NHS
Sheffield

NHS Sheffield Business Plan 2011/12

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Board Meeting

1 March 2011

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Sponsor Director	Ian Atkinson, Interim Chief Executive

Purpose of Paper

To seek Board approval of the 2011/12 Business Plan, comprising the Executive Team's high level objectives (Appendix A) and the Operational Plan (Appendix B).

Key Messages

- The high level objectives and the operational plan are intended to deliver Achieving Balanced Health 4 in the context provided by the requirements of the NHS Operating Framework and the transition to the 2013/14 arrangements as determined by the Health and Social Care Bill.

Strategic/Performance implications including links to Achieving Balanced Health

The objectives and operational plan describe the means by which ABH4 will be delivered during the first full year of transition.

Resource Implications

No new implications identified.

Links to Targets

Both components of the proposed Business Plan describe target delivery and will provide the reference point for 201112.

The Business Plan should be read in conjunction with the Board Assurance Framework and Risk Register.

Associated Risks to the PCT

Individual Directors will continue to review their Risk Register entries in the light of the proposed Business Plan.

Consultation Requirements

No additional requirements identified as ABH4 has been the subject of extensive discussion with stakeholders and the NHS Operating Framework places clear and specific requirements on PCTs

Equality/Diversity Impact
The Business Plan is intended to support delivery of ABH4 intentions to have a continuing positive impact on equality and diversity
Recommendations
The Board is recommended to approve the proposed 2011/12 Business Plan

Appendix A

NHS Sheffield Business Plan 2011/12

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
		Delivery			
1.	Corporate Services	Ensure all appropriate governance mechanisms for the PCT to meet its legal obligations are effective and are taken into account in the transition planning including GPCC and possible Commissioning Support Organisations	• Develop governance framework to fit the functions and form of GPCC	• Effective system of governance which gives assurance to Board and relevant committees and schemes of delegation established	July 2011
2.	Corporate Services	Ensure all appropriate governance mechanisms for the PCT and the PCT cluster to meet its legal obligations are effective and are taken into account in the transition planning	• Develop governance framework to fit the functions and form of clusters	• Effective system of governance which gives assurance to Board and relevant committees and schemes of delegation established	April 2011
3.	Corporate Services	Optimise the HR service/support to the commissioning organisation and provide line management support	• Develop appropriate level of HR support for NHS Sheffield • Establish line management arrangements • Work with strategic HR lead to ensure seamless service	• Effective system of HR provision and support	May 2011
4.	Corporate Services	Develop the Risk and health and safety service for NHSS	• Review and ensure service fit for purpose	• Compliance with statutory and legal requirements	Sept 2010
5.	Finance & Healthcare Procurement	Deliver financial balance in 2011/12 and other statutory duties to support delivery of a sustainable financial position as part of the transition to new commissioning arrangements	• Set 2011/12 budgets which support delivery of financial balance • In year support to budget holders to ensure effective financial management and governance	• Annual accounts for 2011/12 demonstrate delivery of all statutory duties	April 2012
6.	Finance & Healthcare Procurement	Develop and implement 2011/12 Procurement plan to support delivery of ABH4 and QIPP programme; and manage the introduction of Any Willing Procurement rules in line with DoH policy.	• Develop and implement 2011/12 procurement plan • Implement AWP national guidance as required • Work wih GP CC to negotiate 2012/13 contracts with all local service providers	• Procurements implemented to support service transformation requirements • AWP arrangements implemented to comply with national requirements and to expand service provision locally to give more choice to patients • 2012/13 contracts negotiated which deliver vfm and support service transformation	Ongoing Depends on national timetable March 2012
7.	Performance	Delivery of ABH4	• To ensure plans for the implementation of the ABH4 strategy	• Milestones for each quarter in each programme being met and financial	Quarterly

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			are robust and delivered to underpin financial balance in 2011/12 and related reduction in secondary care capacity	benefits of the programme are realised	
8.	Performance	Performance support and accountability	• Provide GPCC with performance support to ensure the transition to GPCC & performance & accountability arrangements are delivered	• PBC level reporting incorporated in formal reporting mechanisms, i.e Board report, Delivery Board etc	Quarterly
9.	Performance	Operating framework performance indicators	• Monitor, assess and report on compliance against performance indicators specified in the Operating Framework.	• Agreed levels of performance are achieved against each standard and report progress at Trust Board	Quarterly
10.	Performance	Local Health Community IM&T programme	• Deliver LHC IM&T programme	• Targets in the plan met, plan updated to timetables at agreed by the SHA	Quarterly
11.	Public Health	Continued improvement in the health of the people of Sheffield.	• Continued broad programme of health improvement activities, both locality and community specific as well as topic specific. • Continue to commission relevant PH programmes.	• Improvement in key population health indicators, e.g. AAACM and life expectancy, as well as sub-population specific indicators such as infant mortality.	March 2012
12.	Public Health	Reduce health inequalities within Sheffield.	• Continued implementation of the joint Health Inequalities Action Plan, including all actions contained therein.	• Revised 'Basket of Health Indicators' identified and agreed. • Measurable reduction in health inequality across the City.	March 2012
13.	Public Health	Ensure that ABH4 and subsequent commissioning strategy documents are underpinned by robust needs assessment.	• Further develop the Joint Strategic Needs Assessment (JSNA) with LA partners, ensuring that it is aligned with joint commissioning priorities. Publish DPH Annual Report. • Conduct specific needs assessments to support GPC and Joint NHS/LA commissioning for both adults and children.	• Programme of detailed joint needs assessments (Deep Dives) agreed with the Adult and Children's Joint Commissioning Groups respectively. • DPH Annual Report published. • Health component of 0 to 19 Partnership plan completed.	October 2011
14.	Public Health	Successful delivery of QIPP programmes.	• Ensure PH leadership of the relevant ABH4 / QUIPP programmes, and appropriate support to others not led from within PH.	• QIPP delivered.	March 2012
15.	Standards and Engagement	Maintain robust assurance systems for quality and safety during transition stage	• Ensure robust CQUINS performance management in partnership with Director of Performance.	• Robust systems in place re quality assurance and patient safety.	June 2011

