

**NHS operational productivity:  
unwarranted variations**

**Mental health services  
Community health services**



## Foreword by Lord Carter of Coles

Like all parts of the NHS, mental health and community services face a number of challenges that can be partly addressed through operational and structural improvements. NHS mental health and community health services account for about £17 billion of NHS expenditure in England, complementing the £52 billion spent on acute services, and providing critical support for over 2 million patients every day.

The role and importance of mental health services are clear, but that of community health services, with a wide range of local specifications and provisions, is not. If the aspirations expressed in the Five Year Forward View are to be met, we will need to shorten the average length of stay in English acute hospitals from its current 7 days to something approaching Denmark at 5.5 days or the United States at 6.1 days<sup>1</sup>, although some estimates put these even lower. To achieve this, the provision and efficiency of community health services will have to be significantly strengthened. The key challenge for mental health services, by contrast, is in meeting the significant levels of unmet demand. Even taking into account the significant expansion in children's mental health services, workforce constraints mean that by 2020/21 we only plan on meeting the needs of a third of children with diagnosable mental health conditions. Improving the productivity of services is an important part of the answer to how we go further in both sectors.

### *Operational improvement – £1 billion savings opportunity to support patients*

Since January 2017 we have engaged with many mental health trusts and providers of community services, and talked to the healthcare teams and patients who use their services. As a result of that engagement, this review has identified critical and unwarranted variations in all key resource areas. It is clear from the performance of some providers that parts of the sectors know what to do well – the challenge we face is how we raise the average standard of performance closer to the level of the best. Our work has identified four important areas where operational improvement must be made.

1. **Staff:** we spend £10.4 billion per year on staff; giving detailed attention to how they use their time, particularly at this moment of critical labour shortages in all grades, is of the utmost importance. Effective rostering, job planning, managing sickness absence, maximising the clinical time of community staff, appropriate skills mixing, and effective training all lend themselves to detailed management attention. This is, however, something that we have found to be missing in too many providers. Culturally, the high levels of bullying and harassment staff report is inconsistent with the continued mantra that our staff are our most valuable asset.
2. **Contract specification:** the approach to contract specification and management is inconsistent and overly bureaucratic. Clinical commissioning groups commission core services against hugely detailed and often very different specifications. These variations are often unwarranted and the approach has resulted in the imposition of

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<sup>1</sup> OECD, 'Health at a Glance 2017'; [https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017\\_health\\_glance-2017-en](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en)

too many reporting requirements – in one case 6,000 in a single trust. This creates confusion and unacceptable frictional cost.

3. **Technology:** the use of technology is not optimal and lags behind even other public sector services, let alone the best in class. Over a quarter of trusts still operate paper-based systems for community nursing services and, where they do exist, many of the case management systems in community and mental health services are cumbersome and time-consuming for staff to use. The inability to provide a single view of the patient across organisations to date is lamentable. This lack of investment in adequate systems is indefensible in 2018, and means valuable staff time is wasted and patients do not receive the best care. While many trusts have, or are implementing mobile working, e-rostering systems and dynamic scheduling, much more needs to be done to ensure these are being used effectively and driving the productivity and efficiency gains that are possible. There must also be questions about electronic procurement, stock management and the use of electronic prescriptions which are not at a sufficiently advanced stage.
4. **Delivery:** ensuring that these issues are dealt with is the responsibility of NHS Improvement in the case of operational matters, and NHS England in the case of commissioning. NHS Improvement needs to have a clear idea of ‘what good looks like’ in these areas by broadening the focus of the clinically led Getting It Right First Time (GIRFT) programme and providing effective benchmarking information to providers through an adapted Model Hospital. The proposed new regional structure across both organisations will need to be implemented at pace to help providers up their game.

In summary, we could find no reason why the system should not move more quickly to adopt best practice, save for the constraints of capability and capacity.

### ***Structural issues – supporting the Five Year Forward View***

There are a number of structural issues in the provision of services delivered in the community that are well recognised but have not been adequately dealt with and which community health services could play a more significant role in resolving.

1. **Delayed transfers of care:** these remain one of the biggest problems in the NHS. They account for about 5,000 beds at any one time. The main NHS reason given for these delays is the number of patients ‘awaiting further non-acute NHS care’. We saw examples where effective use of community health services and social care has reduced average length of stay in acute beds by four days.
2. **Wound care:** research has shown that the NHS spends about £5 billion a year managing wounds, undertaking over 40 million patient visits. But most trusts do not capture clinical information or operate within nationally defined pathways. The GIRFT programme must extend its approach to community health services to support more efficient pathways in the community.

3. **Community hospitals:** in many areas it is unclear how community health services should be provided to best support patients: some areas have inpatient community hospitals while others have none. We were unable to find any evidence that the often expensive provision of inpatient community hospitals improved outcomes. Patients need to access appropriate local services and there is scope for a wide range of community services to be located in ‘hubs’. In doing so we need to achieve a reasonable balance of size and accessibility if such hubs are to secure the confidence of their local communities and funders. A much clearer idea of ‘what good looks like’ is needed but one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure. Effective national leadership working with local sustainability and transformation partnerships (STPs) across community health, mental health, primary care, general practice and social care services needs to take this forward.
4. **Lifetime healthcare costs:** at current funding levels the lifetime healthcare costs of an individual in England are approximately £185,000, and if social care costs are added this could rise to over £220,000<sup>2</sup>. As Lord Darzi’s recent review of health and care<sup>3</sup> draws out, nearly half of this expenditure occurs after the age of 65. The average length of stay for non-elective patients, for example, is 13 days for those aged over 85. It is critical that the management of these groups of patients is undertaken on a much more focused basis to ensure that acute care interventions are minimised and a much more effective system of dealing with the co-morbidities of old age is found.
5. **Integrated care:** The expansion of the role of the Secretary of State for Health and Social Care to include responsibility for social care should make the dream of integrated care more realistic. The dilemma of social care being means-tested and acute care being free at the point of delivery causes inevitable tensions. There must be some way of incentivising acute hospitals to discharge medically fit patients to step-down and intermediate care facilities, for if nothing else it will enable these hospitals to undertake their economically rewarding elective care work and reduce waiting lists for patients. Other healthcare economies have regarded post-acute care, for a limited period, as an essential part of the acute hospital financing package, aiming as they must to keep the optimal flow of patients through the highest risk and most expensive part of the healthcare continuum. Resolving these issues, as part of the move to place the funding of the NHS on a long-term sustainable basis is critical.

I am grateful for the opportunity to extend my work and undertake this review and I would like to thank the cohort of 23 trusts that has dedicated considerable personal time and effort to supporting the work. This review is as much theirs as mine. I would also like to thank my team and all those who advised and supported me over the last 18 months.

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<sup>2</sup> NHS Improvement analysis

<sup>3</sup> The Lord Darzi Review of Health and Care: Interim report: <https://www.ippr.org/publications/darzi-review-interim-report>

I am confident that if the recommendations in this report are implemented, up to £1 billion of efficiency and productivity savings per year can be achieved by 2021. The structural issues will be more difficult to resolve in the short term, and we have not at this stage quantified the benefits although I believe them to be significant. At the simplest level this will mean paying much closer attention to how the wider system supports reductions in avoidable admissions and limits the average length of stay, particularly for older patients. If we are to be successful in delivering the Five Year Forward View, these simple tests must be met.

A handwritten signature in black ink that reads "Carter of Coles." The signature is written in a cursive, flowing style.

**Lord Carter of Coles**

May 2018

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## Executive summary

This review has looked at the productivity and efficiency of mental health and community health services. It has done so in the context of the Five Year Forward View and its delivery plan which are clear that these services provide critical support to patients in the most appropriate setting, and assist the better management of mental and physical health conditions.

The review makes 16 recommendations across eight chapters. They are designed to improve productivity and enable the benefits to be reinvested in improving quality and access to care. We developed them by working closely with trusts delivering these services across England, in particular a cohort of 23 trusts. In doing so we identified many examples of 'what good looks like' in all aspects of service delivery and patient care, and significant good practice. We also found a significant amount of unwarranted variation. The findings are summarised below:

- There is significant good practice but there needs to be stronger mechanisms for sharing this between trusts.
- Workforce productivity is mixed, particularly in services delivered in the community, and NHS Improvement must step up its support for trusts to drive improvements in the engagement, retention and wellbeing of their staff.
- The Getting It Right First Time (GIRFT) programme should extend its approach to community health and mental health services, and specify more efficient and high quality pathways of care for patients.
- The use of mobile working and technology to drive efficiency and productivity is inconsistent and poor in many areas.
- There is scope for trusts to take action across all areas of spend including corporate services, procurement and estates.

### Chapter 1: Mental health and community health services

The NHS in England spends about £17 billion providing community and mental health services. There are currently 53 specialist providers of mental health services and 18 community trusts, but many more trusts deliver some services in these areas. We have found significant diversity in what trusts provide. The Five Year Forward View for Mental Health described a number of challenges facing mental health services, with the critical areas of concern being historical underfunding of mental health services, the extent of unmet need in mental healthcare, which is higher than other sectors, and the lack of parity of esteem with physical health. NHS England is making good progress in tackling these through investment and reform under clear national leadership and with support from partners across the system. Community health services provide an equally important role in supporting patients and the wider health system. This has been described in national strategies including the Five Year Forward View. However, there is a disparity in the extent of clear national leadership between mental health and community health services. We recommend that NHS Improvement and NHS England do more to recognise the role of community health services in a way that builds on the new models of care.



## **Chapter 2: Quality and efficiency across the pathway**

Examining the whole patient pathway is a crucial means of understanding where productivity and efficiency improvements can be made. This includes where patients could be better cared for in terms of quality of care, patient experience, efficiency and value for money. Analysis of an individual's lifetime care costs shows how spend is skewed towards acute hospital care, when in fact providing care to patients in their homes or the community can be better in terms of quality and efficiency. The Getting It Right First Time (GIRFT) programme is well established in 35 clinical work streams, and is supporting improvements in quality and efficiency across these. It must now extend its approach to mental health and community health services. For mental health inpatient services, this approach will support national efforts to reduce the estimated £500 million spent each year on inappropriate out of area placements. Alongside this, there is scope to strengthen and simplify existing commissioning and contract arrangements to drive standardisation in the community health services 'offer'. Trusts currently have to work with a number of commissioners delivering the same service against often different specifications, and the approach to contract management can create an unnecessary administrative burden for trusts. There are also specific areas of care provision that warrant a closer focus and support, specifically healthcare for veterans and restricted patients.

## **Chapter 3: Engaging the workforce**

We recognise that staff are our biggest asset but more can be done to support them in delivering effective and efficient care to patients. All staff in mental health and community health services are committed to delivering high quality services to patients, but we were told that they are coming under increasing strain. Staff engagement, sickness absence, bullying and harassment and retention levels are concerning and show significant variation between different organisations. Effective action must be taken to support trusts in addressing these issues. This includes an emphasis on leadership at all levels in the organisation and the importance of the role of trust boards in driving this. NHS Improvement must work with all trusts to help improve the engagement, retention and wellbeing of their staff.

## **Chapter 4: Optimising clinical resources in the community**

Services delivered in the community account for about 70% of mental health and community trusts' clinical work. To better understand the productivity and efficiency challenges and solutions in these services, the review team collected data from cohort trusts and worked closely with them to analyse this. This showed that there is a large amount of unwarranted variation in metrics such as direct care time per clinical day, and the number and duration of contacts. Similar variation was observed in other services delivered in the community. The review also saw large differences in how services are managed between trusts including the way referrals are managed, approaches to case management and the effective use of administrative resources. We found that a key enabler for improving workforce productivity in these services was the use and uptake of digital technology and mobile working. Often this was inconsistent and poor, with estimates showing that a quarter of community nursing services are still paper-based, and many clinical record systems in mental health trusts being time-consuming and difficult for staff to use. NHS Improvement needs to support trusts to change this by developing guidance on

good operating practices for services delivered in the community, and providing benchmarking metrics for mental health and community health service lines on the Model Hospital by April 2019.

### **Chapter 5: Optimising inpatient services and other clinical resources**

Unwarranted variation was also seen for other clinical services. We examined the inpatient workforce, medical staff, and medicines and pharmacy. For inpatient services, the nursing cost per bed varies significantly between trusts, and for smaller-sized units can be over £100,000 for an occupied bed per year in both mental health and community health wards. The review collected data for care hours per patient day (CHPPD) and reviewed rostering practices. In many cases there was scope for significant improvements to better manage unused hours, approve rosters at least six weeks in advance, and reduce spend on bank and agency staff. NHS Improvement will refine the CHPPD collection methodology, including developing tools to show levels of acuity and dependency, and will develop good practice guidance for all trusts around inpatient workforce deployment and e-rostering. Medical staff job planning is mixed, and early data collected suggests that this is an area that requires further examination. The review also focused on medicines and pharmacy optimisation. This was recognised as a critical clinical service that had a profound impact on costs and care quality across the patient pathway. There were specific challenges facing trusts around the infrastructure that ensures the supply of medicines and how pharmacists were deployed across services delivered in the community and inpatient services. Trusts should assess where they can make changes to allow pharmacists and other pharmacy staff to spend more time on patient-facing medicines optimisation, especially in community settings.

