NHS
Sheffield Clinical Commissioning Group

Quality Impact Assessment of Foundation Trust Cost Improvement Schemes – Assurance of Compliance

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Governing Body Meeting

2 May 2013

Author(s)/Presenter and title	Kevin Clifford, Chief Nurse Jane Harriman, Deputy Chief Nurse
Sponsor	Kevin Clifford Chief Nurse

Key messages

- This paper provides details of the outcomes of the process undertaken in February/March by Sheffield Clinical Commissioning Group in relation to its duty to carry out a clinically-led quality impact assessment of Foundation Trusts Cost Improvement Programmes (CIP's).

- Clinically-led assurance meetings have taken place at all three Foundation Trusts in Sheffield and there is evidence that all providers have a clinically led process to develop and review CIP's to ensure that programmes do not compromise the delivery of quality services and where concerns are raised, that there is an on-going monitoring and review process.

Assurance Framework (AF)

Risk Reference Number: *901*

Is this an existing or additional control:
AF reference 2.1.1a,b,c,d

Equality/Diversity Impact

Has an equality impact assessment been undertaken? Not applicable

Public and Patient Engagement

Please list actions for PPE: Not applicable

Recommendations

The Governing Body is asked to:

- Note the assurance in relation to quality and safety of provider CIPs
- Endorse the proposals for monitoring CIPs.

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1. Introduction

Previously, Monitor and NHS Operating Frameworks have required both Foundation and NHS Trusts to ensure that their cost improvement schemes (CIP) are agreed by Medical and Nursing Directors. This year, the NHS Commissioning Board has set out a requirement in addition to this; that each Clinical Commissioning Group (CCG) should carry out a clinically-led quality impact assessment of all CIP's undertaken by its providers (Everyone Counts: Planning for Patients 2013/14).

This paper provides details of the outcomes of the assurance process undertaken by Sheffield CCG in February/March and follows on from the report presented to the Governing Body in April 2013.

2. The Process for Commissioners.

2.1 Commissioners need to be content that CIPs will not lead to significant clinical risks within the organisation or elsewhere in the system, and that any change in provision does not conflict with agreed clinical strategy or locally agreed clinical priorities.

2.2 The CCG has now held assurance reviews with the three Foundation Trusts. Attendees at these meetings included the Medical and Nurse Directors (or deputies). CCG representation was the Clinical Director and /or Portfolio Lead GP, Chief Nurse or Deputy, Chief Finance Officer and Contract Lead. Where appropriate, specialised commissioners have attended and been engaged in the process.

2.3 Each Trust shared their internal assurance processes, a summary of the main themes, and initial assessment of potential risks and impact on safety and quality.

The CCG was able to gain sufficient assurance in terms of:

- Understanding the programmes and CIP development
- Ensuring that clinician's had been involved in CIP development
- Ensuring that quality and safety issues had been considered
- The impact on the wider system had been considered
- The process including final sign off by the Medical Director / Chief Nurse at Trust Boards

Formal written feedback has been provided to each organisation see Appendices 1, 2 and 3.

2.4 FTs will take the final plans through their own internal governance arrangements and to their Trust Boards in May/June and share with the CCG. The CCG will then provide assurance to NHS England Area Team.

2.5 For Care Home providers, the CCG has now requested the submission of specific assurance and supporting information from the largest local Care Home providers and from those Care Homes that have been identified as a potential risk via the contract renewal process. We are currently awaiting the responses. Once we receive the requested information if deemed necessary, NHSS will then hold specific CIP meetings with care homes to gain further assurance.

3. Reporting and On-going Monitoring

Following the completion of this assurance process, the Contract Clinical Quality Review Groups will review on a quarterly basis, to ascertain whether the impact of the CIPs is lowering standards of quality and safety and monitor any amendments to CIP's in year.

4. Recommendations for the Governing Body

The Governing body is requested to commit to the following recommendations:

- Note the assurance in relation to quality and safety of provider CIPs
- Endorse the proposals for monitoring CIPs.