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			• Monitor action plans of providers for EMSA ensuring areas of non compliance are targeted • Respond appropriately to relevant national/ local reports ensuring all requirements met in full, example - Robert Francis report re: Mid staffs. • Work with CSU/ Consortia to agree and plan smooth transition of appropriate performance monitoring	• All providers remain compliant with EMSA • level of potential risk reduced due to mitigation of robust assurance process	March 2012
16.	Standards and Engagement	Ensure that patients are provided with safe, clinically effective and cost efficient medicines and we get VFM from prescribing budget	• Determine with finance the prescribing and pharmacy budgets taking account of prescribing efficiencies and value for money • Regular performance monitoring of the budgets, taking appropriate action where necessary. • Ensure medicines safety via appropriate systems of medicines governance • Ensure that specialist and high cost drugs are used in accordance with national and local commissioning arrangements • Ensure PNA kept up to date to inform high quality pharmacy services commissioning	• VFM obtained for the prescribing and pharmacy budgets • Evidence of delivery of VFM • Patients are not at risk through medicines use • Effective implementation of commissioning arrangements • High quality services available from pharmacies aligned with identified need	March 2012
17.	Standards and Engagement	Continue to optimise communication to all stakeholders regarding key developments in the various aspects of the PCTs work and transition to new arrangements.	• Develop and agree workplan for Campaign company to undertake consultations / campaigns as required by NHSS for commissioning decisions. • Ensure robust and appropriate communications for staff re new arrangements	• Evidence of Stakeholders involvement in consultations/ campaigns • Staff feel informed and aware of new arrangements	March 2012 June 2011
18.	Standards and Engagement	To ensure that NHSS and providers continue to meet infection control targets.	• Retain robust monitoring systems including MSSA Bacteraemia from January 2011 and in the future E Coli. • Develop and implement a work programme with providers and care homes to ensure there is significant	• Sheffield will remain high achiever of Infection control targets • Community C Difficile cases will remain within trajectory.	Ongoing March 2012

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			reduction of C Difficile in the community setting. • Work with CSU/ Consortia to agree and plan smooth transition of appropriate performance monitoring		
19.	Standards and Engagement	Continue to strengthen Child/ Adult safeguarding systems	• Ensure that the Safeguarding Strategy is implemented. • Delivery of SCR recommendations in timescales, ensuring that improvements are made within services • Strengthening of Adult safeguarding services in health to the mirror standards of children's • Work with CSU/ Consortia to agree and plan smooth transition of appropriate performance monitoring	• the action plan implemented by 2013 and • Assurance from providers will be strengthened. • All IMRs meet Ofsted compliance. • Demonstrable improvements in services will be made • Adult safeguarding service will be resourced and monitoring strengthened.	March 2012 March 2012 September 2011 March 2012
20.	Standards and Engagement	Strengthen contract management for independent contractors	• Embed robust contract management framework for independent contractors that takes forward dashboards and 4 tier approach • Develop and complete negotiations on new PMS contract that mobilises within agreed project timescales and delivers demonstrable value for money • Develop and establish NHSS approach to revalidation and implement infrastructure, systems and processes to meet obligations for responsible officer role	• Independent contractors deliver contractual obligations • PMS review completed and revised PMS contract agreed and in place. • RO appointed and process agreed.	March 2011 March 2011 October 2011
21.	Standards and Engagement	Improve CHC service benchmarking against peer and regional comparators, whilst meeting core quality standards for care management and throughput.	• Develop and implement processes for procuring care that allows for quality monitoring, achieves best value and meets statutory requirements. • Ensure the appropriate quality of care by through effective assessment, care management, and planning of care packages. • Increase the efficiency of the handing of CHC processes, so that	• Introduce NHS standard contract for nursing care. • Transfer procurement of home care packages to LA. • 95% patients reviewed after 3 months and one year. • Reduce eligibility level to less than 100 per 10,000 pop[n] • 95% of eligibility decisions made in less than 28 days of receipt of checklist.	October 2011 March 2012 March 2012

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			outcomes are delivered in less time. recuing the time taken to determine eligibility is determined Efficiency • Ensure the CHC service is equipped to deal with the demands of new business.	• Fast Track packages mobilised within 7 days of receipt of assessment. • Completion of business information project. • Identification of operational models for short and medium term.	March 2012
22.	Strategy	Achieve effective integrated team working between NHSS and Sheffield City Council to deliver intermediate care	• Develop a plan to maximise the benefits for patients, staff and organisation • Work with the Performance Directorate to put in place outcome based performance measures	• Create a joint NHSS & SCC Project Initiation Document and project plan by target date • Measureable improvement to effectiveness and efficiency resulting from joint planning of care and delivery of services	June 2011 December 2011
23.	Strategy	To deliver the LIFT and Capital Programme	• Bring 4 current LIFT schemes to Financial Close and commence construction • Progress Intermediate Care Centre and Parson Cross schemes in line with overall strategy and NHSS's financial position • Complete premises capital schemes in line with Capital Programme, adjusting as necessary to reflect any changing priorities	• Schemes will have reached financial close and be under construction • An agreed strategy and way forward will have been identified and implemented for the ICC and Parson Cross schemes • Capital schemes will have been completed in line with the Capital Programme	by 31 March 2011
24.	Strategy	Ensure NHSS contracts achieve value for money, and highest possible quality of care for the following contracts: SHSC; YAS; St Luke's	• Manage contracts, focussing on achievement of finance, activity, quality and performance standards • Negotiate 2012/13 contracts	• Contracts deliver required QIPP savings • Providers achieve standards • Recompense gained where providers fail to do so • Consistently good clinical quality appropriate clinical interventions	by 31 March 2012
		Quality, Innovation, Productivity and Prevention			
25.	Corporate Services	Review the estates portfolio in relation to service transformation and value for money	• Negotiate Estates contract with Care Trust which covers all PCT properties and represents value for • Review all estates for space utilisation and work with FTs to provide and rationalise the estates portfolio • Work with FTs and other key	• FM services which delivers objectives and is VFM • Improved space utilisation and VFM from properties • Review completed and actions taken	June 2011 March 2012