### **Chapter 6: Optimising non-clinical resources**

Non-clinical resources account for about 30% of mental health and community trust spend, and are a critical enabler of frontline patient care. Expenditure on corporate services tends to be higher on average for mental health and community trusts compared to other provider organisations, owing to their smaller scale. There was also variation in the costs of core corporate services functions, such as the cost per payslip and human resources cost per employee. There are opportunities for trusts in the sectors to collaborate and share their corporate services provision across neighbouring organisations, including sustainability and transformation partnerships (STPs). For estates and facilities management, in the £1.3 billion spend per year by mental health and community trusts there was significant variation in the running costs per square metre, from about £30 to over £230, and in the use of space. There is scope for trusts to rationalise their estate, building on good practice demonstrated by a number of trusts across the sectors, and in line with ongoing work in STPs. One trust found it could dispose of 14% of its properties. NHS Improvement will provide a more comprehensive set of benchmarks for the sectors, and trusts should review their estate to identify opportunities for consolidation and rationalisation. To support this, NHS Improvement will also review the current arrangements for estates leased from property companies. The review also examined trusts' procurement practices and functions. This found significant unwarranted variation in prices paid for the same product, including one type of dressing where the price paid varied from £1.62 to £20.29 per unit. Our engagement showed that trusts are not leveraging their buying power or collaborating at scale to secure the best price. Trusts should use the Purchase Price Index and

Benchmarking tool to evaluate prices paid for products, and NHS Improvement's National Procurement Programme will focus on a set of common goods used by trusts in the sectors to support better cross-sector buying power.

### **Chapter 7: Expanding the Model Hospital**

A key recommendation from the acute hospital sector operational productivity review was the establishment of the Model Hospital to provide benchmarking data to trusts to identify efficiency and productivity opportunities. Expanding and extending benchmarking data on the Model Hospital to include mental health and community health services will be a central element of implementing the recommendations in this review, in particular to show the metrics for services delivered in the community as set out in chapter 4. This will take time to develop fully but rapid progress must be made. As part of this, NHS Improvement will review the branding of the Model Hospital as it expands to incorporate different types of providers.

### **Chapter 8: Securing effective implementation**

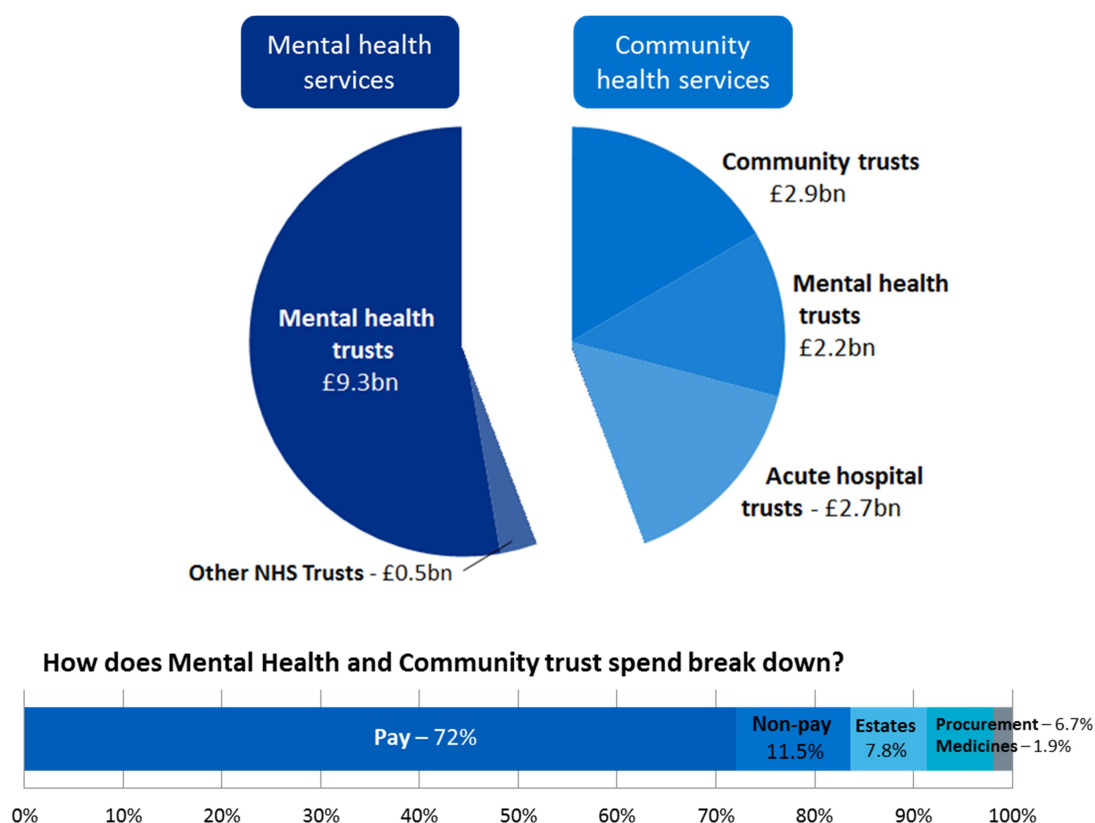
The implementation of the recommendations in this report will be supported by a team in NHS Improvement's Operational Productivity Directorate that will engage with trusts across community health and mental health services. However, it will need leadership and action far beyond that from a range of partners and stakeholders, and the challenge to NHS Improvement, NHS England and individual trusts from this review is how to lead, operationalise and sustain significant action against the review's recommendations. Although some trusts have already started to tackle some of the issues hindering their productivity, achieving long-term efficiencies and improvements to quality will also require targeted support from national bodies working more closely together.

The findings in this report are underpinned by our identification of significant unwarranted variation across clinical and non-clinical resources. We consider that removing this unwarranted variation would result in an efficiency opportunity worth up to £1 billion a year by 2020/21 from a more productive and efficient use of existing resources. Removing this variation will support providers in delivering their required annual efficiencies and existing cost improvement plans. In some cases, delivering the identified efficiencies may require investment in infrastructure to release longer-term benefits for the NHS, patients and the taxpayer. It is critical that all savings identified in this report are reinvested alongside new investment to ensure that more people are able to gain timely access to evidence-based mental health and community health services. The Five Year Forward View for Mental Health is clear that mental health services have been underfunded for decades and our recommendations will help ensure that the investment made to move towards parity of esteem both maximises the support to patients and delivers value for money.

## Chapter 1: Mental health and community health services

Mental health and community health services play a vital role in the NHS. Care should start in someone's home with general practitioners and families, and the importance of these services in contributing to safe, high quality and financially sustainable patient care from home to hospital cannot be overstated. At any time these services are providing critical support for about 2 million people<sup>4</sup>, and each year carry out about 100 million sessions in the community and 120,000 inpatient episodes. The people for whom they provide care and support are often some of society's most vulnerable.

The scope of this review covers the operational productivity of English NHS community health and mental health services. We worked with a cohort of 23 mental health and community trusts and extracted data from their systems to compare and benchmark between them. This data-led approach allowed us to identify productivity benchmarks for key services and outline potential opportunities for improvement. While we recognise that there are significant differences in the services provided to patients, many of the trusts we worked with provide both mental health and community health services and the basic principles of how productivity can be improved apply equally across the different services<sup>5</sup>. The NHS spends about £17 billion per year delivering these services to patients:



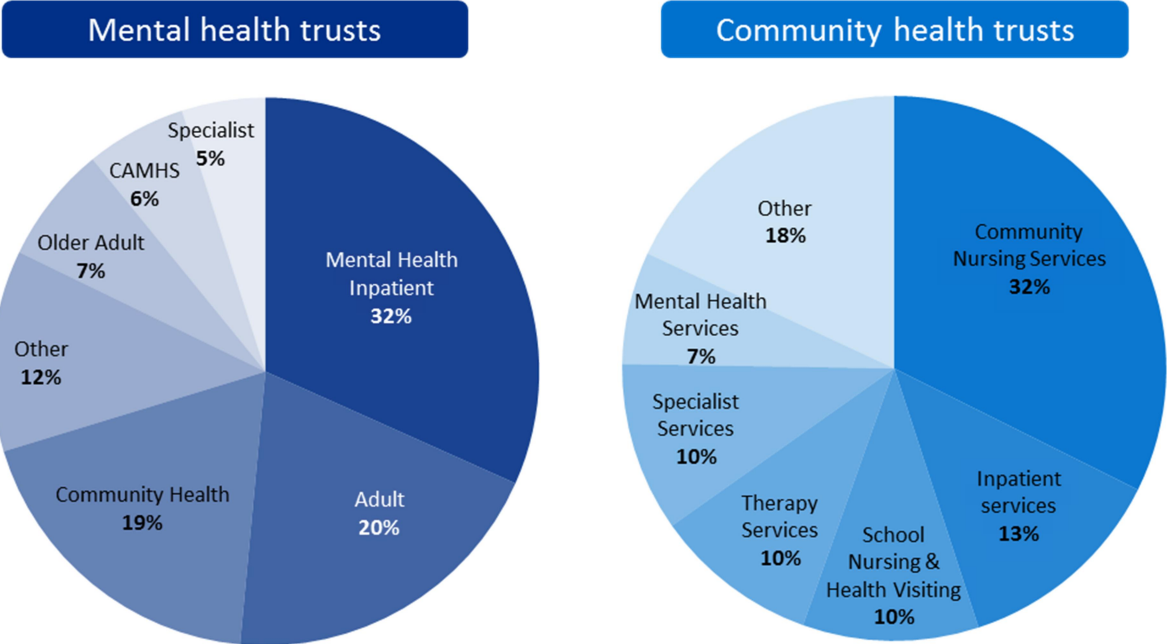
**Figure 1.1 – summary of overall NHS spend and organisations<sup>6</sup>**

<sup>4</sup> Source: Community Services Data Set and Mental Health Services Data Set, November 2017 publication.

<sup>5</sup> For the purpose of this document, 'community health services' refers to physical health services delivered in community settings and community hospitals but not by general practice or acute inpatient services. This includes health services commissioned by local authorities. By 'mental health services' we mean all mental health services including those for children, delivered both in the community and in mental health inpatient wards. While we have not specifically looked at learning disability services, we believe the recommendations can be applied to some of these services. When we refer to services delivered in the community, we mean both community health and mental health services.

<sup>6</sup> Source: Consolidated trust accounts.

There are currently 53 specialist providers of mental health and learning disabilities services and 18 community trusts. However, up to 86 trusts provide mental health services, and up to 190 provide community health services<sup>7</sup>. The review found no two community health or mental health trusts delivered the same set of services, and nearly all trusts we examined provided a mixture of both community health and mental health services. Within this, however, the review identified a core, common set of services provided across the sectors, delivered by a diverse set of skilled professionals, in co-ordination with a number of external partners including GPs, social care, education, housing, and the justice system.



**Figure 1.2 – most common service lines delivered by mental health and community trusts. Service line data taken from cohort trusts, accounting for about 25% of total trust expenditure<sup>8</sup>**

This diversity has meant that national oversight, particularly for community health services, has been limited and has primarily focused on financial performance rather than productivity. NHS Improvement does not maintain a list of which trusts provide community health or mental health services as a secondary service, or have a detailed understanding of what services the different trusts provide. It does not systematically track changes in the provision of different services between providers, including when these move in or out of the independent sector.

<sup>7</sup> Reference Costs 2016/17  
<sup>8</sup> 'Other' represents all other service lines provided by trusts, including dentistry, sexual health and addiction & substance misuse for community trusts, and learning disabilities, eating disorders and IAPT for mental health trusts. 'Mental health inpatient' shows data for inpatient services delivered in: adult and older adult, CAMHS tier 4, forensics and psychiatric intensive care units, amongst others. A similar picture is observed when replicating the analysis using Reference Costs 2016/17

## Mental health services

The Five Year Forward View for Mental Health is clear that for too long people of all ages with mental health problems have been stigmatised and marginalised, and that mental health services have been underfunded<sup>9</sup>. It clearly described the scale of the challenge, both in terms of the prevalence of mental health problems and people's experience of mental healthcare. NHS England is now implementing an ambitious plan to bring improvements to people who use services and the wider public, led by the national mental health director for NHS England<sup>10</sup>.

This includes one of the biggest expansions in key mental health services in Europe, in particular children and young people's mental health, perinatal mental health, adult common mental health services (including Improving Access to Psychological Therapies (IAPT)), crisis services, and Early Intervention in Psychosis (EIP). Central to the programme is an increased focus on prevention and on developing mental health services delivered in the community. This aims to provide upstream interventions that reduce dependency on inpatient mental health beds and crisis services, and reduce inappropriate out of area placements. These will be supported by national standards, improved data to track patient safety and performance of provision, and enhanced service line transparency. NHS England is leading the implementation of this programme with input from partners across the health system, including NHS Improvement. The extent of unmet need in mental healthcare is probably higher than in any other sector, and these factors make it even more important that opportunities for driving true efficiencies are systematically identified. We are very supportive of this approach.

The mental health sector has been undertaking good work in different parts of the country on implementing new care models, bringing back out of area patients, improving crisis pathways and other developments which assume responsibility, risk and opportunity for defined patient populations. There is emerging evidence from the implementation of the Five Year Forward View for Mental Health that these developments are driving value into the mental health system of care, by identifying and reinvesting savings in the parts of patient pathways that deliver better outcomes and care closer to home. Intervening earlier helps to avoid or shorten the need for costly inpatient services, often out of area. In addition, there is good evidence in the Five Year Forward View for Mental Health that mental health developments such as mental health liaison services in acute hospitals, or talking therapies for people with long-term conditions in primary care are driving greater efficiency and value into physical healthcare and the wider NHS.

The mental health sector has a mature leadership and an appetite to work with partners across sectors - such as the third sector, housing, other health and social care partners - to drive productivity, efficiency and better patient outcomes by redesigning patient pathways. Together with commissioners, they increasingly seek to drive out unwarranted variation by developing tools, pathway guidance and learning networks to share best practice. But as this report makes clear, there are areas where they can be supported to make further improvements.

