Sally Shearer, Director of Nursing and Quality

3.2 Plan for delivering the quality priorities

Our quality priorities are a combination of national requirements, locally developed areas for improvement and recommendations from the CQC inspection process, as follows:

Goal	Indicator and milestone	Risk	Monitoring
1. Improve healthy living choices for patients, visitors and staff. (Five Year Forward View)	• Implement patient nutrition strategy (revised menu, stop café voucher system, iwave for oncology & Ryegate) • Implement change to vendor provision (sugar free drinks only, confectionary removed from till, fresh fruit available, salad bar, fruit smoothies, healthy options built into new build tender) • Design metrics for school nursing & HV	• Patient choice. Mitigated by education programmes, displays & events. • Financial impact including cost of iwave, mitigation long term cost savings.	• Kitchen waste • Metrics via performance review • Involve public health in data collection
2. Improve outcomes and access to services for children and young people with mental health needs (Five Year Forward View)	• Improve access and waiting times Tier 3 CAMHS including 16-18 year service • Improve the Intensive Home Treatment Service • Improve Crisis Response • Increase capacity in ED clinics • Develop CAMHS school link pilots for vulnerable children • Roll out IAPT	• Finance • Capacity and capability of teams to lead change (see risk section)	• Divisional performance review • CCG Clinical Quality Reviews
3. Improve inpatient and community care services for children with learning disabilities. (Five Year Forward View)	• Participate in 'Pay More Attention' national study. • Hold a series of listening events • Scope services against national standards • Prepare action plan • Implement change	• Finance • Capacity and capability of teams to lead change (see risk section)	• Patient feedback • Divisional performance review
4. Monitor and publish the number of avoidable deaths of children and young people accessing our services. (Five Year Forward View)	• Undertake Serious Incident reviews on all avoidable deaths • Identify learning from Serious Incidents, inquests, M&M and share learning • Case review to be undertaken on all deaths for annual report	• Low risk. First submission completed	• National monitoring system • Executive Risk Management Committee
5. Improve patient experience and outcomes for respiratory services (Local priority)	• Teach ED/AAU/ ward staff to give high quality discharge information to empower respiratory patients to reduce re-attendance rates in November 2016 audit. • Introduce home antibiotic team and service by July 2016.	• Team capacity. Mitigated by additional CNS employed	• Weekly respiratory MDT meeting • Division governance meeting • National BTS audit .

6. Continue to improve services for our Roma Slovak population (Local priority)	• Research project funding awaited~ health behaviours of Roma families • Develop pod casts for patient information • Bespoke hearing screening • New migrants group	• Finance • Engagement from families ~ mitigated by research project	• Divisional performance review and quarterly deep dive~ patient feedback
7. Implement a system wide transition programme (CQC May 2014)	• 'Ready Steady Go' or adapted transition process embedded in all services by Dec 16	• Capacity and capability of teams to lead change (see risk section)	• Divisional performance review and quarterly deep dive
8. Improve safeguarding in ED by developing research based documentation for safeguarding decision making (CQC 2015)	• NIHR research bed • Tool developed • Local evaluation of safeguarding screening tool underway • Implement and add to audit programme by June 2016	• Tool ineffective Mitigation: Research process used in development	• CQC Action plan monitored by the CCG in addition to divisional and Trust Board subcommittees

3.3 Sign up to safety priorities

The Trust have submitted their application to join the campaign, pledges will be displayed on the website shortly. The pledges include our proposals to:

- Extend our S.A.F.E 'avoidable harm' work alongside the national programme
- Embed the WHO checklist for safer surgery
- Assure safe staffing levels through acuity indicators and twice daily reporting
- Embed our robust medical staff patient safety induction programme
- Implement the GMC guidance for the responsible clinician
- Improve the incidence rates of the use of restrictive practice in our Becton centre
- Gain a deeper understanding of how it feels to use our services, through patient feedback strategy
- Support staff when things go wrong, facilitate learning from adverse events
- Assure robust investigations and actions following serious incidents
- Strengthen our local and national partnership working

3.4 Responsible consultant

The lead for the GMC guidance on the responsible consultant for the Trust is Professor Derek Burke, Medical Director. This guidance re-states the role of the responsible consultant and is mapped against GMC Good Medical Practice. The guidance has been circulated to all consultant medical staff. The Medical Director will be implementing annual face to face patient safety briefings and updates to all trust medical staff (consultants and SAS doctors) which will incorporate this guidance. This will complement the patient safety induction for junior medical staff.

3.5 Quality improvement methodology

The Trust has an integrated approach to safety, governance and continuous improvement to improve quality of care across all areas.

- Areas for improvement are identified locally through our new governance system, partnerships with stakeholders and nationally through network relationships
- We are partners in the Sheffield Microsystems coaching Academy basing improvement work around the patient at micro level and developing a safety and quality improvement culture at team and individual level.

- The Trust has a quality improvement training programme which complements our clinical safety and risk training programme.
- Support and assistance are delivered through Research and Innovation and our Programme Management Office team and Continuous Improvement teams.
- The Trust actively engages with national improvement schemes e.g. 'Ready, Steady, Go' and S.A.F.E.
- National and local methodology is monitored through our governance and risk monitoring process.