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			partners to ensure best use of estates across the city	to rationalise where necessary and appropriate	March 2012
26.	Finance & Healthcare Procurement	Delivery of QIPP savings is an essential component of delivery of financial balance. As a result, ensure full integration of savings proposals with contracting process and the development of a downside financial risk scenario QIPP plan .	• Triangulate QIPP business cases with contract income reduction and contract investment proposals. • Develop additional QIPP actions to support downside risk assessment • Ensure detailed in year financial monitoring re. QIPP schemes	• Savings within QIPP plan are owned by local partner organisations and joint action plans agreed to deliver • In year QIPP schemes deliver in line with plans and where they don't remedial recovery plans are successfully implemented	April 2011 April 2011 Ongoing
27.	Performance	Contract management	• Ensure that contracts with all providers for 2011/12 are closely managed to ensure delivery of high-quality care and achievement of key performance targets within the PCT's affordable envelope	• Monitoring of performance, quality and finance against PCT plans and national requirements	Q4
28.	Performance	Data and information	• Improve the use of intelligence and flow of information to enable timely information is available to affect change and deliver against key objectives.	• Easily accessible timely analysis is available to all NHS S and GPCC on financial activity and performance	Quarterly
29.	Strategy	Ensure effective delivery of ABH (4) QIPP programmes for Elective and Mental Health/ Learning Disabilities care	• Establishment of effective project teams • Key milestones determined for each project • Delivery of project objectives	• Effective clinical and organisational engagement against each project line • Milestones achieved • QIPP savings realised for each project line, within each programme	July 2011 October 2011 January 2012
		Transformation			
30.	PEC	Leadership to promote the clinical transformation needed to deliver the financial savings and service improvements in the QIPP programme	• Leading city wide work on system reform, through events such as Clinical Summits and by working with GPC leads and FT Medical Directors. • Working with the APC, LPC and MMT, and through education events, to support delivery of cost effective, evidence based prescribing.	• Changed clinical culture and behaviour which underpin successful delivery of QIPP. • Transformation of service delivery, particularly around creation of more joined up and responsive unscheduled care, and raising non-elective admission thresholds • Achievement of QIPP savings. • Prescribing indicators benchmark against England's best.	Ongoing
31.	PEC	Supporting the delivery of clinical quality	• Provision of a cost effective education programme for independent contractors.	• High level of clinical engagement from across the professions. Changes in clinical practice e.g. referral and	Ongoing

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			• Clinical input to policy and commissioning decisions and service redesign.	prescribing behaviour, changed thresholds for emergency admission and more proactive management in primary care.	
32.	Finance & Healthcare Procurement	Complete a 3 year city wide medium term financial plan in association with FTs, Local Authority and GP CC to support the agreed city wide service transformation programme and capacity plan	• Build up a health economy wide medium term financial plan through CE/DOF planning summits • Ensure plan can be disaggregated or reconciled to individual organisational plans including for individual GP CC	• Health economy wide financial plan which triangulates with activity and workforce plans so that we have joined up view of capacity requirements across the city	April 2011 and then ongoing
33.	Strategy	Establish an integrated Commissioning Unit with SCC	• Agree remit and structure of the team, including objectives • Consult with staff • Recruit to team	• Establishment of team • Effective accountability to both organisations, including GP commissioners • Achievement of objectives	July 2011
		Transition			
34.	PEC	Providing clinical advice to support PCT corporate and statutory functions during the transition process	• Clinical input to IFR and CHC processes; providing clinical advice to the QIPP programme, dealing with individual clinical performance concerns and contractual issues.	• Achievement of cost reductions through commissioning of clinically appropriate care. • NHS Sheffield remains able to deliver clinical governance / assurance functions whilst it remains a statutory organisation.	Ongoing
35.	PEC	Influencing transition arrangements so that momentum around transformation is maintained	• Shaping a managed process for devolution to new GP led commissioning arrangements.	• Smooth transition to new arrangements. Energy and focus not diverted away from system transformation by the tasks associated with setting up GPCC.	Ongoing
36.	PEC	Reviewing the functions of the Clinical Executive and its role in relation to the development of GP commissioning arrangements	• Revisit the Terms of Reference. • All Clinical Executive members' terms of office expire 31/8/11. We need to decide whether to extend the CE on an interim basis or to stand it down. • Review the recommendations made to the Board in November 2010 in the light of emerging direction of travel for the PCT and GPCC.	• Clear balance of responsibilities between Clinical Executive and GPCC, avoiding unnecessary duplication or confusion. • During the remainder of its existence, the Clinical Executive continues to add value to the developing GPC arrangements, to other contractor professions and the wider clinical community – and offers a good return for NHS Sheffield's investment.	We need to recommend a way forward to the Board in April or May 2011

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
				• Clear decision on way forward and smooth transition.	
37.	Public Health	Successful transition of PH leadership from NHSS to SCC, including transfer of relevant resources. Successful transition of appropriate agreed PH functions to PHE and the National Commissioning Board	• Set out a clear description of future Public Health arrangements for Sheffield. • Develop and agree a transition plan. • Implement plan. • Review PH directorate to make 'fit for purpose' for transferring functions to SCC.	• Transfer of PH leadership and resources to SCC, and other functions to PHE and the NCB, without undue disruption to delivery of PH programmes and health protection function and with minimal loss of PH capacity. • Effective new arrangements established.	March 2012
38.	Public Health	Further appropriate development of Public Health.	• Development of effective working arrangements with GP Commissioning Consortia. • Development of effective working arrangements with SCC Community Assemblies.	• Effective PH input into GPCC and SCC Community Assemblies.	March 2012
39.	Strategy	Ensure that NHS Sheffield provides an appropriate level of support to emerging GP Commissioning Consortia	• Development and delivery of a structured development programme	• Effective development of GPCC as a Committee of the NHSS Board • Effective integration of relevant NHSS staff into emerging GPCC structures to support the transition phases	Key phases to be determined
40.	Strategy	Support the development of GPC strategy in context of city's health and well being strategy	• Establish relationship between GPCC and new Health and Wellbeing Board • Determine process and structure for strategy • provide supporting information and analysis • Work with GPCC to articulate their strategy	• Process for agreeing strategy in place • Draft strategy produced	March 2012
41.	Finance & Healthcare Procurement	Ensure that all financial governance and systems work is completed to support the service transfers under Transforming Community Services; that asset transfers are achieved as appropriate and that new contracts are implemented	• Ensure effective close down of Provider Services financial position at 31 March 2011 as part of handover of financial responsibilities • Complete 6 month review of financial issues as agreed with 3 FT Directors of Finance • Implement new community service contracts with each FT • Complete assets transfers as	• Year end accounts include full breakdown between Commissioner and Provider assets/liabilities • Achieve net zero impact assessment at 6 monthly review with FTs • Achieve improved performance on contract KPIs and specifications	April 2011 September 2011 March 2012