Paper prepared by Jane Harriman, Deputy Chief Nurse

On behalf of Kevin Clifford, Chief Nurse

April 2013

Sheffield Clinical Commissioning Group

APPENDIX 1

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27 March 2013

Professor H A Chapman
Chief Nurse/Chief Operating Officer
Sheffield Teaching Hospitals
10 Beech Hill Road
Sheffield
S10

Dear Hilary

STHFT Efficiency Plan 2013/14

My colleagues and I would like to thank you, David, Kirsten and Neil for the helpful discussion we had earlier this month on the STHFT Efficiency Plan for 2013/14. As agreed, I am writing to confirm the outcome of the meeting and agreed next steps. Our discussions covered several related areas, and I will go through these in turn.

You described to us the process through which the Trust develops its annual Efficiency Plan, which this year will again need to deliver as a minimum the 4% national efficiency target which we jointly understand will be a substantial challenge. Specific plans are developed at service and Directorate level, but with four cross-cutting Programmes (Clinical, Workforce, Procurement, and Commercial and IT), each overseen by a Board-level director. Benchmarking data (for example on nurse staffing levels and length of stay) helps to focus the plans on the areas of greatest opportunity. The plans developed at Directorate level are based on substantial clinical input; the end-product is jointly owned by the relevant directorate Clinical Director, Nurse Director and General Manager, and you are confident that this ensures that any plan which is taken forward should avoid damaging effects on quality or safety.

You also described the process of review of Directorate plans and performance which the Trust's senior management team undertakes, one part of which is to review and agree each Directorate's proposed contribution to the corporate Efficiency Plan. You confirmed that either David or you or a nominated deputy always attend each review meeting, ensuring a strong clinical focus in discussions around potential areas for savings. This performance review process is maintained throughout the year; Directorates which are 'off track', in terms of financial targets and delivery of efficiency savings, will be required to produce recovery plans, but you again emphasised that the strong clinical presence in these discussions ensures that actions are not taken which would damage quality or safety.

The final detailed Efficiency Plan for 2013/14 will contain 300-400 individual initiatives spread across the Trust's 30 or so Directorates, and commissioners will not realistically be able to assure themselves as to the content of each specific initiative. The summary which Neil had provided was at a much higher level, but allowed a useful discussion about the potential risks involved in different types of initiatives. It was clear that, for the many schemes focusing on non-patient services and back-office functions, there was little or no potential risk to patient care. However, the Trust cannot expect to make all of its efficiency savings in these areas, and our discussion focused particularly on the schemes under the 'clinical' and 'workforce' headings, which are the most likely to have a direct impact on patient services. From your description of the developing plans in these areas, it was clear that the Trust's intention was to make only responsible changes, supported by clinicians, rather than apply unsophisticated 'across the board' reductions.

In terms of specific initiatives:

- We noted that the planned bed reductions (which you indicated would amount to the closure during the next 12 months of 3-4 wards) were consistent with the direction of travel of, and heavily dependent on the success of, the joint Right First Time programme. Further reductions would be indicated if planned commissioner benefits from Right First Time – through excess bed day reductions and admissions avoidance – were realised.
- We agreed that it would be helpful for the Trust to share with commissioners the list of the main procurements planned for 2013/14, so that any cross-over to commissioner concerns and priorities could be reviewed.
- We took assurance from the fact that the Trust had not applied any cash-releasing efficiency savings requirements to its cleaning services over recent years and did not intend to do so in 2013/14.

Finally, we spent some time discussing the Trust's clinical governance systems. You described

- the separate Healthcare Governance Committee (on which NHS Sheffield is represented) and the clinical governance groups in each Directorate
- the arrangements in place for reviewing serious untoward incidents and patient complaints (through which NHS Sheffield again receives detailed feedback on individual cases)
- the arrangements for monitoring hospital mortality ratios within the Trust, which remain consistently within the expected range or lower than expected
- a culture of openness within the organisation about clinical safety issues, with above all a focus on doing the right things for patients.

