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Monitor Independent Regulator of NHS Foundation Trusts

Forward Plan Strategy Document for

[insert name] NHS Foundation Trust

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

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

Name	
Position	
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Date	

Approved on behalf of the Board of Directors by:

Name *(usually Chair)*	

Signature

Strategy Guidance - Annual Plan Review 2011

1. Overview

NHS foundation trust plans for 2011/12 – 2013/14 include financial forecasts for three years which will reflect forward looking assumptions, projections or estimations, at least, as to:

- revenues and costs;
- contracts and changes in productivity;
- the likely impact of various external and internal factors;
- key risks, including in relation to the Authorisation, and effective mitigations;
- capital and other investment projects;
- leadership and necessary key skills;
- potential acquisitions and / or disposals; and
- clinical quality objectives and service developments.

Each of the above should be underpinned by detailed planning and proposed actions, identification of key responsibilities and clear accountability, and a shared strategic vision led by the Trust's Board and agreed with governors, commissioners and other key stakeholders. To deliver this the Trust's Board must plan, understand, articulate and clearly communicate:

- the Trust's strategy;
- key delivery risks to the strategy: internal and external; controllable, semi-controllable and non controllable;
- for each of the main parts of the strategy, the key priorities, actions and resources (both financial and human) needed to deliver them;
- measures of progress and milestones along the way;
- how the Board has considered the impact on quality of patient care;
- how the Board has considered how patient safety is safeguarded;
- any regulatory risks and mitigations; and
- communication and stakeholder engagement.

The strategic part of the annual plan is designed to ensure that:

- NHS foundation trust Boards (both directors and governors) have properly considered and delivered the above requirements for good planning to underpin the delivery of high quality healthcare services;
- the Trust's financial plans demonstrate an integrated and effective approach to, and output from, high quality strategy and realistic planning; and
- if not, to identify gaps and actions to fill them.

When assessing the effectiveness of the strategic, operational and financial planning undertaken by a Trust as part of the Annual Plan Review, Monitor will consider the clarity with which a Trust Board can describe its overall strategic vision. Boards should be able to, for each of the main areas of its business, identify key priorities, assess risk, and design a co-ordinated and credible plan for delivery of its three year plan.

This document sets out guidance for completion of each of the main sections within the strategic plan. Within each section, Boards will be expected to describe succinctly the Trust's key priorities (we envisage a range of between 5 and 10 priorities). For each of the priorities in the sections, the Trust's Board should be able to demonstrate a clear link between its overall vision for the Trust, strategic objectives, key operational action plans and the assumptions used to drive the plan.

All measures of progress or milestones must be SMART – Specific, Measurable, Achievable, Relevant, Time-bound.

Where more detailed information is already included within the input sheets from which the financial plans are derived, then this information should be referenced (and where appropriate not repeated) within the sections below.

After each section is a box to add further comment by way of additional clarification, although additional comments, if any, should also be limited in length.

Annex A sets out, at a high level, the main stages in the development of the three year plan and the key elements which underpin each.

Introduction

The sections below should be completed in the plan in such detail as is necessary to demonstrate that the Trust Board has:

- a shared and clear vision;
- planned key priorities;
- considered material risks (both internal and external);
- assessed potential downsides and mitigations; and
- has had regard to views of governors.

The sections cover six categories, set out below:

1. **Strategy**
    - Articulation of strategy over plan period
    - Delivery milestones
2. **External environment**
    - Summary of national & local factors
    - Delivery milestones
3. **Summary financial commentary**
4. **Trust plans**
    - Financial plans
        - Income
        - Service developments
        - Activity and costs
        - Workforce
        - Capital programmes (including estates strategy)
    - Clinical plans
        - Quality accounts
        - Measures to improve clinical quality
        - Safeguarding patient safety
    - Other priorities
5. **Regulatory requirements**
    - Cooperation and competition
    - Compliance with terms of Authorisation

6.Leadership & governance

- Leadership arrangements over plan period

Section 1: Strategy

Guidance: Building on a credible assessment of where it believes the trust's strategic position to be, the Board should set out the vision for the Trust and succinctly set out the strategic priorities to deliver this – and the rationale for these. The Trust Board should be able to articulate:

(i) the key changes required in order to develop the Trust from its present position; and

(ii) the key elements of the organisation that need to be in place to achieve this.

The trust's vision should describe at the highest level the aims of the Trust and in particular how it wishes to be viewed by its patients and service users, staff, commissioners and other key stakeholders.

The strategy, on the other hand, should set out how the trust intends delivering this, including the priorities & objectives over the plan period and, where relevant, the choices trusts have made in developing these. These main priorities for the next three years are likely to be high level.

The strategy should reflect the trust's external environment, its internal capabilities and other relevant factors. Where appropriate, trusts should articulate assumptions and underpinning evidence behind these. A good strategy will also set out the milestones by which its progress/delivery will be assessed.

In preparing the strategy, the Trust's Board of Directors should have regard to the views of the Board of Governors. Comment as to the likely timescales for the delivery of the strategy may be appropriate particularly if this falls outside the three year period of the annual plan.

