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Sheffield Teaching Hospitals NHS

NHS Foundation Trust

Forward Plan Strategy Document for

Sheffield Teaching Hospitals NHS Foundation Trust

Plan for y/e 31 March 2012 (and 2013, 2014)

This document completed by (and Monitor queries to be directed to):

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Date	**31 May 2011**

Approved on behalf of the Board of Directors by:

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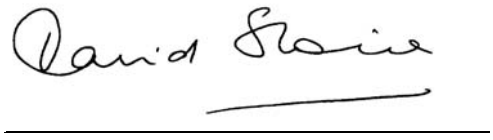

Annual Plan Review 2011

Section 1: Strategy

The Trust's current position and vision are summarised as:

At the conclusion of 2010/11 we have achieved the following outcomes:

- Delivered a real financial surplus to maintain a consistent record of financial stability in spite of a highly challenged main commissioner (NHS Sheffield) that instigated significant restrictions during the year on elective activity/referrals.
- Achieved all national targets for the year as a whole.
- Continued to develop and embed our major staff engagement programme
- Strengthened public and patient involvement and the role of the Governors.
- Managed an extremely difficult winter with major losses of capacity causing us to use sub – contracted activity with a consequent loss of margin.
- Improved on the targets for control of infection, including ending the year with 6 consecutive months without a single case of Trust Attributable MRSA Bacteraemia.
- Received an HSMR (Hospital Standardised Mortality Rate) estimate for 2009/10 – significantly lower than would be expected.
- Successfully completed our internal reconfiguration of clinical services across our two major sites.
- Continued to develop the Estate, including the new Hand Unit, The Surgical Assessment Centre and the expanded Renal Unit.
- Initiated and completed the successful merger with adult community services in the city.
- Worked collaboratively with our main commissioner on schemes to improve patient pathways in a number of specialities.

However, there are indications of clear pressures on the Trust that we will need to address and meet now and in the forthcoming years.

Uppermost amongst these are:

- A continued increase in demand for the Trust's services, particularly emergency medical care, which is a combination of population need and a lack of alternatives to admission. This is placing significant pressure on targets due to the displacement of elective activity.
- The continuation of demanding efficiency targets.
- An increase in the hospital capacity used for the completion of the assessment process for those patients in need of continuing health care which has taken up to 100 beds at any one time (typically 60 beds).
- Significant financial pressures on our main commissioner, resulting in very challenging contractual negotiations.
- A need to develop and embed relationships with GP commissioners at a time of considerable uncertainty in national reforms.

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- Ensuring that the merger with community services delivers the genuine transformation of care for patients and the way we deliver pathways of care particularly for long term conditions.
- Key parallel challenges amongst our main partners – University of Sheffield and Sheffield City Council.
- A clear national expectation and requirement that the quality and productivity challenge must largely be delivered in providers.
- Growing expectations from patients and commissioners for increasing quality and more readily accessible measures of outcomes.
- Continuing to improve rates of Healthcare Acquired Infections in a hospital population which is more acutely unwell and ageing.

In summary we are a successful Foundation Trust which consistently meets high standards, but our capacity has been stretched by an increasing volume of patients and demanding efficiency targets. We recognise that the current economic environment alongside growing expectations, ever more sophisticated interventions and policy uncertainty will demand the highest level of performance from our Governors, our Board, our management and our clinical teams. Continued success forms the heart of our vision whilst recognising our approaches and priorities must adapt.

The Trust's strategy over the next three years is to:

The vision for the Trust for the next 3 years remains as declared in 2009 when the new Corporate Strategy for the period 2009/13 was launched. The Board has recently agreed that during 2011/12 this requires to be refreshed, which will be challenging in view of uncertainties surrounding the economic environment and the emergent national reforms. This refresh will include a far greater degree of specificity regarding the tactics for particular challenges and specialties to ensure that we are best placed to manage and excel in the extremely challenging conditions of the future. The overarching objectives will remain and are as follows:

Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) will be a provider of world class health services and top quality teaching and research.

This vision is nothing less than patients, their families, and staff, should expect of a leading-edge healthcare organisation in the 21st century. It means that by 2013 we aim to be:

- One of the top 100 international hospitals of choice, providing clinically excellent, patient-centred services in a clean, safe, comfortable and accessible environment.
- A premier centre for healthcare teaching and research
- A healthcare employer of choice
- Recognised for consistently achieving the highest standards in the way patient care is delivered by our staff.

The strategy will continue to be built on the 3 pillars of **Achieving Clinical Excellence**, being **Patient Focussed** and having **Engaged Staff**. In support of these aims are the enablers of **Leadership Development**, **Optimal Configuration of Clinical Services** and **Financial Strength and Stability**.

Our strategy refresh during 2011/12 will ensure that our Board, Governors and staff shape "how" we will meet our ambitions whilst delivering high quality services in a framework that ensures financial sustainability and stability.

Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's strategy, with milestones of delivery of each over the period of the plan:

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
1. Secure robust contractual agreements with our commissioners which support the strategic vision by protecting our income base and limiting risk.	High quality clinical services can be delivered only from a secure and adequate income base. Services provided need to be remunerated according to the Payment by Results regime. Capacity has been planned to deal with demand at expected levels. Commissioners are challenged in supporting the cost of the necessary level of activity to meet this demand.	Finalise acceptable contractual terms for 2011/12 as a matter of urgency. Work collaboratively with NHS Sheffield to appropriately reduce demand for emergency and elective hospital services, adopting distinct strategies for each. Ensure that Trust's cost base is appropriately reduced to reflect income losses. Implement an agreed £3m investment programme to increase the provision of intermediate care and other alternatives to hospital care. The programme is funded by NHSS and will be jointly managed by the Trust. Establish the role of the PTC cluster in next year's process and initiate negotiations in early autumn given the ongoing challenges.	Negotiate an entirely new contract based on national contractual terms yet to be published by DoH. Protect the interests of the Trust through a Local Implementation Agreement which clarifies the application of the standard national contractual terms. Building relationships with new commissioner especially GPs.	Work to ensure stable contractual relationships with new commissioners in the future.
2. Fully realise the benefits of the internal service reconfiguration.	Improved flow through the hospital care pathway will support the delivery of performance targets and increase efficiency. For emergency care this means better integration of front	Following service moves, commence the new integrated Neuro/ General Critical Care service at RHH. (1/7/11) Continue to bring	Complete the RHH Critical Care Scheme (1/5/12)	

	door services, specialty triage to ensure patients are directed to the right specialist first time, improved hospital processes to reduce delays, and strengthened external capacity to eliminate delayed transfers of care. For elective care it means improved scheduling, greater certainty of bed availability, flexible use of theatre lists, and reduced length of stay through extended recovery.	more Trust work back on site and decrease use of sub-contractors to meet activity targets. This applies particularly to Orthopaedics. Assess potential for a major elective specialty to relocate from NGH to RHH.		
3. Develop a clinical service plan and new organisational arrangements for the newly transferred community services.	This strategic change has widened the service portfolio beyond acute services and extends the terms of authorisation. This will increase control over preceding and succeeding parts of the patient pathway and will offer solutions to improve quality, effectiveness and efficiency.	Six month transitional period to ensure optimal configuration of acute and community services. Introduce improvement programme to realise maximum benefit from pathway integration. (31/12/2011)	Progressively improve integrated care pathways, especially for long term conditions. Expand the capacity of community services and in parallel reduce acute hospital capacity, especially inpatient wards.	
4. Drive forward the Service Improvement Programme to secure required efficiency savings over the next 3 years in response to national efficiency targets and withdrawal of commissioner growth.	The firm financial foundation underpins the Corporate Strategy and is seen as essential to all other aspects. The target efficiencies have been largely delivered in the past 4 years but fundamental reform is now indicated to deliver the same value in a period of funding constraint. There are 3 main components to the strategy:	Continuing length of stay project aiming for best performance. Joint leadership with the reconfiguration programme to ensure best fit. Further work on re-defining an affordable workforce followed by a re-balancing based on staff turnover. Productive Operating Theatre project to be initiated with support from the Institute for	Major review of Trust-wide Outpatient services.	

	Clinical improvements leading to, amongst other things, significant reduction in hospital stay; Engineering a reduction in the cost of the workforce through genuine efficiencies; Re-designing the corporate functions to reduce the size and cost of administrative functions and eliminate duplication of effort.	Healthcare Improvement. Re-assessment of clinical outputs aligned to Consultant job-plans. Schemes to reduce the expenditure on high cost drugs through efficient procurement and improved working practices.		
5. Continue to develop Specialised Services	This is core to the Trust's position as the tertiary service provider in North Trent which is recognised by the Yorkshire and the Humber and East Midlands SCG's. This is also core to the service strategy of the Trust in developing specialised services built on expertise that has gained a strong reputation for delivery over the last 10 years.	Work with commissioners following their review of vascular services, ensuring we have a sustainable, viable and high quality service in the future. Strengthen our position as a tertiary centre for Trauma services within the SHA strategic review of capacity and provision. Further develop Stereotactic Radiosurgery through commissioning the second Gamma Knife. Consolidate the provision of an acute Oncology service to the Cancer network, planning for possible changes to referral rules. Continue to localise Oncology and Chemotherapy services in line with local capability. Further develop	Continue to grow the Pulmonary Vascular Service and seek SCG designation for Occupational Lung disease as niche services based at RHH. Continue to seek designation of a Sheffield Cochlear Implant service.	

