Memorandum of Agreement

To Support a Joint Approach to Delivering the Sheffield Mental Health Transformation Programme

(Including Risk and Benefit Share)

Agreement Between:	Sheffield City Council Sheffield Health and Social Care NHS Foundation Trust NHS Sheffield Clinical Commissioning Group
Date:	June 2018
To Be Reviewed:	Annually (*In Line With National and Local Planning Timescales*)

CONTENTS

AGREEMENT

1. Overview

1.1 The purpose of this agreement (herein referred to as the 'MOA') is to set out the proposed joint approach that Sheffield City Council ('SCC'), Sheffield Health and Social Care NHS Foundation Trust ('SHSC') and NHS Sheffield Clinical Commissioning Group ('SCCG') (collectively referred to as 'the Parties') have agreed to take in terms of delivering the Sheffield Mental Health Transformation Programme (herein referred to as 'the Programme').

1.2 The Parties acknowledge that whilst this MOA is not legally binding, it does nonetheless provide a framework that will underpin the joint approach. This includes:

- 1.2.1 The benefits of the Programme from a clinical quality, service user, carer and organisational perspective;
- 1.2.2 How the Programme will be refreshed and expanded, so as to meet the system wide efficiency requirement in 2018/19 (and beyond) including workforce development, capacity management and also financial efficiency;
- 1.2.3 The scope of the Programme and the future level of ambition;
- 1.2.4 How the Programme will be delivered;
- 1.2.5 How financial risks and benefits will be shared; and
- 1.2.6 How the Programme (and therefore this MOA) will be governed.

1.3 The MOA does not however:

- 1.3.1 Aim to change organisational form or undermine the sovereign obligations of each respective Party; or
- 1.3.2 Replace (either in full or in part) any existing contractual arrangements, particularly those that are legally binding.

2. Background

2.1 The Sheffield Mental Health Transformation Programme was born from a collective need to secure better joined up services, better clinical outcomes and better value for money through economies of scale, reducing overlaps, eliminating wastage and through innovation and creativity. Rather than take the traditional 'organisational specific' approach to transformation, which has historically been defined by an underlying perception that financial risks will undoubtedly be 'shunted' which inevitably leads to confrontational behaviour, the Parties have designed, developed and are currently implementing a joint transformation programme consisting of 24 project areas, including 8 large scale transformational schemes.

2.2 The overarching aim of the Programme is to address what are predominantly long-standing issues in Sheffield, whilst remaining focused on quality and prevention. Taking a more holistic approach to the delivery of mental health care will genuinely promote parity of esteem by strengthening support across the wider health system for people with mental health problems who tend to (a) have more negative experiences and outcomes

when they receive health care, and (b) place a disproportionate level of demand on general health services. It will, as noted above, also help to focus on the wider determinants of mental ill health and develop more preventative services. This is very much in keeping with national policy and guidance, including (but not limited to) the Mental Health Five Year Forward View[1] and No Health Without Mental Health[2], which respectively aim(ed) to promote person centred care underpinned by principles relating to health and social wellbeing, prevention, promotion and early intervention.

2.3 The Parties acknowledge that In 2017/18 the Programme was intended to improve quality and realise efficiencies on behalf on SCC and SCCG only; SHSC had a separate programme aimed at delivering cost improvements. In 2018/19 however there will be one single efficiency target and therefore one single plan for delivery (see section 5 for further details).

3. Overarching Principles

3.1 The Parties agree that the following 'high level' principles will form the basis of this MOA:

- 3.1.1 There will be a clearly defined rationale for why we are jointly embarking on this work including, but not limited to, the positive impact this will have on clinical quality and outcomes (see section 4);
- 3.1.2 There will be one efficiency target in 2018/19 (see section 5);
- 3.1.3 There will be one single plan for the delivery of the efficiency target (see section 5);
- 3.1.4 There will be one integrated planning and delivery team (herein referred to as 'the Delivery Team') (see section 5);
- 3.1.5 There will be a risk and benefit share agreement (see section 6);
- 3.1.6 Delivery of the Programme will be overseen by the Mental Health, Learning Disability and Dementia Delivery Board (herein referred to as 'the Board') (see section 7);
- 3.1.7 There will be no 'cost shunting', all cost pressures relating to the Programme will be addressed jointly (see section 8);
- 3.1.8 No single organisation will be financially disadvantaged or suffer from a reputational perspective as a result of the Programme (see section 8); and
- 3.1.9 There will be a clear statement of ambition, including an agreed timeline for when this ambition can become a reality (see section 9).