Content of plans

As part of this, plans should describe

- The trust's current position in terms of progress towards the delivery of its overall vision and strategy;
- where in this context it aims to get to over the next three years; and
- the main priorities which will need to be delivered to secure the required progress.

The plan should consider any relevant factors across each of the three years of the plan period and where necessary indicate how risks (e.g. financial stability, maintaining patient safety) will be mitigated.

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 of £? (check with Rob what figure should be inserted here) to maintain a consistent record of financial stability in spite of a highly challenged commissioner that instigated significant restrictions during the year on elective activity/referrals.
- Achieved all of the following targets at year end: (then list them – get from Annette Peck).
- Continued to develop and embed our major staff engagement programme
- 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 making the Trust one of the safest providers amongst all Teaching Hospital Trusts, including ending the year with 5 consecutive months (check with Chris Morley) without a single case of MRSA.
- Received an HSMR estimate for 2009/10 – significantly lower than would be expected.
- Completed our internal reconfiguration of clinical services across our two major sites.
- Initiated and completed the successful merger with adult community services in the city.

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 which in 2010/11 required efficiency savings of £ (get number from Rob) and we estimate to be ~% (get from Rob) for 2011/12.
- 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 (insert new number from Richard) beds at any one time.
- Significant financial pressures in 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.
- Ensuring that the merger with community services delivers the genuine transformation of care for patients and the way we deliver in certain pathways.
- 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.

In summary we are a highly successful Foundation Trust which consistently meets the most exacting standards, but is finding its capacity stretched by an increasing volume of patients. We will continue to be a successful organisation in the future, but 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. This 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 that 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 in light of the greater certainty we now have regarding 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 means that the clinical services, teaching and research which we provide will be recognised internationally.

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 will 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.

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:

While the priorities in the table below should not be exhaustive, they should represent the key initiatives n the trust's strategy and be consistent with the following sections, where we expect an appropriate level of detail to rest.

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 current levels. Commissioners appear unable to support the cost of the necessary level of activity to meet this demand.	Agree acceptable contractual terms for 2011/12 as a matter of urgency (this is a major risk to the plan at the current time). Work collaboratively with NHS Sheffield to appropriately reduce demand for hospital services but recognising the duality of responsibility which this requires. Realise the benefit opportunities presented by the Transformation programme especially in the provision of enhanced intermediate and continuing care services.	Negotiate of an entirely new contract. Protect the interests of the Trust through a Local Implementation Agreement which clarifies the application of the standard national contractual terms.	Work to ensure a more stable contractual relationship for the future.
2. Fully realise the benefits of the internal service reconfiguration.	Refine the assessment and treatment of patients presenting with acute medical and surgical conditions to guarantee fast triage and expert care by the appropriate specialist in the designated ward first time. Conclude the unification exercise to enable maximum	Following service moves, plan for new integrated Neuro/ General Critical Care service at RHH. (1/5/11) Continue to bring more Trust work back on site and decrease use of sub-contractors to meet activity targets.	Complete Critical Care Scheme (1/5/12)	

	patient contact with the most experienced clinicians. Critical mass of expertise in one base encourages research and innovation and ability to sub-specialise which are vital for the growth of specialised services. Through innovative capital investment reduce the length of stay for surgical pathways and re-use the vacated capacity for new continuing care or close and reduce the cost base.			
3. Develop a clinical service plan and new organisational arrangements for the newly transferred community services.	This strategic change will widen the service portfolio outside the acute service mission and extends the terms of authorisation. This will increase control over preceding and succeeding parts of the acute pathway and will offer solutions to improve both quality and effectiveness.	Introduce improvement programme to realise maximum benefit from pathway integration. (31/12/2011)	Increasingly realise the benefits of integrated care pathways and robust community services on acute activity.	
4. Drive forward the Service Improvement Programme to secure required efficiency savings over the next 3 years in response to national efficiency gain 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.	Continuing length of stay project aiming for best performance. Joint leadership with the reconfiguration programme to ensure best fit. Major study to test current skill mix compared to that required of the directorates followed by a re-balancing based on normal		

	There are 3 main components to the strategy: Clinical transformation 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.	turnover Productive Operating Theatre project to be initiated with support from IHI Widening of the telephone remind system to reduce patient DNA rates. Re-assessment of clinical outputs aligned to Consultant job-plans.		
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 SCG. 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.	Reinforce our position as a centre for Vascular Services in the Y&H SCG review of Vascular services with a potential increase to the referral base. Strengthen our position as a tertiary centre for Trauma services within the SHA strategic review of capacity and provision. Consolidate the provision of Primary PCI following completion of the roll-out. Consolidate the provision of an acute Oncology services to the Cancer network. Localise Oncology and Chemotherapy services in line with local capability.	Continue to grow the Pulmonary Vascular Service and seek SCG designation for Occupational Lung disease as niche services based at RHH. Closely align the Occupational service to the joint bid with Health and safety Laboratory for appointment as the National Centre for Workplace Health being procured by DoH, DWP, HSL.	