		Radiotherapy capacity. Expand Neurosciences Satellite clinics.		
6. Use the research infrastructure to continue to build clinical research activity in areas of research excellence.	This is fundamental to the second mission of the Trust to be the base for world class research. The award of 2 BRUs in 2008 facilitated the creation of modern clinical research facilities on both major campuses. There is current potential for excellent research in Neurological conditions and Cancer and a growing potential in Infection, Respiratory Disease, Diabetes and Medical Devices.	Create a STHFT/University of Sheffield Strategy Board chaired by Sir Andrew Cash addressing Clinical Matters, Teaching and Research and a Clinical Research Strategy Board chaired jointly by the Pro Vice Chancellor for the Faculty of Medicine Dentistry and Health and the Medical Director. Create a joint STHFT/ University of Sheffield Clinical Research Office to ensure development of clinical research and to meet the needs of researchers more readily. Match the research themes of the Trust and its two partner Universities to increase the translational and clinical research activities. Ensure strong and rapidly responsive research governance to meet the fast changing standards required by MHRA and HTA. Exploit any commercial opportunities for IP arising from research activities. Utilise existing Local research Network and	Create a group of academic directorates to increase high quality clinical research activity and income. Seek sustainable future for ongoing research projects including the Virtual Physiological Human and D4D utilising DoH enabling funds based on commercial potential of the devices and unique consultancy.	Establish the status of academic directorates within a Trust Centre for Biomedical Clinical Research to make a resulting further step-change in R&D output and quality.

		sustainability/flexibility funding to support strategic themes.		
7. Assure the future Leadership of the Trust by continuing to expand and develop the Leadership Development Programme.	Leadership is one of the three foundations of the Corporate Strategy and is a pre-requisite for the achievement of an engaged workforce which is the third strategic pillar. Clinical Leadership is a fundamental structure of the STH governance philosophy enabled by senior and skilled management support. We are providing greater structure to developing future clinical leaders by an internal programme supported by a strong educational partner.	Enrol the first delegates on the MSc programme for clinical leadership and roll out the certificate and diploma opportunities. Continue to encourage staff participation in the Leadership Forum to disseminate the underpinning organisational values and behaviours. Further develop the new Performance Management system to provide a context in which successful leadership can flourish and less successful outcomes can be turned around. Work with Associates/ Affiliates of international standing including Pfizer, the Health Foundation (Improving Flow, Safety and Cost programme) and the Institute for Healthcare Improvement of Harvard University following one successful fellowship.		
8. Pursue a refreshed Informatics Strategy taking account of the position of the National Programme for IT	This is central to the clinical excellence pillar of the strategy in terms of providing an infrastructure in which patient level data can be accessed accurately and without delay by those who need it and an ability to	Further integrate Trust systems by: fully integrating the PatientCentre patient administration system; achieving single departmental foundation systems; improving staff access to information at the point of care	Reduce interfacing complexity and move towards the use of a strategic integration engine. Introduce scheduling module to support 18 week RTT management. Improve the use of	

	share patient data to improve their overall clinical management within the Trust and in the wider NHS.	including from off site locations. Enable the electronic sharing of patient information between organisations and the use of the NHS Number. Improve Clinical Quality and Safety through IT to support improved clinical communication and patient handover. Install wireless network and provide clinical staff with multi-function intelligent devices. Improve staff access to information and knowledge through training and development utilising e-learning technologies and improved desk-top access to real-time information. Take advantage of the national 'Clinical Dashboard' initiative. Improve patient access to information about their care and wellbeing by: extending the use of the 'Patient Reminder' system; improving access to patient information in reception and clinic waiting areas; supporting the SCR and the use of Healthspace. Improve the security of the information we hold and transfer by raising awareness of the Information Governance Assurance	information to support clinical pathways. Introduce electronic prescribing. Take advantage of the national Summary Care Record (SCR). Utilise wireless network to auto-register and track patient progress through main pathways.	Consider Lorenzo against best of breed alternative to EPR.

		Framework and consolidating the role of the Senior Information Risk Owner.		
9. Plan to meet the NHS Sustainability requirements by 2015, 2020 and 2050.	Sustainability is an objective relating to the 'Patient Centred Pillar' of the Corporate Strategy in terms of providing an environment that is within the carbon footprint of the Trust which is set to reduce (all things being equal) by 10% of the 2007 level by 2015.	Training of 'Be Green Representatives' to disseminate ideas for behaviour change and to identify specific improvement measures. Continued work by the Sustainable Strategy Development Group at Board level supported by the Sustainable Development Partnership Group and the Sustainable Development Manager. Board approval of a Sustainable Development Plan, with focus on Trust-wide, all inclusive objectives. Introduce energy saving investments including electricity voltage regulators, improved insulation and decentralised heating/hot water. Instigate a review of tele-medicine alternatives to hospital attendance and re-design the management of chronic conditions based on supported self-care. Link to the strategy to integrate selected Community Services.	Continued energy saving investments including electricity voltage regulators, improved insulation and decentralised heating/hot water. Set improvement metrics at Directorate level and incorporate in the performance management regime.	Implement an estate reduction plan sensitised to the impact of increasing demand and the ageing population.
10. Maintain the excellent standards achieved on undergraduate and	This is central to the tri-partite mission of the Trust which sees education closely	Development of infrastructure to provide a city- wide videoconferencing		

postgraduate education and training for all professions by ensuring the best possible 'student' experience whilst attached to the Trust. The MPET review of funding national reform of Deanery functions will present major challenges to the provision of education and training.	integrated with clinical service and research as the underpinning core of all the services we provide, as well as developing the future workforce.	facility connecting all the principle teaching sites. Developing the new clinical skills facility on the central campus as a high standard hub for the future including clinical staff from all health sectors and developing the Medical Education Centre on the Northern campus to balance the clinical skills training capacity on all sites as well as testing its potential as a Trust 'Conference Centre'. Developing Quality assurance systems to facilitate excellence in education. Carefully planning the redistribution of trainee doctors, undergraduates in medicine, nursing and allied health professions, their trainers and teachers to optimise training opportunity in a reduced hours environment. Learning from the HIEC proposal based on the 3 themes of patient safety, (led by Bradford Hospitals), maternity care (York University) and long term conditions /dignity in care (led by STH).		

Section 2: External environment

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
1. The impact of the economic downturn on healthcare funding is of considerable concern. Despite some growth to PCTs 2011/12, we are anticipating a reduction in income from NHS Sheffield of about £14m including the tariff reduction of 1.5%. There is some growth in activity outside Sheffield but insufficient to compensate.	The risks of this situation to the Trust are serious. Agreement of contractual terms with the PCT Consortium for 2011/12 has been difficult and there is much important detail still to be worked through.	The Trust is being careful to ensure that the financial basis on which the 2011/12 Contract is being agreed is clear and well understood by both parties. We are trying this year to ensure that we have a common view of the activity targets required, and therefore that the underlying assumptions are acceptable. We will continue to maintain a position of working within the PbR Guidance, although there is a considerable threat from the rules on emergency readmissions (see below).	A reduction in planned contract income, but with PbR rules applying to the activity delivered. We are working with NHSS on a collaborative plan for reducing delayed transfers of care and avoidable hospital admissions. To secure the necessary investment by the PCT in alternative services we have agreed a financial risk sharing agreement for activity in Geriatric and Stroke Medicine. Despite the difficult environment, working relationships remain strong and constructive.	The Contracts Team of the Trust is made up of senior managers in Service Development, Finance and Information Services. The team is accountable to the Directors of Service Development and Finance and significant issues are escalated rapidly. The Trust produces monthly Contract Monitoring information which is discussed in detail with the Consortium every month through one formal Review meeting and other more ad hoc meetings.
2. Income levels can be significantly altered as a result of PbR Tariff and other price changes.	There is a period of relative stability in the tariff changes for 2011/12. The Trust is making an overall gain on the new tariffs and in principle we have agreed to neutralise this gain in the contract settlement. However, the new rules on emergency readmissions pose a considerable threat to income for activity which is clinically justified and unavoidable. We	The Trust has put considerable effort into ensuring that the coding, classification and pricing of activity for 2011/12 is accurate and understood.	In view of the financial position of the PCT, the risk of significant in year income challenges remains. The Contracts Team is experienced in dealing with such challenges effectively. The Trust will seek to influence tariffs where appropriate with information from the Patient Level Costing System.	The financial reconciliation with the Consortium is completed every quarter based on the monthly information provided. The Contracts Team is therefore able to report on a quarterly basis on the contract income which is due, any outstanding challenges and the degree of risk associated with these, and the impact of any concessions made.

	have agreed as part of neutrality that income for emergency readmissions will remain with the Trust unless we agree a joint plan for avoiding readmissions. No such plans have yet been put forward by the Consortium.			Financial Plans consider the potential for income changes in some detail.
3. The CQUIN scheme for 2010/11 was complicated and posed considerable challenges. We are seeking a scheme for 2011/12 which is simpler, clearer, with a strong expectation of delivery.	The specialised services component of the scheme has been agreed. Progress has been slower on the local scheme but there is greater realism in the expectations for this year. All performance standards will be the subject of negotiation in the context of overall contract agreements.	Resources have been committed within the financial plan to support the delivery of quality standards and the monitoring requirements. There is already a dedicated management post within Information Services. We maintain our position that the quality of our services is high and we will therefore be prepared to commit to only modest improvements.	We were successful in earning the majority of possible CQUIN income in 2010/11, but with a considerable degree of complexity and challenge. We have a sense that our commissioners are prepared to support us in earning this income in recognition of the quality of our services. Nonetheless there is a risk that we will not earn the full 1.5% and this is recognised in the financial plan.	The Chief Operating Officer / Chief Nurse is accountable for the overall delivery of the CQUIN scheme, and individual lead responsibilities are being assigned for each indicator. The Deputy Chief Nurse is managing the process through a team which is closely aligned to the Contracts Team. Information Services are responsible for producing the monitoring information, as far as possible monthly, and at least quarterly.
4. There is an increasing burden of external regulation and standards which must be achieved. There are conflicting priorities within these standards.	As part of the financial neutrality agreement, we are negotiating reduced local requirements with no financial consequences.	The Performance Management framework of the Trust captures all national standards and other enabling performance indicators.	The Trust has a good track record of achieving all external targets.	Chief Executive and Trust Executive Group oversee results monthly.
5. NHS Sheffield in particular is pursuing a series of QIPP schemes to reduce both emergency and elective demand	This year we are working closely with the PCT to ensure that assumptions about demand are aligned and are more	Recognising the financial constraints for NHSS, we are agreeing to several measures which will reduce activity and	The expected outcome is a more realistic QIPP plan. There are very significant financial risks to the Trust in	The leadership has come from Trust Executive Group. The Contracts Team is working on the detailed targets, and