3.6 Quality improvement governance system

The Trust Board agreed a revised ward to board quality governance process on 26th January 2016. The review (CQC recommendation May 2014) reflects the Monitor well led framework (2015) and although 'work in progress' is now being embedded. Key improvements are:

- A strengthened system for tracking quality improvement through the introduction of consistent quality metrics and bi monthly divisional reviews that report quality issues alongside performance and finance.
- A monthly subcommittee of the board (Quality Committee) to oversee all aspects of quality improvement including the escalation of risk and quality assurance on behalf of the Trust Board.
- A clear, effective and transparent process for sharing the learning from complaints, serious incidents, audits, patient feedback, incidents and Trust Quality Priorities that cascades from the Board to the clinical and non-clinical areas.

3.7 Three quality priorities for 2016/17

- Improving healthy living choices for patients, visitors and staff.
- Improve outcomes and access to services for children and young people with mental health needs
- Improve inpatient and community care services for children with learning disabilities.

3.8 Risks to quality

Risk	Mitigation
Financial. Insufficient funding for staff to deliver to quality standard	Transformation programmes (i.e. roster, specialist nurse/AHP review, redesign of cleaning service, community service review). Monitored through QIA, BAF processes.
Capacity and capability of workforce to deliver change programme and work differently across the city.	Leadership and transformation programme under development to equip staff with systems leadership skills
Governance. Poor definition of standard required, failure to allocate resources against priorities, failure to monitor progress against standards	Review of governance procedures against Monitor well led framework 2015. Design of consistent quality metrics. Monitoring of audit programme.

3.9 Seven day Services

The Trust is an early implementer for the 7-Day Services clinical standards. In partnership with NHSIQ, Sheffield Teaching Hospitals NHS FT and Sheffield CCG we are preparing an action plan to achieve compliance by March 2017. The Trust is working with the national team to identify appropriate clinical outcome measures for paediatrics. In common with other paediatric centres, the Trust averages 40 deaths per year, and has a low average length of stay. This highlights the importance of agreeing paediatric specific measures to ensure the focus is on improving care for patients in the areas of risk rather than those prescribed nationally based on adult settings.

Key actions within our plan include:

- Continued expansion of the General Paediatrics team as per approved Business Case (in response to CQC recommendation May 2014), to increase consultant level cover over evenings and weekends

- Utilisation of clinical network approach and formalised pathways to achieve compliance in key specialist areas jointly
- Moving from on-call to shift systems in key areas, such as diagnostics
- Working with the national team to share learning across the paediatric early implementers to ensure national consistency
- Ensuring any recruitment or changes in pathways incorporate 7-day working principles
- Implementation of key recommendations in RCPCH Facing the Future 2015 guidance.

Challenges to achievement common to all specialist paediatric centres relate to the provision of specific interventions by small number of specialist staff, hence the requirement to work jointly on solutions if we are not to incur considerable costs.

3.10 Quality impact assessment process

The Trust has a Quality Impact Assessment policy which is currently used robustly within our efficiency programme, but has yet to be fully embedded into 'business as usual' functions. The process that the Trust is implementing to ensure consistent application and use is:

- Quality Impact Assessment pro-forma to be incorporated into business case and CIP proposal templates.
- The assessments will be signed off weekly by the Medical Director and Director of Nursing and Quality.
- Monitoring of quality impact will be through the Divisional Performance Reviews. For trust wide initiatives such as the Cost Improvement Programme this will be via relevant Trust Board sub-committees
- An overview of all Quality Impact Assessments together with any exceptions will be reported monthly to the Quality Committee which is a sub-committee of the Trust Board.

3.11 Triangulation of indicators

The Trust maintains a focus on a wide range of indicators relating to quality, safe staffing, and finance and workforce routinely monitors such indicators each month within a number of key meetings. The triangulation of these indicators is achieved through a variety of routes as outlined below:

Trust Board and Sub-Committees

- Reviews monthly quality, safety, financial and workforce indicators. Quality indicators include CQC action plans and mock inspection process, infection rates, ED waits, waiting times, diagnostic waits, Friends and Family information, safe staffing report. The indicators are discussed alongside the Trust I &E position and detailed performance by division. A workforce report is also reviewed quarterly.

- Sub-committees of the Trust Board include the Quality Committee, the Finance & Resources Committee, and the Risk and Audit Committee, all chaired by Non-Executive Directors. The Committees meet monthly and there is cross over between membership of the committees. Headlines from the three committees are presented and discussed at the monthly Trust Board meeting. The Committees each have a specific focus and provide assurance and challenge as detailed below:

    - *Finance & Resources Committee:* - provides assurance through a monthly review of finance and resources performance indicators, including summary workforce indicators, and are concerned with the development and delivery of the Trust's Annual Business Plan.
    - *Quality Committee:* provides assurance and is concerned with systems and processes for the continuous improvement of safe and effective services. It is concerned with standards of care, and, in particular, ensuring appropriate clinical governance structures, processes and controls are in place to promote safety and excellence in patient care and ensure the effective and efficient use of resources through evidence-based clinical practice.
    - *Risk and Audit Committee* – along with other responsibilities, this Committee is responsible for the BAF and assesses strategic risk relating to all aspects of the Trust's business.

- Standard quality indicators reviewed monthly by Board include rates of infection, access targets including A&E waits, RTT incomplete waiting times, diagnostic waits, A&E quality indicators, ambulance turnaround times, and standard monthly performance includes I&E position, detailed performance by Division/Department showing split by pay, non-pay and income against plan, cash position and capital expenditure.