Overall, the discussions left us confident, in principle, that the Trust is approaching the development of its efficiency plans for 2013/14 in a way which should ensure that patient safety and quality of care remain paramount. We need to be realistic, of course; our discussion was around the principles underpinning a high-level draft plan, not the final detailed schemes, and commissioners will inevitably rely on the Trust for further, ongoing assurance about the practical impact that its Efficiency Plan is having during 2013/14.

In terms of next steps, therefore, we agreed that

- the Trust would share with us a final summary of its Efficiency Plan for 2013/14, after this has been approved at its Board meeting in April
- approval of the Efficiency Plan by the Trust Board would confirm to commissioners that it had been 'agreed by the Medical and Nursing Directors of the provider as having been assured as clinically safe', as required under Planning For Patients 2013/14
- in-year monitoring of all aspects of patient safety and quality of care would continue, led within STHFT by the Healthcare Governance Committee, but also through the Clinical Quality Review Group with NHS Sheffield and the new Quality Surveillance Group being established by the Local Area Team.

Planning For Patients 2013/14 sets in train a new process of engagement between commissioners and providers about how providers ensure that efficiency savings are made without a damaging

impact on safety or quality. As we noted in our discussions, this does not in any way lessen the imperative to deliver these efficiency savings, but it does introduce a new external element to what has been, over recent years, mostly an internal issue for providers. No doubt our local approach to this engagement process will develop over time, but we believe that the discussions we had with you last week offer a good foundation for the future.

With best wishes.

Yours sincerely

Kevin Clifford
Chief Nurse
(signed by Jane Harriman in absence of Kevin Clifford)

Copy to
At STH:
David Throssell, Medical Director
Kirsten Major, Director of Strategy and Planning
Neil Priestley, Director of Finance
At NHSS:
Julia Newton, Chief Finance Officer
Anil Gill, CCG GP
Zak McMurray, Joint Clinical Director
Alastair Hill, Head of Contracting
At NHSCB
Cathy Edwards, Head of Specialised Commissioning

APPENDIX 2

Jane Harriman
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8th April 2013

John Reid
Director of Nursing
Sheffield Children's Hospital NHS FT
The Children's Hospital Sheffield
Western Bank, Sheffield,
S10 2TH

Dear John,

Re: Sheffield Children's Hospital - Cost Improvement Plan 2013/14

My colleagues and I would like to thank you, Derek, Jeremy and Isabel for the helpful discussion we had last week on the SCH Cost Improvement Plan for 2013/14. As agreed, I am writing to confirm the outcome of the meeting and agreed next steps. Our discussions covered several related areas, and I will go through these in turn.

You described to us the process through which the Trust develops its annual Cost Improvement Plan, which this year will need to deliver an efficiency gain, which we jointly understand to be in the region of £4.6 million against a total trust value of contracted services of £150million. Through our discussion we understand the process for developing robust initiatives involves specific plans being developed at service and Directorate level, each overseen by the directorate clinical and managerial lead. Where appropriate you use benchmarking data and modelling tools to help to focus the plans on the areas of greatest opportunity. The plans developed at Directorate level are based on substantial clinical input. We also understand that both the Medical Director and Chief Nurse have in place a robust clinical quality risk assessment process, this risk assessment process is undertaken on all potential CIP initiatives to provide assurance on clinical quality and safety. We understand that the risk assessment process is objective and reports through your Clinical Governance Committee and then onto your Board. The end-product is initiatives that are jointly owned by the relevant directorate Clinical Director, Nurse / Medical Director and General Manager, and you are confident that this ensures that any plan which is taken forward will avoid damaging effects on quality or safety.

You also described the process of on-going review of Directorate plans and performance which the Trust's senior management team undertakes, one part of which is to review and agree each Directorate's proposed contribution to the corporate Efficiency Plan. You confirmed that either Derek or yourself or a nominated deputy always attend each review meeting, ensuring a strong clinical focus in discussions around potential areas for savings. This performance review process is maintained throughout the year; Directorates which are 'off track', in terms of financial targets and delivery of efficiency savings, will be required to produce recovery plans, but you again emphasised that the strong clinical presence in these discussions ensures that actions are not taken which would damage quality or safety.