within the healthcare system. Whilst it is important that the leadership comes from the PCT, the Trust is giving full clinical and managerial support to this process in order to ensure that plans are as realistic as possible.	realistic than previously. We will make a major contribution to the change process with the new responsibility of managing community services.	demand for services. Having been successful in reducing outpatient follow ups in 2010/11, we are agreeing to a further smaller reduction, but without the sanction of the thresholds which applied last year. We are also cooperating in the development of surgical thresholds in Orthopaedics which will reduce demand and therefore our reliance on a sub-contract in the independent sector. A limited number of other demand management schemes have been factored into the activity targets.	managing the large reduction is service volumes implied by even this scaled down plan.	the implementation of the changes will be led by the Medical Director and Chief Operating Officer / Chief Nurse. The Medical Director has also been leading joint Clinical Summits with NHSS.
6. The PCT Consortium gave notice on the existing Contract (the national contract for 2009/10) a year ago, and therefore we have to negotiate a new contract for 2011/12 based on the latest national contract. This contract does not provide for any extension beyond 31 March 2012 and therefore we are entering into a new contract for one year only (with only 10 months to run).	We remain concerned that the terms of the national contracts are biased towards commissioners, and require extensive clarification in a local agreement. The management effort in negotiating the new contract to protect the interests of the Trust will be considerable. The new contract will expire on 31 March 2012 and it is therefore essential that the next version of the national contract is published by DoH by December 2011, much earlier than has been the case to date.	The operation of the existing national contract has been less problematic than originally feared. We have in place a robust Local Agreement on Implementation which contains important clarifications. We have agreed a three month extension of the existing contract to enable the negotiation of the new contract to take place.	We expect to have a new contract and Local Implementation Agreement in place for this year. However, this is now unlikely to be by 1 July due to the slow progress on agreeing the annual contract terms for this year.	Performance against all national and local standards which are contained in the contract is reviewed monthly by Trust Executive Group. Director level responsibilities are assigned for each standard. The Contracts Team manages the business and financial terms of the contract itself.

7. Following the MPET Review The Trust seems likely to lose significant amounts of funding over the next 3 to 4 years.	This will add to the financial challenges.	This risk is recognised in the Financial Plan.	This change will add to the requirement for future efficiency savings.	The Trust will continue, via the Director of Finance, to monitor the position and will make representations about the values and transitional arrangements.
8. The risk of the Trust losing services as a result of open market procurement by the PCTs remains.	There has been less emphasis on the procurement of services by commissioners in the last year, with NHSS being more receptive to the re-design of existing services. Joint work has been undertaken on Hearing Services but this remains under threat. There is a continuing tension around working collaboratively to improve services but finding ourselves exposed to open market competition.	We respond positively to service re-design proposals or invitations to tender. However we are not prepared to offer services at less than the true cost. We have some protection on notice periods and compensation in the contract, and staff may have rights under TUPE.	Gradual fairly small scale service change. The continuing concern that routine services will migrate to the private sector, potentially undermining the provision of complex acute services.	Continuing dialogue with commissioners about their service re-design, procurement, and QIPP plans. Seeking to influence future service changes by offering our expertise wherever possible.
9. A possible reversal in the generally upward trend in referrals as a consequence of action taken by commissioners (NHSS in particular) to restrict demand. Fewer patients being referred to the Trust and a subsequent decrease in activity being required in some specialties.	There is a huge financial challenge in downsizing staff numbers and infrastructure to the extent required by the combined effect of the internal P&E plan and action being taken by NHSS to restrict demand. Judgement is also required to assess how realistic the commissioner's plans are, and this will be kept under continuous review.	Close working with NHSS to understand the full impact of their plans and challenge their assumptions where necessary. Jointly agreed QIPP plan and activity targets. The Trust will seek opportunities to grow elective and specialist work in the wider catchment area of Yorkshire and East Midlands. Clinical cooperation in the agreement of protocols and treatment thresholds.	The expected outcome is that the Trust will be aware of where reductions in activity are likely to be required and have plans in place to mitigate the impacts as far as possible. It is anticipated that the Trust will continue to grow activity in those areas where opportunities arise.	Robust business planning is embedded in the Trust, is overseen at Board/Director level, and supported by the senior contracting team. The Trust produces monthly Contract Monitoring information including referrals which is reviewed in detail every month.
10. Emergency demand on hospital services has continued to grow as a consequence of the ageing population. The PCTs factor	Emergency pressures on the NGH (acute) site continue to interfere with the ability to admit elective cases, which creates further waiting time	The specialty of Acute Medicine has been reconfigured to deal with these pressures. Patients are triaged on admission to the appropriate specialty	The measures which have been put in place are expected to ensure improved care pathways for patients, and a more sustainable way of dealing with both	Responsibility is with the Chief Operating Officer / Chief Nurse and the Medical Director. The Trust measures and takes action in response to the

demographic change into their activity targets but generally aim to balance this through demand management initiatives.	pressures. The lack of beds interferes with the efficient use of available theatre capacity. Elderly patients are increasingly complex to manage during their hospital stay and delays at discharge continue to be a problem.	for their condition. The Trust is working with NHSS to secure a funding envelope for additional intermediate care provision to deal with the delays in discharge. The transfer of some elective surgery away from the acute site is being explored to limit the impact of emergency admissions on planned elective work.	emergency and elective admissions. Removing the delays from the system will enable further efficiencies to drive improvements in the flow of patients through the hospital pathway.	number of emergency admissions, the level of medical outliers, length of stay, percentage of discharges from Medical Assessment Units, and Delayed Transfers of Care.

Section 3: Summary financial commentary (NOT TO BE PUBLISHED)

2010/11 Outturn

The Trust's 2010/11 outturn position can be summarised as follows:

- I&E surplus of £2.45m (0.3% of turnover).

- When impairments are taken into account the adjusted position is around £3m ahead of plan.

- Turnover for the year was £803.5m which is an increase of 2.0% over 2009/10. Patient Services income was in total broadly as planned and grew by just 1.6%.

- Several Directorates ended the year with deficits reflecting the on-going efficiency target requirements and income losses relating to the marginal emergency tariff and a local agreement to cap out-patient follow-up activity. Directorate deficits were offset by central contingencies.

- The NHS Sheffield financial challenges created some uncertainty around income from reduced referrals and contract challenges. However, ultimately the issues were resolved satisfactorily from the Trust's perspective. Around 90% of available CQUIN funding was secured.

- Key expenditure areas of pay and drugs grew by 3.3% and 3.4% respectively over 2009/10 levels, although hosting arrangements and cost/case income recharges would account for a significant part of the growth. The combined depreciation and financing charges reduced by around 12%.

- Capital expenditure in the year was a significant £39.1m but, due to operational and planning constraints, this was an under spend of £15.1m.

- Total assets employed grew marginally to £361.3m. Net current assets were £23.6m due to resources held for future capital investment. Borrowings totalled £54.5m.

- Cash balances were a very sizeable £64.9m due to funding held for future capital expenditure of around £28m; deferred income (largely R&D) of around £14m; pay provisions expected to be utilised in 2011/12 of around £4m; and underlying cash balances of around £19m.

- Subject to audit, the Trust's 2010/11 Financial Risk Rating is 4.

- Overall, therefore, the 2010/11 financial results are satisfactory and maintain financial stability. However, the pressures within a number of Directorates and NHS Sheffield give cause for concern as we move into more austere times.

2011/12 Financial Plan

This is clearly the first year of the new 4 year Spending Review with minimal growth for the NHS, major efficiency requirements and a general squeeze on the acute sector. Potential changes from the Government's NHS Reforms add further to the potential uncertainty and complexity. It is clear that, after several years of growth and expansion as required by the NHS Plan, the financial future for acute providers will now be very challenging for a number of years. The 2011/12 Financial Plan can be summarised as follows:

- A balanced plan for 2011/12 with the intention of achieving a small I&E surplus.

-A major efficiency requirement (for the 6th year in a row) arising from the 4% national efficiency target, underlying pressures and contracting issues.

-A small reduction in activity reflecting the net effect of NHS Sheffield's QIPP Plan and some growth from surrounding areas.

-No other "technical" income losses with mitigation of risks through the contract negotiations.

-A small reduction in MPET income from Health Authority funding changes but with the potential MPET Review consequences not being implemented for 2011/12.

-Satisfactory provision for inflation, VAT and Employers NI pressures, subject to energy prices and other general economic factors, but with minimal investment in hospital revenue developments.

-No change in CQUIN income available (1.5%) but with the expectation of earning a bigger proportion of the available sum than in 2010/11.

-The likely need for resources to enable further workforce reductions.

-The absorption of the majority of the NHS Sheffield community services from 1 April 2011 with total turnover in excess of £50m. The agreed transfer arrangements included the 4% national efficiency requirement which equates to around £2m. Of this at least £0.7m will come from management cost savings which are largely identified. Funding for redundancies and slippage has been secured from NHS Sheffield. A modest level of investment is expected from NHS Sheffield as part of plans to redesign urgent care pathways.

-Total capital expenditure is planned to be around £50m reflecting the under spend from 2010/11 and the commitment of resources created from historic I&E surpluses. No further PDC, loans or PFI deals are expected but the Trust will enter into a 10 Year lease for the 2nd Gamma Knife (capital value £3.1m).

-A £60m working capital facility will be maintained but there is no expectation of it being used.

-Cash balances will be committed on the capital expenditure plans and deferred income and provision balances are expected to reduce. Otherwise the balance sheet is expected to remain stable.

-The 2011/12 Financial Plan shows a Financial Risk Rating of 3.

-The key risks to the 2011/12 Financial Plan are the delivery of efficiency targets and contract/activity issues.

Prospects for Future Years

The prospects for future years inevitably look challenging due to the general economic climate and consequent Government expenditure plans; resulting further significant efficiency targets; uncertainty around tariffs and business rules; commissioner price challenges; minimal or no investment; and potential activity reductions from commissioner QIPP plans, competition, shifts to community settings, etc. Capital funding is likely to be equally constrained and there will probably be growing pressure on working capital. Key assumptions the Trust is making for the 2012/13 and 2013/14 financial years are:

-4% national efficiency targets.

-Tight but adequate inflation funding in the “tariff uplift”.

-Further potential income losses relating to the Marginal Emergency Tariff and new rules around non-payment for Emergency Readmissions within 30 days, albeit mitigated by exemptions for tertiary drift, revisions to current rules and some minor tariff gains on complex activity.

-Otherwise, neutrality around tariff, business rules and pricing/counting changes.