- On a quarterly basis a more detailed quality report includes also details of Friends and Family feed-back, clinical incidents and complaints, SUIs and other quality indicators.
- On a quarterly basis the Trust Board receives a detailed Workforce report which provides details across a number of workforce indicators, including numbers of staff in post, sickness levels, compliance with mandatory training and rates of PDRs completed.
- From April 2016 the inclusion of the 'Stress Test' will also be added to the monthly Performance Report, which will include indicators showing waiting time performance, clearance times and activity over a three-month period to indicate risks to future performance.
- Work is underway to develop a standard integrated board report which will include a wider range of quality indicators, workforce and finance indicators which will be reviewed monthly by the Board.

Trust Executive Group

- The Trust Executive Group is the main management group below Trust Board and membership includes the Trust Executive Directors, Divisional Clinical Directors and Associate Directors, and with representatives of all key departments such as Risk Management, Research and IM&T. It brings together the senior clinical and non-clinical leaders of the Trust and is responsible for all aspects of the Trust's business and is responsible for the standards of clinical care, performance, financial and operational management of the Trust. It receives very similar information to that received by the Board, with monthly reports on performance and finance with more detailed workforce and quality reports received on a quarterly basis.

Divisional Performance Reviews

- A Performance Review Meeting is held monthly with each of the four clinical divisions, at which current performance against quality, finance and workforce is reviewed on a divisional basis. The Review meetings are Chaired by the Chief Executive or the Chief Operating Officer, with other Executive Directors also present. Each month the Review considers current performance on finance and activity against plan, performance against key quality indicators including access targets, and also focuses on specific areas for improvement including currently timeliness of discharge summaries and review of pathology results. The Performance Reviews also include an assessment of performance against key workforce indicators such as sickness absence rates, long term sickness management, compliance with mandatory training and PDRs (CQC recommendation 2014) and staff turnover.
- Divisional level finance indicators and narrative report are presented and discussed including income and expenditure, cost improvement plans, workforce and agency costs, forecast outturn.
- A more detailed report is now produced at divisional level including an extended range of quality indicators and we plan to develop a single integrated performance report covering all the performance, workforce, quality and finance indicators at Divisional level, including CQC actions.
- Quarterly and annual review and forward planning agenda items are timetabled in to the Divisional Performance review meetings for 2016/17.
- Annual cyclical activity is considered across the groups listed above including planning and discussion time on meeting agendas for both in year and forward plans for quality improvement, quarterly and year end reviews, resilience (including planning for Winter) and corporate planning – all of which include the triangulation of quality, workforce and finance plans.

The Board intends to use this framework to regularly monitor the quality of services delivered and where this departs from NHS Constitutional and CQC standards, to identify areas for improvement

4. APPROACH TO WORKFORCE PLANNING

One of the key strategic risks facing the organisation is the ability to recruit, develop and retain a high quality workforce to ensure the continued delivery of high quality services in the future.

Over the last few years, the Trust has sought to align service and financial planning with workforce planning. Given the complexities involved, this has proved challenging and work continues to improve this position. As part of this year's business planning round, the Human Resources team has been closely involved in the work relating to service and financial planning with a view to understanding some of the workforce issues arising out of this planning.

Following this planning process the Board identified a number of key strategic workforce issues that need to be addressed in order to maintain high quality services. A summary of these issues, by staff group, is detailed below,

4.1 Nursing Workforce

- *General Nursing* - The Director of Nursing and the Head of School of Paediatrics have produced a document which assesses the gaps in workforce supply for junior medical staff within the Yorkshire and Humber region. This analysis has been used to inform strategic workforce planning (in conjunction with Health Education Yorkshire and the Humber). A reduction in the availability of junior medical staff has identified the need to ensure robust training, education and development of senior nursing staff. The Trust and HEE have therefore developed a training course with a local Higher Education Institute to develop our own cohort of Advanced Nurse Practitioners. The challenge this presents is that the pool of candidates for these higher posts comes from the Trust Paediatric Nursing Workforce, again in conjunction with HEE, we have agreed an increase in the number of commissioned nurse training places to supplement this trained nursing workforce.

- *Nurse Training* - The decision (in light of the challenges identified above) has been made to increase the numbers of paediatric nurses being trained by Sheffield Hallam University by an additional 20 places per year. The Trust routinely employs approximately 80% of newly qualified staff coming out from each set. This change came to fruition in September 2015 and will continue in future years.

A decision has also been made to alter the intake dates for training which will result in newly qualified nurses joining the Trust in April and September instead of January and September. The September intake has always orientated well, however, the increased winter pressures cause issues with the orientation and induction of the January intake. This change will take effect from April 2016 and will enable the intake to be up and running more effectively and more speedily.

- *Skill Mix* - The skill mix of the Nursing Workforce is also being looked at and a piece of work is being developed with HEE using the Calderdale Framework to help support and develop staff in Support Worker roles and bands 2 to 4. This will set up a consistent approach to competencies, training and job descriptions and support the qualified nursing staff within the Trust. The Calderdale Framework has previously been shown to give a good return on investment for Support Worker staff and helps to retain experienced and skilled staff

- *Specialist Nurses* - Funding has previously been switched from Medical staff to fund Advanced Nurse Practitioners (as outlined above); however, the provision of the training was not effective enough as there were insufficient numbers on the courses run by the Universities. Discussions have therefore taken place between the Trust, HEY&H and also the University regarding making the training more robust and effective. This new course commenced in September 2015 and feedback is being given to the Trust to show progress on this key initiative

- *Health Visiting* - Substantial effort and resource was invested in the Health Visiting workforce to ensure that the specific targets to increase staff numbers in line with the agreed trajectory was

achieved by March 2015. However, notification has been given that funding reductions in the public health budget will now require the rationalisation of this staff group and work is underway with commissioners to redesign this service.