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<sup>9</sup> Five Year Forward View for Mental Health: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

<sup>10</sup> <https://www.england.nhs.uk/mental-health/taskforce/imp/>



The Five Year Forward View for Mental Health is a crucial step towards achieving parity of esteem, and this review fully supports its plan for delivery. Our recommendations set out how this plan must be accompanied and underpinned by an increased focus on productivity. It is critical that all savings identified from implementing the recommendations and any new funding are used efficiently and productively to expand services to ensure that the programme's aims are met. This will ensure that the existing resource supporting mental health improves patient outcomes.

### Community health services

Community health services provide a wide range of care from pre-conception to end-of-life, from prevention to managing specialist diseases and long-term conditions. Most community healthcare is delivered in people's homes. However, care is also delivered in clinics, care homes, nursing homes and community hospitals. These services are critical for supporting the elderly population, people with disabilities and people with long-term conditions. They are therefore becoming more important as the population ages. By 2025, the number of people aged 65 and over is expected to increase by 20% to 12.4 million, and the number of people living with a disability is expected to increase by 25% to 2.8 million<sup>11</sup>. The number of people with multiple long-term conditions has been predicted to rise to 2.9 million in 2018<sup>12</sup>. The King's Fund recognised that pressures on community services may lead to rising levels of unmet need, but that this was difficult to measure<sup>13</sup>.

In response to these pressures, the Five Year Forward View<sup>14</sup> highlighted the need to better use community services to help manage pressure on the wider health system, particularly to support primary care and general practice, preventing admissions, providing step-up and step-down services, offering alternative pathways to patients and as a route home from hospital.

When appropriately deployed, community health services can support the delivery of more efficient, higher quality care for a whole health economy, such as for STPs, or integrated care systems (ICSs). For many community hospital services, the accountable officer for people receiving inpatient services is the trust's medical director or individual consultant physicians. For people receiving care delivered in the community, these services are typically led by a nurse who is wholly accountable for the care delivered. For an example of how community health services fit within the wider health system, see Figure 1.3.

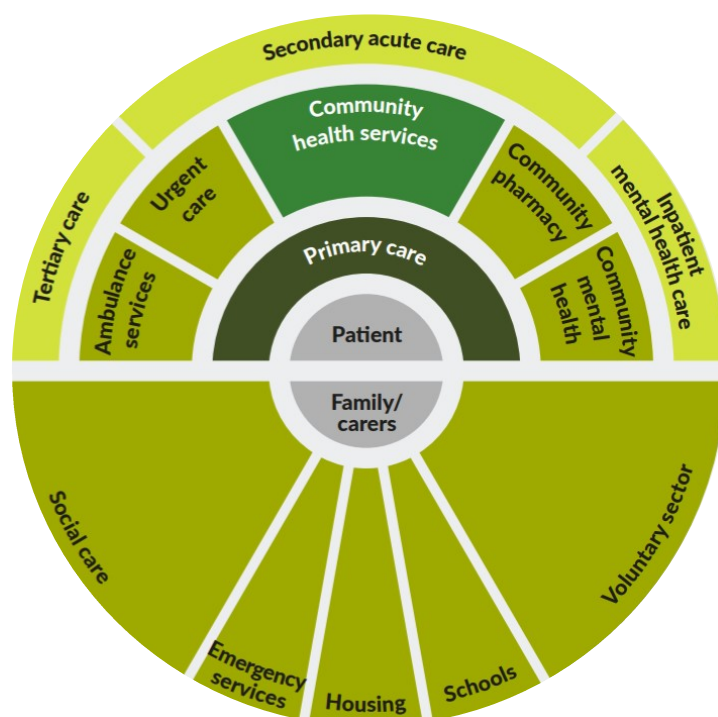
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<sup>11</sup> Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study. The Lancet July 2017

<sup>12</sup> Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

<sup>13</sup> Kings Fund [https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining\\_community\\_services\\_report.pdf](https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf)

<sup>14</sup> <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>



**Figure 1.3 – where NHS community health services fit within the wider system<sup>15</sup>**

Many national strategies, including *Transforming Community Services* (2008), the *Liberating the NHS white paper* (2010) and the *NHS Five Year Forward View* (2014, 2016)<sup>16</sup>, have outlined the impact and importance of community health services. They agree that such services have a great impact across the patient pathway and for all healthcare providers from primary and preventative care, to acute hospitals and emergency care.

### National leadership for community health

At a national level we were struck by the disparity in leadership capacity and focus from the Department of Health and Social Care, NHS England and NHS Improvement between mental health and community health services. For mental health services, there is now a clear ambition and a delivery programme set up to secure parity of esteem supported by strong leadership. This approach is making a real impact for patients.

Many national programmes depend on or touch on community services, such as NHS RightCare’s work supporting local health economies to improve outcomes, and work on urgent and emergency care, improving patient flow and delayed transfers of care (DTOCs). Chief among these programmes are the development of local STPs and ICSs, and work to develop and implement new models of care, such as the ‘Vanguard’ programme, Integrated Care Pioneers, and the work done to create multispecialty community providers<sup>17</sup>. These recognise that local services can provide better and more joined-up care

<sup>15</sup> Kings Fund [https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining\\_community\\_services\\_report.pdf](https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf)

<sup>16</sup> Transforming Community Services, <http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Healthcare/TCS/index.htm>; Liberating the NHS white paper, <http://webarchive.nationalarchives.gov.uk/20130104164502/http://www.dh.gov.uk/health/2011/07/liberating-the-nhs/>; NHS Five Year Forward Views refers to the ‘NHS Five Year Forward View’ and ‘Next steps on the NHS Five Year Forward View’, its delivery plan.

<sup>17</sup> <https://www.england.nhs.uk/new-care-models/>



for patients when organisations across health and care work together and develop shared proposals for how local services can be improved. A key element of each is an effective role for community health services in integrating services between acute hospital services, general practice and primary care. The move to ICS aims to dissolve the current financial and organisational boundaries in order to better drive this way of working.

The review also encountered gaps including a lack of national work to identify how community health services can meet the needs of a 21st century healthcare system that cares for patients in their homes and their local communities. Alongside this, there is no clear vision for how community health services can support the wider system, for example with services that can relieve pressure on primary care providers – in particular general practice – reduce avoidable admissions to hospitals, or support weekend discharge from hospitals. Nor is there an assessment of the extent to which these services are currently provided locally.

We identified many examples of good local schemes, often championed by individual clinicians and supported by individual clinical commissioning groups (CCGs). These schemes have the scope to make significant improvements if delivered at scale across the NHS. This includes Integrated Care Services (iCares) in Sandwell and West Birmingham Hospitals NHS Trust<sup>18</sup>, which provides specialist interventions to increase the amount of care provided in people's homes, improve care management and reduce hospital admissions. However, there is not a clear evidence base of how community health services can best meet the needs of patients in their homes and communities, or play their role within the wider system to reduce avoidable admissions to hospital and support more effective discharge.



### **Case study – Integrated care pioneer**

In 2015 Torbay and South Devon NHS Foundation Trust changed its model of care to support its integrated care organisation status and better serve its increasingly ageing population. Bed occupancy audits showed that about a third of its beds were occupied by patients fit for discharge to community health services. The trust therefore expanded its intermediate care team to provide services over seven days and created health and wellbeing teams with an additional 60 staff to provide an alternative to hospital admission and care for patients in the community or at home.

As a result, the trust's community hospitals saw 35% more patients and reduced its average length of stay from 14 days to 10. The trust now cares for 40% more patients outside hospital and uses about 25,000 fewer bed days a year compared to 2015. This has meant that it has reduced its total number of beds, including community hospital beds by about 20%. Partly as a result of these changes, alongside other cost improvement plans, the trust achieved savings of £40 million in 2017/18.

There is a need to better recognise the position of community health services, specify their future state and ensure they play their full role in supporting the wider system. This should bring together existing national work streams within a single delivery plan and support local areas to focus their resources on how to achieve it. It should also learn from best practice

<sup>18</sup> <https://www.swbh.nhs.uk/services/integrated-care-service-icares/>

from across the health system, and specifically from new models of care that are being developed as part of the New Care Models programme such as the Integrated Care Pioneers and 'Vanguards'.

### **Recommendation 1 – Learning from new models of care**

**NHS England should codify and share the learnings from new models of care and the successful 'Vanguards' to support community health services to play their full role in supporting the wider system.**

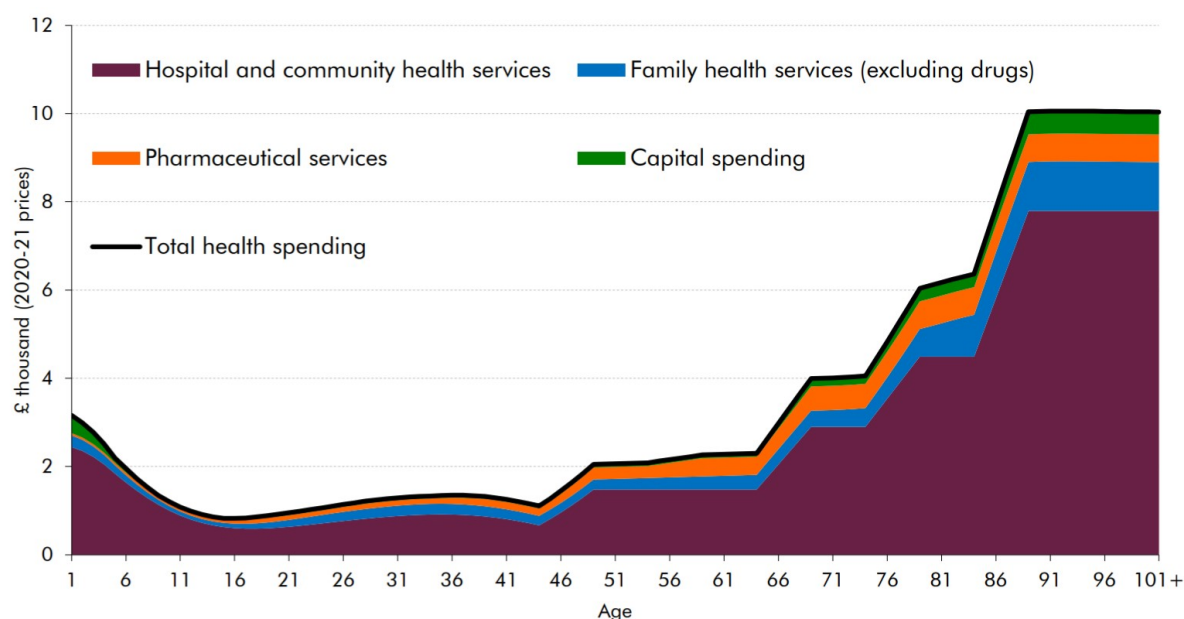
In delivering this, attention should be paid to:

- Identifying those community health services that will have the most significant impact on supporting people to remain healthy and well in their own home, in particular prevention and health improvement, admission avoidance, patient flow through urgent, emergency and acute hospital settings, and improved quality outcomes.
- Identifying the local and national barriers to integrating the contribution of community health services to the wider system.
- Identifying how to work across STPs, ICSs, acute hospital and primary care providers, local authorities and commissioners to develop an evidence base for how community health services can support the wider health and care system and develop business cases to deliver this.
- Identifying the areas where additional national investment would support the above, release cost pressures on the acute hospital and primary care sectors and develop robust outcome measures for community health services.

## Chapter 2: Quality and efficiency across the pathway

The provision of safe, high quality care to patients and the public is the primary concern of any health provider and NHS employee. It underpins this review. There are a number of national quality indicators for mental health and community health services, such as the safety thermometer and venous thromboembolism risk assessments. Implementation of the Five Year Forward View for Mental Health is driving important improvements in the measurement and specification of clinical outcomes where the International Consortium for Healthcare Outcome Measurement (ICHOM) is working with clinicians to develop outcomes standards for a range of mental health conditions. We have found, however, that there is a lack of consistent and comparable patient outcomes data for community health services. For example, clinical information such as the healing rates for wounds is simply not available nationally and not always available locally. Trusts should ensure that locally collected outcome data is considered alongside productivity improvements, including through mechanisms such as quality impact assessments.

Public spending on health services is about £2,100 on average for every person in the UK<sup>19</sup>. However, analysis suggests that an individual's lifetime cost is greater than this from about age 65 and is more than five times higher once someone reaches age 90.



**Figure 2.1 – lifetime healthcare costs<sup>20</sup>**

UK population growth is expected to be skewed towards older people with the number of those aged 65 and over growing by 33% compared to a 2% increase in the number of working age adults. The growth in the number of people aged 85 and over will be even steeper. Analysis of Figure 2.1 suggests that the average individual lifetime healthcare cost is about £185,000, but with social care this could be as high as £220,000<sup>21</sup>. In considering healthcare costs we must look at the overall cost across sectors. For example, a £10,000

<sup>19</sup> HMT, Public Expenditure Statistical Analyses, 2017: <https://www.gov.uk/government/statistics/public-expenditure-statistical-analyses-2017>

<sup>20</sup> 'Fiscal sustainability and public spend on health', Office for Budget Responsibility, 2016: [http://obr.uk/docs/dlm\\_uploads/Health-FSAP.pdf](http://obr.uk/docs/dlm_uploads/Health-FSAP.pdf)

<sup>21</sup> NHS Improvement analysis of OBC fiscal sustainability report and costs of social care.

intervention in the community to provide preventative falls and district nursing services to a patient over a 12-month period could negate the need for between £30,000 and £40,000 on average to be spent on residential or nursing care<sup>22</sup>. Effective management of patients in the community can also help avoid costly unplanned admissions, such as a hip replacement, for which the average cost is about £6,800<sup>23</sup>.