Ref. No.	Directorate	Key Objective	Actions	Measure of Success	Timescale
			permitted by DOH		
42.	Finance & Healthcare Procurement	Develop budgets and related financial risk management arrangements at GPCC level	• Establish budgets at GP practice and consortia level in line with expected new scope of GP CC commissioning, together with new risk management arrangements • Establish any pace of change arrangements • Establish new financial monitoring arrangements incorporating QIPP monitoring	• GPCC work in partnership with PCT to deliver statutory breakeven duty	May 2011 to establish budgets March 2012 for performance measures
43.	Finance & Healthcare Procurement	Ensure clear financial governance arrangements are developed and maintained throughout the transition to GPCC, National Commissioning Board and in the case of Public Health budgets to the Local Authority	• Ensure active engagement of both internal and external audit in supporting the financial governance transition process • Establish revised SFIs and scheme of delegation to support the transition including the requirements of PCT cluster arrangements	• Excellent financial governance is maintained as demonstrated by external assessments such as Audit reports	March 2012

NHS Sheffield

Single Planning and Assurance Framework 2011 – 2015

Appendix B

Introduction:

This document is the first draft of narrative to provide assurance that NHS Sheffield's strategic and operational plans are congruent with National Priorities as outlined in "Liberating the NHS: Equity and Excellence" which sets out the new government's vision for the management of health services and the subsequent NHS Operating Framework, published in December 2010.

It should be recognised that this document has been produced at short notice and takes account of emerging issues as part of this first stage of the planning process. Work will continue between now and the final version in mid March and will be developed as further intelligence and awareness of key issues become known.

The document recognises the biggest challenge faced in Sheffield; to ensure services are affordable and sustainable in an era of very little growth in healthcare funding, but in the context of continuing demand for services and reduction in funding for other public services – an over-reliance on hospital care in the city and on long-term care. We must achieve greater efficiency and effectiveness of our spend on health services, so that health care in Sheffield is affordable and create a system that is in balance.

Key messages from this supporting narrative are;

- Plans have been submitted relating to the performance measures, activity and finance using our best and most upto date intelligence to inform them.
- Workforce plans will be submitted by 18 February as per the specified timescale.
- Further work will be undertaken to further refine plans
- The plans support the delivery of our strategic priorities, outlined in our Strategy – Achieving Balanced Health
- We have an excellent record of delivery
- Our Strategy and operational plans are supported by strong performance delivery and risk management processes – including the delivery of our QIPP programme.
- The key priorities, operational & QIPP plans will be delivered, whilst we undertake and support organisational transition.

At the time of writing this report we still have significant risks and issues to manage in 2010/11 to achieve overall financial balance - 2011/12 will be an exceptionally challenging year in financial terms.

The document reflects our approach to make the changes that are needed in partnership with Sheffield City Council, the NHS Foundation Trusts, and Primary Care practices in the city. GPs, as commissioners and as the mainstay of healthcare provision, are key partners. Also, of course, we can only establish a sustainable health care system and reduce health inequalities with the support of the public and patients who we serve.

Idris Griffiths
Interim Director of Performance and Delivery

Single Planning & Assurance Framework 2011 – 2015

Section 1 - Long Term Vision & Shared Priorities

NHS Sheffield has set out it's strategy for Health and Healthcare for 2011/12 in the fourth version of "Achieving Balanced Health (4)". Our long term priority remains the reduction of health inequalities in Sheffield – an ambition which is shared by all the partners that are signatories to the strategy; these include Sheffield City Council and our four existing Practice Based Consortia. It outlines the approach to deliver our twin objectives of reducing health inequalities and establishing a sustainable healthcare system.

The Strategy has been developed building on previous years strategic intentions and takes account of achieving priorities outlined in Health Ambitions and the requirements outlined in the Operating Framework. It combines the ambition to reduce health inequalities, with a programme of service redesign that enables efficiencies to be realised and creates a sustainable healthcare model that is focussed on community service provision and less reliant on hospitalisation. This programme of service improvement for 2011/12 and beyond is NHS Sheffield's QIPP plan.

We recognise that we need to deliver our quality and efficiency commitments with a clear focus on QIPP, and are committed to driving up quality whilst improving productivity. We are clear about our priorities to:

- Ensure that patients are safe at all times
- Improve the patient experience and listen to patient feedback
- Ensure health care is effective and focus on health care outcomes
- Implement quality standards and achieve all targets
- Manage clinical risk and poor performance

We have set a target to increase life expectancy, in the most deprived parts of the city, by at least four months each year. We are intending to use the life expectancy at birth in the most deprived fifth of the City as a measure of the extent to which the health of the least well off in our City is improving. In this way we intend to 'add years to life'

NHS Sheffield will focus efforts on;

- Major causes of early mortality and morbidity – coronary heart disease, stroke, diabetes and respiratory disease
- Modifiable risk factors for disease – e.g. smoking, alcohol, obesity
- Specific communities in our population - people with mental health problems and children and young people
- Tackling health inequalities – as measured by the slope index of inequality in life expectancy at birth (males and females).

NHS Sheffield has identified 10 health priorities which include;

1. Coronary Heart Disease
2. Chronic Respiratory Disease
3. Stroke

4. Diabetes
5. Mental Health
6. Smoking
7. Alcohol
8. The health of Children and Young People
9. Addressing inequalities in life expectancy in priority areas
10. Cancer

Priorities and improvements in these areas will be managed as part of an overall programme management approach to delivery and as part of our QIPP programme management – as detailed in a later section.