- *Recruitment* - Given the challenges presented by the turnover of the nursing workforce, a number of actions have been taken to ensure the provision of a safe and sustainable paediatric nursing workforce in the future. The Trust is actively recruiting nursing staff onto permanent contracts when covering for maternity leave, in order to ensure safe minimum staffing levels.

4.2 Medical Workforce

- *Training Grade Doctors* - There are a number of issues affecting the doctors in training, both nationally and regionally. Nationally, decisions have been made to reduce the number of training posts in certain specialties, such as Anaesthetics and Surgery. This has led to gaps in medical rotas which can then affect the stability of services and lead to increased reliance on locums and costlier Clinical Fellows. Given that many of the Trusts training posts are run-through posts, the overall length of training is being extended. This is mainly down to the gender profile of paediatric trainees being predominantly female, some of whom take maternity leave and then return to the programme working part time. This extends the length of training and reduces the numbers of available Consultants in the short term. New rules state that maternity leave cannot be covered by a Locum Appointment for Training and has to be a Locum Appointment for Service. Whilst this is a legitimate change, it has resulted in maternity leave vacancies becoming less attractive to applicants as the service will not count towards their training.

- *Consultant Grade* - The Trust is strengthening the General Paediatric Consultant workforce to ensure a robust and sustainable general paediatric Consultant workforce and to increase consultant level of cover for evenings and weekends. There is a national drive for Trusts to reduce reliance on training grade doctors for service provision in hospitals, and trainees are expected to be in post to be trained. This shift will require Consultant grade staff to be available, both on site and on-call, for more time within the week. This may mean for more hours during the day but also time at the weekends. This links into the need for the Trust to provide a seven day service.

4.3 Trust submission to Health Education England

As part of the Trust's approach to strategic workforce planning, we liaise closely with HEE to inform Regional and National Commissioning intentions. As part of the most recent workforce planning round, the Trust submitted the returns detailed below to respond (on a Divisional basis) to questions posed by HEE in relation to strategic workforce issues:

DIVISION	**MEDICINE DIVISION**			
Brief description of the challenges or risks to your workforce	**What is driving this workforce challenge**	**Which major staff group is affected by this challenge/risk.?**	**What is the job role/AfC level band of those affected**	**Will the challenge be managed locally or is this a regional/national challenge**
Older workforce in some areas – several very senior/experienced staff due for retirement in next 12-18 months	Age profile of workforce and future planning not done far enough in advance (Not always notified of planned retirement dates)	All staff groups but majority that cause a challenge for us in terms of service delivery are in medical and nursing	Consultant and Senior (band 7+) Nurses	Will be managed locally but suspect it is a challenge often experienced nationally
Lack of trainees and recently qualified staff in particular areas, e.g. community paediatrics, child protection, Looked	Block contracts have made service development more difficult in these areas, with negative impact on recruitment. No long term training and development plan in place	Mostly medics but also affects nursing staff.	Junior doctors and nurses	Has been identified as a regional challenge but again suspect it's a challenge nationally

After and Adoptive Children's Health	for junior / trainee staff. Some specialties not as "glamorous" and popular as others.			
High turnover rates of support workers	Relatively lower paid grade so staff want to move on and progress	Support workers	Band 2/3	Trying to manage locally
7 Day Working – creates challenges in staffing rotas and additional funding required to pay staff to work unsocial hours	National strategy/ direction of travel Public expectations/demands	All staff but clinical staff groups most challenging	All but mostly medics, nurses and AHPs	National challenge
Single handed specialties where only have one consultant running a whole service	Relatively small organisation and some very small, highly specialised teams	Mostly medics but also nurses and some very specialised AHPs	Consultants, junior doctors, nurses, AHPs	Local challenge due to size of organisation
DIVISION	**SHEFFIELD DIAGNOSTIC GENETICS SERVICE**			
Shortage of STPs. This will potentially lead to inappropriate grading for new STPs in order to promote recruitment and a shortage of key staff	Expanding service and requirement and lack of trainees in previous years	Clinical Scientists in genetics	Clinical Scientists Band 6 and 7 immediately then higher grades in future years as natural wastage occurs through retirement	National challenge and there is a national workforce review underway
Shortage of STPs. This will limit availability of backfill for staff to be released for HSST and other training programmes including those associated with 100,000 genomes.	Workforce planning for senior staff requires development of the middle grade workforce to make them competent for senior positions. Training is becoming available but will create backfill pressure	Scientists	Band 6 for shortage and bands 7 and 8 regarding release for training	Training will be delivered through national initiatives but resourcing release of staff for training is likely to be a local issue.
Training capacity in genomics for STP rotations.	Adoption of STP programme	Scientists responsible for training	Clinical Scientists Band 7 and 8 with some PTP/technologist input	Likely to be addressed nationally eventually but impacting increasingly on department.
Lack of apprenticeships for IT (at least unaware of one)	Expansion of requirement for IT support and the need for a good skill mix in this expanding area	Ultimately the NHS will be increasingly dependent on good IT infrastructure	All IT staff	Should be managed both regionally and nationally
Challenge of recruiting IT professionals on NHS salaries	Expansion of requirement for IT support and the need for robust recruiting in this expanding area	Ultimately the NHS will be increasingly dependent on good IT infrastructure	All IT staff	Should be managed both regionally and nationally
Still significant problems with PTPs across the board regarding supporting programme and outputs.	Resistance to change and challenge of introducing new programme into this environment	All NHS services	Genetic technologists Band 5-7 mostly	Should be managed both regionally and nationally
DIVISION	**COMMUNITY WELLBEING & MENTAL HEALTH**			
Inability to recruit trained / skilled CAMHS nurse practitioners into Community CAMHS. Band 5 nurses cannot be recruited and Band 6 staff typically require an extended (1 – 2 years) ad hoc local development plan to provide the required competencies.	The absence of a training pathway into CAMHS within RMN pathway and/or for newly qualified RMNs. CAMHS is a post-registration career for RMNs but there are no suitable courses and no training places. (Relevant experience – but not training - can only be acquired via in-patient/Tier 4 posts;	RMN (CAMHS)	Band 5 and 6	Regional: numbers are relatively small and recruitment foot-print is local or regional