6. Build on the foundations of the Biomedical Research Units (BRUs) in Bone Metabolism and Cardio-Vascular activities to create a bid to become recognised as an Academic Medical Centre by 2012	This is fundamental to the second mission of the Trust to be the base for world class research. The early signs from the BRUs are encouraging and the creation of modern clinical research facilities on both major campuses is creating the impetus for widening this base. There is current potential for research in Neurological conditions and Cancer and a growing potential in Infection, Diabetes and Medical Devices.	Create a BRC Strategy Board chaired by the Pro Vice Chancellor for the Faculty of Medicine Dentistry and Health/Non Executive Director to deliver BRC by 2012. Create a joint STHFT/ University of Sheffield Research Office to unify the encouragement of 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 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 sustainability/flexibility funding to support strategic themes.	Bid for BRC status based on improved BRU performance and widened clinical research base. Seek sustainable future for D4D utilising DoH enabling funds based on commercial potential of the devices and unique consultancy.	Secure BRC status and make a resulting further step-change in R&D output.
7. Assure the future Leadership of the Trust by continuing to expand and develop the Leadership Development Programme focussing initially on	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.	Enrol the first delegates on the MSc programme for clinical leadership and roll out the certificate and diploma opportunities. Continue to		

future Clinical Leaders.	Clinical Leadership is a fundamental structure of the STH governance philosophy enabled by senior and skilled management support. We intend to provide greater structure to developing future clinical leaders by an internal programme supported by the best educational partners we can find.	encourage staff participation in the Leadership Forum to disseminate the underpinning organisational values and behaviours. Implement 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 share patient data to improve their overall clinical management within the Trust and in the wider NHS.	Further integrate Trust systems by: fully integrating PatientCentre; achieving single departmental foundation systems; improving staff access to information at the point of care 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	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 information to support clinical pathways. Take advantage of the national Summary Care Record (SCR).	Consider Lorenzo against best of breed alternative to EPR.

		communication and patient handover. Install wireless network and provide clinical staff with multi-function intelligent devices. Use IT to support and drive service improvement and efficiency by improving access and strengthening staff engagement and communication. 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. Support the Research and Innovation Agenda through a dedicated computer software development and support team. Improve the security of the information we hold and transfer by: raising the awareness of the Information	Utilise wireless network to auto-register and track patient progress through main pathways.	

		Governance Assurance Framework; consolidating the role of the Senior Information Risk Owner; ensuring the encryption of all removable media; implementing the Informatics Business Continuity Action Plan; improving identity management and access control.		
9. Plan to meet the NHS Sustainability requirements by 2015.	Sustainability is a core objective of 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.	Consolidate the Trust's membership of the City of Sheffield Low Carbon Working Group. Establish the Sustainable Strategy Development Group at Board Director level supported by the Sustainable Development Implementation Group and a Sustainability Project Manager. Establish the project approach under 6 workstreams: - Travel - Facilities Management - Procurement - Workforce - Community engagement - Buildings. Raise the profile of energy conservation by a planned PR campaign linked to staff engagement.	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. Introduce 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 postgraduate education and	This is central to the tri-partite mission of the Trust which sees education closely integrated with clinical service and	Development of infrastructure to provide a city- wide videoconferencing facility connecting all the principle teaching		

training for all professions by ensuring the best possible 'student' experience whilst attached to the Trust and working with the Universities to ensure that Curriculum development is keeping pace with and is relevant to modern clinical practice. The MPET review of funding will present a major challenge to the provision of education and training and will require ingenuity and innovation to maintain high standards in what we anticipate will be a reduced and reformed funding system in the future.	research as the underpinning core of all the services we provide.	sites. Building 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', (May 2011) Developing Quality assurance systems to facilitate excellence in education including a medical workforce monitoring board, educational supervision for all trainees and close liaison with the merged Yorkshire and Humber Deanery. 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 following and in synchronisation with, the reconfiguration of service provision within the city, Learning from the HEIC 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) to enhance the translation of research into education and practice building particularly on the experience of the CLAHRC and Devices For Dignity.		

Section 2: External environment

Guidance: This section should reflect the significant external impacts on the Trust's plans and, for each of these:

- a brief description of the related risks and impact on the delivery of the plan;
- the actions taken and / or planned to be taken to mitigate the impact and residual risks which may then remain;
- the expected or planned outcome, measures of progress; and
- the person accountable in each case.

Key external impacts will vary by Trust and also evolve or develop over time, and are likely to be both local and national. Some potential factors are set out below, but these are not intended to be exhaustive.

Where there is overlap between this and other areas of plans (e.g. commissioner intentions reflected here and in income plans), then trusts should provide a high level reference here, while covering the details in other areas. Where plans are not consistent from section to section Monitor may require further clarity from trusts.

National factors

Setting out the impact of national issues e.g.:

- Overall healthcare funding and the wider economic environment (both with regard to the Trust and its commissioners);
- Tariff changes;
- Innovation and technology;
- Pay – national negotiations; and
- Changes in national policy or law.

Local factors

Covering, where applicable, local issues and mitigation plans such as:

- Any provider impact of demographic changes;
- Demand management and commissioning behaviour;
- Local pay negotiations;
- Changes in local policy;
- Quality incentives / penalties;
- Other contractual arrangements and challenges;
- Service reconfiguration; and
- Competition, cooperation and patient choice.