A further example is end of life care. 91% of the UK population want to die at home or in a hospice, yet nearly 55% die in hospital<sup>24</sup>. This has a much higher associated cost, with hospital costs averaging £4,500 per person in the last three months of their life, compared with £500 per person for providing end of life care through other health and social care services, such as community health services<sup>25</sup>. This exemplifies a larger problem where services delivered in the community and in primary care can support the wider system by providing more patient-centred care at lower cost than in an acute hospital. According to the King's Fund, up to 55% of patients in hospital medical beds would be better cared for elsewhere, whether at home or in other settings such as intermediate mental and physical healthcare<sup>26</sup>.

As also saw international good practice where intensive and targeted care programmes provide and co-ordinate care to older patients in their homes and community<sup>27</sup>. From these programmes, Massachusetts General Hospital and ChenMed have been successful in reducing acute hospital admissions and inpatient bed days by more than 25% on average. This has also led to reduced costs<sup>28</sup>.

Much inefficiency is often generated at the boundary between different service providers. This can have a real impact on patient outcomes and experience. We explored the interfaces between community health services, mental health services, and the wider health system, and how these affect quality of care and cost of care across different types of providers. We particularly focused on how trusts support work across the wider healthcare continuum, and how patient choice and system workflows interrelate within this (see Figure 2.2).

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<sup>22</sup> Falls prevention service based on analysis of the cost of regular visits by a specialist community nurse for active case management of the elderly from Reference Costs 2016/17, and LaingBuisson Care of Older People UK Market Report 28th edition, 2017.

<sup>23</sup> NHS 'National tariff payment system for 2017/18 and 2018/19'; <https://improvement.nhs.uk/resources/national-tariff-1719/>

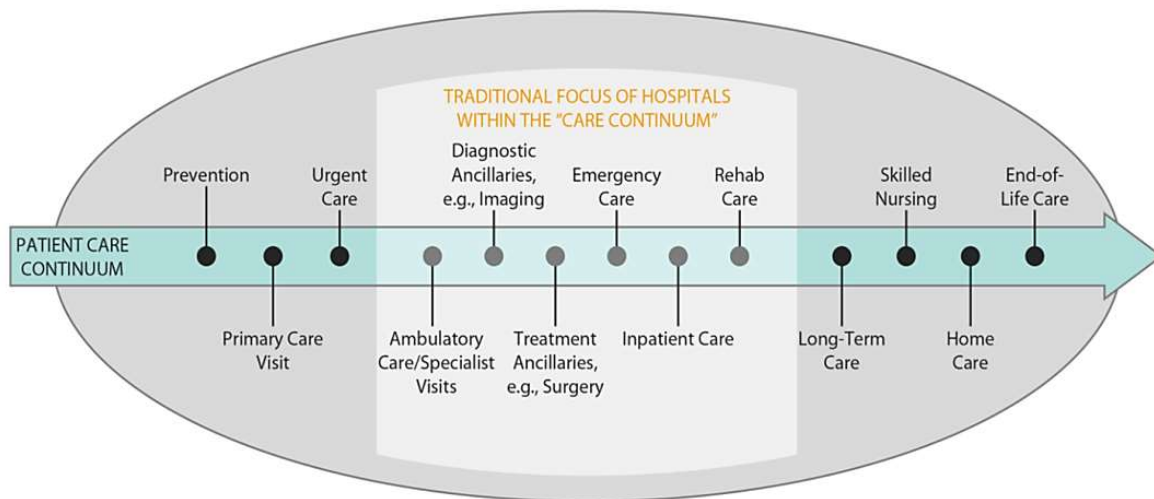
<sup>24</sup> Can giving patients choice be cost effective for the NHS? Marie Curie Cancer Care, September 2013, <https://staging1.mariecurie.org.uk/blog/can-giving-patients-choice-really-be-cost-effective-for-the-nhs/48274>

<sup>25</sup> Exploring the costs of care at the end of life. Nuffield Trust, September 2014, <https://www.nuffieldtrust.org.uk/research/exploring-the-cost-of-care-at-the-end-of-life>

<sup>26</sup> Thompson and Poteliakhoff, 2011; 'Data briefing: Emergency Bed use: What the numbers tell us', King's Fund, <https://www.kingsfund.org.uk/publications/data-briefing-emergency-bed-use>

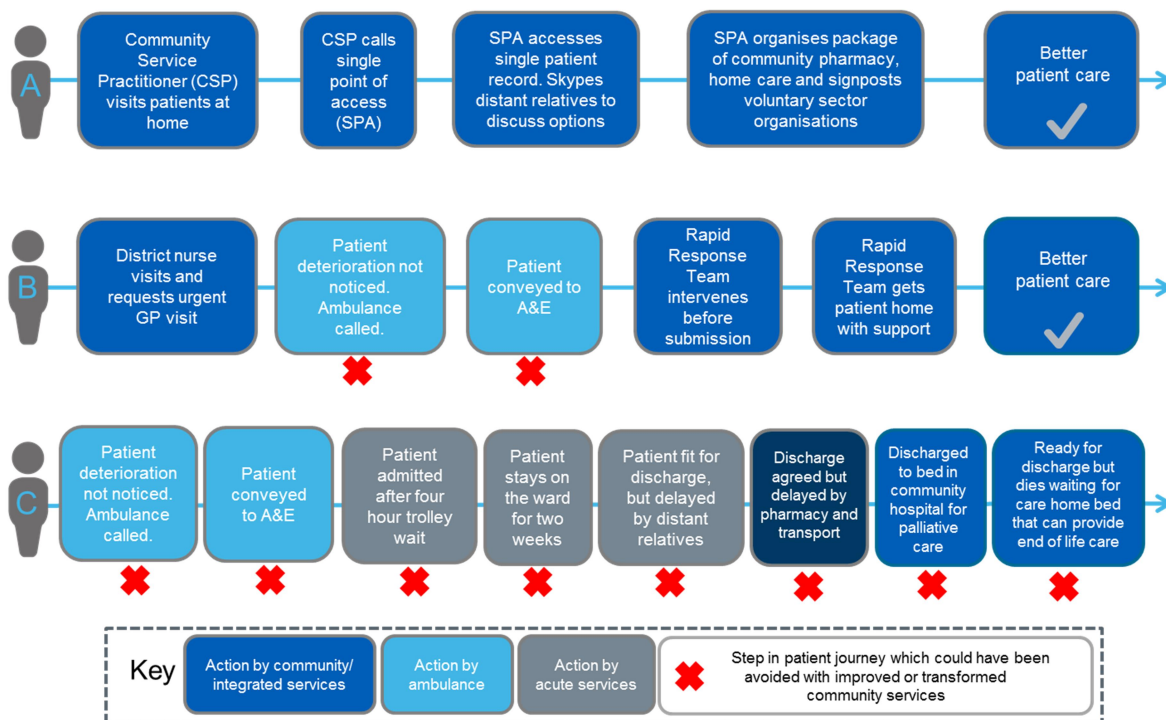
<sup>27</sup> Kodner, 2015; 'Managing high risk patients: the Mass General care management programme', *International Journal of Integrated Care*, 15, and 'Concierge care for low-income seniors: How high-touch care improves outcomes and reduces costs', ChenMed: <https://www.chenmed.com/news/report-finds-value-based-care-model-leads-significant-cost-savings-health-gains-seniors-six>

<sup>28</sup> Kodner, 2015, described how the return on investment for each dollar of investment was between \$2.65 and \$3.35 for the two patient groups in the programme.



**Figure 2.2 – healthcare continuum<sup>29</sup>**

The healthcare continuum conceptualises a point that is well recognised across the NHS – that care for people does not start and finish at the point where organisations, professions or types of services meet. We used this principle in our analyses and discussions with trusts, and showed how the management of patient care could be improved and how steps to prevent an admission are often missed. An example is shown in Figure 2.3.



**Figure 2.3 – example patient journeys, Department of Health and Social Care internal analysis**

Figure 2.3 suggests where community health services can prevent avoidable admissions to acute hospitals, provide better care for patients, and improve the flow of patients through the wider health system. However, information on the number of hospital admissions and how effective services are in preventing these is not routinely available or analysed. The

<sup>29</sup> Based on <http://www.himss.org/definition-continuum-care> and <http://www.selfcareforum.org/about-us/what-do-we-mean-by-self-care-and-why-is-good-for-people/>

Five Year Forward View for Mental Health is driving positive steps to tackle this, but further work in this area is needed for community health services.

### **Getting It Right First Time (GIRFT)**

The GIRFT programme is now well established and focused on reducing unwarranted variations in clinical settings for 35 work streams. For each specialty or pathway, its principles are to identify specific areas of unwarranted variation based on local and national data, and provide a detailed, clinically led engagement process with each trust to improve patient outcomes. So far, the programme has made 1,100 visits to trusts and published reports on three clinical work streams with another 10 reports due to be released in 2018. As a by-product of improving patient pathways and clinical outcomes, it is expected to deliver more than £1.4 billion of savings by April 2021.

### ***GIRFT and community health services***

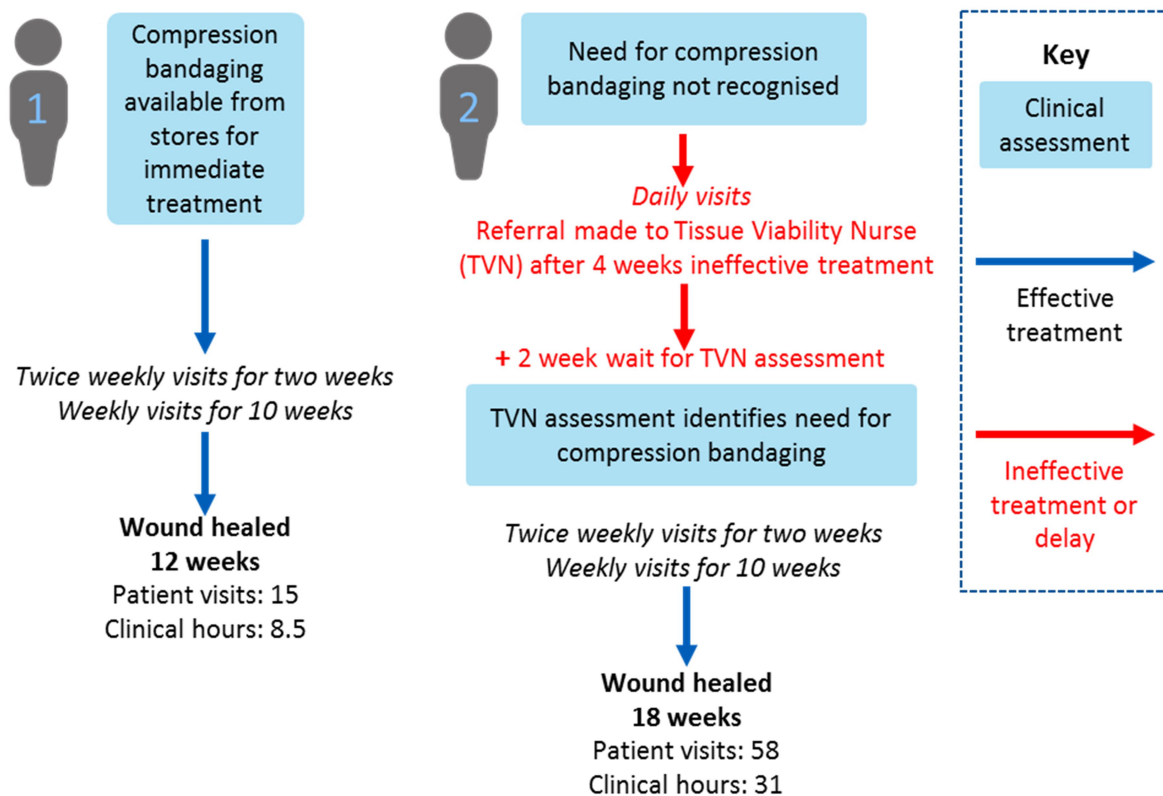
The GIRFT programme should develop the business case around extending its approach to community health services. One of the most significant areas of community health service provision we identified in discussion with cohort trusts was wound care. Managing wounds is a critical service in community nursing. Latest estimates suggest that the NHS manages about 2.2 million wounds per year. Management of these wounds and associated co-morbidities included 18.6 million practice nurse visits, 10.9 million community nurse visits, 7.7 million GP visits and 3.4 million hospital outpatient visits. The annual cost to the NHS of managing these wounds is about £5 billion after adjusting for co-morbidities<sup>30</sup>.

We worked with tissue viability nurses from some of our cohort trusts to understand the issues trusts faced when providing wound care services. This work identified that there is scope for improvements in the wound care pathway for patients, where the GIRFT programme can help to reduce unwarranted variation.

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<sup>30</sup> Guest et al. (2015) Health economic burden that wounds impose on the National Health Services in the UK. *BMJ Open*, 5(12).





**Figure 2.4 – variation in pathways for patients with a lower leg wound requiring compression bandaging, NHS Improvement analysis**

Figure 2.4 shows an example of the variation in wound care pathways that patients often experience, compiled with expert help from nurses in our cohort trusts. The experience of patient 1 saves about £2,300 per patient compared to patient 2<sup>31</sup>. Clearly, variation at this level does not give the best patient outcomes or experience, nor is it the best use of resources, and represents a significant opportunity. Most trusts, however, do not capture basic information on wound care including the number of patients with wounds, wound types, treatment plans or, most critically, wound healing rates. Many trusts also lack protocols for how to manage different types of wounds. We observed significant variations in how specialist tissue viability nurses were deployed and in the use of mobile technology. Variation in how much providers pay for wound care supplies was as high as 36% for some foam dressings. This is just one example of the need to improve and standardise clinical practice in community health services, and following this review the GIRFT programme will pilot an approach for wound care services.