Through the detailed presentation provided by SCH you provided a high level summary of the key areas where CIP will be achieved in 2013-14 these broadly fit into the areas of:

1) Theatres – Maximising efficiency of theatre capacity
2) Improvement in I.T. – Moving towards Electronic records
3) Inpatient Transformation – Medical, Surgical, HDU, Transformation
4) Outpatient Transformation – reduced DNA increase in use of technology

You provided assurance that each initiative identified for delivery within the four transformational areas had been or will be subject to the robust internal quality assurance process outlined above. As part of this element of the discussion you also provided a summary of where there will be an impact on staffing during 2013-14. We acknowledge that SCH have a robust process in place for undertaking clinical quality risk assessment and that there is an absolute need to drive efficiency to meet the demands of tariff reduction.

There was significant concern raised by NHSS CCG of the impact on clinical quality in relation to community services if the level of identified financial reduction associated with staffing in community services is achieved. Can I request that you provide further assurance of your plans in this area as we understand from the brief discussion that the majority of the saving would be delivered through re-grading of staff and not actual reductions in staff numbers, can you confirm this? Given our concern in this area NHSS CCG will also ensure close monitoring of waiting times for community service in 2013-14 through contract management process to gain further assurance of continued delivery.

Overall, the discussions left us confident, in principle, that the Trust is approaching the development of its efficiency plans for 2013/14 in a way which will ensure that patient safety and quality of care remain paramount. We need to be realistic, of course; our discussion was around the principles underpinning a high-level draft plan, not the final detailed schemes, and commissioners will inevitably rely on the Trust to give further, on-going assurance about the practical impact that its Efficiency Plan is having during 2013/14.

In terms of next steps, therefore, we agreed that:

- The Trust would share with us a final summary of its Cost Improvement Plan for 2013/14, after this has been approved at its Board meeting in April or May

- Approval of the Cost improvement plan by the Trust Board would confirm to commissioners that it had been 'agreed by the Medical and Nursing Directors of the provider as having been assured as clinically safe', as required under *Planning For Patients 2013/14*

- In-year monitoring of all aspects of patient safety and quality of care would continue, led within SCH by the Clinical Governance Committee and also through the Clinical Quality Review Group with Sheffield CCG and the new Quality Surveillance Group being established by the Area Team

Planning For Patients 2013/14 sets in train a new process of engagement between commissioners and providers about how providers ensure that efficiency savings are made without a damaging impact on safety or quality. As we noted in our discussions, this does not in any way lessen the imperative to deliver these efficiency savings, but it does introduce a new external element to what has been, over recent years, mostly an internal issue for providers. No doubt our local approach to this engagement process will develop over time, but we believe that the discussions we had with you last week offer a good foundation for the future.

With best wishes

Yours sincerely

Jane Harriman
Deputy Chief Nurse

Copy to

At SCH:

Derek Burke Medical Director
Isabel Hemmings Chief Operating Officer
Jeremy Loeb Director of Finance

At Sheffield CCG

Kevin Clifford – Chief Nurse
Julia Newton Director of Finance
Ian James Atkinson – Head of Contracting
Dr Trish Edney – GP lead
Dr Richard Oliver – Joint Clinical Director

APPENDIX 3

Sheffield Clinical Commissioning Group

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8th April 2013

Liz Lightbown
Chief Operating Officer/Chief Nurse
Sheffield Health and Social Care Trust
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S10 3TH

Dear Liz,

Re: Sheffield Health and Social Care Trust (SHSC) - Cost Improvement Plan 2013/14

My colleagues and I would like to thank colleagues at SHSC for the helpful discussion we had on 28th March in relation to SHSC Cost Improvement Plan for 2013/14. As agreed, I am writing to confirm the outcome of the meeting and agreed next steps. Our discussions covered several related areas, and I will go through these in turn.