-Continued pressure from commissioners to reduce activity levels with a requirement for offsetting cost reductions and consequences in respect of fixed costs, time lags and restructuring costs.

-No further commissioner investment in service developments.

-Significant reductions in MPET funding.

-The intention to maintain a small planned I&E surplus but placing no advance reliance on such resources in capital expenditure plans.

-No changes to CQUIN funding.

-Major internal efficiency savings requirement and major cost constraints.

-No further PDC, loans or PFI deals.

-No material fixed asset acquisitions or disposals whilst acknowledging the potential for some asset rationalisation and the potential for community service assets to ultimately transfer to the Trust.

Section 4: Trust plans

Financial plans: income

2010/11 Activity

The Trust broadly delivered its 2010/11 internal activity plan but there were modest under performances in elective in-patients and general critical care. Actions for 2011/12 include a reassessment of requirements/contract targets in both areas; a drive to reduce medical outliers which impact on elective capacity; and consideration of the transfer of some elective Orthopaedic services to the Royal Hallamshire Hospital.

2011/12 Income

Key points in respect of the 2011/12 income are as follows:

- "Head of Terms" agreement has now been reached with the Trust's main Commissioner Consortium on the 2011/12 contract which equates to around 97% of patient services contract income. Some details are still to be finalised but it is expected that the annual contract agreement will be signed in June.
- Other contracts inevitably follow the main Consortium process but proposals have been sent out to all other commissioners and good progress is being made on securing agreement.
- Planned patient services income is reduced from 2010/11 levels due to the national tariff/price reduction and the NHS Sheffield QIPP plan.
- The Trust does not anticipate losing income in 2011/12 from the new rules on non-payment for Emergency Readmissions within 30 days. Given the lack of clarity and unfairness of many aspects of these rules, agreement has been reached with commissioners not to remove this funding as part of a neutrality agreement around pricing and counting changes.
- Whilst the Trust achieved around 90% of its available 2010/11 CQUIN funding, it is anticipated that the scheme being agreed for 2011/12 will enable the Trust to achieve 95-100% of available funding.

- The Trust has modelled the “steady state” activity requirement to achieve the 18 weeks RTT target and other requirements. Across all commissioners this shows a very small increase. However, the Trust has then agreed to reflect just under £9m of activity reductions from the NHS Sheffield QIPP Plan in the initial 2011/12 contract. Around £5m of this is at the PCT’s risk and normal PbR rules apply.

- However, the Trust has agreed to a “risk share” arrangement around Care of the Elderly/General Medicine activity given the joint “Transformation Plan” in this area. In return for a £3m investment package to remove delayed discharges and avoid some admissions the Trust has agreed that contract activity should be reduced by £4m. Any income variances from this level will attract a 50:50 risk share. The Trust has recognised that this is a departure from normal PbR rules but regards this as such an important area for change that it believes this to be appropriate. All other areas of non-elective activity remain under normal PbR rules.

- The Trust has secured a commitment from NHS Sheffield to provide some non-recurrent funding in 2011/12 to meet the appropriate unavoidable cost consequences of the capacity reductions necessitated by the QIPP Plan.

- Whilst the MPET Review consequences are not now being implemented for 2011/12, the Trust is anticipating some small reductions in MPET funding given pressures on the Health Authority MPET budget. Precise details are still awaited.

- All other elements of the Trust’s income are felt to be relatively stable for 2011/12.

Key income risk	Amounts and timing 2011/12 2012/13 2013/14	Mitigating actions and delivery risk
1. Patient services activity reductions due to commissioner QIPP Plans, Choice, shifts to the community and under performance.	2011/12 relatively minor in addition to that reflected in the contract. Unable to quantify for 2012/13 and 2013/14 but estimating 1% income loss each year.	- Continue to provide high quality services. - Work closely with GPs and other commissioners. - Address medical outlier issues. - Reconfigure services to protect elective capacity. - Maintain good 18 Week RTT target performance.
2. Tariff/Business Rule Changes.	Relatively small in 2011/12 given the contract agreement. Unable to quantify for 2012/13 and 2013/14 but a major concern.	- Maintain awareness of changes. - Manage consequences via contract negotiations and operational changes.
3. CQUIN Income.	Total income value around £9m per annum. Risk for 2011/12 is less than £1m but position for future years is less clear.	- Protect position through contract negotiations. - Strong focus on delivering quality improvements.
4. Losses through contract penalties.	Significant possible penalties apply for a wide range of performance indicators.	- Agree appropriate handling strategies in contract negotiations. - Strong focus on delivering targets.
5. MPET Income Losses (particularly from the MPET Review).	Potential losses of £0.5m in 2011/12 and £3.5m in 2012/13 and 2013/14.	- Attempt to influence national policy. - Good costing of MPET services.

Financial plans: Service developments

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
Organic / innovation:				
1. Improve the integration of 'front door' emergency services: the Emergency Department, GP Assessment Unit, admissions process and intermediate care support services.	Improve quality of care especially for elderly patients. Respond to new quality indicators for Emergency Care together with loss of Walk In Centre to another provider, WIC activity contributed to A&E waiting times.	Re-balance resources through the Emergency Care plan. Develop community intermediate care and improve integration. Work with NHSS to maximise the effectiveness of GP involvement and participate in an early evaluation of the GPAU. Ensure through the local authority that the social care contribution is also maximised.	Included in 2011/12 financial plan.	Reduced level of long-stay admissions to medical sub-specialities. Increased level of short stay discharges from MAU. Reduced medical outliers. Patients admitted to the right ward.
2. Improve the efficiency of surgical capacity. Particular emphasis on Orthopaedics where currently very significant use is made of off-site capacity to match demand.	Major contribution to financial efficiencies, required for delivering 18 weeks and cancer targets.	Single point of access for surgical admissions at NGH through the new Surgical Assessment Centre. Reduce medical outliers in surgical beds. Re-balance the theatre schedules, improve surgical cover through team working, and increase list utilisation.	Further reconfigure surgical capacity, with separation of a major part of surgical activity onto the RHH (elective) site.	Achieving targets for elective surgery as cost effectively as possible. Improved 18 week position in Orthopaedics. Meeting Cancer targets in all specialities.
3. Implement alternative pathways for chronic diseases through improved provision of	Transformation of current services by reducing the need for care and treatment in the hospital	Develop the potential for chronic diseases including diabetes and COPD through integrated	In financial plan 2011/12.	Affordability of the alternatives compared to existing services factored into NHSS

community services and joined up pathways. Consider the place for tele-health solutions beginning with remote diagnosis and treatment initiation for Stroke.	environment in selected conditions. Innovation through tele-health to maintain patient contact with specialist care with an emphasis on self-care with support.	community and hospital services. Establish a Tele-Health Project team following the securing of the tele-health solution for Stroke services from the SHA.		QIPP plan.
4. Continue to strengthen the new single site Stroke service able to meet the national stroke strategy standards and best practice guidelines.	Response to the national report 'Mending Hearts and Brains' by providing a single unified service close to Neurology. Patient experience and downstream economic benefits and uniformly high standards for all Sheffield residents 24/7. Improvement in morbidity and mortality.	Delivery of the care pathway kept under regular review with issues addressed in a timely manner by the Stroke Project Implementation Group Further improvements to the TIA pathway and the management of high risk patients Adoption of telemedicine to enhance the existing provision of thrombolysis to STH patients.	Medical, nursing, therapy workforce needs are met Additional resource implemented to ensure 24/7 high risk TIA service in place.	Continued compliance with best practice guidance. Accreditation against Stroke Assurance Framework by NHS Yorkshire & Humber, 31/03/12 Pathways adhered to by all partners Costs at least covered by best practice tariff income.
5. Continue implementation the IT Strategy taking account of the position of the National Programme for IT and Trust business needs.	Underpins efficient business practice, integrated systems and services. Contributes to improving clinical quality and safety.	Fully implement PatientCentre. Improve staff access to information and knowledge, including installing a wireless network. Improve patient access to information. Support the SCR and use of Healthspace. Risk around resources and critical staff shortages.	Progressing work at desired speed will need both financial and staff resource	Full implementation of PatientCentre by November 2011. Full benefits of e-discharge and ICE realised. Progress wireless business case. Implement SCR.
6. Continue to implement plans for responding to several 'Improving Outcome Guidance' reports issued by NICE/National	Achieve specified standards for cancer treatments for all residents of the cancer network improving their experience and	Refine with Commissioners the implementation plans for IOGs covering: •Brain/CNS •Young People	Detailed resource plan for each implementation mostly agreed by commissioners. Outreach facilities in	Resources identified in each plan signed off by commissioners. Workforce recruited

Cancer Action Team building on our position as Cancer Centre for the North Trent Cancer Network.	safety. Meets the objective of expanding specialised services and localising access wherever possible.	• Hepato-Biliary/Pancreatic • Palliative and Supportive Care • Chemotherapy • Radiotherapy • Agree implementation timescales Agree any additional payments.	network hospitals. Additional Oncologists to provide outreach/ acute service. Pathways for palliative and end of life care agreed with community providers. Specialised equipment procured to meet designation standards.	to plan. Outreach services delivered safely and to standard. Acute Oncology service established to plan. Equipment available as new Consultants start. New pathways delivered across hospital/ community interface.
7.Implementation of the decontamination 'supercentre' in partnership with 'Synergy'.	Contributes to improving clinical quality and safety. Efficient business practice, integrated systems and services. Allows more flexibility in operating capacity between sites.	Commence transfer of services to new facility starting June 2011 and to be completed in Oct 2011. Transfer of staff under TUPE conditions.	Financial consequences already in Plan for 11/12. 15 year contract agreed.	Successful transfer of service. Ongoing compliance with all national standards regarding decontamination. Efficiency of decontamination process and use of resources.
8. Progress planning with regional partners and internally regarding attainment of major trauma centre status for April 2012.	Area of activity growth and providing access to high quality, specialist services for patients with major trauma.	Establishing and participating in sub-regional working groups. Gap analysis against designation standards. Contribution to detailed regional implementation plans. Development of detailed business case containing impact assessment, resource requirements and operational readiness. Decision making on becoming a major trauma centre – within STH and regionally. Major trauma system in region established.	Key resource requirements are currently being identified but will include capital developments as well as service organisation, provision and revenue investment.	Robust STH decision making based on gap analysis and business case. Delivery of major trauma system in region. Improved patient outcomes from major trauma.