Alongside this the GIRFT programme will examine those clinical specialties where the community elements of the patient pathway are most relevant. For example, the importance of health services in the community as a preventative and management service for patients with diabetes and for the geriatrics medical specialty are clear. As the GIRFT programme rolls out it is important that these interfaces are identified and included within the work of the programme where appropriate.

<sup>31</sup> Analysis based on Reference Cost data for 2016/17.

## **GIRFT and mental health services**

A lack of access to the right care at the right time is increasing demand for more restrictive bed-based care and longer lengths of stay in these mental health care settings. Often this results in out of area placements when no local bed is available. This is also driven by the lack of service capacity in community mental health services including intensive home treatment, crisis service provision and rehabilitation services. The availability of social care input and housing also play a key part in preventing admissions and minimising delayed transfers of care. Out of area placements are rarely desirable as the patients' care is disrupted and these are associated with longer lengths of stay and higher costs. The cost of providing out of area beds for non-specialist services is estimated to be more than £500 million per year. Much of this spend is incurred by local CCGs, but in some cases mental health providers meet some or all of the costs. NHS Benchmarking data suggests that the cost of one additional acute bed uses the equivalent resources as community care provision for 40 adults or 100 young people<sup>32</sup>.

In many trusts, redesigning pathways to shift the pattern of spend towards local, intensive, services delivered in the community has proved successful in sustainably improving pathways and outcomes, and delivering value for money.



### **Case study – Reducing out of area placements**

Sheffield Health and Social Care NHS Foundation Trust invested more than £5 million over five years to improve quality and access to interventions shown to prevent admission, support post-discharge recovery and reduce out of area placements. These included reducing the size of its inpatient wards, deploying psychologists on inpatient wards, opening a crisis house, providing enhanced intensive community mental health and early intervention in psychosis services, and re-provision of the trust's psychiatric intensive care unit. These changes allowed the trust to make £1.5 million recurrent annual savings, reduce average length of stay from 56 to 31 days, and eradicate out of area placements from 3,000 bed days in 2011/12.

The GIRFT programme is currently being extended to include mental health specialties to help address the challenge of improving pathway design to reduce out of area placements in three key areas:

- **Acute and urgent mental healthcare pathway:** as highlighted in the Crisp Commission report into adult acute psychiatric care<sup>33</sup>. The most recent nationally reported data suggests that a minimum of £100 million a year (20% of the total) is spent on acute out of area placements.
- **Rehabilitation and complex needs pathway:** as highlighted by the Care Quality Commission (CQC) in its recent survey and briefing on mental health rehabilitation inpatient services<sup>34</sup>.

<sup>32</sup> Data taken from NHS Benchmarking Network. This refers to one child and adolescent mental health services (CAMHS) inpatient bed using the equivalent resources as community care provision for 100 young people.

<sup>33</sup> 'Old Problems, New Solutions' Improving acute psychiatric care for adults in England', 2016  
[https://www.rcpsych.ac.uk/pdf/Old\\_Problems\\_New\\_Solutions\\_CAAPC\\_Report\\_England.pdf](https://www.rcpsych.ac.uk/pdf/Old_Problems_New_Solutions_CAAPC_Report_England.pdf)

<sup>34</sup> [http://www.cqc.org.uk/sites/default/files/20180301\\_mh\\_rehabilitation\\_briefing.pdf](http://www.cqc.org.uk/sites/default/files/20180301_mh_rehabilitation_briefing.pdf)



- **Child and adolescent mental health services (CAMHS) tier 4 acute care pathway:** where the average length of stay is 72 days (compared to 11 days in Sweden<sup>35</sup>), and there are still too many instances of children having to travel significant distances for inpatient care.

In partnership with NHS England and building on the work already in train as part of Five Year Forward View for Mental Health delivery, this work will provide a specific focus for improving these pathways, and support reductions in out of area placements based on examining where:

- Core community mental health services can be strengthened, so that people can access evidence-based integrated packages of interventions recommended by the National Institute for Health and Care Excellence, and social support from the outset of their care.
- 24/7 crisis services can be made available across England by April 2019, and interfaces with key external stakeholders – particularly A&E, police and ambulance services – are effective.
- Investment should be made in alternatives to admission through innovative models of care such as crisis recovery cafes and intensive home-based services, and through innovative partnerships with the housing and voluntary sector.
- Therapeutic and ‘purposeful’ admissions can be used to optimise inpatient length of stay alongside clear discharge planning, supported by high quality community services engaged in discharge planning from the point of admission.
- Agreements can be made with commissioners so that money spent on out of area placements is reinvested in local services that reduce demand for and improve flow through inpatient care, including agreed risk-sharing arrangements to support this.

The programme will apply the GIRFT methodology<sup>36</sup> and NHS England’s work to develop and roll out best practice care models for each pathway.

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<sup>35</sup> Data from CAMHS international comparisons report, NHS Benchmarking, 2017; not publicly available.

<sup>36</sup> <http://gettingitrightfirsttime.co.uk/girft-methodology/>

## Recommendation 2 – Quality of care and Getting It Right First Time (GIRFT)

**The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress in undertaking work in mental health. For mental health, this should include supporting the elimination of inappropriate out of area placements for adult mental healthcare by 2021.**

Delivered by:

- Analysing each specialty and identifying priority areas that involve community-based aspects of the patient pathway by autumn 2018.
- Piloting a new project to test the GIRFT approach on wound care services delivered in the community to reduce unwarranted variation in clinical quality, productivity and efficiency, linking with the NHS England and NHS Improvement Wound Care Strategy Board.
- Starting the work on mental health, including completing all data collections by December 2019 and publishing three national GIRFT reports by April 2020 that describe the standard model of care for each pathway.

### Commissioning for mental health and community health services

Effective commissioning of these services is critical, as the diversity and intricacy of the services delivered by the NHS are unparalleled<sup>37</sup>. Delivery of the Five Year Forward View relies on NHS England, CCGs and local authorities commissioning care in a person-centred way. The approach to co-operation and competition sets out 10 principles, including that commissioners must commission services from the providers that are best placed to deliver the needs of their patients and populations<sup>38</sup>. These principles remain at the heart of the system. During the review we found that the way in which services are commissioned directly affects the productivity and efficiency of mental health and community trusts and their contribution to the wider health system.

Most services are commissioned on a block contract basis from CCGs, with local authorities and NHS England the next largest commissioners by value.

| Mental health trusts |     | Community trusts  |     |
|----------------------|-----|-------------------|-----|
| CCG                  | 69% | CCG               | 67% |
| NHS England          | 14% | NHS England       | 8%  |
| Local authorities    | 6%  | Local authorities | 17% |
| Other                | 10% | Other             | 9%  |

**Figure 2.5 – lead commissioner for service lines delivered by community and mental health trusts. Provider financial returns for month 12, 2017/18<sup>39</sup>.**

<sup>37</sup> NHS England: <https://www.england.nhs.uk/commissioning/>

<sup>38</sup> <https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition>

<sup>39</sup> Figures may not sum to 100% due to rounding.

All cohort trusts have more than one CCG commissioner and often they have five or more. Many trusts provide services in multiple STP areas. NHS England also commissions a significant amount of specialised services including children and young people's inpatient care, high-secure mental health services, and in community health, wheelchair services. Local authorities are significant commissioners of community and mental health trusts, including school nursing and health visiting. Other services often provided by trusts include health services in custody and for police forces. This can mean often relatively small providers are required to navigate a complex set of requirements from a large number of different commissioners.

There are several ways existing commissioning and contracting mechanisms could be strengthened particularly as providers and commissioners increasingly work together within STPs and as part of ICSs. There is scope to simplify service specifications and introduce greater consistency for patients and providers across and beyond STP footprints. Trusts reported that service specifications differed between commissioners for similar services and were often commissioned in different ways. This made services more likely to be fragmented across different local areas and harder to manage, at increased cost. The management of contracts could also be streamlined. We identified examples where trusts were held accountable against a large number of key performance indicators (KPIs). A community health trust conservatively estimated its administrative cost for providing performance reports to commissioners was £150,000 a year. This puts high frictional costs into services for providers and commissioners, for limited value. Similar principles may apply to local authority commissioned services.

NHS Improvement analysis has shown that very few contracts include activity or outcome based payment mechanisms. In mental health services only 4% of providers use an episodic payment approach, with a further 2% using a capitated approach<sup>40</sup>. There are, however, some promising examples. Oxfordshire CCG worked with Oxford Health NHS Foundation Trust to develop an outcomes-based commissioning model for adult mental healthcare. Further work is required in this area, and NHS Improvement and NHS England should support commissioners and providers to make improvements. As part of this, they should further develop currencies and the payment systems for mental health and community health services to allow a clear categorisation of services, and incentivise the collection of high quality activity, cost and outcome data. This will support longer-term benchmarking between providers.

Developing 'model frameworks' for commissioning key services would have several benefits. It will ensure commissioners can easily access the most up to date standards for key services, it will increase transparency for patients and providers, and it will reduce bureaucracy for providers and commissioners. These model frameworks can be increasingly linked to outcomes and patient pathways, and will support the development of ICSs in the longer term. This would need to be done in partnership with all providers, including the independent sector, and commissioners, and supported by a thorough analysis of data on commissioning and service specifications at a local level.

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<sup>40</sup> NHS Improvement analysis as part of national tariff analysis and assessment.

## The role of community hospitals

Community hospitals are defined by NHS Benchmarking as a healthcare facility undertaking inpatient care with typically less than 100 beds<sup>41</sup>. The services provided are likely to include inpatient care for older people, rehabilitation, maternity services, end of life care, outpatient clinics, day care, minor injury and illness units, diagnostics and day case surgery. A hospital may also provide a base for outreach services provided by multidisciplinary teams. Generally sites with a 24-hour A&E, no beds or those providing complex surgery are not considered community hospitals. Community hospitals are important institutions for local patients. Many can trace their roots back to war memorial hospitals, and they attract significant support within local communities.

We have tried to examine the role of community hospitals, but this work was hampered by the sheer diversity of what is considered to be a community hospital and the lack of centrally collected information. As a result, we found it necessary to focus on the inpatient services associated with community hospitals, but even then information is very limited. Acute hospital trusts often operate community hospitals as part of their wider community health services, but these inpatient beds are not always reported separately from acute beds. From the data we collected<sup>42</sup>, we were told that there are about 4,200 community hospital beds in England. Commissioners often purchase beds from private and independent sector providers, and we found examples where the acute hospital trust provided the community beds but the local community trust staffed the ward. Community hospitals and community beds are a strategic asset to the NHS and are critical for patients. However, this lack of information means they are not always used effectively for either purpose. In many areas it is unclear how community health services should be provided to best support patients: some areas have inpatient community hospitals while others have none. We were unable to find any evidence that the often expensive provision of inpatient community hospitals improved outcomes.

We examined inpatient community hospitals in community trusts. There are about 2,200 beds in these organisations, and they represent about 13% of their total spend. Data from NHS Benchmarking shows that only a quarter of community hospitals' estate is less than 20 years old and 26% is 100 years old or older<sup>43</sup>. We examine the cost profile of providing these services in chapter 5: this clearly shows significant variation in the nursing cost within different community hospital wards and that greater costs are associated with small and isolated wards.

We also examined how these community inpatient beds were being used and why the patients were on wards. To do this we surveyed bed occupancy in four geographically different community trusts over one day in February 2018. We received data on 206 patients from wards largely providing physical rehabilitation care<sup>44</sup>. This showed that on the day of the survey the average length of stay ranged from 10 days to 31 days, and that nearly two-thirds of all patients were classed as fit to leave. For patients classified as clinically 'fit to leave', there was a range of reasons why the patient was still in the bed on the day of the survey.

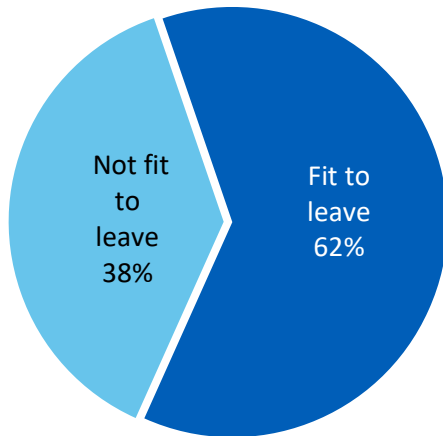
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<sup>41</sup> NHS Benchmarking Network Community Hospitals Report, December 2016; not publicly available

<sup>42</sup> This was collected as part of the care hours per patient day (CHPPD) data collection set out in chapter 5.

<sup>43</sup> NHS Benchmarking Network Community Hospitals Report, December 2016; not publicly available

<sup>44</sup> 98% of data from rehabilitation (physical health) wards; 2% from 'other' ward types.



| Reason patient classified as fit to leave was still in a bed | %   |
|--|-----|
| Awaiting package of onward care                              | 28% |
| Awaiting equipment   | 19% |
| Awaiting social care / services input                        | 14% |
| Family involvement / choice                                  | 14% |
| Awaiting specialist opinion / further assessment             | 7%  |
| Other  | 18% |

**Figure 2.6 – bed occupancy survey data showing proportion of patients classified as ‘fit to leave’ across wards and reasons why patients had not been discharged.**

The survey was undertaken during the busy winter period, with staff reporting pressure on beds and delays in discharging patients due to waiting for elements of their care. Most patients in the survey required an increased level of care and assessment, and so often had a longer length of stay at the time of the survey. Although target discharge dates were set on admission, these were often moved later following review and we found differences in how they were set and monitored.