Working towards a revised nursing skill mix.	Financial risk as we need to re adjust the mix of RMN / RNLD v Support Workers and in the medium term we are over-subscribed on the former Need to retain experienced staff. Need a clinical focus for developmental roles, which may go some way to achieving this	RMN / RNLD Nursing Support workers RMN / RNLD Nursing	Bands 5-7 Band 2-3 Bands 5-6	Local challenge but will play into national procurement and commissioning Local challenge
Special Schools, nursing provision	Slow progression with still lack of clarity regarding school nurses no longer been based in 3 schools	All school nursing staff are affected as they are being utilised to ensure the schools have cover as this has been a difficult area to recruit to, with examples of staff staying one day and leaving as well as another new starter giving back word at short notice.	All level of qualified nursing as well as additional stress to HCPL's from reluctant staff and trying to manage the cover.	This is a local challenge specific to Sheffield. There is a plan in partnership with commissioners however this is demonstrating slow progression.
Appointing band 6 experienced staff	Numerous band 6 nurses have left the service for different reasons. There is difficulty in replacing these staff as there are very few nurses with the appropriate qualification making recruitment a challenge.	All School Nursing as band 6 staffing gaps have been filled by band 5 to try and fill some of the gap however this does leave a risk as we do not have the expertise which a SCPHN qualification brings.	Mainly an increased pressure on the SCPHN band 6 nurses in post.	This is a regional and potentially national challenge. To address this locally we have sent 2 band 5 staff on the SCPHN course who will be in a position to apply for a band 6 role when qualified.
Potential decrease in contract value from the local authority.	This would mean a reduction in what the service can deliver, this would be agreed in partnership with commissioners.	All staff would potentially be at risk as this would mean we would have to continually review staffing.	Full service could be affected.	This challenge will be managed locally but is impacted by the national agenda.
Skill mix workforce trajectory; phased reduction impacting on the HV Service delivering key elements of Healthy Child Programme. Unable to maximise the appropriate level of skills to identified health needs of children and families	Local funding channelled towards qualified Health Visitor recruitment (band 6) in response to the National Implementation Plan 2011-2015	Community Nursery Nurses	Band 4 Support delivery of the Healthy Child Programme	Locally agreed for the interim to maintain 'over' planned trajectory whilst under establishment of qualified Health Visitors Agreement from area team commissioners re additional recurrent funding

4.4 Workforce efficiencies

As part of the Trust's approach to delivering efficiencies, we have a well-established Programme Management Office to support the organisation to deliver efficiencies. This is set alongside the cost improvement programme that the Trust sets out each year. The cost efficiency programme for the next year sets out workforce efficiencies. The Trust has offered a Mutually Acceptable Resignation Scheme (MARS).

5. APPROACH TO FINANCIAL PLANNING

5.1 Financial forecasts and modelling

As at 18th April 2016, the Trust's forecast financial position in 2016/17 is the delivery of a £2.352m surplus, (excluding the impact of impairments), and an overall annual FSRR of 4 at the end of Quarter 4. To deliver this plan position, the submission includes combined efficiency/revenue generation targets of £5.25m, which in percentage terms is c3.1% of operating expenses. (The table below highlights the key elements of the plan submission.

Financial Position Overview

I&E		
	2015/16 FOT	2016/17 Plan
	£m	£m
Income	166.451	179.229
Charitable Income	3.200	1.500
Total Income	***169.651***	***180.729***
Operating Expenditure	(161.719)	(170.285)
	7.932	***10.444***
Depreciation	(4.584)	(4.916)
PDC Dividend	(1.777)	(2.150)
Net Loan interest	(0.960)	(1.045)
Plan Surplus / (Deficit) before impairment	**0.611**	**2.333**
Impairment	0.000	(7.500)
Plan Surplus / (Deficit) after impairment	**0.611**	**(5.167)**
Memo:		
Plan surplus before impairment		2.333
Adjust for donated capital contribution		(0.800)
Adjust for donated asset depreciation		0.819
2016/17 Plan control total		**2.352**

Balance Sheet and FSRR		
	2015/16 FOT	2016/17 Plan
	£m	£m
Fixed Assets	104.533	111.192
Current Assets	14.524	13.504
Cash	30.203	14.083
Liabilities	(63.323)	(57.990)
Reserves	**85.937**	**80.789**
FSRR		
Capital Service	2.000	3.000
Liquidity	4.000	4.000
I&E margin	3.000	4.000
I&E variance	4.000	4.000
FSRR	**3.000**	**4.000**

This position submitted within this plan is based upon the adjusted £2.352m control total set out for this Trust as per the details set out in the APR return. The financial plan position also assumes receipt of the £2.1 Sustainability and Transformation fund allocation to deliver that control total.