4. Benefits

4.1 The Parties agree that creating a single efficiency target and a single plan for delivery will avoid unnecessary duplication, promote economies of scale, allow the pooling of resources and prevent decisions being taken that could have unintended consequences on other parts of the health and social care economy. Having a single plan and a single delivery team will allow transformation to cut across traditional organisational boundaries and therefore present opportunities to improve whole pathways of care and

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf

therefore improve clinical quality, improve clinical outcomes and generate a greater level of efficiency.

4.2 The Parties further agree that this approach will allow for the pooling of clinical expertise; meaning any decisions taken will take account of a multitude of different clinical opinions both from a primary and secondary care perspective, physical and mental health perspective and from differing clinical viewpoints including (but not limited to) medical staff, nurses, social workers, psychologists, occupational therapists and healthcare assistants. This will further support the anticipated improvements in clinical quality and outcomes.

4.3 From a service user perspective, the Parties agree that taking a collaborative approach across wider care pathways will mean that inefficient practice can be proactively addressed without recourse to organisational parameters. The Parties agree that this will ensure pathways are seamless, onward referrals are substantially reduced (if not eradicated), the provision of care is much more holistic (based on need) and outcomes become the way we jointly measure success (including Patient Reported Outcome Measures). The Parties agree that not only do they want to improve clinical efficacy but also the experience of those who use services.

4.4 The Parties further agree that families and carers will also benefit from taking a collegiate approach through improved coordination between different services and providers, a greater focus on prevention and early intervention and more community based support. The Parties acknowledge and appreciate the enormous contribution families and carers make in terms of providing care and support across the city, and are committed to ensuring that they themselves receive appropriate support as required. Caring for our carers will, as part of this collaborative approach, be a key priority. Carers will therefore form a key component of ongoing engagement and consultative work.

5. Single (Financial) Efficiency Target

5.1 The Parties agree that there will be one single efficiency target in 2018/19. For the avoidance of doubt this will initially combine SCCGs Quality, Innovation, Productivity and Prevention (QIPP) requirement, SHSCs Cost Improvement Programme and SCCs efficiency programme (relating to working age mental health services only) (see section 9).

5.2 The combined level of efficiency required in 2018/19 is £7.1m. For the avoidance of doubt this will be delivered through projects that impact on a number of different areas across health and social care spend. It is not the intention of the Programme to simply reduce spend across mental health, learning disability and dementia services. The Programme is aimed at delivering best value, economies of scale and parity of esteem.

5.3 The Parties agree that having one single efficiency target will enable one single delivery plan to be developed; the Sheffield Mental Health Transformation Programme. This will remove potential areas of overlap and duplication and will enable resources to be used to create a single delivery team. An overview of the practical aspects of how the team will operate is detailed in *Appendix A*.

5.4 All Parties acknowledge that having a single team approach will mean that larger scale transformational projects can be developed which, it is envisaged, will ensure that significant improvements can be made in terms of clinical quality and outcomes and that large scale efficiency savings can be made.

5.5 The Parties agree however that whilst the aim will be to develop and deliver large scale transformation; there will still be a need to develop and deliver small scale transactional schemes. Although such schemes were previously almost always delivered at an organisation specific level, these will in future become part of the Programme.

5.6 The Parties agree that the joint delivery plan will, in the first instance, be based on the existing plans that all three organisations have developed (and in some instances are already delivering). It is acknowledged however that there may be a requirement to identify new project areas and/or refine existing projects. The Parties agree however that once finalised; the plan will need to be signed-off by the Board and by the respective governance processes of each individual Party.

5.7 The joint plan will continue to be referred to as the Sheffield Mental Health Transformation Programme (until such a time the Board agrees otherwise).