The data indicates that nearly half of patients could have been managed at home with one quarter of beds freed up – this raises questions about the role inpatient services play in the wider system. Patients need to access appropriate local services and there is scope for a wide range of community services to be located in medical ‘hubs’. In doing so, we need to achieve a reasonable balance of size and accessibility if they are to secure the confidence of their local community and funders.

### Improving services for patients

Community health services are a critical part of the wider healthcare system and need to work increasingly closely with mental health services in the community, primary care and social care partners. There is scope to better recognise the contribution that community hospitals make to patients and the public, and to articulate how they should evolve to support this. Community hospitals are an important part of the fabric of the healthcare system which commissioners and providers need to address together. This should include examining how the existing estate is being used, and how it might underpin the movement towards local ‘hubs’ that host a range of services and can support local communities and other health and care services, including primary care and acute hospitals. We have seen good examples of where this work has already been started.



### Case study – Helping care for patients in their homes

Patients with diabetic foot ulcer infections involving osteomyelitis can require long term treatment with intravenous antibiotics, and some will require these to be administered three times a day. Kettering General Hospital NHS Foundation Trust recognised that in the absence of sufficient capacity in its community teams these patients often needed to be treated in hospital as an inpatient. Following a successful pilot in 2015, the trust has already reduced numbers of acute inpatient admissions and estimates that it will save 1,900 bed days a year, or about £360,000<sup>45</sup>.

Community health services work at a double interface: with general practice services on the one hand and with hospital care on the other. Much of the inefficiency in patient flow arises from frictional delays at these two 'handoff points'. Acute hospitals often report difficulties arranging community health services for older patients ready to leave hospital, particularly at weekends, and we estimate that about 18,000 of the 100,000 total number of NHS acute hospital beds are currently occupied by patients who have been there for 21 days or more<sup>46</sup>. Community health services can also do more to prevent admission to acute hospitals. Therefore, we recommend that local commissioners, overseen by NHS England, should specify standard response times, including at weekends, for community health providers to support hospital discharges and avoidable admissions.

As mentioned in chapter 1, the move to Integrated Care Systems aims to dissolve these financial and organisational boundaries. NHS England should codify and share the learnings from the successful 'Vanguards' about how this should best be done. It will be important that community trusts put institutional self-interest aside and respond flexibly to the opportunities created by the development of primary care networks delivering GP services to populations of 30-50,000 people. These may mean that community health services are increasingly provided as part of expanded primary care teams, or as part of integrated primary, community and acute hospital provision, rather than by standalone community trusts.

Community trusts often provide services not just to the NHS, but since 2013 to local authorities when councils were transferred the budgets and commissioning responsibility for health visitors, sexual health services and other clinical preventative services. As these council budgets have been reduced, many community trusts have correspondingly seen their income reduce. Given that commissioners are in many cases legally required to periodically market-test community health provision (which operates as a mixed supply side), and local health needs differ, there will inevitably need to be locally sensitive service specifications drawn up which cannot be entirely nationally standardised.

The findings around community hospitals and inpatient beds in many ways reflect a wider problem, that it is unclear how community health services should be provided to best support patients. Effective national leadership working with local STPs across community health, mental health, GP and social care services need to take this forward.

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<sup>45</sup> NHS Improvement analysis.

<sup>46</sup> NHS Improvement and NHS England analysis of sitrep data. HES 2017/18 data also shows that about 40% of all bed days are inpatients whose length of stay was 21 days or longer.

### **Recommendation 3 – Driving standardisation in the community health services ‘offer’**

**NHS England should help strengthen commissioning and contracting mechanisms for mental health and community health services. This should include supporting providers and commissioners to work together within sustainability and transformation partnerships to develop model frameworks for specifications of services.**

Delivered by:

- Clinical commissioning groups and providers, working in their STP or ICS and with local authorities, should review current performance reporting arrangements and agree proposals to reduce bureaucracy.
- Local commissioners, overseen by NHS England, should specify standard response times, including at weekends, for community health providers to support hospital discharges and avoidable admissions.
- NHS Improvement and NHS England should further develop currencies and the payment systems for mental health and community services, and describe the progress made against this during 2018/19. This should support a clear categorisation of services, incentivise the collection of high quality activity, cost and outcome data and facilitate benchmarking between providers.

### **Veterans’ healthcare**

Mental health and community health services play a crucial role in caring for Armed Forces veterans. *Armed Forces Charities’ Mental Health Provision*<sup>47</sup> highlighted the range of service charities working with veterans in mental health. The report identified 76 armed forces charities in the UK that provide mental health support for the armed forces community. These organisations use their understanding and experience of the broad spectrum of veterans’ mental health needs – such as depression, anxiety, substance misuse, post-traumatic stress disorder and simple trauma – to address the growing number of veterans seeking help from the NHS, charities and other agencies. Data suggests armed forces charities providing mental health support currently serve 7,000 to 10,000 people per year. People suffering from multiple traumas can require more specialist treatment, often with residential care offered as part of the recovery pathway. Charities have raised concerns that this small but significant group could in future be unable to access the full range of services they require.

NHS Improvement, with NHS England, the Department of Health and Social Care, the Ministry of Defence, the Confederation of Service Charities and the GIRFT programme have launched the ‘Veterans Covenant Hospital Alliance’. The Alliance aims to improve the healthcare that veterans receive from the NHS and is currently made up of over 25 acute hospitals across England, Scotland and Wales. It seeks to showcase high quality veterans’ healthcare and support NHS hospitals to learn from each other by sharing good practice.

<sup>47</sup> [https://www.dsc.org.uk/wp-content/uploads/2017/06/DSC-Focus\\_On\\_Armed\\_Forces\\_Charities\\_Mental\\_Health.pdf](https://www.dsc.org.uk/wp-content/uploads/2017/06/DSC-Focus_On_Armed_Forces_Charities_Mental_Health.pdf)



This includes committing to the Armed Forces Covenant, providing statutory and charitable mental health services, raising awareness among staff of veterans' healthcare needs, and establishing clear links with service charities and local support providers. When hospitals demonstrate they are delivering these high standards, they will be publicly accredited as 'Veteran Aware'. Learning from the Armed Forces Charities report, the Alliance is engaging with service charities and others, including Combat Stress, to do more to support improvements to mental health services for veterans and the armed forces community in the future.

### **The restricted patient system – improving the pathway**

Restricted patients are offenders who have been diagnosed with a mental health disorder<sup>48</sup>, detained in hospital for treatment and subject to special controls by the Secretary of State for Justice, such as those who are transferred to a secure hospital unit from a prison or are subject to a restricted hospital order imposed by the court. A restriction order or direction means that the clinicians responsible for restricted patients' care do not have the power to decide on some matters relating to their management without the consent of the Secretary of State for Justice. For instance, clinicians must make formal applications to the Mental Health Casework Section (MHCS) of Her Majesty's Prison and Probation Service (HMPPS) to seek the Secretary of State's consent to allow a restricted patient community leave, to transfer to a different hospital, or for discharge. There are about 4,800 restricted patients in hospitals in England and Wales<sup>49</sup>.

Some trusts raised concerns that these decisions had recently been subject to significant delay, often of several months or more. This causes problems in the effective treatment of the restricted patients and increases providers' costs. One trust estimated that delays in decisions to move patients to step-down placements were likely to increase the costs of managing those patients by about 20% this year alone. MHCS told us that since June 2017, there have been delays in some casework decisions caused by staff vacancies. It drew up a backlog recovery plan in June 2017, designed to prioritise critical decisions and ensure all other decisions continued to be made in order of receiving the application. MHCS worked with NHS England throughout 2017 to regularly review this plan. As a result, the plan was revised to prioritise reducing delays for decisions on hospital transfers rather than community leave, as this had an immediate impact on the wider system. MHCS has had additional staff resources in place since January 2018, allowing it to eradicate the remaining backlog of community leave decisions by early May 2018.

Aside from the specific circumstances that caused the backlog of decisions in 2017 MHCS acknowledges stakeholders' concerns and feedback that delays in making decisions about restricted patients can have a substantial impact on costs and the patients' health. MHCS told us that while it had internal targets against which it measured its performance, these targets were not published and it intended to review them with stakeholders in the next financial year. MHCS has also identified that in some cases, delays can occur because it does not receive sufficient information in the initial application to allow a decision to be made. MHCS recognises that a review of its guidance and application forms is necessary to avoid having to seek further information. It also recognises that it must provide clear

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<sup>48</sup> In legislation, these people are referred to as 'mentally disordered offenders'.

<sup>49</sup> Offender Management Statistics quarterly: October to December 2017:

<https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2017>



guidance to clinicians and ask the right questions at the right time, ensuring it receives all relevant information necessary to make a timely comprehensive assessment of risk.

The review examined the process and identified significant scope to make longer-term improvements. We found there is no memorandum of understanding between DHSC, the Ministry of Justice and HMPPS governing the operation of the process, and no published performance management framework for HMPPS. Applications are not submitted digitally, and there is scope to make improvements in the way work flows. We recognise that the restricted patient system is an area of interest to the independent review of the Mental Health Act which is underway (reporting autumn 2018). It will be important that the improvement work is informed by any directions from that work.

#### **Recommendation 4 – Restricted patients**

**The Department of Health and Social Care, Ministry of Justice and their arm’s length bodies should work more closely to improve the administrative management of restricted patients.**

Delivered by:

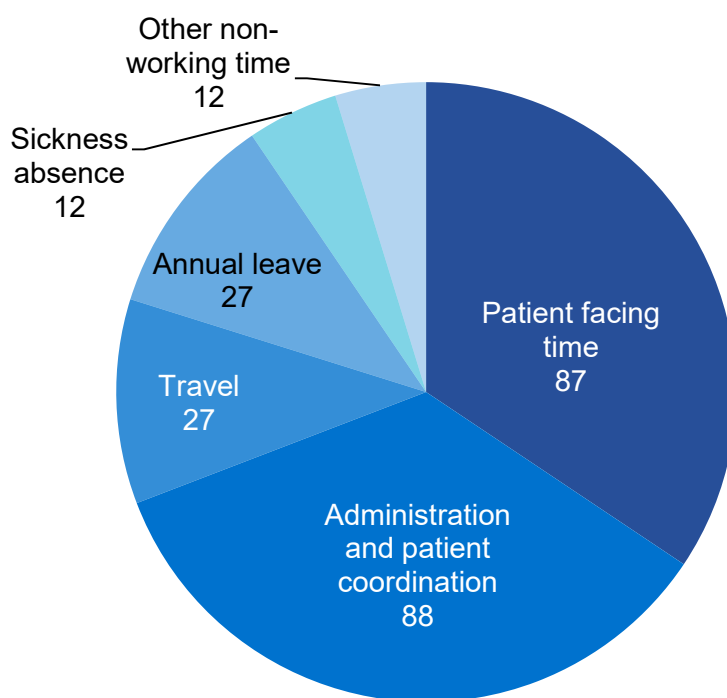
- The Department of Health and Social Care and the Ministry of Justice agreeing a memorandum of understanding between the departments and covering their Arm’s-Length Bodies.
- A transparent joint performance management framework and key performance indicators are implemented by April 2019 and guidance to trusts on applications processes is strengthened.
- HMPPS and NHS England developing a joint improvement plan by April 2019 to improve the process; this should consider development of a digital platform to manage applications.

## Chapter 3: Engaging the workforce

### Workforce as a key factor in driving improvements

Staff across the NHS work incredibly hard and are our biggest asset. At £10.4 billion per year<sup>50</sup>, they represent nearly three-quarters of total trust expenditure and the largest investment made by community and mental health trusts. Throughout the review we have seen how hard staff work and the brilliant services they deliver to patients, despite the pressure they are under on a daily basis. Good staff engagement is key to ensuring patients receive the best care. However, we were struck by levels of bullying and harassment, sickness absence and vacancy rates, and low staff engagement.

This chapter examines the organisational factors that affect staff, covering culture, leadership and people practices. Chapters 4 and 5 build on this theme to explore the opportunities to improve the productivity of the workforce, including minimising travel time, administration and patient coordination. These are based on the principle of how staff can be better supported, managed and deployed to spend more time with patients. We analysed how an average healthcare professional delivering services in the community spends their time.



**Figure 3.1 – average number of days per working year spent on different activities by a frontline healthcare professional delivering services in the community, NHS Improvement analysis of electronic staff records and data collected by the review<sup>51</sup>.**

This shows that about one-third of a community-based clinician's time is spent delivering care directly to patients. This chapter focuses on how we can maximise patient-facing time by supporting staff.

<sup>50</sup> Consolidated trust accounts, 2016/17. Referenced in Figure 1.1.