It is recognised that our ability to tackle health inequalities is compromised by the current imbalance in our system. Our objective to achieve a sustainable health system is to ensure resources, including clinical and managerial time and focus, are available to tackle health inequalities and reduce the over-reliance on hospitalisation.

In creating a sustainable healthcare system we will aim to;

- Improve advice and support to enable self care including use of technology to support patients to stay healthy,
- Improve access to a wide range of primary and community based services, including intermediate care
- Improve access to, whilst streamlining mental health services
- Reduce demand on hospital services, decrease length of stays and admissions
- Reduce demand on Urgent care services, OP attendances, and hospital beds.
- Reshape the workforce to reflect the reduced reliance on hospitalisation.

Delivery of our priorities is supported by Informatics, as an enabler, through our LHC IM&T Plan. The Sheffield Informatics Plan seeks to create a balance between ensuring that ICT supports the aims and objectives of the individual partners and the need to release efficiency, effectiveness and economic benefits through collaborative action.

The development of a city-wide Assisted Care Strategy, builds on the existing small-scale telehealth projects with the aim of embedding assistive technology into health community. Successful discussions have already been held with CHD clinicians who are hoping to introduce for heart failure patients. In other areas, it will be implemented through contracting and service specification developments.

Section 2 - Capacity and Demand Assumptions

There are inefficiencies in aspects of the health care system that ultimately threaten the sustainability of the health system as a whole. Symptoms of inefficiency include the potential financial overspend within the health care system and our position in comparison with other areas when the potential to make efficiencies is assessed.

NHS Sheffield has used Programme Budgeting to help identify particular clinical areas where we use more resources than most.

Areas of further efficiency include reducing avoidable emergency admissions, reducing lengths of stay in hospital, reducing variations in elective referrals and reducing variations in elective treatment. Our QIPP plan will focus on tackling these areas amongst others.

We have undertaken a less detailed exercise than in previous years to assess likely demand and to project hospital activity requirements for future years. Simply on the basis of historic trends and demographic projections, we would calculate an increase in the activity requirement year-on-year. However, benchmarking data on NHS Sheffield's use of acute hospital services shows that we are at the high end of the spectrum in terms of referrals, outpatient attendances (particularly follow-up), emergency admissions and length of stay.

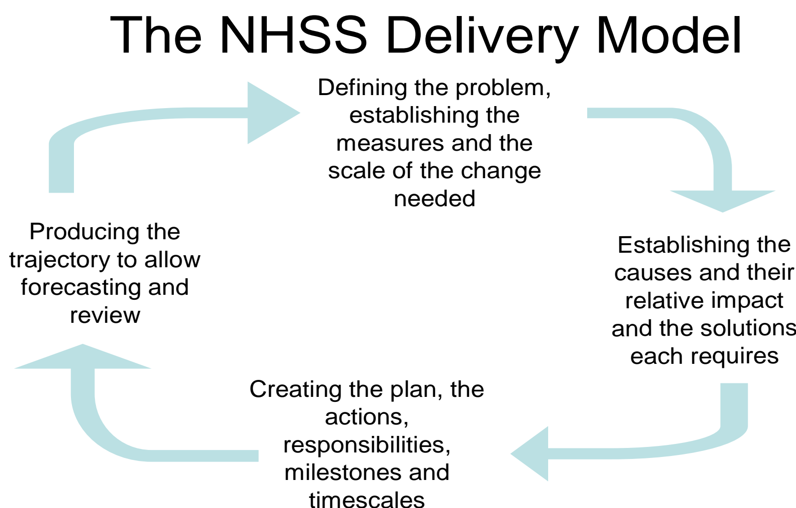
Our developing QIPP plans target all of these areas and we are confident that there is scope for the significant net reductions in activity which we are projecting over the planning period. We have not built into our plans the ability to reduce waiting times below current levels, which meet the overall 18-week wait requirement. Our projection for hospital bed capacity is very approximate at this stage and will require further discussion with our providers.

Delivery of National Priorities& transition

NHS Sheffield has strong arrangements in place to ensure delivery of healthcare standards, vital signs targets, its business plan and the QIPP programme.

We have a proven track record of delivering against national priorities in both CQC annual health check assessments and WCC objectives. Establishing NHS Sheffield as one of the top performing PCT's nationally.

NHS Sheffield continues to develop the metrics required for a robust and comprehensive assessment and performance management process relating to all its initiatives in this regard. The formal arrangements that we have as an organisation to monitor our performance are set out in summary form below and represent our "planning to deliver" framework.



In 2010/11 in view of our financial constraints and current system of healthcare we aim to achieve at least the same level of performance against key targets and measures as we did in 2009/10 and will continue to adopt this approach in future years.

NHS Sheffield's plans have taken into account the requirements of the operating framework in maintaining and improving quality, recognising the need to achieve these objectives within our financial constraints. These are included in the priority areas within our strategic plan and our programme of improvement.

The table below demonstrates how our local initiatives align with and support the Pathways outlined in *Healthy Ambitions.*

Healthy Ambitions	**NHS Sheffield's Priorities**
Staying Healthy Pathway	• Heart Disease • Respiratory • Diabetes • Smoking • Alcohol • Obesity: adult and child weight management • Reducing health Inequalities
Maternity and Newborn Care Pathway	• Maternity Services • Reducing Health Inequalities
Long Term Conditions	• Heart Disease • Chronic Respiratory Disease • Stroke • Diabetes • Effective & sustainable community health services • Intermediate Care
Children's Pathway	• Children and Young People • Obesity: adult and child weight management
Planned Care Pathway	• Planned care • Specialised Services • Cancer • Inequalities (Enhanced Public Health Programmes) • Productive Discharge
Acute Episode Pathway	• Urgent Care reform • Effective & sustainable community health services • Stroke • Reducing demand on hospitalisation
Mental Health Pathway	• Mental Health • Unscheduled Care • Inequalities (Enhanced Public Health Programmes)
End of Life Pathway	• End of Life • Reducing inequalities in life expectancy • Cancer