6. Risk and Benefit Share

6.1 The Parties agree that the risk and benefit share arrangement that will underpin the transactional element of this MOA will be based on a full pooled budget approach; which, for the avoidance of doubt, will be limited to total expenditure in the following 'in scope' areas:

CCG	SCC	SHSC
1. SHSC Contract (not including learning disability services) 2. Other Mental Health Contracts and Grants (NHS and VCF Sector) 3. CHC (Mental Health or Dementia Primary Diagnosis – over 18s)	1. Mental Health Purchasing Budget (18-65 years) 2. Mental Health Partnerships and Grants	1. CCG Commissioned Services (not including learning disability services, corporate departments or overheads)
Estimated in scope Budget = £98.0m	**Estimated in scope Budget = £7.0m**	**Estimated in scope Budget = £50.0m**
Estimated Proportion of Total Budget in Scope = 11%	Estimated Proportion of Total Budget in Scope = 1%	Estimated Proportion of Total Budget in Scope = 42%

It should be noted that the CCG's figure includes circa £74m of services commissioned from SHSC.

6.2 The proportions of the risk and benefit share arrangement for 2018/19 will be based on the savings requirement for in scope areas for each respective Party. This equates to 24.7% for SCCG; 36.6% for SCC; and 38.7% for SHSC. The risk and benefit share arrangement will be refreshed each year, commencing in January, so that agreement can be reached by March. The Parties agree however that this will be dependent on individual respective planning timescales.

6.3 In the course of refreshing the MOA, different options will be discussed and negotiated. It is possible therefore that the shares in the MOA may change based on the respective saving requirements for in scope areas of each individual Party for that particular financial year.

6.4 For the purposes of the 2018/19 risk and benefit share arrangement, savings from the Improving Access to Psychological Therapies (IAPT) scheme will not fall within the MOA as savings will be used to fund the investment in the service. The Delivery Team (see section 5.3) will however be responsible for delivery of this scheme, with issues being escalated in the same way as other project areas.

6.5 The Parties acknowledge that the differing proportions of 'in scope' spend, compared to the total organisational budget, highlights the level of flexibility that the different organisations will have in terms of offsetting cost pressures in 'out of scope' areas. As a consequence the Parties agree that their respective Directors of Finance/Resources will meet quarterly to review the pool position, specifically at months 3, 6, 9 and 12.

6.6 Depending on the relative financial positions of 'in' and 'out of' scope areas, it is possible that any one Party, as a result of the risk and benefit share arrangement, could move from meeting their control total/plan to failing to meet it. This is clearly not in the spirit of the MOA and therefore the Directors of Finance/Resources will factor this into their discussions during the regular meetings as detailed in section 6.5. The Parties agree that in the spirit of collaboration the risk and benefit share arrangement must be fairly outworked.

6.7 Prior to or during these meetings any Party can propose a capping of risk, if as a result of financial pressures in 'out of scope' areas; the respective Party will not meet its control total and/or statutory obligations. This includes, but is not limited to, the Integrated Care System control totals and the potential impact this may have on respective financial positions.

6.8 The risk and benefit share agreement will be administered by respective finance leads from each of the Parties. This will be overseen by a Finance and Contracting Sub-Group, who will report directly to the Board.

6.9 Where there is a requirement to undertake a financial adjustment as a result of the risk and benefit share arrangement; this must first be agreed by the Board and, where required, by the respective governance processes of each individual Party.

6.10 For the avoidance of doubt, any costs relating to transformational change, including but not limited to redundancies, resignation schemes and estate costs will be factored into individual business cases and therefore be considered 'in scope', resulting in the costs being apportioned on the same basis as other 'in scope' expenditure. For example if there are disposal costs of a particular building as a result of an agreed transformation scheme, then these costs will be added to the pool calculation even though estates costs are out of scope. In addition any costs associated with project management capacity will follow the same process; therefore the costs will be included within each respective business case. Any decisions however to include additional costs in the pool must first be agreed by the Board and, where required, by the respective governance processes of each individual Party.