Acquisition, etc.:				
9. Achieve full integration of community services following the transfer of these services to the Trust on 1 April 2011 under Transforming Community Services.	Fundamental to the strategic aim of widening the vision to include health-care not restricted to hospital care. Key objective to fully integrate pathways to create service efficiencies. Improvement of patient experience through removal of interfaces and reduction of access points.	A Transition Support Team has been established for a period of six months to enable organisational structures and staffing plans to be finalised.	A separate financial plan has been signed off for the transfer of community services, which includes requirements for management savings and QIPP.	Integration of community services with Trust services. Integration of leadership and administrative functions providing greater efficiency. Improved city-wide pathways and interfaces between hospital and community services.
10. Work in partnership with Yorkshire and Humber SCG and Doncaster & Bassetlaw Hospitals to deliver an acceptable service model which responds to the SCG review of Vascular Services in meeting designation standards by June 2012.	Meets the objective of expanding specialised services and making them accessible to greater numbers leading to improved experience and safety. Meets the commissioner vision to concentrate expertise in fewer centres consistent with local access for routine treatments.	Co-operate with the SCG's local planning process including an assessment of compliance against designation standards (core and non core) Reinforce the arguments for continued "Specialist Centre" designation. Plan human and physical capacity for any additional network specialised activity.	All in place and case well established Physical capacity review across all network services to localise more and deliver more specialist interventions in the Centre.	Designation as a vascular centre with a wider catchment. Agreed plan to absorb additional activity across the network services and Centre. Capacity at the Centre is available to plan.
Transferred / discontinued activity:				
11. Joint plan with NHSS to create alternatives to hospital care for complex elderly patients who are currently delayed in hospital.	Ability to use Trust capacity to meet demand for acute care is being frustrated by inadequate community infrastructure for which plans are delayed. Alternative capacity could be used for health gain which contributes to the sustainability agenda.	Finalise plans with NHSS and begin immediate implementation. Review impact and use available resources flexibly to respond to demand. Once delays in hospital beds have been removed, use some specialised staff resource to improve flow through the patient pathway.	Plan for investment by NHSS being agreed. Opportunities to redeploy hospital staff in community services.	Removal of delayed transfers of care, reduction in medical outliers and close medical wards. Flow through acute beds and these new beds into continuing care is improved and patients have reduced dependency.

Financial plans: activity and costs

Table A (Items included in the CIPs worksheet in the financial template:

Key operating efficiency programmes	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
The Trust has had to deliver around £150m of efficiency savings over the last 5 years. The 2011/12 Financial Plan requires a further £23.5m of hospital efficiency savings, largely due to the national efficiency target, but the Trust has set itself the stretch target of delivering £36m of hospital savings to cover Directorate deficits brought-forward and/or contracting losses. A further £1.9m of efficiency savings are required for the newly acquired community services. Similar amounts are likely to be required in the following 2 years. The Trust will again focus its work on efficiency through its Service Improvement Programme.	2011/12 Stretch Target £38m (including community services). 2012/13 Target £30-35m. 2013/14 Target £30-35m.	To maintain financial strength and stability. Via the focus on Service Improvement, to improve the quality and safety of services and other functions.	The Trust approaches the task from 2 angles as follows:- 1. Service Improvement Programmes for Clinical Improvements (key areas are length of stay, theatre productivity, outpatient productivity, drugs, critical care staffing, hospital at night and clinical support services), Workforce (staff reduction schemes, administration systems, sickness and absence management, terms and conditions, etc.) and Corporate (procurement, energy, hotel services, IT benefits, back office functions, insurance, single switchboard, etc). 2. Directorate efficiency targets (deducted from budgets) driving savings from operational budgets drawing on the Service Improvement workstreams. Directorate financial and efficiency plans and in-year performance are closely performance managed.	Board focus. Operational management at all levels. Clinical engagement. External consultancy support. Project management. Leadership and development	Delivery of targets as identified. Performance will be monitored on a monthly basis.

Table B (Other savings/efficiencies – not included in the CIPs worksheet in the financial template):

Other savings/ efficiencies	Amounts and timing	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
The Trust intends to shut a number of medical wards on the basis of a plan agreed with NHS Sheffield which, with investment in alternative provision, will improve discharge and reduce admissions. Part of the savings will accrue to the Trust due to improved length of stay (included in A above) and part will accrue to the PCT from reduced excess bed day payments and reduced admissions. A risk share has been agreed.	The contract agreement assumes an income reduction of £4m in relation to Care of the Elderly and General Medicine.	Improved services for older people. Savings to NHS Sheffield. Savings to the Trust.	Alternative services put in place. Ward closures. Monitoring of actions and consequences.	Alternative services in community. Management/clinician focus. Monitoring information.	The milestones for 2011/12 relate to commissioning new community facilities, transferring “delayed discharge” patients to the community facilities; redesigning the “front door” support; and closing wards on a phased basis. The Sheffield Transformation Project will determine milestones for future years.

Financial plans: Workforce

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
1. Staff Engagement	Effective involvement of staff in decision-making and planning of services is critical to improving efficiency and effectiveness. Existing mechanisms used to engage staff and elicit their views are critical in the achievements of Trust objectives. The Trust undertook four large open space staff engagement events during September and October 2009. The purpose of these events was to ask our staff what it means to work in our Trust. Since then the Trust has acted on the comprehensive feedback we received and has a steering group to keep this agenda moving forward. During 2011 the Trust continued with the roll out of the 'Let's talk' staff engagement events at care group and directorate level and is addressing the issues identified. Staff engagement leads identified and Steering group established. A Trust staff engagement strategy has been developed to reflect best practice identified in the MaCleod report.	Specific intentions for 2011/12 are to: Measure employee attitudes to identify areas in need of improvement and implement identified improvements through directorate and Trust wide 'Let's talk' focus groups involving a cross-section of staff. Work with directorate staff engagement leads to implement our staff engagement strategy and embed the following principles throughout the organisation:- - Involve staff in decision making and planning processes. - Allow staff the opportunity to voice ideas to which managers listen. - Keep employees informed about what is going on in the organisation/directorate/ department. - Fair and just management processes for dealing with problems i.e. effective grievance and whistle blowing policies. - Provide staff with opportunities to perform well and develop their job. - Involve staff in identifying core values and behaviours. - Establish joint leadership and staff engagement executive group. Continue to Promote NHS organisational values to ensure they are real, simple and can be shared with and owned by all staff. Improve and develop models of partnership working and staff involvement to closely	Identify leads to champion the delivery of key actions. Establish governance arrangements i.e. the introduction of a staff engagement steering group chaired by the Chief Executive. Promote NHS Organisational values at trust induction Engaging leadership style to be addressed through new leadership development programmes	Improved performance of staff engagement and staff satisfaction scores as identified in the Care Quality Commission National NHS Staff Survey. Improved workforce efficiency measured through Human Resource Key Performance Indicators. .

	Approved by Trust board Recognition that it needs to be closely aligned with leadership development strategy. Staff engagement strategy is underpinned by 3 work streams: Health and wellbeing, The staff journey, Staff involvement.	align the contribution of staff with the strategic direction of the Trust. Develop a Partnership Agreement with the Staff Side to promote close and co-operative working. Develop managers and leaders to ensure effective workplace participation of staff. Develop communication standards and audit directorates/departments against the standards. Promote staff health and wellbeing as identified in the Boorman report. Develop staff experience through the concept of a staff journey providing the appropriate support, development and involvement along the journey.		
2. Leadership	One of the three enabling strategies or foundations which underpin our vision is leadership development. The case for leadership development is compelling: We have a demanding agenda to deliver in the next three years. A high proportion of our most senior existing leaders could retire within the next five years. We must have the capability and capacity to deliver our vision. The Trust has many talented people. Within the organisation there is a wealth of individuals and teams who have experience and ability to manage	The Trust's leadership strategy underpins the corporate strategy and emphasises the following key actions: A focus on leadership capacity building to ensure we have a faculty of staff who can support development centre activities. An executive group which meets to ensure a consistent approach to leadership and organisational priorities. A bi-annual leadership forum to focus the most senior 200 staff in the organisation on leadership and performance. A talent management strategy that identifies and develops the top 100 performers in the Trust. The commissioning of a clinical leaders programme to encourage and develop clinicians to fulfil leadership	Continuation of stake-holding agreement with Sheffield Hallam University. As identified in the Trust management arrangements the Chief Executive will take the lead for Leadership with delegated responsibility to the Corporate Development Director supported by the Director of Human Resources and Organisational Development.	Maintain the delivery of national targets and standards. Delivery of financial balance. Attainment of Trust objectives. Improved workforce efficiency measured through Human Resource Key Performance Indicators. Improved performance of staff satisfaction and engagement scores as identified in the Care Quality Commission

	and lead change and contribute to the Trust's wider agenda. The Trust has also consistently invested in leadership development and has productive partnerships with both Sheffield Hallam University and the Institute for Innovation and Improvement. However, to meet the challenges set out above the organisation has developed a leadership strategy that will take us from 'good to great'. Increasing our leadership capability is also dependent on the recognition that change can sometimes be more difficult in a successful organisation than a failing one. Talent management depends on new senior employees recognising leadership behaviours in practice they would wish to model and reflect the organisational values. The development of excellent leadership behaviours is recognised as a key driver in becoming a customer focussed organisation which puts the patient experience at the heart of everything we do.	and management roles. The commissioning and implementation of a STH senior leadership programme in partnership with Sheffield Hallam university to prepare our senior leaders for the challenges ahead. Involve existing leaders in identifying leadership behaviours and competencies required to deliver excellence. Development of an effective and comprehensive performance management framework which includes good management practices such as appraisal, personal development planning, mentorship and coaching and performance reviews and succession planning. The framework will also identify the leadership qualities the organisation expects at each level and the opportunities to support development to fulfil the Trust's expectations of its leaders. Creating a dedicated leadership and development centre hosted by the Learning and Development Department. The creation of a "learning link" with a top 100 FTSE company regarded as being at the forefront of leadership development to assist Trust leaders to develop their business acumen. The Trust now has a very productive partnership with John Lewis.		National NHS Staff Survey.
3. EWTD	Maintain a compliant and safe workforce, whilst improving the clinical service and patient experience.	Actions to be taken during 2011/2012 include: Medical and Surgical reconfiguration August to December 2010 and the implementation of Hospital at Night (H@N) at Royal Hallamshire Hospital, necessitated complete review	Timely action in an effort to ensure the right level of medical and dental workforce is maintained in hard pressed clinical areas.	Continued EWTD compliance. Ensured safe patient care.