QIPP Programme Management

Our programme for 2011/12 will be even more challenging than 2010/11 and we will need to ensure that we are reflecting our agreed process of transition to enable GP commissioning consortia to effectively manage our many change programmes. Our intention therefore is to:

- Use the established partnership boards to drive provider changes.
- Our consortia and PCT management teams are viewed as one resource
- Our Clinical Commissioning Executive Team, made up of NHS S Executive Team and Consortia clinical and managerial leads, oversees the programme
- Our contracting intentions reflect our priorities and our delivery arrangements to ensure better coordination of our contracting and delivery work with our providers

Process for delivering 2011/12 ABH4/QIPP programme

We are currently assessing the contribution of existing and planned schemes to ensure they fit with the strategic priorities and that they are able to deliver financial efficiencies over the next 1 – 4 years. In year 1 we have identified that we required a programme that will save £36.5m, with £21m being saved from schemes that have commenced in 2010/11 and the process is underway to identify schemes to delivery the remaining £15m. We are establishing the financial efficiency required by each of the seven programmes, to deliver the overall sum. The savings plans have been developed using information from evidence from Better Care Better Value, NHS comparators, core cities benchmarking and programme budgeting.

We have introduced, following a risk assessment of the 10/11 QIPP programme, a more robust gateway approval process for business cases. This includes revised documentation that will ensure each project lead makes a strong, concise case which shows how and when savings will be delivered, identifying operational risks, mitigating strategies, securing clinical engagement, etc. It is intended that by "raising the bar" at the outset of the planning stage, we will ensure that only projects which are likely to deliver.

First cut of QIPP milestones for 2011/12

As requested we have attached a high level summary of milestones, by programme, month by month. A pragmatic approach has been adopted due to the short timescale for completion of this work, and so is not as complete or robust as we would like. These milestones are for existing QIPP projects which are already live and which will continue into next year, or already approved projects with a clear start date. The full QIPP programme will include new projects and monitoring arrangements will be applied with rigour to these, including the identification of milestones. These will be included in the next iteration of this document.

Despite robust arrangements existing with NHS Sheffield, some high level risks remain which are highlighted at section 6.

Section 3 – Organisational Arrangements

NHS Sheffield has with its partners established a strong relationship to manage the transition to the new healthcare organisation. In response to Transforming Community Services, agreement was reached across all the key partners as to the most appropriate service alignment for Sheffield, which would provide the greatest opportunity to transform services and create a sustainable health system. Plans are now being finalised in line with the required process and timescale overseen by two provider Partnership Boards (Adult and Children's) consisting of representatives from across the key provider organisations and GPs.

PBC clinical and managerial representatives are now fully integrated into the decision making structure of NHS Sheffield, including a Clinical Commissioning Executive Team (CCET) that meets weekly, the Planning and Delivery Board's which oversee the development and implementation of our ABH4/QIPP programme and the Trust Board which has ultimate responsibility for direction setting, decision making responsibilities and performance of the organisation now and taking account of the future.

In respect of the transition outlined in the White Paper, NHS Sheffield will build on the strong and positive relationships established with the existing PBC and specific transition arrangements have been put in place to ensure that this is given the required focus through a Transition Board, using a range of sub groups to inform the ongoing discussions.

The PEC has reviewed its role in respect of the future and transitional arrangements and is now referred to as the 'Clinical Executive', they will retain an active leadership role with our clinical peers, with a major role around engagement with key opinion formers in the city, including the four professional committees and the FT Medical Directors.

Partners are committed to work together to develop the right solution for the public of Sheffield. A single pathfinder application has been made in relation to the existing four consortia.

Consortia clinical leads have been invited to be clinical champions for each QIPP Programme area in 2011/12. Consortia clinicians and managers have been asked to participate in the scrutiny of project documents in the sifting and prioritisation process for new schemes for next year.

Approval of Plans

The requirements of the Operating Framework have been highlighted in the Trust Board in January 2011 and further discussions have taken place at the CCET following publication of the specific planning guidance. It was agreed that given the timescale for submission of the initial draft, that NHS Sheffield colleagues would prepare the submission.

Following submission of this initial draft, this will be shared and discussed as part of the ongoing development for the final draft through the CCET with final approval being made at Trust Board in March/April 2011. This will also take account of any imminent changes that result as part of the transition programme, including any developments of cluster arrangements. In the meantime, existing networks across South Yorkshire PCT Executive colleagues will provide a forum to share the content of our plans.

Section 4 - Contracting round 2011/12

Our intention is to use the 2011/12 contracting round to support the delivery of our key priorities and QIPP programme as well as engaging with key providers of healthcare to engender a joint and coherent plan for the reform of healthcare services in Sheffield.

At individual programme level, each scheme lead will be clear about the actions that need to be taken, through the partnership and/or contractual means, to ensure that the intended benefits will be realised.

Full details will be provided in the subsequent submission as requested.

Section 5 – Shared Priorities with Partner organisations Partnership/engagement

Our strategy confirms that we remain committed to working with and for the people of Sheffield, in partnership with local NHS organisations, including GPs as both providers of healthcare but also our clinical and managerial leaders from within the PBC as part of our transition arrangements, the City Council and organisations in the Voluntary, Community and Faith sector and in the independent sector to provide the best possible sustainable health services for each and every individual.

It is recognised that we can only make the changes that are needed in partnership with Sheffield City Council, the NHS Foundation Trusts, and Primary Care practices in the city. GPs, as commissioners and as the mainstay of healthcare provision, are key partners. Also, of course, we can only establish a sustainable health care system and reduce health inequalities with the support of the public and patients who we serve. This is demonstrated through;

A series of Clinical Summits, co-ordinated by NHS Sheffield’s Clinical Executive (PEC) have strengthened clinical engagement with the system reform agenda and have shaped our priorities, notably our major focus on unscheduled care and improving services for people aged 75 and over.

Commitment to joint work has been strengthened through the agreement of a joint vision, partnership framework and workplan with Sheffield City Council (SCC) in relation to joint commissioning and in response to the reform outlined in the White Paper.