6.11 Please see A*ppendix* B for a series of practical (hypothetical) examples which illustrate how the risk and benefit share will work.

7 Governance

7.1 The Parties agree that each individual project that forms part of the Programme will have a named Senior Responsible Owner (SRO). SROs will be required to report to the Board every 4-5 Months (as a minimum twice a year). In addition SROs have the opportunity to escalate issues either directly to the Board for an immediate strategic view or to the Programme Lead and/or the Programme Sponsors to take through the appropriate governance process of the appropriate Party. There are 3 Programme sponsors, one representing each of the Parties.

7.2 The Parties further agree that the Board is responsible for overseeing the Programme; although for the avoidance of doubt this does not undermine or replace the sovereign obligations and/or decision making processes of each respective individual organisation.

7.3 In the short term issues will be taken through individual organisation's own governance and decision making processes. The Parties will endeavour however to identify a mechanism to escalate issues and problems that cannot be resolved at a Board level.

7.4 For clarity this MOA underpins the way in which SCC, SHSC and SCCG have agreed to work together to specifically (although not exclusively) deliver the Programme. This MOA therefore articulates the mechanism by which the Programme will be delivered and the financial risk and benefit share arrangement. The Parties acknowledge therefore that this MOA is very much centred on delivery not strategy. Decisions of a strategic nature will be taken by the Board, as detailed above (acknowledging and subject to the sovereign obligations of each Party).

7.5 The Parties acknowledge that wider members of the Board will have an interest in the terms of this MOA, and therefore in the spirit of openness and transparency the Parties agree that this MOA will be shared with each constituent member. The Parties further agree however that the MOA may be extended to include other organisations with an interest in delivering the Programme and/or the resultant outcomes. This will be done with the agreement of all current Parties and enacted in line with section 10 (see below).

8. Impact of Programme

8.1 The Parties agree that no single organisation will be financially disadvantaged as a result of the Programme. In addition all Parties agree to work jointly to ensure no single organisation suffers any reputational damage as a result of the Programme. The Programme will be delivered jointly and therefore the Parties agree to accept joint accountability and responsibility for the impact of the Programme; both positive and negative.

8.2 There will be no 'cost shunting'. Costs associated with the Programme, including but not limited to staffing and estate costs, will be jointly addressed by the Parties.

8.3 The Parties agree that the outcomes of the Programme may result in activity being delivered by a different organisation or stopped altogether. In this eventuality the Parties agree that funding should 'move with activity'. The Parties further agree that it is important that decisions are taken that are in the best interests of patient care, which may impact on individual organisations. Whilst the financial impact of such decisions will be jointly addressed, the Parties accept that decisions must as far as possible be focused on clinical and social care priorities not the priorities of individual organisations.

8.4 In addition the Parties further agree that any procurement related decisions (as noted above) will be taken in line with the legal framework that underpins public sector procurement[3] and the rules governing contracts and procurement of the Party undertaking the procurement. The Parties will agree how best to undertake procurement activity taking into account the nature of the procurement and the advice of their respective officers.

8.5 By signing this MOA each Party accepts that they are entering into an agreement that is based on mutual trust and good faith. It is not legally binding. It is important therefore that the terms of this MOA are continuously reviewed to ensure that they are a) relevant and b) fit for purpose. Changes to this MOA can be made, but any such changes must be agreed by all Parties and enacted in line with section 10 (see below).

9. Scope and Ambition

9.1 The Parties agree and acknowledge that the current scope of the Programme is aligned with the Better Care Fund pooled arrangement, therefore the areas of spend as detailed in Section 6.1 are included.