SHSC described to us the process through which the Trust is currently undertaking to develop its annual Cost Improvement Plan, which this year will need to deliver an efficiency gain, which we jointly understand to be in the region of £5.5 million of which an initial £3.5 million has been identified through internal CIP initiatives.

Through our discussion we understand the process for developing robust initiatives involves specific plans being developed at service and Directorate level, each overseen by the directorate clinical and managerial lead with significant clinical input. We also understand that although yet to be fully implemented the trust intends to introduce a robust clinical quality risk assessment process; this risk assessment process which is overseen by the Medical Director and Chief Nurse will be undertaken on all potential CIP initiatives to provide assurance on clinical quality. We understand that the risk assessment process is objective and will report through your Quality Assurance Committee and then onto your Board and you informed us that all risk assessments for identified initiatives will be complete and approved by your board in June. The end-product will be CIP initiatives that are jointly owned by the relevant directorate Clinical Director, Nurse / Medical Director and General Manager, and you are confident that this ensures that any plan which is taken forward will avoid damaging effects on quality or safety.

You also described the process of on-going review of Directorate plans and performance which the Trust's senior management team will undertake, one part of which is to review and agree

each Directorate's proposed contribution to the corporate Efficiency Plan. SHSC confirmed that either Tony Flatley or yourself or a nominated deputy always attend each review meeting, ensuring a strong clinical focus in discussions around potential areas for savings. This performance review process will be maintained throughout the year; Directorates which are 'off track', in terms of financial targets and delivery of efficiency savings, will be required to produce recovery plans, but SHSC again emphasised that the strong clinical presence in these discussions ensures that actions are not taken which would damage quality or safety.

Overall, the discussions left us confident, in principle, that the Trust is approaching the development of its efficiency plans for 2013/14 in a way which should ensure that patient safety and quality of care remain paramount. We need to be realistic, of course; our discussion was around the principles underpinning a high-level draft plan and as yet SHSC have not undertaken the risk assessment process on all of the identified initiatives, and commissioners will inevitably rely on the Trust for further, on-going assurance about the practical impact that its Efficiency Plan is having during 2013/14.

In terms of next steps, therefore, we agreed that

- The Trust would share with us a final summary of its Cost Improvement Plan for 2013/14, after this has been approved at its Board meeting in June

- Approval of the Cost improvement plan by the Trust Board would confirm to commissioners that it had been 'agreed by the Medical and Nursing Directors of the provider as having been assured as clinically safe', as required under *Planning For Patients 2013/14*

- In-year monitoring of all aspects of patient safety and quality of care would continue, led within SHSC by the Quality Assurance Committee and also through the Clinical Quality Review Group with Sheffield CCG and the new Quality Surveillance Group being established by the Area Team

- We work jointly to develop new initiatives to achieve the outstanding £2 million CIP gap for 2013-14

Planning For Patients 2013/14 sets in train a new process of engagement between commissioners and providers about how providers ensure that efficiency savings are made without a damaging impact on safety or quality. As we noted in our discussions, this does not in any way lessen the imperative to deliver these efficiency savings, but it does introduce a new external element to what has been, over recent years, mostly an internal issue for providers. No doubt our local approach to this engagement process will develop over time, but we believe that the discussions we had with you last week offer a good foundation for the future.

With best wishes

Yours sincerely

J. Harriman

Jane Harriman
Deputy Chief Nurse

Copy to

At SHSC:

Tim Kendal – Medical Director
Tony Flatley - Deputy Chief Nurse
Paul Robinson - Director of Finance
Clive Clarke - Deputy Chief Executive
Ken Lawrie - Director of Commercial Services
Liz Lightbown - Chief Operating Officer/Chief Nurse

At NHS Sheffield CCG:

Kevin Clifford – Chief Nurse
Julia Newton - Director of Finance
Zak McMurray - Joint Clinical Director
Steve Thomas - GP Lead Mental Health
Ian James Atkinson - Head of Contracting

At NHSCB:

Cathy Edwards – Head of Contracting