The table below should reflect the significant external impacts on the Trust's plans.

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 and is really beginning to bite in 2011/12. Despite growth to PCTs of about 2% in 2011/12, we are anticipating a reduction in income from NHS Sheffield of about £12m 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 is proving difficult and there is much important detail still to be worked through. However, income challenges from the PCT Consortium were much less onerous in 2010/11 than previously, and resulted in only very limited adjustments to contract income.	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 which are required, and therefore that the underlying assumptions are reasonable. 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 are considering 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 are seeking as part of neutrality that income for emergency	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. Financial Plans consider the potential for income changes in some

	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.			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. There is an increasing burden of external regulation and standards which must be achieved.	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. As part of the financial neutrality agreement, we are negotiating reduced local requirements with no financial consequences.	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. The Performance Management framework of the Trust captures all national standards.	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 Trust has a good track record of achieving all external targets.	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. Chief Executive and Trust Executive Group oversee results monthly.
4. NHS Sheffield in particular is pursuing a series of QIPP schemes to reduce both emergency and elective demand within the healthcare system. Whilst it is important that the	This year we are working closely with the PCT to ensure that assumptions about demand are aligned and are realistic. We will make a major contribution to the change process with the new responsibility of	Recognising the financial constraints for NHSS, we are agreeing to several measures which will reduce activity and demand for services. Having been successful in reducing outpatient follow ups in 2010/11, we are	The expected outcome is a more realistic QIPP plan. There are very significant financial risks to the Trust in managing the large reduction is service volumes implied by even this scaled down plan.	The leadership has come from Trust Executive Group. The Contracts Team is working on the detailed targets, and the implementation of the changes will be led by the Medical Director and Chief Operating Officer / Chief Nurse. 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.	managing community services.	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 range of other demand management schemes have been factored into the activity targets.		Medical Director has also been leading joint Clinical Summits with NHSS.
5. Staff – section not required?				
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 new contract for one year only.	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 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	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	The Trust will continue, via the Director of Finance, to monitor the

amounts of funding over the next 3 to 4 years.			savings.	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 demographic change into their activity targets but generally aim to balance this through demand	Emergency pressures on the NGH (acute) site continue to interfere with the ability to admit elective cases, which creates further waiting time pressures. The lack of beds interferes with the efficient use of available theatre capacity. Elderly	The specialty of Acute Medicine has been reconfigured to deal with these pressures. Patients are triaged on admission to the appropriate specialty for their condition. The Trust is working with NHSS to secure a funding envelope for additional	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 emergency and elective admissions. Removing the delays from the system will enable further	Responsibility is with the Chief Operating Officer / Chief Nurse and the Medical Director. The Trust measures and takes action in response to the number of emergency admissions, the level of medical outliers,

management initiatives.	patients are increasingly complex to manage during their hospital stay and delays at discharge continue to be a problem.	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.	efficiencies to drive improvements in the flow of patients through the hospital pathway.	length of stay, percentage of discharges from Medical Assessment Units, and Delayed Transfers of Care.

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

Guidance: this section should provide a summary of the current financial state of the trust, the key assumptions made in compiling the financial plan and a synopsis of the material changes over the three years of the plan. Expectations are that the summary will not itself be more than 2-3 pages in length.

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 £806.7m which is an increase of 2.2% 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 3.5% 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 maintaining the £6.7m I&E surplus planned in 2010/11.

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

-ACTIVITY??

-CONTRACT??

-A stable MPET income position with the potential MPET Review consequences not being implemented for 2011/12.

-R&D??

-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 the intention of earning a bigger proportion 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 contract income of £x and total turnover of £y. The negotiated transfer arrangements included the 4% national efficiency requirement which equates to just over £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. INVESTMENTS??

-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 ?.

-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”.

-TARIFF CHANGES/BUSINESS RULES IMPACT?

-ACTIVITY CHANGES?

-No further commissioner investment in service developments.

-Significant reductions in MPET funding.

-The intention to maintain a planned I&E surplus of £6.7m 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

Guidance: Monitor expects trusts to set out the principal drivers of income in their plans, making reference to the proportion of income under contract and where contracts have been signed. Where there is risk to planned income this should be indicated with any accompanying mitigating actions.

Trusts should indicate key risks to income and the tariff and activity assumptions used, indicating the rationale for these. This will overlap with other areas of the plan (e.g. commissioner intentions and historic commissioner track record).

Where trusts' income in 2010/11 has materially diverged from the plan submitted in 2010 we expect trusts to indicate what actions have been taken to ensure this is not repeated.

As much as possible, trusts should make reference to the relevant data in the financial template in this commentary.

Enter text – suggest less than 500 words

Need to cover:

- Contract position/issues (main consortium and other).

-Changes from 2010/11 activity.

-CQUIN.

-MPET.

-R&D.

-Other.

-Risks (below).