9.2 The Parties further agree therefore that the following areas of mental health, learning disability and dementia spend are currently excluded from the Programme:

9.2.1 Learning Disability Services (SCCG and SCC Commissioning Expenditure);
9.2.2 Sheffield Teaching Hospitals NHS Foundation Trust (Mental Health, Learning Disability and Dementia Specific Expenditure);

[3] https://www.gov.uk/guidance/public-sector-procurement-policy

9.2.3 Yorkshire Ambulance Service (Mental Health, Learning Disability and Dementia Specific Expenditure);
9.2.4 SCCG Non-Contracted Activity (Mental Health, Learning Disability and Dementia Specific Expenditure);
9.2.5 Children and Young Peoples Mental Health and Learning Disability Services;
9.2.6 SCCG 3rd Sector Grant Agreements (Mental Health, Learning Disability and Dementia Specific Expenditure);
9.2.7 Mental Health, Learning Disability and Dementia Related Prescribing Costs
9.2.8 Mental Health, Learning Disability and Dementia Elements of the Public Health Grant;
9.2.9 Section 12 Medical Fees;
9.2.10 Costs of Social Work staff who are subject to the secondment agreement between SCC and SHSC; and
9.2.11 The costs of CHC staff.

9.3 The Parties agree however that in terms of future aspirations, it is the ambition that other areas of mental health, learning disability and dementia spend in Sheffield may be included within the scope of the Programme. This would be subject to further work and agreement, in accordance with each Parties own decision making processes, based on an assessment of risks and benefits.

9.4 The Parties further agree that as the scope of the Programme is extended, the role of the Board will also need to evolve to ensure that the collective decision making mechanism incorporates organisations and staff who will have an interest in the development and delivery of the Programme; as well as expertise and experience that will be invaluable in terms of informing future decisions. The Parties acknowledge however that there will also be potential benefits in terms of extending this MOA beyond the current tripartite arrangement. This may include (but not be limited to) incorporating other organisations into the Delivery Team on either a permanent or 'issue specific' basis.

9.5 To enact the stated level of ambition, the Parties acknowledge:

9.5.1 That this may require changes to the existing Better Care Fund pooled budget, so that all areas of spend as detailed in sections 9.1 and 9.2 are included;
9.5.2 That this may in turn mean the section 75 agreement that underpins the Better Care Fund will need to be amended;
9.5.3 That the Delivery Team may naturally expand, as there will be staff associated with the areas of spend as detailed in section 9.2;
9.5.4 That this additional funding may need to be factored into the risk and benefit share agreement in both the section 75 agreement and as detailed in section 6 (given the respective proportional splits may change); and
9.5.5 That the overall Programme may need to be refreshed given the opportunities this will present in terms of wider care pathways and the potential for an all age approach to every aspect of mental health and learning disability care and treatment across Sheffield.

9.6 The Parties agree therefore that the overall ambition, subject to further decisions by all Parties concerned, is to have:

9.6.1 One single budget for all aspects of mental health, learning disability and dementia services in Sheffield;

9.6.2 One single efficiency target covering all aspects of mental health, learning disability and dementia services in Sheffield; and

9.6.3 One integrated team responsible for delivering the Programme, encompassing all organisations and all staff who were previously involved in the commissioning and provision of mental health, learning disability and dementia services in Sheffield.

9.7 An implementation plan detailing when this may be enacted is detailed in *Appendix C*. Given the scale of ambition and the complexity associated with combining budgets and teams who/which have historically had limited interaction; the implementation plan has been intentionally split into four stages:

9.7.1 **Stage 1** details the action required to establish a single budget and single delivery team by 1st April 2018 (incorporating the budgets as detailed in section 9.1);

9.7.2 **Stage 2(a)** details the action required to bring together all budgets and teams associated with 'adult' and 'older adult' mental health and dementia services by 31st December 2018;

9.7.3 **Stage 2(b)** details the action required to bring together all budgets and teams associated with 'adult' and 'older adult' learning disability services by 31st March 2019;

9.7.4 **Stage 3** details the action required to potentially include other organisations (and staff) in the MOA and the Delivery Team; and

9.7.5 **Stage 4** details the actions required to incorporate 'children and young peoples' mental health and learning disability budgets and teams by 30th September 2019 (acknowledging that this will involve significant preparatory work given the historical separation in terms of commissioning and provision across Sheffield plus an appreciation of the work already underway in terms of developing all age services across mental and physical health services in Sheffield). In particular all parties acknowledge that Sheffield Children's Hospital NHS Foundation Trust ('SCH') will need to be involved in any such preparatory work from the outset, given their role as a (significant) provider of children and young people's mental health and learning disability services across Sheffield. Currently no such discussions have been had at a strategic level with SCH.