		and redesign of working patterns. Close management of the working patterns required to ensure continued compliance. Active recruitment of Medical Staff in hard pressed Clinical Specialities continues. Continue to maintain an internal locum bank to protect rotas against non compliance and reduce the use of external agencies. Following the success of the implementation of H@N at Royal Hallamshire Hospital, it will be introduced at Northern General Hospital. A H@N Lead Clinician to be identified for each area to ensure working practices for each clinical area are understood and considered ahead of H@N becoming operational. Further redesign of all working patterns at NGH will be required to comply with New deal and EWTD regulations.	Maintenance of Trust medical/dental locum bank. Intensive management of working patterns within Clinical Directorates. Implementation of change as necessary to ensure compliance is maintained in conjunction with service reconfiguration. During the implementation of H@N necessity to closely manage the change to ensure compliance is maintained.	Improved Junior doctor training/ education.
4. Workforce Profiling Programme/ Introduction of Workforce Planning Tool	The Workforce Profiling Programme and introduction of Trust wide workforce plans incorporated into the business planning process will support the Trust in continuing to coordinate workforce planning across the organisation building on work completed last year. The Trust intends to continue work to ensure that the paybill is as efficient as possible within high safety standards and without impact upon quality to contribute to the Trust's plans for financial stability.	Regular production of key high level and detailed workforce analysis information/workforce key performance indicators shared with Trust Managers and compared with activity and business planning information. 13 workforce schemes have been set up to support Care Group and Directorate Managers in facilitation of reductions in head count. These include a mutually agreed resignation scheme, a review of potential retirements in line with the transitional statutory retirement process, review of fixed term contracts and agency staff. Four of these schemes involve the purchase and introduction of	Project Management Resource. Workforce planning skills development. Service redesign skills development. Organisational Change skills development facilitated through HR support. Monitoring and performance management of Workforce Plans carried out through governance arrangements and HR Business partner model.	Monitoring of pay bill costs against target. Control and monitoring of actual AFE/FTE establishments against workforce plans and recruitment projections. Ongoing through 2012/13. Accurate workforce information. Regular monitoring of workforce plans against 13

	Efficiencies which are to be made within services and result in staff changes are to be designed around patient pathways, with workforce planning and skill mix assessments based upon activity and service planning information. Within these plans key risk areas are protected from efficiency saving targets. These processes have been established to ensure that service remains patient centred and supports "excellence as standard" strategic objectives. The programme will support the Trust objective to ensure that staff are engaged and involved within the business planning process. This will be ensured through continued consultation processes and involvement of staff within process and service redesign exercises.	improved IT kit/resources to support the Trust in improving administrative pathways and reduce administration time/head count. These schemes include self-service check-in technology, call-centre technology, and maximisation of benefits from e-discharge processes. These schemes will support identification of non-essential posts with staff reduction through natural wastage and the redeployment processes. Maintenance of a flexible workforce comprising of staff on the Trust re-deployment register, thus reducing the need for agency workers. Maintenance, monitoring and update of workforce controls around recruitment, bank and agency usage. Management, monitoring and risk assessment of identified opportunities through Programme governance systems. Process mapping and service redesign activities to be supported at directorate level. Staff side and Medical Staff representation within Programme Governance arrangements and consultation with staff regarding planned workforce changes. Frontline medical and non medical staff involvement in process, service, pathway and systems redesign. Continued systems development of Electronic Staff Records to support the production of robust workforce plans, Workforce Key Performance Indicators and central recording of staff training.	Enhanced workforce governance arrangements.	workforce schemes with regular feedback through programme governance structure to the Trust Executive Group and Senior Management meetings.

5. Recruitment Strategy and management of redeployment	The exercise of critical judgement in determining the nature and level of recruitment through the year in order to ensure that patient services are not compromised whilst allowing for anticipated restructures within teams. Staff displaced as a result of organisational change will be assigned to new teams through a redeployment process.	Maintain effective recruitment controls which critically examine the need for new or replacement posts and to prioritise appointments. Redesign the recruitment control process in conjunction with in order to facilitate local control. Establish a framework for redeployment which allows for assessment of individuals ability and retraining potential against opportunities within the Trust.	Commitment from key senior managers to continue the vacancy control process. Input from HR and Finance to develop the new framework. Development of information systems.	Targets on pay and workforce size determined and achieved. Redeployment candidates reassigned within suitable timeframe. The need to reduce staff numbers through redundancy minimised.
6. Maintain an effective Employee Relations Environment. Provide a service that adds value to directorate managers.	Continue with ongoing process of HR policy review. Maintain and develop a positive partnership working relationship. Provide an effective HR business partner approach to support the delivery of Trust business plans resulting in a proactive HR Service. Support integration of Community Services Care Group post TCS.	Continue the review of HR policies to ensure they are fit for purpose and compliant with equality legislation requirements. Provide training to managers on new policies for effective implementation and consistent application. Monitor and review policy application for consistency, equality and fitness for purpose. Monitor and review employee relations practice to ensure efficiency and effectiveness. Monitor and review case type by themes to identify trends and patterns for proactive management intervention Maintain and develop business partner relationships with managers. Review of staff terms and conditions of service. Embed a culture of partnership working with trade unions to ensure the delivery of workforce objectives. Introduce a formal partnership agreement to confirm the purpose and extent of partnership arrangements.	Delivery of training programmes along with coaching for managers to support the workforce agenda. Delivery of timely operational Employee Relations service. Maintenance of information systems to support monitoring process.	Improved workforce efficiency measured through Human Resource Key Performance Indicators i.e. sickness management, disciplinary and grievance activity. Improved industrial relations. Improved business partner relationships.

Financial plans: Capital programmes (including estates strategy)

Key capital expenditure priorities	Amounts and timing (including financing schedules)	Contribution to the strategy (incl. service delivery)	Key actions and delivery risk (inc. finance risks)
Development:			
1. Laboratory Reconfiguration- A scheme to replace outdated accommodation; to improve configuration of laboratories in relation to clinical services; and to provide new purpose built facilities to enable efficient processing of routine high volume tests.	Cost £16.3m funded mainly from £16m FTFF loan. Commenced on-site 2010/11 and due to complete 2012/13.	Improved efficiency. Ability to maintain/develop laboratory services. Improved estate.	On-site. Deliver to time/budget.
2. Royal Hallamshire Hospital (RHH) Critical Care Unit- A scheme to create a new facility for Neuro and General Critical Care with up to 29 beds.	Cost £6.8m funded from internally generated resources. Due to commence on-site July 2011 and due to complete May 2012.	Improved quality of critical care facilities. Addresses estate issues. Marginal increase in capacity. Single more flexible unit.	Deliver to time/budget.
3. Catering Infrastructure- A scheme to reconfigure patient catering services; to upgrade plant: and to improve patient food.	Cost £7.3m funded from internally generated resources. Undertaken in phases commencing in 2010/11. To be completed 2013/14.	Improved efficiency. Improved patient food. Removal of backlog maintenance pressure.	On-going issues around planning, service continuity, staff changes and scheme delivery.
4. 2nd Gamma Knife- A scheme to develop facilities and install a new Gamma Knife within the RHH.	Cost £3.3m for building work funded from internally generated resources. Gamma Knife value £3.1m on a 10 year lease (in place). Commenced 2010/11 and due to complete September 2011.	Expansion of service. More resilience. Improved quality of service for patients using RHH Gamma Knife.	Challenges around completion of work and installation. Risk re private hospital competition.
5. A&E Expansion- A scheme to expand the Northern General Hospital (NGH) A&E Department and to enable redesign of the “front door”.	Scheme still under development. £2m identified in 5 Year Plan but may cost more. To be funded from internally generated resources. Timescales to be established but may commence in 2011/12.	Expansion of Department to cope with growing demand. Enable improved triage including Primary Care. Improved facilities. Possible need to cope with Trauma Centre developments.	Immediate actions are to agree the specification and enabling works to create capacity.

6. Medical Outpatients – Two related schemes at NGH to create new centralised respiratory and diabetes/endocrinology outpatient facilities.	Schemes still under development. Expected cost around £4.8m in total funded from internally generated resources. May commence 2011/12 and due to complete by 2013/14.	Improved facilities. Improved efficiency. Estate improvements.	Immediate actions to confirm specifications and complete design work.
Maintenance:			
1. Estates Infrastructure- An annual programme to undertake key maintenance of estate infrastructure, e.g. heating, electrics, lifts, roofs, fabric, etc.	An annual budget of £3.5m per annum funded from internally generated resources.	To ensure safe and reliable services. To address backlog maintenance issues.	On-going challenges of prioritisation and reconciling works with operational pressures.
2. Ward Refurbishment Programme.	2011/12 resources diverted to RHH Critical Care scheme but thereafter annual budget of £3m funded from internally generated resources.	Quality of patient environment. Address backlog maintenance and statutory compliance issues.	Ongoing challenges of prioritisation and operational management.
Other capital expenditure:			
1. Wi-Fi Project – A scheme to introduce a wireless IT network across the Trust's facilities.	Cost around £3m funded from internally generated resources. To commence 2011/12 and to complete in 2012/13.	Improved efficiency. Improved quality and safety.	Immediate actions are to complete the tender process and commence implementation.
2. Medical Equipment Replacement- Budgets to enable mainly the replacement of medical equipment (both major and minor).	Resources of £10.6m identified for 2011/12 with a £6.5m annual budget thereafter. Funded from internally generated resources.	Safe and effective services. Some capacity expansions.	Major challenges relate to agreeing specifications and prioritisation and procurement processes.
Other estates strategy			
None			