5.1.1 Activity / Contractual Position

At the time of submitting this plan, contracts have not been signed with either NHS England or NHS Sheffield and our collaborative commissioning associates. However, negotiations are well advanced and the submitted plan position is based on the latest offers received from NHS England and expected from our lead Collaborative Commissioner. Whilst there are still significant elements of detail to agree within the contractual arrangements, we believe the remaining differences can be solved and the financial quantum agreed. It is this quantum that underpins our submitted financial plan.

5.2 The Planning Process within the Trust

Within the guidance template for the plan narrative submissions, Monitor has specifically asked the Trust to comment on the internal consistency of the planning assumptions. This section briefly outlines the key elements of the planning process undertaken by the Trust:

- The activity plan has been developed by Divisions (including clinical staff) using a "bottom up" approach based on the latest activity performance, queue, waiting list and demand data.
- These activity plans have been scrutinised and challenged by both management and the Trust Executive Directors for reasonableness of projection and deliverability. In addition, the methodology and detailed assumptions have been shared with commissioners who have also commented and challenged assumptions.
- As a result of these challenges, the activity plan has undergone several iterations until at a point where the requirements are generally accepted.

- These have been matched to resource requirements consisting of both human resource and physical capacity and a process undertaken to identify key requirements, bottle-necks etc. The timing of additional accommodation being generated through the phased opening of our New Ward block build and the recently opened operating theatres have also been triangulated to ensure a reasonable match of capacity available to required is made.
- The Trust Executive Group authorised early starts (pre-Christmas) to the recruitment process to attract key staff to ensure capacity is in place to deliver early in 2016/17 and has received regular updates as to the progress of those key appointments. This position is not yet finalised and continues to be under review.
- Divisions have risk rated their investment requests and efficiency proposals so the impact of agreed proposals are understood. Investments have been approved by Executive Directors on the basis of risk and decisions clearly communicated. Investments in quality related initiatives have been scrutinised and prioritised in a relative risk basis

5.3 Key Financial Drivers in the plan submission

National Tariff arrangements for 2016/17:

- The Trust has based the plan upon the latest published tariff for 2016/17. For this Trust, which had selected the ETO option for 2015/16, this represents an effective "rollover" from the current year, with a net headline uplift of 1.1% for Non PbR services and c1.8% for PbR services.
- The impact of the removal of the Marginal Specialised Service deduction of 30% has also been taken account of in Trust plans and this increases our income by c£1.6m compared with the 2015/16 plan.

Sustainability and Transformation Fund

- The Trust has included receipt of £2.1m in our financial projects as per the communication to the Trust. The requirements of receiving this, (delivering a £2.35m surplus), have also been factored into our plans. Upon factoring both the receipt of the £2.1m STF into our position and the higher level of efficiency requirement necessary to deliver the surplus, the Trust's FSRR is projected at a level 4 for 2016/17.

Expenditure
The key elements of the Trusts plan are based upon:

Tariff uplift elements:

- Detailed costing work has been undertaken at individual post level to calculate the impact of pay award uplifts at 1%, the impact of incremental scale progression uplifts (including consultants) and the impact of the NI change on pension costs. In addition, costs such as the impact of local and unfunded Clinical Excellence awards etc. have been individually calculated. Reductions have been made since the previous version of the plan submission by making more challenging assumptions with regard to containing the impact of incremental drift. The resulting calculation shows an anticipated cost increase in 2016/17 of c£3.8m – or 3.4% of baseline 2015/16 budgets. This compares to 3.3**%** contained within the tariff.
- Similarly, rather than applying tariff uplift percentages to individual expense items, detailed work has been undertaken with Divisions to assess unavoidable cost pressures. These have been reviewed and risk assessed before inclusion within the plan position. The combined impact of non-pay, (including drugs), cost uplifts including within our planning assumptions is c3.0%.
- The plan also contains revenue provision for an increase of c£0.8m of capital related items (depreciation, PDC dividend and loan interest charges). This is based on the increasing asset base and loan charges to fund the New Ward Block build which is due to come into full operational use by the 4th Quarter of 2016/17. The plan also contains a provision for £7.5m of impairment upon bringing that asset fully into use. Again, the provision within the tariff for capital cost related uplifts is 3.1%, equivalent to around £0.25m on this Trust's baseline capital costs

- *Other key investments included within the plan:*

    - Significant investment in improving quality/addressing clinical or organisational risk . This includes:

        - Costs associated with incremental impact of the New Ward Block
        - Costs associated with likely cost of developing Yorkshire & Humber Genomics Centre
        - Investment in OPAT service reducing inpatient stays
        - Investing in strengthening paediatric medical rota
        - Investment in additional neonatologist capacity
        - Investment to deliver quality required by specialised service standards, including Major Trauma and CAMHS Tier 4
        - Investing in additional ward cover for the hospital at night

    - Investment in capacity to deliver the increase in activity
    - Provision of contingency

5.4 Financial Impact of efficiency plans

The financial plan position is based upon delivery of c£5.25m of combined revenue generation / efficiency savings (c3.1% of operating expenses).