Our Strategic Priorities, Achieving Balanced Health (4), has joint ownership between out co-commissioners, the four existing Practice Based Consortia and the Sheffield City Council. Consultation with them, will be undertake on the detail of the plans to ensure that it genuinely sets out a common programme of work.

The most recent JSNA was used to inform our priority setting process and the citywide Health and Well Being Board has agreed the priorities reflected in ABH (4).

We will work in partnership with our providers and independent contractors to drive up standards of care, and engage service users, carers and local people. We will set measurable standards and outcome measures of expected performance and ensure that these are achieved by robust performance management arrangements and the contracting process.

We will also work across health / social care boundaries with the Local Authority to drive up standards in independent providers for example with voluntary sector and independent organisations.

Principles and views established from the public of Sheffield are retained in the underpinning Achieving Balanced Health (4) following the 'Big Conversation' reflected in ABH 3 in detail. In addition, we have established the 'Your Health Matters' campaign to engage individuals and local groups of people and will take the content of our plans into these conversations.

The process for approving both the Operating Plan and Achieving Balanced Health (4) is through our internal structures of CCET, Planning Board, and Delivery Board and finally at Trust Board in March – all of which have representations from GP's, the Sheffield Foundation Trusts and LINK.

Section 6 - Performance Delivery and Risk Management (including QIPP)

We will build on our successful approach of ensuring performance delivery which has been established and developed over the past few years, resulting in a proven track record of delivery as outlined in Section 2.

In 2010/11 there remain some key risks which have been monitored as part of the SAAP. These fundamentally relate to finance and workforce with a few individual quality and outcome indicators falling below the required level. The financial risks are included in the table below and the workforce issues will be addressed when the workforce submission is made in February. NHS Sheffield is aware of the quality and outcome indicators that have fallen below the required level of performance. This is being managed within our overall approach to delivery against key measures within the current financial climate; that we will aim to maintain or achieve some improvement against the 09/10 outturn. In these cases the current performance is above the 09/10 position.

At this stage in the planning process, however, there are clearly a wide range of risks and uncertainties. We believe that the assurances provided throughout this document illustrate our ability to deliver and that we have resilient arrangements in place that will mitigate potential risks. Key areas of risk relate to managing the financial pressures, at the same time as reforming the healthcare system to successfully manage demand to reduce the reliance on hospitals, whilst at the same time as undertaking organisational transformation. Key high level risks for 2011/12 are as follows:

Risk	Mitigating Actions
Final breakeven out-turn position for 2010/11 will not be achieved or will require further slippage with cost pressure implications for 2011/12	• Use strong financial governance mechanisms • Deliver against existing recovery plan • Contract negotiations and settlements that reflect this. • Delivery process and programme management approach • Robust overview by CCET and Trust Board including clinical and managerial reps from PBC

Failure to achieve 10/11 QIPP Programme.	• Detailed risk assessment has been undertaken (copy already returned to SHA) and will be actively managed through the delivery programme and structures – described in previous section.
Achievement of QIPP Programme in 11/12.	• £21m of the £36.5m (60%) of these savings are due to accrue from schemes in our existing QIPP plan. • Development of business cases for the remaining £15.5m are currently in progress. • Robust 'gateway' approval process to be implemented based on ability to delver financial savings • schemes within QIPP focus on reducing demand for hospital activity, thus allowing the hospitals to reduce their overall capacity.
Unable to realise reduction in Hospital Capacity	• To build on the 'Sheffield Way' – the mutual agreement with providers as to the shared clinically, operational and financial vision for Sheffield into formal agreements to deliver the required transformational change • Clear message to STHFT regarding intention to redesign acute healthcare systems in Sheffield, especially in terms of non-elective care. • Provide sufficient assurance to providers to take out capacity – based on successful programme delivery • QIPP schemes deliver increased capacity in community & primary care services
Tariff Assumptions - Our current assessment of changes to inpatient and outpatient prices is that they will not reduce our costs by a full 1.5%.	• Review the implications of the road test tariff to test whether our current assumption of an overall reduction in costs of 1.5% is realistic. • Plan assumes a gross benefit of c£7m currently on acute contracts but we have also included contingency reserves to cover 50% of this value if the overall saving proves lower • work through our understanding of best practice tariffs (current indications are that there may be significant reductions in costs in certain areas), specialist top ups and readmissions to understand the financial implications of these. • marginal rate adjustment for emergency activity is unchanged, we do not anticipate a material impact of this on the financial plan, especially given that our current activity is below this baseline with Sheffield Teaching Hospitals.
Contract negotiations & managing Providers expectations regarding financial envelope	• We have written to all our main providers, setting out our expectation that spend in 2011/12 will be lower than in 2010/11 • In 2010/11, we successfully negotiated contract caps on activity with both Sheffield Teaching Hospitals and Sheffield Children's Hospital which have given a financial benefit of c£2m. The plan assumes that we can renegotiate similar arrangements in 2011/12.
Unable to manage financial pressures in Continuing Healthcare Spend based on 10/11	• Continue to deploy a significant proportion of our management resource, including investment of additional resources to the Nurse Assessment team, to review packages of care. Successfully reduced expenditure without compromising quality of care since the new team in place in latter part of 2010/11.

experience.	• Ensure delivery of the QIPP programme in relation to this area to realise financial savings
Adverse impact on health services resulting from Local Authority financial settlement	• Working closely with local authority on their plans to reduce adult social care spend by 7% (or £13m) and on the most appropriate deployment of £7.6m funding via the NHS. Aim is as a minimum to secure no reduction in service activity against the 2010/11 baseline. • Agree to pull into one place the efficiency/cost reduction plans of the PCT, LA, and 3 FT's to understand the potential implications for all parties across the health economy.
Proposals for use of 2% 'headroom' are not approved	• Further QIPP plans would be developed to address financial difference.
Plans failing to deliver in financial or activity envelopes	• Operational and performance leads have already identified key risks against headline performance measures, which will be managed through our approach to delivery.
Impact of organisational change on capacity to deliver	• Robust partnership & transition arrangements in place to maintain focus and capacity within organisations • Engender a workforce with flexibility in roles & functions to provide necessary resilience • Establish workforce plans that support the overall priority • Risks to delivery of key targets and programmes identified and managed effectively through process described above.