Clinical plans

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	Performance in 2010/11	3 year targets / measures for 2011/12 2012/13 2013/14
1. To keep our patients safe from infections such as C.difficile. To keep our patients safe from infections such as MRSA, MSSA & E.Coli Bacteraemia.	Helps achieve clinical excellence Patient Focussed	Infection Control Programme Risks – non-compliance with Infection Control Programme	184 Trust attributable cases of C.difficile. 9 Trust attributable case of MRSA Bacteraemia Data Collection on MSSA Bacteraemia started in January 2011 and will start for E.Coli Bacteraemia from June 2011.	C.Diff • 2011/12 - as per DH trajectory (134 Trust attributable cases or less) • 2012/13 and 2013/14- as per DH trajectory MRSA •2010/11,11/12,12/13 - No more than 10 Trust attributable cases MSSA & E. Coli- trajectories to be set from 2012/13
2. To help keep patients informed about how long they will wait in outpatient departments.	Patient Focussed	Development of customer service standards Outpatient reception staff training. Failure to engage with the standards or training.	66.5% of patients were not told how long they would wait to see the doctor / nurse (2009/10 Outpatient Survey. Repeat Survey in 2011). Customer service standards developed and launched.	•2011/12 – improve on 2010-11 baseline by 20% •2012/13 – improve 2010/11 baseline by 40% •2013/14 - improve 2010/11 baseline by 45%
3. Safety – Achieve NHSLA Level 3.	Achievement of: Clinical Excellence Patient Focus Engaged Staff	Implementation of project plan and monitoring of policy compliance organisation wide. Evidence quality assurance and validation exercise. Non-delivery of project and requirement to ensure high levels of policy compliance. Changes to Standards.	Maintained Level 1 compliance and develop systems and processes across the organisation to enable compliance with the 50 criteria.	•2011/12 Retain Level 1 and prepare for L2 compliance and assessment. •2012/13 Achieve Level 2 •2013/14 Achieve Level 3

4. Safety - Safer Surgery – reduce avoidable incidents in the perioperative pathway.	Achievement of: Clinical Excellence Patient Focus Engaged Staff	Audit and test the 'culture' of the check. Risk of non-delivery – failure to effectively implement WHO safer surgery checklist.	Introduced and implemented team brief and checklist into theatres. Monthly monitoring takes place with compliance figures circulated to all key stakeholders.	●2011/12 Audit and test the 'culture' of the check. ●2012/13 Ensure checklist is fully adopted in all theatres. ●2013/14 Incorporate compliance monitoring into Quality Improvement reporting and maintain compliance.
5. Safety - Reduction in Inpatient Falls.	Achievement of: Clinical Excellence Patient Focus	Introduce measures and roll out interventions. Link work to National Service Improvement initiative. Risk of non-delivery – failure to effectively implement care bundles and limited impact of Interventions.	Established work streams and interventions. Developed and implemented care bundles.	●2011/12 Introduce measures and roll out interventions (reduce falls by 20% on work stream wards) ●2012/13 Roll out interventions across the organisation (reduce falls by 20% across STH) ●2013/14 Improvement in overall compliance (reduced by a further 10%) and incorporate compliance monitoring into Quality Improvement reporting.
6. Safety - Reduction in Ventilator Acquired Pneumonia (VAP) rates.	Achievement of : Clinical Excellence Patient Focus	Introduce measures and roll out interventions. Risk of non-delivery – failure to effectively implement care bundles and limited impact of interventions.	Established work stream and interventions. Developed & implemented care bundles.	●2011/12 Introduce measures and roll out interventions, reduce VAP rates by 30% ●2012/13 Roll out interventions across the organisation, reduce VAP rates by a further 30% ●2013/14 Assess potential for further reductions and establish routine compliance monitoring processes.
7. Safety - Improved care for deteriorating patients.	Achievement of: Clinical Excellence Patient Focus	Introduce measures and roll out interventions. Develop actions plans to resolve	Work stream and interventions established. Developed and implemented care	●2011/12 Introduce measures and roll out interventions. Achieve 80% compliance with pathway on work

		newly identified barriers. Risk of non-delivery – failure to effectively implement care bundles. Roll out of H@N To NGH site.	pathways. 1st Wave pilot wards: All SHEWs trigger cases @ 2hrs receive appropriate intervention.	stream wards and/or develop actions plans to resolve newly identified barriers. Introduce Hospital @ Night at Northern site. •2012/13 Roll out interventions across the organisation and highlight further developments for improvement. •2013/14 Assess potential for further reductions and establish routine compliance monitoring processes.
8. Stroke – Continued improvement in Stroke care services. (Quality Report objective)	Takes into account the views of patients, staff, clinical advice and best practice. Addresses Department of Health "Vital Sign" standard, implementation of National Stroke Strategy & related Stroke Accelerated Programme of Improvement.	Centralisation of stroke services on one site, with one point of entry. Development of specialist ambulance protocol for direct admission to stroke unit. Development of consistent treatment procedures with neighbouring DGH's. Key risk is closure of beds on stroke unit due to unforeseen circumstances e.g. norovirus.	95% of patients diagnosed with a stroke spent at least 90% of their inpatient stay on a stroke unit.	Maintain the standard of at least 80% of people who have suffered a stroke spending at least 90% of their time on a dedicated stroke unit.
9. Primary PCI	Links with "Achieving clinical excellence" and "Being patient focused". Aim is to improve survival rates by offering 'gold standard' heart attack (primary angioplasty) treatment to all South Yorkshire, North Derbyshire and North Nottinghamshire patients by end of 2011.	Delivery risks - capacity expanded sufficiently to meet predicted demand, ambulance and hospital protocols applied correctly.	74.5% achievement of call-to-balloon target (within 150 minutes) (Latest available data) 86.1% achievement of door to balloon target (within 90 minutes).	Maintain / exceed 75% target for call-to-balloon time and door to balloon time. Report performance bi-monthly to N Trent Cardiac Care Cardiac Commissioning Group.

10. Venous Thrombo-Embolism (Quality Report objective)	Achieving excellence in all clinical services through implementation & measurement of evidence based practice. Supports Trust objectives to audit NICE guidance throughout STHFT and to 'be patient focused'.	Completion of VTE risk assessment form for every patient admitted to STH. Surveillance of returns and feedback to Directorates on performance. Key risk to initiative is failure to complete risk assessment by admitting clinician.	At least 90% of patients had been risk assessed for VTE during February & March 2011.	Maintain completion of risk assessment, using DH form, for 90% of admitted patients. Achieve at least 95% of patients who have been identified as requiring treatment to prevent thromboembolism receive preventative treatment during 2011/12.
11. Improving the care received by older people using our services (Quality Report objective)	Achievement of: Clinical Excellence Patient Focus	Increase the number of people over 65 who are screened for nutritional requirements within 48 hours of admission, and who have an appropriate care plan, after screening. Reduce the number of patients who develop pressure ulcers whilst in hospital.	65% of people over 65 are screened for nutritional requirements within 48 hours of admission, 51% had an appropriate care plan, after screening. 89 hospital acquired pressure ulcers were reported in Quarter 2of 2010/11.	Achieve 70% of people over 65 being screened for nutritional requirements and 60% for an appropriate care plan in 2011-12. 10% reduction in hospital acquired pressure ulcers during 2011/12.
12. Reducing the number of operations cancelled for non clinical reasons. (Quality Report objective)	Patient Focus – to improve the overall patient experience.	Monitor the cancellation rates and the reasons given on a continuous basis. Investigate specific situations and wider areas of concern with the surgical departments concerned, to ensure that the reasons for the cancellations are resolved, or prevented from happening again.	768 cancellations in 2010-11.	Fewer than 768 in 2011-12.

The Board of Directors (The Board) approved strategy Excellence as Standard sets the overall strategic direction supported by a number of local initiatives such as the Patient Safety First Campaign and the Quality Report priorities. The Board delegates responsibility to the Medical Director and Chief Nurse/Chief Operating Officer to provide strategic leadership to the Quality agenda.

The clinical plan (as per the Monitor Plan) is predominantly an enhancement of previous commitments to ensure quality and safe practice is developed and embedded. This work supports national initiatives and encourages ongoing compliance with CQC registration. Some metrics have been revised based on the Trusts experience of the first year of implementation.

The Quality Report priorities are embedded within the clinical plan and were developed and influenced by feedback from external stakeholders such as LINks representatives, OSC and NHS Sheffield. Internally the objectives have been supported and developed in collaboration with key staff members, clinicians, Operational Board and the Clinical Management Board. The Board of Directors have approved the Quality Report priorities.

1. **How the Board has gained assurance regarding the implementation of Monitor's new Quality Governance arrangements and how these will be developed across the plan period**

Monitor's new Quality Governance arrangements have prompted a review of the current structures and activities to enable the Board to systematically review its current arrangement against the requirements of the quality governance arrangements. Through a Trust Executive Group development session the Trust will undertake a strategic analysis of the current situation. Consideration is being given to identifying external facilitation support for this process.

The outcomes of this work will provide a framework for enabling a dynamic and transparent approach to Quality Governance and ultimately Board assurance. The Board will ensure alignment of all work streams through the mechanisms of this review.

2. **How the Board will be made aware of, and take appropriate action regarding, serious and reputational related complaints (and SUIs)**

The Board has established a committee structure of the Audit Committee, Human Resources Committee and Healthcare Governance Committee, which enables serious and reputational related issues to be escalated. This happens predominantly but not exclusively though the Healthcare Governance Committee. The Board receives information from all Committees through the routine submission of minutes, forwarding of papers and verbal briefings from the relevant Chair. SUIs are routinely highlighted to the Board under the agenda of *'matters to be raised with the Board'*. All committees have a Non-Executive Director Chair.

The Board annually reviews the work plan for the Healthcare Governance Committee which provides a systematic approach to the monitoring and review of quality and safety. This work plan incorporates the reporting of complaints, incidents, inquests, serious incidents, mortality statistics, clinical audit reports and CQC compliance to facilitate Board awareness.

Tools such as the Clinical Assurance Toolkit provide wards and departments with a coordinated, comprehensive and up to date range of standards. This enables the provision of accurate and timely feedback to Committee members as part of the systematic reporting process.

Patient Experience reports which detail closed and ongoing complaints are submitted to the Healthcare Governance Committee on a quarterly basis, following scrutiny and review by the Patient Experience Committee. SUIs and complex Inquests are reported to the HCGC by the Head of Patient and Healthcare Governance, the minutes are then submitted to the BoD.