The dedicated PMO for the Cost Improvement Programme have identified a 3-year programme with significant value in relation to schemes. The efficiency plans in the Monitor submission contain validated and robustly risk adjusted schemes only. This validation is reflected in the revised RAG rating as above.

We are continuing to work through the opportunities presented by the PMO with operational services to reflect the higher stretch target we have been asked to achieve in relation to our control total. This includes further review of the Carter recommendations, and benchmarking our programme with other organisations.

Governance of the programme has been strengthened with Executive Led Programme Board meetings and robust performance management at Divisional level.

5.6 Agency rules

The Trust is fully engaged with the Monitor rules on price caps for agency staff and reports compliance or otherwise weekly as requested. Since the 23rd November, managers are asked to adhere to the Monitor caps for agency spend for all staff groups and to use Framework agencies only. The most recent return shows the Trust having 7 agency assignments that breach the cap rates. Three of these are for paediatric theatre nursing where the Trust has recently had difficulties with recruitment into vacancies. The requirement to meet service demands has resulted in payment above the cap rates for these assignments. All assignments above the cap are escalated at divisional level and are expected to be re-negotiated.

The Trust's annual nursing agency cap as a percentage of actual spend is set at 3% for 2015/16. For the year to 29th February 2016, the Trust's nursing agency and bank spend as a percentage of total nursing spend was 2.5%. Excluding bank staff assigned through NHS Professional this is 0.7% on agency staff alone which is well within the 3% ceiling.

The PMO is reviewing the potential full year impact of savings from the introduction of the agency caps based on current usage. The submitted financial plan currently includes a forecast expenditure value of £3.56m in 2016/17 – equivalent to our notified agency expenditure cap for the year, set at 3% of anticipated pay expenditure. This is achievable provided the Trust's spend with NHS Professional is deemed to be bank and not agency as per the guidance issued by the TDA.

Compliance with the cap rates will become increasingly challenging, particularly for medical staffing, and the Trust needs to balance the risk of providing a safe service and compliance with the lower cap rates from 1 April.

5.7 Procurement

The Trust recognises the importance of an effective procurement function in relation to unlocking efficiency. It embraces the work being undertaken as a consequence of the Carter report and will fully engage in the process. At present the Trust, by virtue of its status as a specialist Trust has not received an ATC score but will be required to submit data to support the benchmarking process such as the price paid for its top 100 most common non-pay items.

5.8 Capital Planning

The Trust's internal capital prioritisation processes focus on a rolling 3-5 year capital planning horizon. Recent and current capital programmes have been dominated by the capital requirements of delivering the Trust's major capital schemes – delivering the New Ward Block & Outpatient facilities, two new operating theatres and the new charitably funded 3T MRI suite. The remaining capital allocations are effectively devoted to risk assessed "do minimum" investments to maintain a cash position which is significantly constrained in this and future years. The results of this approach and process are summarised in the table below

Capital expenditure summary					
	2015/16 FOT	2016/17 Plan	2017/18 Plan	2018/19 Plan	**4 Yr Total**
	£m	£m	£m	£m	**£m**
New Ward Block & Outpatients	15.907	12.398	0.000	0.000	**28.305**
New operating Theatres	2.777	0.000	0.000	0.000	**2.777**
EDMS	1.650	0.000	0.000	0.000	**1.650**
Replacement of Aseptic suite	0.000	1.126			**1.126**
Transformation of vacated space		1.100			**1.100**
Essential Medical Equipment replacement	0.681	1.166	0.150	0.750	**2.747**
Routine Estates, Health & Safety, replacemer	0.895	1.610	1.514	1.254	**5.273**
General IMT	0.602	0.603	0.812	0.852	**2.869**
Other	1.218	0.551	0.397	0.417	**2.583**
Contingency		0.500	0.500	0.500	**1.500**
	23.730	**19.054**	**3.373**	**3.773**	**49.930**

It is important to note that the current prioritisation process has resulted in a capital programme significantly over-subscribed and with a high level of risk. The Trust Board are currently reviewing the adequacy of the capital investment programme, and, whilst mindful of the cash position now and in future, assessing whether the risk being carried within the programme is acceptable and sustainable.

With regards to IT investment, the Trust is also working with other organisations in Sheffield and through the Working Together Programme on joint plans for the development of digital connectivity and would expect to seek Transformation Funding to support the use of technology in the delivery of healthcare in the future linked to plans for service transformation.

6. LINK TO THE EMERGING SUSTAINABILITY AND TRANSFORMATION PLANS

The Trust is working with partners in the local health economy both in Sheffield and in the wider sub-region, on transformation plans which, over the next few weeks, will be developed further to form part of the South Yorkshire and Bassetlaw STP. Main areas of work relating to the transformation of services which the Trust is engaged in with partners are detailed below:

a) Transformation of Sheffield services

- *CAMHS Transformation plans* – The Trust is working with Sheffield CCG, Sheffield City Council and the voluntary sector on developing services in line with the national policy described within *'Future in Mind'*, which aims to transform mental health services for children and young people. CAMHS Transformation funding has been allocated nationally to invest in a redesigned service, including services for those with eating disorders. This work has also included the need to reduce waiting times for mental health services to meet new access targets which are introduced from April 2016. This work also includes the continuation of CAMHS providing services for those aged 16-17, and the extension of Children's IAPT.