10. Duration and Amendments

10.1 The MOA is intended to cover the full period of the Programme; therefore from the point of signature until 31st March 2021.

10.2 The Parties will periodically review this MOA via the Board. It is possible therefore that changes will be made both prior to and during the delivery phase. All such changes must however be agreed by the Board and approved by each Party in accordance with their own decision making processes before ratification prior to being enacted.

10.3 Despite not being legally binding, the Parties have agreed that in the spirit of collaboration it is possible for any one Party to terminate this MOA (and therefore their

involvement in the Programme), but they must give at least 3 months (90 days) notice. In the spirit of collaboration any termination would need to include a collaborative review of the implications regarding the delivery, risk share and resourcing of the Programme. In this period the Parties will continue to contribute to agreed project costs.

10.4 As stated previously, the risk and benefit share arrangement will be agreed annually, based on the saving requirements for the following financial year.

SIGNATURES

By signing this MOA Sheffield City Council, Sheffield Health and Social Care NHS Foundation Trust and NHS Sheffield Clinical Commissioning Group agree to adhere to the principles as detailed in this MOA. They accept that whilst this is not legally binding, it does nonetheless set out the agreed joint approach to the delivery of the Sheffield Mental Health Transformation Programme.

Signed By:	
For and on Behalf of:	Sheffield City Council
Signature:	
Title:	
Date:	

Signed By:	
For and on Behalf of:	Sheffield Health and Social Care NHS Foundation Trust
Signature:	
Title:	
Date:	

Signed By:	
For and on Behalf of:	NHS Sheffield Clinical Commissioning Group
Signature:	
Title:	
Date:	

Appendix A

Integrated Planning and Delivery Team

Objective(s)	a. To help develop and to deliver the Sheffield Mental Health Transformation Programme through a structured programme and project management approach. b. To ensure that each project is adequately resourced and that implementation groups are appropriately constituted. c. To ensure EIAs and QIAs are completed for each individual project. d. To ensure that other priorities, as agreed by the Sheffield Mental Health and Learning Disability Delivery Board are enacted. e. To address and resolve issues relating to service delivery and clinical quality (as agreed by the Board). f. To develop and maintain a framework for monitoring delivery, which will include metrics for each individual project. g. To help ensure that the principles of this MOA are upheld; particularly those relating to clinical quality.
Membership	Membership will be agreed by the Programme Sponsors, but membership is likely to consist of: • Commissioning staff from within CCG and SCC Mental Health Commissioning Teams (which will expand as the scope of the Programme expands). • SHSC staff currently responsible for transformational change and/or the delivery of the Trusts cost improvement programme. • Other co-opted members as agreed by the Board.
Location	The Joint Delivery Team will be located within SHSC. The team will, as a minimum, be collocated at least one day per week.
Accountability	Although the Joint Delivery Team will be accountable to the Board; the sovereign obligations of individual team members will be upheld, particularly where there is a legal or statutory imperative to do so.
Leadership	a. The Joint Delivery Team will be led by the Deputy Director for Mental Health Transformation. b. Although existing line management arrangements will initially be left unchanged; it is anticipated that a new structure will be established. This will be agreed by the Board and reviewed periodically to ensure it remains effective. c. The new structure will be established via a series of secondments. The terms and conditions of individual staff members will not therefore be changed.

Appendix B

Risk and Benefit Share Examples

(Note: These figures have been used to purely illustrate the mechanism by which the Risk and Benefit Share arrangement will work)