3. **How the Board will ensure that clinical quality improvements will be monitored over the period**

The current reporting systems provide assurance from a variety of sources regarding the quality of service provision such as the Performance Management Framework, the Intelligent Board Dashboard, Top Risk Report/Assurance Framework, National Survey/inspection reports, External Agency Visits, Internal Audit Annual Plan and Internal Audit Reports.

Other priorities

Priority	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Membership plan for the future	To develop a vibrant system of engagement with the local community.	Increase the number of Patient and Public members of the Trust in line with the number of Staff Members, but with a strong focus on quality of engagement.	Governor commitment to take part in community activities to promote Trust membership.	Continue with Health Lectures for members. Formulate action plan around the positive response received to questionnaire seeking out the views of the membership and how they wish to be involved. Continue to refresh engagement activities to fully establish a representative Membership.

Section 5: Regulatory requirements

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Service Performance - Emergency Services	Meeting the emergency services target.	A number of programmes of work are underway to mitigate the risks created by the new emergency services targets: Appointment of additional consultant medical staff. Commencement of an emergency care project. Increased use of the Clinical Decision Unit (CDU). Retrospective analysis of breaches.	Daily monitoring Monthly monitoring by TEG Monthly monitoring by the Board

		Unified system of PITSTOP. Increased awareness across the NGH site.	
Service Performance – Cancer Waiting Times	Achieving all Cancer targets, particularly those that disproportionately affect cancer centres* Breast symptomatic 2 Week Wait – breaches caused by patient choice. *31 days diagnosis to treatment (surgery) – elective capacity and HDU issues. *62 day GP referral to treatment – late referrals from surrounding DGHs, complex pathways and capacity constraints. 62 day screening referral to treatment – due to small overall numbers this continues to be vulnerable to a very small number of justified breaches.	Local plan agreed with NHS Sheffield includes emphasising patient responsibility to attend in the 2 weeks, process issues, and identifying patients disengaged from 2ww pathway. Surgical specialties continuously reviewing potential breaches and capacity Maintain strong links with the North Trent Cancer Network and close links with referring DGHs regarding referral delays. Breach reallocation policy agreed and implemented from Q4 10/11. May need to consider more stringent reallocation policy (e.g. Christie's '38 day') to recognise the specific issues of the Cancer Centre. Review of key cancer pathways and development of breach escalation policies with bespoke trigger points. Continue close scrutiny of individual breaches but most result from clinical condition of patient and are unavoidable.	Monthly monitoring by the Board and TEG
Service Performance – Healthcare Acquired Infections	Continuing to improve performance on Healthcare Acquired Infections to the level required by the mandatory targets. The MRSA and C Diff targets have been reduced significantly for 2011/12. The target for C Diff looks particularly challenging.	Robust arrangements are in place to improve Infection Prevention and Control through the Trust Infection Control Programme. Performance against the Healthcare Acquired Infection Targets is monitored monthly, and progress with the Infection Control Programme is monitored	Monthly monitoring by the Board and TEG

		quarterly.	
Financial stability, profitability and liquidity.	Inability to deliver I&E balance or surpluses to maintain financial stability and enable necessary investment.	Key actions are: - Robust financial and strategic planning with realism about the future. - Strong contract negotiations/joint planning with commissioners. - Major focus on Trust efficiency programme. - Strong performance management processes. - Development of management and leadership capacity. - Realistic capital investment plans. - Strong focus on working capital/liquidity.	Monthly monitoring by the Finance Committee and the Board.
Ongoing compliance with CQC registration	Maintaining registration through an economic downturn. The uncertainty of the new arrangements and how they will evolve. Maintaining high quality standards in all areas in a financially constrained system demanding major efficiency savings.	Robust arrangements are in place to monitor quality as part of performance management framework.	Revised performance management framework introduced from Q2 of 2011/12.
Effective risk management	Managing risks/opportunities successfully going forward	• Assurance Framework rebuilt in line with Trust strategy and updated twice a year • Quarterly Top Risks report	• Assurance Framework updates considered regularly by the Board • Quarterly review of Top Risks by the Board

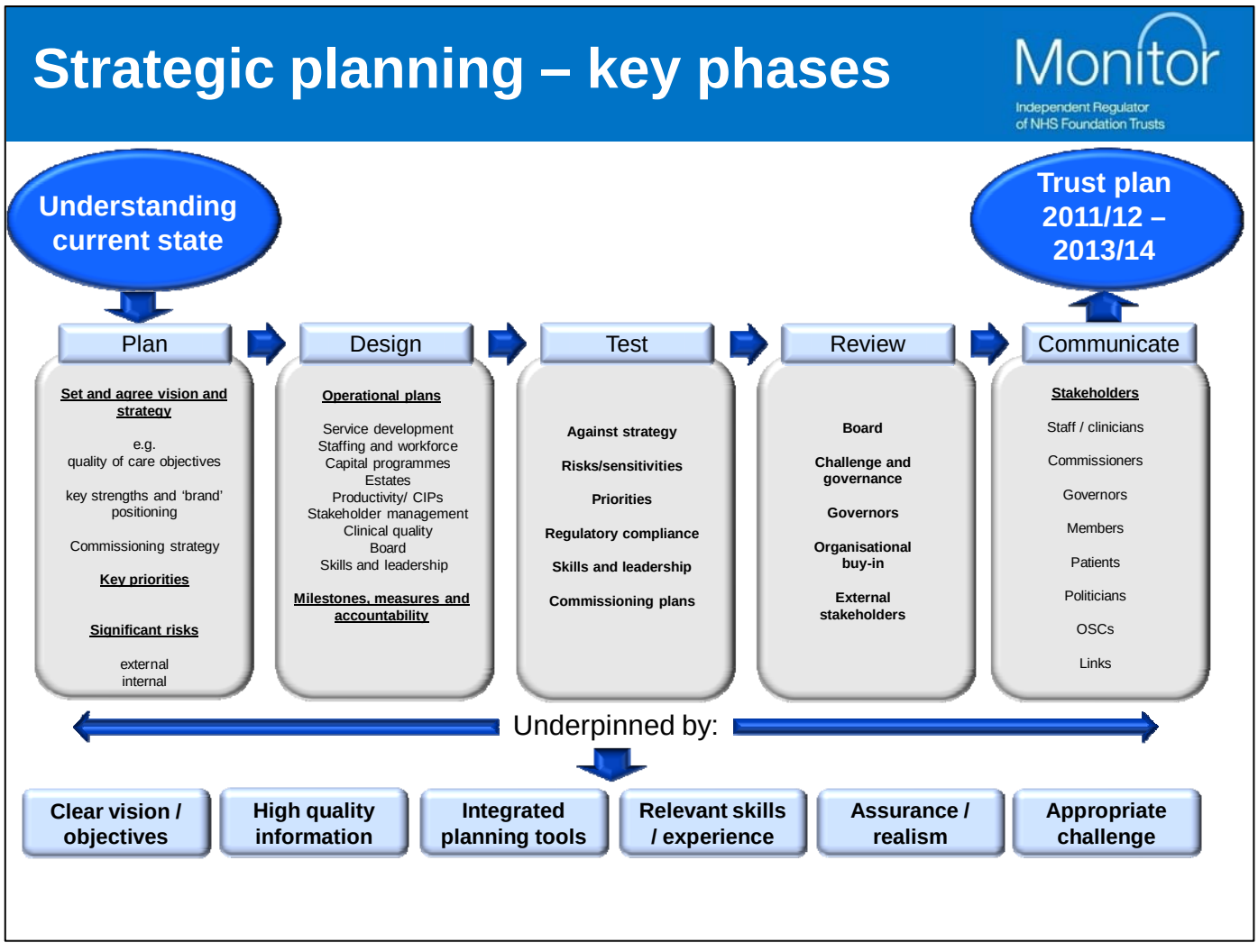
Section 6: Leadership and governance

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2011/12 2012/13 2013/14
Developing the leadership skills to manage in a downturn	Leaders who have succeeded in an era of growth not having the necessary skills to manage in the different environment of the coming years.	Investment in improving skills and capacity for delivering efficiency savings. Leadership Programme for Trust 'Top Leaders' commenced in conjunction with Sheffield Hallam University.	Leadership Forum - twice a year. Key element of the Service Improvement Programme with investment prioritised in the 2011/12 Financial Plan.
Developing Clinical Leadership	Increased requirements for effective clinical leadership to deliver high quality and efficient services.	Clinical leaders programme commenced in conjunction with Sheffield Hallam University. Driving the use of SLR/PLICS in all clinical specialties to support clinical leaders in understanding costs and improving performance.	Programme commenced in Spring 2011. Directorate action plans completed and submitted
Improved performance management arrangements	Ensuring consistent performance in all areas across the Trust as a whole.	Performance management framework in place.	Arrangements fully implemented.
Improved risk management arrangements	The downturn will create new risks and opportunities.	External review of risk management effectiveness (Moore Carter & Associates), completed Autumn 2010.	Action plan in place with Board monitoring arrangements.

The Director of Service Development has met regularly (approximately quarterly) with Governors to discuss the key issues facing the Trust and seek their input /advice. This is also complemented by the Director of Finance briefings to Governors which take place on a quarterly basis.

The submission of the annual plan was discussed at the Governors council in March 2011 and Governors expressed their support for the key themes / issues to be set out in the plan.

Annex A


Strategic planning – key phases
Monitor
Independent Regulator of NHS Foundation Trusts
Understanding current state
Trust plan 2011/12 – 2013/14
Plan
Set and agree vision and strategy
e.g.
quality of care objectives
key strengths and 'brand' positioning
Commissioning strategy
Key priorities
Significant risks
external
internal
Design
Operational plans
Service development
Staffing and workforce
Capital programmes
Estates
Productivity/ CIPs
Stakeholder management
Clinical quality
Board
Skills and leadership
Milestones, measures and accountability
Test
Against strategy
Risks/sensitivities
Priorities
Regulatory compliance
Skills and leadership
Commissioning plans
Review
Board
Challenge and governance
Governors
Organisational buy-in
External stakeholders
Communicate
Stakeholders
Staff / clinicians
Commissioners
Governors
Members
Patients
Politicians
OSCs
Links
Underpinned by:
Clear vision / objectives
High quality information
Integrated planning tools
Relevant skills / experience
Assurance / realism
Appropriate challenge