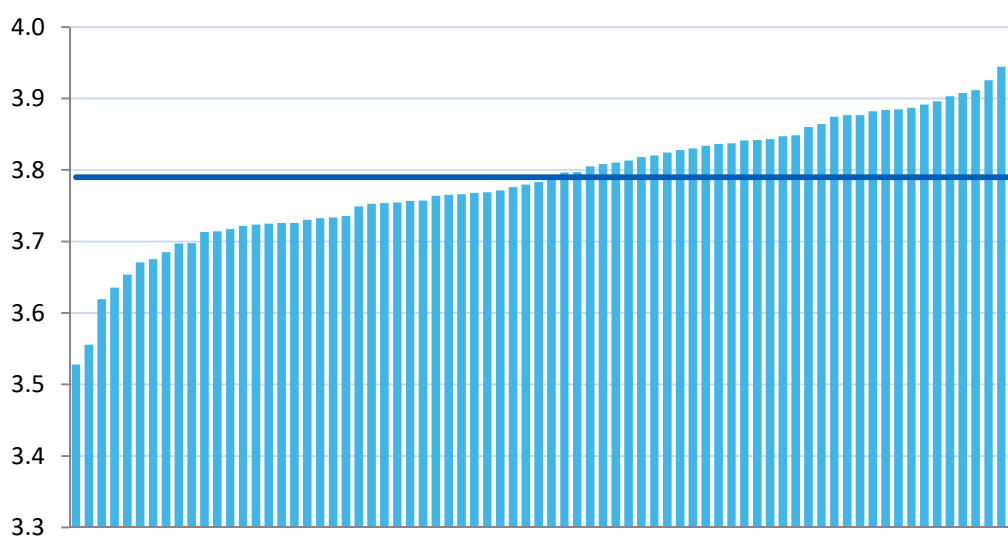
<sup>51</sup> Figure 3.1 sums to 253 days, which is the average number of days that a member of staff is contracted to work in a year

## Culture, leadership and staff engagement

Successive reviews and research have shown a clear link between productivity and leadership that builds positive workplace cultures. The influence and impact of good leadership at all levels, in particular line management, is a critical factor in staff engagement. The Corporate Leadership Council<sup>52</sup> found that the line management relationship had four times the impact on staff engagement compared to other factors such as their day-to-day-work.

Clinical outcomes tend to be better in organisations with higher engagement scores as shown by CQC 'outstanding' organisations such as Northumberland, Tyne and Wear NHS Foundation Trust and East London NHS Foundation Trust.

The NHS Staff Survey<sup>53</sup> provides invaluable information on the views and experiences of people working in the NHS. The range of staff engagement scores across mental health and community trusts is shown below in Figure 3.2.



**Figure 3.2 – staff engagement score out of 5, mental health and community trusts, NHS Staff Survey 2017**

Compared with the acute hospital sector, staff working in mental health and community trusts report poorer levels of overall satisfaction, and are less likely to recommend the organisation as a place to work or receive treatment. This is concerning as engagement is a key enabler in improving sickness absence and staff turnover. Fostering a culture of 'collective' leadership is an important factor in improving staff engagement and patient care<sup>54</sup>. The CQC report, *Driving improvement case studies from seven mental health trusts*<sup>55</sup> found that engaging and empowering staff are some of the most significant drivers of improvement. The case study below highlights one trust's journey.

<sup>52</sup> Corporate Leadership Council, referenced in McCarthy T (2016) Improving Efficiency and Productivity Through People.

<sup>53</sup> <http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/>

<sup>54</sup> West, M; Eckhert, R; Stewart, K and Passmore B (2014) Developing Collective Leadership for healthcare. The Kings Fund and Centre for Creative Leadership

<sup>55</sup> [http://www.cqc.org.uk/sites/default/files/20180320\\_drivingimprovementmh\\_report.pdf](http://www.cqc.org.uk/sites/default/files/20180320_drivingimprovementmh_report.pdf)



### Case study – Engagement ‘champions’

In December 2015, CQC rated Lincolnshire Partnership NHS Foundation Trust as ‘requires improvement’ for safety, effectiveness and leadership. The trust appointed members of staff as ‘champions’ to engage with staff and patients, drive positive change and update the board on the trust’s progress. The executive team was keen to learn from other trusts that CQC had rated as ‘outstanding’. The trust recognised the value of the connections it had with other trusts and continued to build on them, as well as implementing what it had learned across the organisation. In April 2017, the trust was reviewed by CQC and rated ‘good’.

As part of work with the cohort trusts we saw numerous examples where excessive work demands have detrimental effects on stress levels, absenteeism and staff turnover. Research by Dixon-Woods et al<sup>56</sup> into culture and behaviour in the English NHS showed how consistently delivering high quality care is undermined if organisations do not have improvement objectives and if staff have unclear goals, or are not clear on their priorities. When this is combined with stress, high workload, and lack of autonomy it can contribute to a culture of ‘learned helplessness’, which can feel oppressive to frontline staff.

Rates of staff innovation to develop new ideas, small or large, are too low in the NHS. We have seen examples of staff not feeling able to take the opportunity to make improvements. This is largely down to culture, in particular the support available to staff from leaders, whether staff feel safe to make suggestions (often described as ‘psychological safety’), and whether staff are equipped with the necessary skills to make performance improvements. Being able to deliver incremental improvements is also intrinsically motivating to staff and therefore has an impact on engagement. East London NHS Foundation Trust, by developing a team-based approach, has been able to support staff and is seeing improved engagement from them, service users and carers.



### Case study – Organisational culture

East London NHS Foundation Trust has taken a proactive approach to improving organisational culture through a large-scale quality improvement programme. It has reduced incidents of inpatient violence by 40% across some wards, reduced waiting times for treatment in the community by 55 weeks for certain services, and improved its staff engagement level to the highest level for any comparable trust at 3.96 for 2017. In 2014 the trust committed to using quality improvement across the whole organisation, and to involving staff and service users in identifying issues and developing solutions. The trust partnered with the Institute for Healthcare Improvement for guidance over this period, and has trained over 2,000 staff across several quality improvement areas<sup>57</sup>.

Organisational culture is a strategic priority for NHS provider organisations and this is reflected in the new well-led framework (2017)<sup>58</sup>, developed by CQC and NHS Improvement, and the national strategy for improvement and leadership development,

<sup>56</sup> <http://qualitysafety.bmj.com/content/23/2/106>

<sup>57</sup> The trust’s reflections on establishing its organisational culture programme are summarised here:

<https://improvement.nhs.uk/resources/east-london-nhs-foundation-trust-one-trusts-experience-culture-programme/>

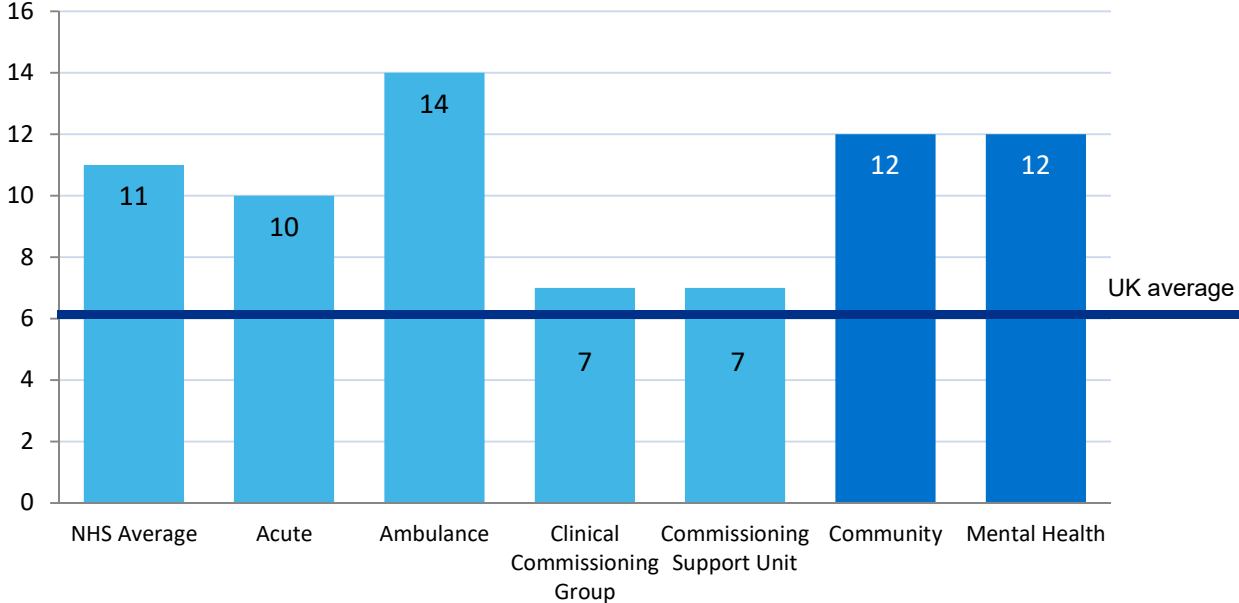
<sup>58</sup> <https://improvement.nhs.uk/resources/well-led-framework/>

*Developing people – improving care* (NILD 2016)<sup>59</sup>. This strategy highlighted how better team-working, staff engagement and clear organisational values can unlock improved financial performance and higher quality care. Alongside this, the recently published guide *Valued care in mental health: improving for excellence*<sup>60</sup> highlights a series of resources to help trust boards plan and actively lead strategic cultural change. NHS Improvement has also launched a toolkit<sup>61</sup> to help organisations assess their own cultures using an evidence-based approach. NHS Improvement must speed up the learning from these publications in terms of what is needed at a national level to make highly engaged cultures in healthcare the norm.

**Supporting the health and well-being of our staff**

Staff experience the culture of their organisation through its people management practices, the behaviours of all levels of leadership, the deployment of staff, and its approach to staff development. Organisational culture has a direct impact on the performance of the organisation and its staff. Sickness absence management and how staff are supported and managed back to work are key line management activities.

Staff sickness absence is too high across the NHS, but sickness absence rates are over 1% higher in mental health and community trusts than acute hospital trusts. This equates to about 12 days of care lost per staff member per year and costs NHS mental health and community trusts about £400 million in lost days per year. Within these sectors, there is significant variation in reported sickness rates.



**Figure 3.3 – average number of working days lost per staff member per year to sickness absence, 2017/18<sup>62</sup>**

We heard many reasons why sickness, vacancy and turnover rates are higher for community and mental health trusts, such as intensity of work, varied geography and local

<sup>59</sup> [https://improvement.nhs.uk/uploads/documents/Developing\\_People-Improving\\_Care-010216.pdf](https://improvement.nhs.uk/uploads/documents/Developing_People-Improving_Care-010216.pdf)  
<sup>60</sup> <https://improvement.nhs.uk/resources/valued-care-mental-health-improving-excellence/>  
<sup>61</sup> <https://improvement.nhs.uk/resources/culture-and-leadership/>  
<sup>62</sup> Sickness date source: NHS Improvement analysis of Electronic Staff Record (ESR).

labour market competition. Trusts also identified work-life balance, levels of patient acuity, team vacancies and the availability of support for staff as key drivers for sickness absence. Work with acute hospital trusts suggests that many routinely under-report sickness absence<sup>63</sup>, and we reached the same conclusion for community and mental health trusts. This is because data is recorded in the electronic staff record (ESR) by line managers, and compliance will vary. We also found that different methods were used to calculate sickness absence rates. Some trusts used 365 days as the denominator, whereas some used an individual's actual working capacity – taking into account annual leave, training, and working patterns. This makes it difficult to benchmark nationally.

NHS Improvement is implementing the people strategy recommendations in the 2016 report into the operational productivity of NHS acute hospitals, and this programme now includes mental health and community trusts. Work is ongoing to:

- **Review sample sickness absence policies:** the policies reviewed from cohort trusts showed that while most contain points about supporting staff with their health and wellbeing, the policy's overall ethos is often punitive and reactive, prescribing steps for staff management through a process. Often 'return to work' interviews are not carried out and definitions of short-term and long-term leave are not well understood or defined. In addition, the policies often did not align with other relevant policies, such as annual leave, causing confusion and variation of practice in trusts.
- **Scope a programme to help reduce sickness absence rates for mental health and community trusts by 1%:** this includes focusing on improving staff wellbeing and organisational cultures to reduce sickness absence. This programme, co-produced with NHS England and in line with the Stevenson-Farmer Review<sup>64</sup>, is being taken forward with trusts across the sectors.

NHS Employers has released an online toolkit to help managers support staff with respect to sickness absence<sup>65</sup>. It includes practical advice on what to do when a person calls in sick, common reasons for sickness absence and what to do if staff members are frequently off sick. The resource includes a tool which enables trusts to identify how much they could save by reducing their sickness absence. NHS Employers currently has about 800 users of the toolkit and is undertaking further work to ensure that all staff are aware of the support that is available.

During the review we encountered a number of trusts who have managed to show the positive impact of culture on sickness absence.

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<sup>63</sup> Lord Carter of Coles (2016) Operational productivity and performance in English NHS acute hospitals: Unwarranted variations.

<sup>64</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf)

<sup>65</sup><http://www.nhsemployers.org/news/2014/07/new-online-tool-takes-headache-out-of-sick-leave>

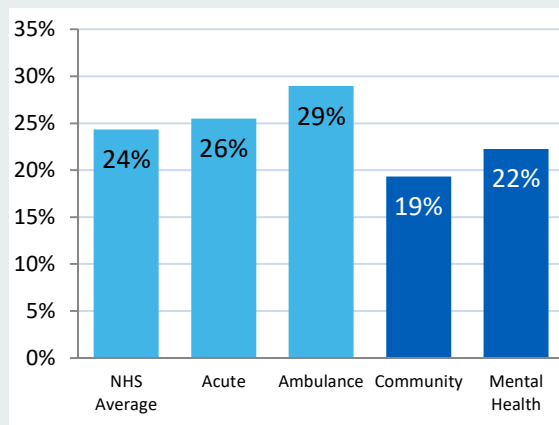


## Case study – Approach to management

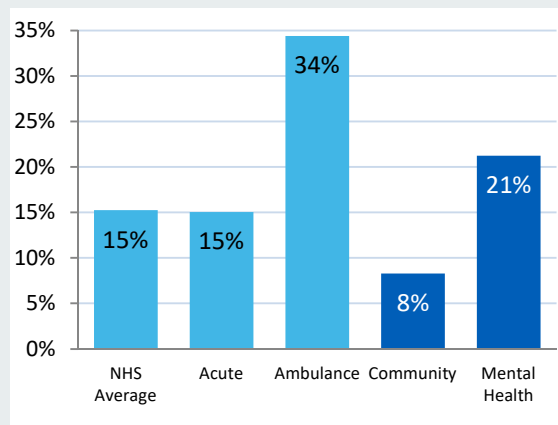
In 2015 Norfolk and Norwich University Hospitals NHS Foundation Trust started changing its approach to managing its teams by focusing on 'Knowing Your Staff'. This was done in partnership with local trade unions and focused on returning autonomy back to line managers, encouraging them to manage staff as individuals rather than requiring them to follow a rigid policy. In its January 2018 board report the trust notes a positive effect on its sickness absence rates, which reduced from 4.4% to 3.9% despite tighter thresholds for action. It will be extending the approach to its disciplinary policy in the next year. This change equated to 37 more staff at work each day. The approach won recognition from the Social Partnership Forum and the Healthcare People Management Association.