Key income risk	Amounts and timing 2011/12 2012/13 2013/14	Mitigating actions and delivery risk

Financial plans: Service developments

Guidance: the main service development priorities in the plan should be described in enough detail so as to provide evidence as to:

- the contribution they are expected to make to the plan;
- financial impact (income, costs);
- the actions necessary to implement them;
- key risks;
- any regulatory requirements;
- resourcing requirements (financial and human capital); and
- measures by which the delivery of the service development will be tracked and assessed.

In addition the plan should make reference to how previous developments have subsequently performed and any appropriate lessons learnt. Each of the priorities above should be categorised under one of three headings:

(1) organic or innovation (i.e. delivered internally by the Trust or through co-operation);

(2) acquisition, merger, investment, tender etc (i.e. through some form of corporate action or activity external to the Trust); or

(3) by transferring out / discontinuing an activity (in agreement with commissioners).

Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference should be made to those service development plans.

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. Consolidate the Acute Physician presence and maximise the utility of the MAUs and admissions process. Maximise benefits from the redesign of the 'front door' services in A&E.	Fast access to correct specialist service first time. Major contribution to financial efficiency programme by reducing length of stay and avoiding unnecessary admissions.	Re-balance the resources between the medical sub-specialties. Refine the flow of patients through the hospital pathways. Work with NHSS to maximise the efficiency of GP sessions within the hospital front door services.	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 community services and joined up pathways. Consider the place for tele-health solutions beginning with remote diagnosis and treatment initiation for Stroke.	Transformation of current services by reducing the need for care and treatment in the hospital environment in selected conditions. Innovation through tele-health to maintain patient contact with specialist care with an emphasis on self-care with support.	Secure the tele-health solution for stroke diagnosis. Develop the potential for chronic diseases including diabetes and COPD through integrated community and hospital services. Establish a Tele-Health Project team following the securing of the tele-health solution for Stroke services from the SHA.	In financial plan 2011/12.	Affordability of the alternatives compared to existing services factored into NHSS 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 for a prevalent condition which creates a long-term financial burden from associated disability much of	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	Workforce needs, medical, nursing, therapy, 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.

	which can be prevented.	patients.		
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.
Acquisition, etc.:				
6. 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 vacancy factor.	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.
7. 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	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	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	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

designation standards by June 2012	expertise in fewer centres consistent with local access for routine treatments.	Centre" designation. Plan human and physical capacity for any additional network specialised activity.		to plan.
Transferred / discontinued activity:				
8. 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 as part of contract agreements and begin immediate implementation. Keep impact under constant review 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 and hence reduction in medical outliers. Potential to 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

Guidance: this section should set out any significant activity and cost initiatives in the plan period, identifying:

- activity assumptions with timing and linkages to the delivery of the plan;
- key actions/initiatives and potential delivery risks;
- changes in resource requirements (capital and human); and
- key milestones underpinning delivery.

Clearly, in some instances there will be overlap with other priorities included in other sections (e.g. income, workforce strategy, capital expenditure and service development strategy) and where this is the case these should be referenced in the section. The key focus of this section will be to bring together activity and operational efficiency priorities not already identified elsewhere (e.g. procurement, other non-front line services, development and realisation of specific commercial opportunities, improvements in financing or other costs etc.).

Cost Improvement Plans (CIPs)

Cost improvement programs should be related to efficiency savings and consistent with activity and workforce initiatives. Where relevant details related to CIPs are included within the input sheets from which the financial forecasts are derived, then reference to those CIPs should be made in the section below. In addition, Trusts should make reference to historic CIPs, indicating for instance:

- how successfully historic CIP programs have been delivered; and
- the degree of 'stretch' reflected by the new CIPs.

In order to improve consistency amongst Trusts the following is more detailed guidance on the types of schemes which Monitor considers to be true efficiency savings and to be included under the CIP category in the financial template.

<u>Cost improvement schemes should include:</u>

- Reduction in existing costs to deliver the same level of activity; and
- Savings generated through efficiency schemes, for example, income generated at the same cost level or at marginal cost (only the net additional income to be included).

Details of these should appear in table (A) below.

NB: The CIPs worksheet in the financial template requires FTs to identify the proportion of recurrent/non-recurrent schemes. FTs are also required this year to specify what proportion of CIP schemes have been identified in detail at the time of submission.

<u>Items which we would not expect to be included in the CIPs worksheet in the financial template (but may be included elsewhere in the financial template):</u>

- Operating costs which are removed as a result of disinvestments or reduction in contracted/non-contracted activity;
- Income generation or repatriation schemes (unless through improvements to efficiency as set out above) as these should be included under service developments;
- Non-operating savings e.g. changes to depreciation methodology or other accounting adjustments;
- Quality initiative income e.g. CQUINs, QIPP; and

- Exceptional items.

Details of these should appear in table (B) below.

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	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 in respect of Clinical Improvements (key 2011/12 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 other 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.

likely to be required in the following 2 years. The Trust will again focus this work through its Service Improvement Programme.					

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.	**TBC**	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.	**TBC**

Financial plans: Workforce

Guidance: The main workforce focused priorities envisaged in the plan should be described, identifying

- the actions necessary to implement them;
- key risks to implementation;
- resourcing requirements (financial and human capital); and
- measures by which the delivery of the planned changes in workforce size, mix or configuration will be tracked.