- *Redesign of Children's Community Services* – the Trust is working with Sheffield CCG and Sheffield City Council on a redesign of children's community services, which will take into account the reduction in Public Health funding (£1.3m over three years). The work will include the redesign of Health Visiting and School Nursing to form a new Public Health Nursing Service which will particularly focus on the most vulnerable families. It is likely to lead to the development of a number of locally based multi-professional teams providing a range of integrated services to support children and families, linked with local authority early years' provision.

b) Working Together Vanguard projects

The Working Together Programme is a group of seven acute trusts who have formed a partnership, supported by a PMO to work in partnership with a focus on improving clinical services across the geographical area. Whilst the partnership has been in place for two years, during 2015, the partners applied for recognition as a Vanguard under the acute care collaboration programme, and Working Together was awarded Vanguard status during the autumn 2015. There is also a Working Together Commissioner Group of CCGs who work to the same footprint as the Working Together provider group and are working with providers to support and achieve change.

Within the Working Together Programme the configuration and delivery of the care of healthcare for children has been identified as a key work-stream of the Programme. The main reason for this is to address the workforce and quality issues facing services across the sub-region. In view of this, there are two specific work-streams which relate to children's services and in which Sheffield Children's NHS FT is taking a lead role. These are as follows:

- *Children's Surgery and Anaesthetics* – this is a project aimed at improving compliance of services with nationally defined standards for surgery and anaesthetics in children. Commissioners have led work to assess current compliance and have drawn up a specification detailing the standards which need to be met in this area. Providers have been asked to specify whether they are able to meet the specification at speciality level.

  In order to support the delivery of safe and effective care, through the Vanguard programme, Sheffield Children's have proposed to set up and host a Managed Clinical Network for Children's Surgery and Anaesthesia and funding has been allocated to support this plan, including funding for clinical leadership, infrastructure and support and it is expected that the MCN will be in place from May 2016.

- *Sheffield Children's and The Rotherham Paediatric partnership* – also as part of the Vanguard plan, it has been agreed that Sheffield and Rotherham trusts will work together to set up a partnership to support the on-going delivery of paediatric services in Rotherham, in order to address workforce and quality issues. Funding has been allocated through the Vanguard to support this work, and an MCN will be established between the two trusts by the end of March 2016. It is proposed that the MCN will be extended to cover other trusts in the Working Together programme in the future.

c) South Yorkshire and Bassetlaw STP

The Trust is fully involved in the development of the South Yorkshire and Bassetlaw STP, the planning for which is underway. The Trust Chief Executive is a member of the Leadership team responsible for the development of the plan, with other Directors are heavily engaged in a number of specific work-streams including the Maternity and Children's plan work-stream. This work proposes more significant systems-wide change to the delivery of services in South Yorkshire and Bassetlaw in the future.

7. MEMBERSHIP AND ELECTIONS

During 2015/16, the Trust recruited almost 200 new members and we currently have almost 11 thousand members. In order to ensure that our membership is current a data cleansing exercise of our membership database was conducted during 2015/16, resulting in a loss of around 350 members. Our overall membership figures therefore remain very similar to those for the previous year, despite a successful year of recruiting new members.

The 2015 Council of Governor Elections officially closed on 23 July 2015 and results were published on the Trust website. Nominations were sought for 13 seats across nine constituencies including Sheffield, Rotherham, Patients in Sheffield and the Rest of the UK, and Non-Clinical and Nursing Staff. In total we received 17 nominations from people who wish to stand for election including four current Governors seeking reappointment. Two constituencies were contested: Sheffield South West and Staff Nursing & Midwifery. The majority of other constituencies had Governors elected unopposed leaving only two vacant seats - one Sheffield Patient and one in Sheffield North East.

Both new and current Governors were invited to attend a bespoke Governwell Core Skills Training Day at the Trust on the 23 October 2015. Governors are regularly encouraged to participate in a varied back to the floor programme joining members of the Board visit areas of the Trust to provide an opportunity for engagement with patients and staff. Governors are also invited to attend city wide events attended by the Trust, allowing governors to engage with local people and hear their views first hand.

We are actively involving Governors in the current work we are undertaking to refresh the Trust's Strategic Direction with Governor involvement in the Strategic Development Working Group. All Governors were encouraged to attend a recent joint Strategy Session held with the Board of Directors on the 18 January 2016 at which a helpful debate was held around key strategic themes. This involvement will continue over the next six months as we work with our Governors to ensure that the views of members, the public and key stakeholder organisations are reflected in the development of our future strategy. The next few months will also see Governors involved in stakeholder consultation work to input into the appointment of our next Chairman.

The Trust's membership strategy is focused on recruiting and nurturing a membership where as many members as possible are actively engaged in the activities of the Trust; developing and retaining our members; and providing accurate and timely information to assist members in making informed choices.

Our membership strategy centres on delivering a membership that is fully representative of the diverse communities the Trust provides services to. In the past twelve months we have particularly noted the effectiveness of social media as a recruitment strategy and will continue to capitalise on social media to increase the coverage of our engagement activities in as cost effective a manner as possible.

As in previous years, all members were invited to our annual members' meeting (AMM) held on the 15 September 2015 at the end of which our seven new Governors began their term of office.