Section 7 - Alignment of Finance & Activity

Consideration of alignment between plans will include workforce in due course and this will be included in the final iteration of this document.

There has been very little time to cross-check the activity and finance data before submission. This is obviously work we will take forward in detail before the March submission.

Some causes of apparent anomalies would include the following.

- Our QIPP plans will target significant savings on excess bednights. This will have the effect of reducing planned expenditure without reducing the number of hospital spells.

- Similarly, where our QIPP plans target outpatient attendances and emergency admissions, these will target specific specialties or HRGs which have a different price to the overall average. This could also mean, correctly, that the change in hospital activity is not exactly the same as the change in planned expenditure.

- Similarly, our financial plans will assume that we have to invest in some hospital services which do not produce activity measured in the currencies contained in the templates we are required to submit. Examples include critical care, radiotherapy, high-cost drugs and so on. Investments of this kind will produce increase expenditure with no apparent increase in activity

- Activity and finance are planning the changes in patterns of care – but the activity has not been adjusted in this iteration. The main effect is likely to be a reduction in total non electives but this has not been planned with regard to G&A or other and the specific areas where the money will be released

Section 8 - Financial Assumptions

It must be stressed that the financial plan for 2011/12 is still at an early stage. Due to significant changes in the financial planning parameters, as a result of the publication of the NHS Operating Framework and recently confirmed SHA guidance, major changes have been made from the draft plan submission in December 2010. We are in midst of contract negotiations and are still working through the implications of the road test tariff.

2010/11 Outturn

We continue to report a forecast breakeven position in 2010/11. As discussed in the narratives which have supported our in-year FIMS reports, there are significant risks associated with delivering this position. At month 9, we identified £5m savings still to be secured and a £1m risk of non delivery but are working hard to close this gap. The financial plan for 2011/12 assumes a break-even position.

As well as assessing the "bottom line" position each month we review our forecast recurrent or underlying position. Many of the pressures experienced in-year are recurrent, whilst some of the solutions to mitigate these pressures have been non-recurrent. The current assessment, therefore, is that we will move into 2011/12 with around a £3m underlying financial pressure. This is stated after taking into account the full year effect of 2010/11 QIPP schemes.

2011/12 Control Total

The financial plan is to deliver a surplus of £0.5m, representing the control total recently agreed with yourselves at the SHA. As noted above, the recurrent deficit resulting from significant financial pressures faced by NHS Sheffield in 2010/11, coupled with the requirement to use 2% of our resources non recurrently, means that in order to achieve the 2011/12 control total we will need to deliver savings through our QIPP programme of circa £37m (gross) and circa £27m (net of supporting investment). Our existing QIPP programme was already designed to deliver £21m in 2011/12. We are currently in the process of validating the schemes which make up the existing programme, alongside proposals for new schemes which will deliver a minimum £37m.

2% Topslice/Recurrent Headroom

The plan includes a provision for recurrent headroom (equivalent to 2% of recurrent resources or £18.7m) and matching non recurrent expenditure. This expenditure covers a range of restructuring costs and investment to support delivery of our QIPP programme.

Resource Availability

We have fed into the plan the resource assumptions notified in the PCT allocation announcement as well as the recent notification of £1.5m top-slice for cancer drugs fund and £0.5m for school fruit.

Expenditure Assumptions

The financial plan is predicated on a number of assumptions outlined below:

- We are still working through the implications of the road test tariff guidance but at present we have made a global assumption that net impact of tariff and non tariff changes will deliver a 1.5% reduction in hospital spend. We have made no separate assumption regarding any additional benefit arising from the marginal rate adjustment for emergency activity; mainly because we are assuming that we will remain below the 2008/09 threshold level of activity with our main provider. We have not finalised the quantification of the impact of non payment for some readmissions, but we have assumed that any benefit will be required to reinvest in redesigning systems to reduce emergency activity, in the widest sense, to achieve our strategic aim of reducing acute capacity and moving more activity closer to home.

- We have written to all our main providers outlining our expectation that improved system efficiency will form a major part of any CQUIN scheme for 2011/12 because it is about improving quality of care and patient experience. Care closer to home (fewer emergency admissions and re-admissions, fewer excess beddays, and fewer outpatient follow-up appointments) ought to be better care. We also wish to explore the use of CQUINs to support the construction of a set of different incentives and risk management arrangements which will incentivise improved system efficiency on a win/win basis i.e. the provider is rewarded for helping to redesign service provision and manage activity within an affordable overall envelope, rather than for carrying out extra activity which the commissioner cannot afford.

- We have had initial discussions with Sheffield City Council regarding the use of the £7.6m non recurrent growth for joint working between health and social care but further negotiations are required to conclude this agreement.

- We are continuing to work with partner organisations with regards to £1.5m spending commitment for re-ablement. We intend to build on work in current financial year to redesign systems to reduce length of stay and to provide alternatives to admission, to support our strategic aim of reducing acute capacity and moving more activity closer to home.

- We have assumed general drugs cost inflation of 4%, taking into account the impact of category M price changes, assumptions regarding the cost of new drugs and savings from drugs coming off patent, full year impact of this year's efficiency savings and the anticipated impact of new efficiency schemes.

- Forecast spend on continuing care in 2011/12 makes provision for additional £6m spend, on top of 2010/11 forecast recurrent spend, based on the experience of the current year and forecast activity modelling. The full year impact of 2010/11 QIPP as well as the anticipated impact of 2011/12 QIPP is anticipated to deliver savings of circa £2.5m, leaving a planned net increase in expenditure of £3.5m. We recognise that it will be challenging to contain expenditure increases to this level.

- We have incorporated the draft SCG/NORCOM financial plan into our financial plan assumptions. There is a 'confirm and challenge' meeting on 21 January to review proposals for unavoidable cost pressures and QIPP schemes.

- The financial plan makes provision circa £2m contingency.

- Our QIPP plan includes an assumption that we will make cash releasing savings on our corporate costs in line with previous commissioner management cost savings targets, although this will need revisiting once there is clarity on replacement "running cost" envelopes

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