Workforce priorities should be consistent with activity assumptions and CIPs. When considering the main workforce priorities, the following may be included:

- Changes in headcount (including benchmark evidence), mix or flexibility (i.e. mix of agency, bank, permanent);
- Key recruitment, training, retention and development initiatives;
- Redundancy and natural wastage programmes;
- Pay, rewards and other key remuneration initiatives or workstreams; and
- Other workforce issues which may impact the plan.

We will publish plans in full except where the Trust indicates that it wishes to exclude specific limited information for publication purposes. For instance, where there are workforce related activities which include commercial or confidential matters which the Trust may not at this stage wish to be published in full, the Trust should indicate this clearly on its plan submission.

Where proposed workforce changes may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan together with the specific actions proposed to mitigate it.

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	Our 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	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	Improved performance of staff engagement and staff satisfaction scores as identified in the Care Quality Commission National NHS Staff Survey. Improved workforce efficiency measured

	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 20/11 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. 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.	principles throughout the organisation:- - Involve our staff in decision making and planning processes. - Allow people 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 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 our staff experience through the concept of a staff journey providing the appropriate support, development and involvement	through new leadership development programmes	through Human Resource Key Performance Indicators. .

		along the journey. From the first day of recruitment to the last day of employment.		
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 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	Our leadership strategy underpins the corporate strategy and emphasises the following key actions. A focus on leadership capacity building within the organisation to ensure we have a faculty of staff who can support development centre activities. An executive group now 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 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 in the next 3 years Involve our 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	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 National NHS Staff Survey.

	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.	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.		
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 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	Timely action in an effort to ensure the right level of medical and dental workforce is maintained in hard pressed clinical areas. 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.	Continued EWTD compliance. Ensured safe patient care. Improved Junior doctor training/ education.

		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.	During the implementation of H@N necessity to closely manage the change to ensure compliance is maintained.	
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. 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	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/FTE. 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 13 schemes involve the purchase and introduction of 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 are to be progressed and maintained and in totality will support identification of non-essential posts with management of WTE reduction through staff resignation/contract end and the redeployment processes.	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. Enhanced workforce governance arrangements.	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 workforce schemes with regular feedback through programme governance structure to the Trust Executive Group and Senior Management meetings.

	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.	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. Regular communication on Programme purpose and progress. 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.		
5. Recruitment Strategy and management of redeployment	The Trust will need to exercise discretion and critical judgement in determining the nature and level of recruitment throughout the year in order to ensure that patient service is not compromised whilst allowing for anticipated restructures within teams.	To continue to manage and maintain effective recruitment controls which critically examine the need for new or replacement posts and to prioritise appointments To redesign the recruitment control process in conjunction with Finance and senior managers in order to facilitate local control.	Commitment from key senior managers to continue the vacancy control process. Input from HR and Finance to develop the new framework. Development if information systems.	Projected targets on pay and workforce size determined and achieved. Redeployment candidates reassigned within suitable timeframe. The need to

	Staff that are displaced as a result of organisational change will be reassigned to new teams through a developed redeployment process.	To establish a framework for redeployment which allows for assessment of individuals ability and retraining potential against opportunities within the Trust.		reduce workforce 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 with system of review of HR policies to ensure they are fit for purpose and compliant with equality legislation requirements. Provide awareness and 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. Develop and embed a culture of partnership working with trade unions to ensure the delivery of all 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)

Guidance: the main capital expenditure priorities in the plan should be documented, together with amounts, timing and linkages to the delivery of the plan. In addition, key actions and delivery risk underpinning each should be identified. Each of the capital expenditure priorities should be shown under the following main headings:

- **Development** – this includes building of new capacity (through whatever funding source) or significant reconfiguration or upgrade of existing facilities
- **Maintenance or replacement capex** – this includes planned or urgent maintenance capital expenditure or expenditure to replace existing facilities
- **Other capital expenditure** – this includes purchases of equipment, technology, intellectual property and significant IT expenditure etc.
- **Other estates strategy** – this includes net proceeds or expenditure on estates reorganisation or other estates strategy to either use the existing estate more efficiently or to release proceeds from surplus or unused assets.

Where financing is in place, we expect Trusts to make this clear. Delays either in proposed capital investment programmes (including financing, maintenance, equipment, refurbishment or new builds) or in the delivery of an estates strategy may risk impacting service provision or clinical quality. In these cases, this potential risk should be recognised explicitly in the plan together with the specific actions proposed to mitigate it. Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to those capital expenditure plans should be made.

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 May 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 patient 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 facilities. 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 £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

Guidance: the clinical component of the Trust's plan should describe:

- the main quality priorities for the three years of the plan;
- key actions required to deliver these;
- the risks to delivery of these; and
- how the Board will measure progress for each and gain appropriate assurance in a reliable and consistent manner.

For the purposes of the plan, trusts should consider safety, clinical effectiveness and patient experience in elaborating on quality plans.

These priorities should be consistent with those disclosed in the quality accounts within the Trust's published report and accounts. It is important that clinical objectives reflect not only the Trust's own strategic focus but also the needs of commissioners, patients and service users. Trusts may find Monitor's Quality Governance framework helpful; in appraising quality arrangements within the organisation.