Scenario 1		Plan	Actual	Gap		SCCG	SCC	SHSC		SCCG	SCC	SHSC	Total
SCCG	QIPP in scope	(1.8)	(1.4)	0.3									
SCCG	Pool Over/(Underspend)	100.0	100.2	0.2									
SCCG	Net in scope position	98.3	98.8	0.5		25%	37%	39%		0.1	0.2	0.2	0.5
SCCG	Out of Scope	753.8	760.3	6.5		100%				6.5	0.0	0.0	6.5
SCCG	Reserves	7.0	0.0	(7.0)		100%				(7.0)	0.0	0.0	(7.0)
SCC	Purchasing reduction	(2.6)	(0.5)	2.1									
SCC	Pool Over/(Underspend)	10.0	9.9	(0.1)									
SCC	Net in scope position	7.4	9.4	2.0		25%	37%	39%		0.5	0.7	0.8	2.0
SCC	Out of Scope	1,326.6	1,336.6	10.0			100%			0.0	10.0	0.0	10.0
SCC	Reserves	10.0	0.0	(10.0)			100%			0.0	(10.0)	0.0	(10.0)
SHSC	CIP in scope	(2.7)	(1.8)	0.9									
SHSC	Pool Over/(Underspend)	53.0	52.5	(0.5)									
SHSC	Net in scope position	50.3	50.7	0.4		25%	37%	39%		0.1	0.1	0.2	0.4
SHSC	Out of Scope	67.7	68.3	0.6				100%		0.0	0.0	0.6	0.6
SHSC	Reserves	1.0	0.0	(1.0)				100%		0.0	0.0	(1.0)	(1.0)
		2,322.0	**2,324.0**	**2.0**						**0.2**	**1.1**	**0.7**	**2.0**

Pre risk share reported variances	Plan (not inc. Control Total/Planned Surplus) £m	Actuals £m	Position before risk share £m	Risk Share (Income) / Payment £m	Final Var. £m
SCCG	859.0	859.0	0.0	0.2	0.2
SCC	1,344.0	1,346.0	2.0	(0.9)	1.1
SHSC	119.0	119.0	0.0	0.7	0.7
	2,322.0	2,324.0	2.0	0.0	2.0

Scenario 2		Plan	Actual	Gap		SCCG	SCC	SHSC		SCCG	SCC	SHSC	Total
SCCG	QIPP in scope	(1.8)	(1.4)	0.3									
SCCG	Pool Over/(Underspend)	100.0	100.2	0.2									
SCCG	Net in scope position	98.3	98.8	0.5		25%	37%	39%		0.1	0.2	0.2	0.5
SCCG	Out of Scope	753.8	760.3	6.5		100%				6.5	0.0	0.0	6.5
SCCG	Reserves	7.0	0.0	(7.0)		100%				(7.0)	0.0	0.0	(7.0)
SCC	Purchasing reduction	(2.6)	(0.5)	2.1									
SCC	Pool Over/(Underspend)	10.0	9.9	(0.1)									
SCC	Net in scope position	7.4	9.4	2.0		25%	37%	39%		0.5	0.7	0.8	2.0
SCC	Out of Scope	1,326.6	1,336.6	10.0			100%			0.0	10.0	0.0	10.0
SCC	Reserves	10.0	0.0	(10.0)			100%			0.0	(10.0)	0.0	(10.0)
SHSC	CIP in scope	(2.7)	(1.8)	0.9									
SHSC	Pool Over/(Underspend)	53.0	50.6	(2.4)									
SHSC	Net in scope position	50.3	48.8	(1.5)		25%	37%	39%		(0.4)	(0.5)	(0.6)	(1.5)
SHSC	Out of Scope	67.7	69.2	1.5				100%		0.0	0.0	1.5	1.5
SHSC	Reserves	1.0	0.0	(1.0)				100%		0.0	0.0	(1.0)	(1.0)
		2,322.0	**2,323.0**	**1.0**						**(0.2)**	**0.4**	**0.9**	**1.0**

Pre risk share reported variances	Plan (not inc. Control Total/Planned Surplus) £m	Actuals £m	Position before risk share £m	Risk Share (Income) / Payment £m	Final Var. £m
SCCG	859.0	859.0	0.0	(0.3)	(0.2)
SCC	1,344.0	1,346.0	2.0	(1.6)	0.4
SHSC	119.0	118.0	(1.0)	1.9	0.9
	2,322.0	2,323.0	1.0	0.0	1.0

Appendix C

Implementation Plan

Implementation plan covering the period 1st December 2017 – 31st March 2019	Memorandum of Agreement_Appendix