As trust plans change elements of the provision of care to patients, Boards need to demonstrate that any potential risks to quality have been assessed and, where necessary, mitigating measures are in place.

In addition, where trusts have existing clinical concerns at the time of the plan process – whether as a result of Monitor, CQC or other parties – plans should indicate how the trust will address these over the plan period.

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 infection 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 - as per DH trajectory • 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 Training for outpatient reception staff Risks – 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 (Taken from the 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 Engage Staff	Implementation of project plan. Monitoring of policy compliance organisation wide. Evidence quality assurance and validation exercise. Risk of 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 Engage 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	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)

		effectively implement care bundles and limited impact of Interventions.		•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 newly identified barriers. Risk of non-delivery – failure to effectively implement care bundles.	Work stream and interventions established. Developed and implemented care pathways. 1st Wave pilot wards: All SHEWs trigger cases @ 2hrs receive appropriate intervention.	•2011/12 Introduce measures and roll out interventions. Achieve 80% compliance with pathway on work 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	Takes into account the views of patients, staff, clinical advice and best practice. Addresses Department of Health "Vital Sign" standard,	Centralisation of stroke services on one site, with one point of entry. Development of specialist ambulance protocol	95% of patients diagnosed with a stroke spent at least 90% of their inpatient stay on a stroke unit during 2010/11.	Maintain the standard of at least 80% of people who have suffered a stroke spending at least 90% of their time on a

objective)	implementation of National Stroke Strategy & related Stroke Accelerated Programme of Improvement.	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.		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	65% of people over 65 are screened for nutritional requirements within 48 hours of admission, 51% had an appropriate care plan,	Achieve 70% of people over 65 being screened for nutritional requirements and 60% for an appropriate care plan in 2011-12.

		plan, after screening. Reduce the number of patients who develop pressure ulcers whilst in hospital.	after screening. 89 hospital acquired pressure ulcers were reported in Quarter 2of 2010/11.	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.

Indicate below any underlying information and commentary regarding how the Board has prepared its clinical plans, including:

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
2. how the Board will be made aware of, and take appropriate action regarding, serious and reputational related complaints (and SUIs).
3. how the Board will ensure that clinical quality improvements will be monitored over the period

Also indicate any current issues and trends relating to these items.

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 strategically lead 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**

Monitors new Quality Governance arrangements has 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 have 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 or verbal briefings from the 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

If trusts have any other strategic priorities not covered in the sections above, they should place them here, along with the attendant strategic rationale, resources required, risks involved and delivery milestones:

Priority	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Add rows as necessary				

Section 5: Regulatory requirements

Guidance: the plan should identify current and future regulatory risks, including CQC concerns and risks to the Authorisation. The plan should also identify key actions to mitigate any material risks to Compliance identified and how progress towards rectification will be measured.

This includes, but is not limited to:

- •Service performance;
- •Clinical quality and governance;
- •Governance processes and procedures;
- •Financial stability, profitability and liquidity;
- •Risk to the provision of mandatory services;
- •Co-operation and/or competition rules;
- •Meeting requirements regarding information governance standards; and
- •Having regard to the NHS constitution.

Ensuring ongoing regulatory compliance, with the processes, procedures, assurance and oversight in place to first predict potential breaches with confidence and then take action where necessary, is central to the design and delivery of a high quality plan, and then its implementation.

Clear and realistic evaluation of current or future regulatory risks and accountabilities over the three years of the plan is a key requirement.

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14

Service Performance	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. Unified system of PITSTOP. Increased awareness across the NGH site.	Daily monitoring Monthly monitoring by TEG Monthly monitoring by the Board
	Achieving all Cancer targets, particularly those that disproportionately affect cancer centres* Breast symptomatic 2ww – consistent inability to meet the threshold caused by patient choice. *31 days diagnosis to treatment (surgery) – elective capacity issues recently badly affected by lack of HDU due to flu. *62 day GP referral to treatment – breaches shared with DGH's adversely affect STH performance (above (31 day target) also contributes to this 62 day target. 62 day screening referral to treatment – continues to be vulnerable to a small number of justified breaches.	Local plan agreed with NHS SH 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. 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. Continue close scrutiny of individual breaches but most result from clinical condition of patient and are unavoidable.	Monthly monitoring by the Board

	Continuing to improve performance on Healthcare Acquired Infections to the level required by the mandatory targets.	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 quarterly.	Monthly monitoring by the Board
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.	As per actions.
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

Guidance: the leadership skills, and supporting governance processes and procedures are a key factor in the delivery of any plan. Over the course of the plan period, these may fundamentally change as:

- •Current contracts expire or key personnel leave;
- •Current gaps are filled;
- •Service development initiatives (either organic or external) are implemented;
- •Workforce, efficiency or estates programmes are rolled out;
- •Acquisitions, investments or mergers are considered and progressed;
- •Specific and material financial or operational challenges grow or decline;
- •The role of governors becomes more important; and
- •External impacts change.

As a result, planning, and planning for, leadership change, succession and development is core to ensuring that skills are in place to design and then deliver the Trust's strategy. These should be supported by effective and functioning governance and assurance processes and procedures. Where there are shortfalls, gaps or specific risks then plans need to be in place and described to rectify them. Clear evaluation of current or future skills gaps and requirements going forward, leadership change and governance changes is important.

In the context of the current state of Board leadership and effectiveness, and the needs in the future to deliver the three year strategy against a changing regulatory framework where Monitor's governance oversight role is likely to change, the Trust Board should set out its priorities for leadership and governance development and evolution, consistent with the plan. This may in many cases entail external advice and periodic re-assessment to assist the Board to agree and then build its own effectiveness.

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. Rolling-out SLR/PLICS to	Programme commenced in Spring 2011. Directorate action plans

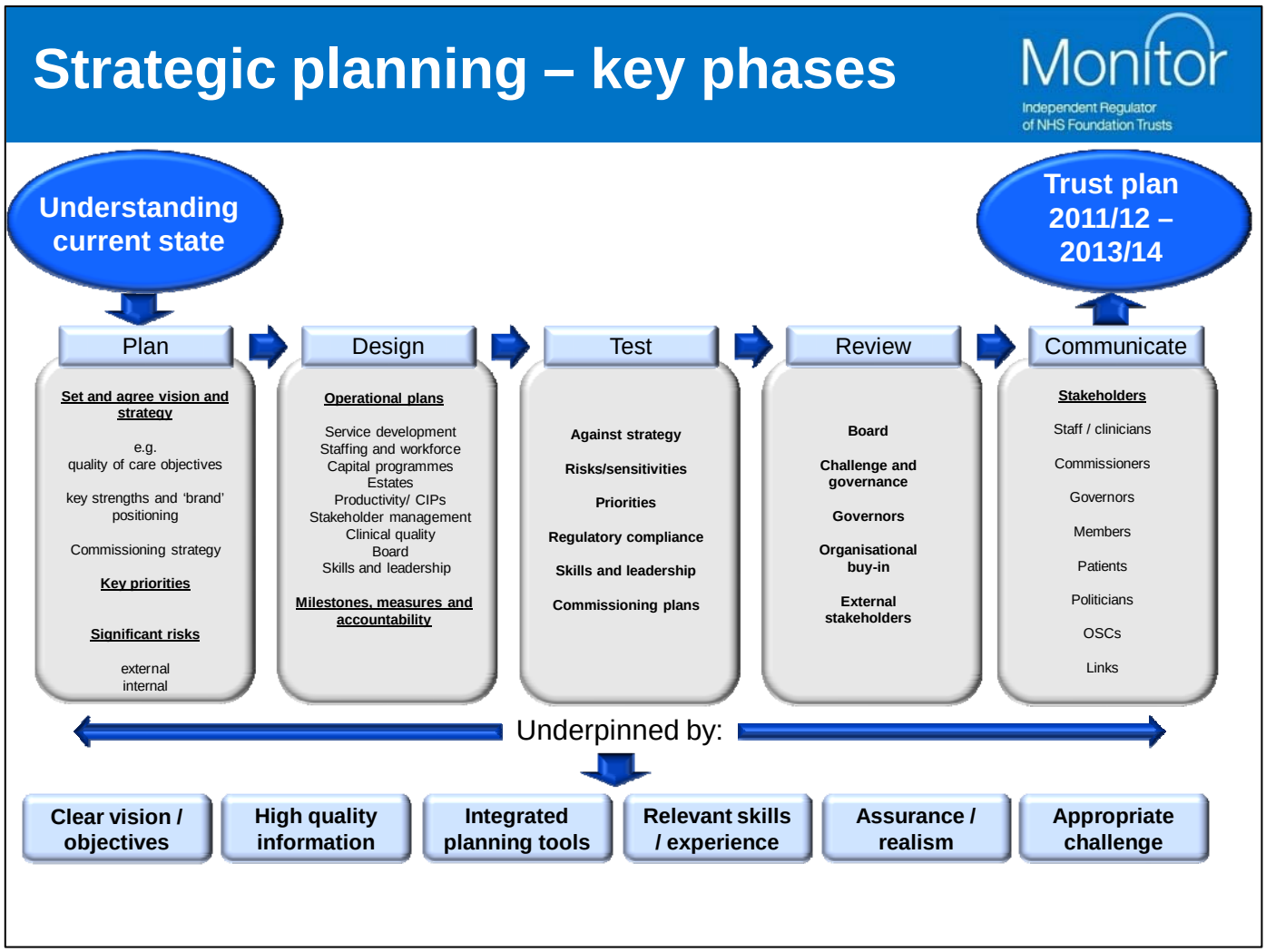
		all clinical specialties to support clinical leaders in understanding costs and performance.	completed and submitted
Improved performance management arrangements	Ensuring consistent performance in all areas across the Trust as a whole.	Performance management framework in place.	Arrangements fully implemented.
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.

In preparing the trust's "forward plan", the board of directors must have regard to the views of the board of governors. In that respect, please set out below how the board of governors have been engaged (including any material feedback received) in relation to the production and finalisation of this plan.

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