### Taking action to reduce bullying and harassment

The NHS Staff Survey reports a higher proportion of mental health staff than community staff experiencing physical abuse, harassment, bullying, and abuse from patients, relatives or the public.



**Figure 3.4 – percentage of staff experiencing harassment, bullying or abuse from staff, NHS Staff Survey 2017**



**Figure 3.5 – percentage of staff experiencing physical violence, NHS Staff Survey 2017**

Figure 3.4 highlights the staff survey results for staff experiencing harassment, bullying or abuse from other staff in the last 12 months. Trusts reported they had also been working on reducing these levels with some results, shown by a small reduction for mental health trusts and nearly a percentage point improvement for community trusts since 2016. However, all trusts we spoke to recognised that there was further to go and that levels overall were too high.

### Taking action to reduce incidents of violence against staff

Staff who experience violence in the workplace are four times more likely to take sick leave than those who experience any other type of work injury<sup>66</sup>. Figure 3.5 shows the proportion

<sup>66</sup> Roche et al (2010) Violence Toward Nurses, the Work Environment, and Patient Outcomes, *Journal of Nursing Scholarship* 42:1, 13-22.

of staff experiencing physical violence, where the level for mental health trusts is higher than the NHS average. For many staff this was a key cause of stress at work leading to sickness or leaving their job. Trusts all had plans to address this issue but many told us they found it difficult to identify an approach with a sustainable impact. Research<sup>67</sup> and World Health Organization guidelines<sup>68</sup> both cite that specific interventions can have a positive impact on reducing incidents of violence against healthcare workers. The key areas identified are organisational commitment, and training staff, for example, in de-escalation techniques, advanced communication skills, and empathy and environmental changes. While there is a national commitment to address this issue, work needs to be accelerated.

NHS Improvement and NHS England are working together and have set up a pilot programme to reduce violent incidents against staff. This will focus on four key areas:

- developing leadership capability and accountability,
- assessing current security management systems and standards,
- developing staff support, and
- raising public awareness.

The pilot will assess the viability of these interventions and produce a detailed proposal to take them forward. The programme will also work to identify and share best practice from areas where violent incidents are low.

### ***Leadership at all levels in the organisation***

The role of trust boards is crucial with good leadership being fundamental to high quality care. NHS boards face common performance and people development challenges. While NHS organisations invest a great deal in creating clinical, operational and financial strategies, few have leadership strategies that support developing organisational culture, understanding staff engagement and patient engagement.

A high functioning board works as a team that models the organisation's values, is visible and accessible, has maximum effect from up to date knowledge of best practice and standards, and has appropriate levels of constructive challenge. Clinical leadership is also essential to driving change in a manner that both supports staff, and delivers better care for patients. Boards should include experience from across the public and private sectors.

It is important to have leadership at all levels of the organisation, sharing core values and a vision. This includes supporting frontline supervisors or team leaders and ensuring they are trained in people management and trust policy. This training should be pre-appointment, on appointment and regularly refreshed to ensure managers have the skills to undertake these roles. We saw many instances of staff having been promoted to management posts without the training to support them to undertake the role. Work to implement the people strategy recommendation from the acute hospital sector review will explore the development of principles for optimal organisational design. This will include using best practice from NHS and external bodies to review organisational reporting structures from the chief executive to

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<sup>67</sup> Hahn et al (2012) Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: a cross-sectional survey. *Journal of Advanced Nursing* 68(12), 2685-2699

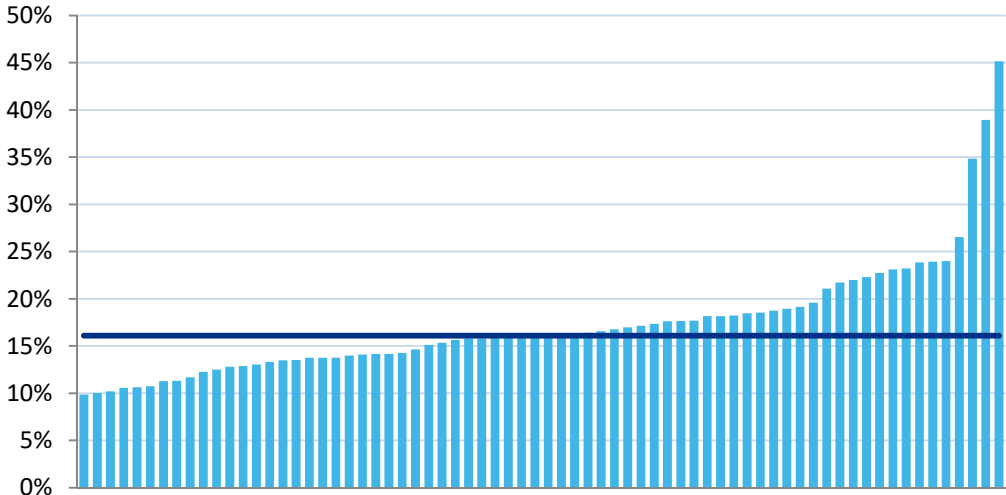
<sup>68</sup> [http://www.who.int/violence\\_injury\\_prevention/violence/activities/workplace/en/](http://www.who.int/violence_injury_prevention/violence/activities/workplace/en/)



the frontline, defining management roles and responsibilities throughout the organisations to clarify accountabilities, and enabling as much decision making as possible to be delegated to the frontline. NHS Improvement has scope to improve the participation of mental health and community trusts in its support programmes for executive and non-executive development, culture and leadership.

**Retaining staff and creating opportunity**

The turnover rates for some mental health and community trusts range from 9% to 45%<sup>69</sup>, with the average being significantly higher than in the acute hospital sector.



**Figure 3.6 – 12-month turnover rate, community and mental health trusts, December 2017<sup>70</sup>**

Several external factors influence retention rates, such as an ageing workforce, national pay policy and access to continuous professional development (CPD). However, trusts can significantly improve retention in a relatively short time. Measures include empowering and engaging staff, and developing their CPD and flexible working offers. Sandwell and West Birmingham Hospitals NHS Trust improved nursing staff turnover by 3% over one year by developing CPD and a staff benefits package. The frontline manager’s critical role must not be ignored, and the line manager relationship has been shown to be four times more influential than other engagement factors. It is an often quoted truism that ‘people often join organisations but leave managers’<sup>71</sup>.

To help trusts improve retention, NHS Improvement and NHS Employers launched a programme in June 2017 to first stabilise and later reduce NHS leaver rates by 2020 with a particular focus on clinical staff. The programme will support trusts with the highest leaver rates to develop retention improvement plans. These will identify specific actions to address leaver rates and performance goals over 12 months. The programme includes training masterclasses for directors of nursing and human resources, and improvement resources for trusts. All mental health and community trusts with high turnover rates will be

<sup>69</sup> Including TUPE transfers.  
<sup>70</sup> NHS Improvement analysis of Electronic Staff Record (ESR) data.  
<sup>71</sup> Corporate Leadership Council, referenced in McCarthy, 2016; ‘Improving Efficiency and Productivity Through People’

invited to participate in the programme. NHS Improvement will be providing an update on progress in autumn 2018.

All community and mental health trusts should have a fully developed retention strategy. A strong retention plan should be based on:

1. Understanding the problem – trusts should assess which parts of their organisation are most challenged, which staff groups have the highest turnover, and what aspects have the greatest impact on patient care and safety. This should include developing an understanding of why staff leave the organisation and, just as importantly, why they stay.
2. Staff engagement – using evidence gathered through staff engagement to inform the plan and develop solutions.



### Case study – Career progression

Northumberland, Tyne and Wear NHS Foundation Trust supported Band 2, 3 and 4 support staff to pursue a range of career development pathways leading to pre-registration nursing courses. This is part of a wider strategy to 'grow our own', which includes a training academy and a partnership with Sunderland University. About 750 healthcare support staff are at various stages of career progression, 150 of whom hold foundation degrees or equivalent qualifications and are moving towards becoming registered nurses. The trust expects to produce about 60 registered nurses per year by 2021.

### Training

As with any NHS sector, continuous professional training is critical for delivering high quality care to patients and keeping staff safe. Individual organisations are responsible for their own training programmes, which are typically informed by recommendations from the national professional and representative bodies. Our review assessed training processes in our cohort trusts in partnership with a specialist training provider<sup>72</sup>. It identified a significant opportunity for trusts to modernise their training offer and management.

Despite advances in the availability and suitability of alternative training mediums, such as e-learning, many trusts still offer much of their training in face-to-face settings. Increasing online and decreasing face-to-face learning – to achieve a more appropriate blend – reduces staff time away from the job, as well as associated travel expenses. Doing this while streamlining administration for learning and development teams would lead to a savings opportunity of about £400,000 a year for an average sized trust employing 3,000 staff.

Trusts also employ significant resources to monitor training completion with manual tracking remaining common. Where processes are automated, trusts often use multiple systems which then require manual consolidation. Streamlining these processes could save over 1.5 hours of monitoring time per employee, worth over £110,000 a year for an

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<sup>72</sup> Relias Learning Ltd.

average sized trust<sup>73</sup>. Furthermore, the ESR system does not always interface with third party learning management systems, which means that trusts that have chosen these systems have to manually input data into ESR. An average sized trust could therefore identify a total savings opportunity of about £500,000 a year from reviewing its training processes.

Surprisingly, few trusts require staff to complete any training before their first day on the job, and some trusts have policies that do not allow this. Where staff do complete training before starting, they report arriving more confident and prepared, as seen in practice at Mersey Care NHS Foundation Trust. We found that streamlining induction programmes in this way could reduce the time taken for a new staff member to reach their potential productivity by 25%. It is also often the case that staff will have completed some training at a previous employer – particularly regular mandatory training. Better recognition of this and transferring, or ‘passporting’, this information through collaboration between organisations is possible, and this review strongly encourages this to take place. Developing a national shared digital training record would support all trusts to make savings in this area.

In the longer term there is also scope for NHS Improvement to increase its offer in this area, by supporting trusts to implement alternatives to face-to-face training, and supporting the development of national training packages<sup>74</sup> and a shared training record. Where there is scope to streamline management and modernise training, we encourage national professional and representative bodies to work constructively with employers, Health Education England and NHS Improvement to do this. Work has already begun with a national streamlining steering group and regional groups supporting local innovations. The national group has identified the adoption of the core skills framework (CSF)<sup>75</sup> and use of the Oracle Learning Management system aligned to ESR for reporting and transferring information between trusts.

Given the challenges workforce shortages pose for providers, it is important to see training as part of the solution and move towards a competency-based approach, where training is viewed as an opportunity to upskill the workforce, create meaningful development opportunities and improve staff experience, engagement and retention.

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<sup>73</sup> Taken as a trust employing 3,000 staff.

<sup>74</sup> Health Education England is undertaking a national training for restrictive practice to support this.

<sup>75</sup> <http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework>

## **Recommendation 5 – Optimising workforce well-being and engagement**

**Improving cultures are critical to better staff engagement, driving positive change across organisations and improving both productivity and care quality. NHS Improvement should work with all mental health and community trust boards to help improve the engagement, retention and wellbeing of their staff.**

Delivered by:

- As part of the development of its operating model, NHS Improvement to take a stronger, leading role in supporting providers to improve their people and talent management.
- NHS Improvement applying the *Developing people – improving care* framework and methodologies to trusts, and supporting a wide range of programmes with national partners during 2018/19. Given the particular challenges for mental health and community providers, the NHS Improvement people strategy, leadership and quality improvement teams must ensure the programme targets support to these trusts' particular needs.
- NHS Improvement working with NHS Employers will develop a model sickness absence policy with guidance on how to reduce levels and highlight current resources available by spring 2019.
- NHS Improvement undertaking a review of bullying and harassment with NHS England and the Social Partnership Forum during 2018/19.
- NHS Improvement working with NHS England to pilot a violence reduction programme in 14 organisations in 2018/19.
- NHS Improvement's people strategy team, working with NHS England, leading an improvement collaborative with mental health and community trusts that will support trusts to refresh or build their health and wellbeing plans in line with the 'Healthy Workforce Framework'. This will drive the reduction of sickness absence levels in community and mental health trusts by 1% by April 2020.
- NHS Improvement increasing awareness and uptake of improvement and leadership development support and programmes undertaken by mental health and community providers during 2018/19.
- NHS Improvement continuing to roll out its existing retention programme to ensure all mental health trusts are supported to retain their existing clinical workforce during 2018/19.
- NHS Improvement developing its role in provider training, in particular working with Health Education England, professional and representative bodies to support the development of standard training materials for trusts, and supporting the development of a shared training record by winter 2018.
- Trusts reviewing their training offer, in particular the processes for monitoring training, to explore whether they can adopt more efficient processes to improve staff productivity by spring 2019.

## Chapter 4: Optimising clinical resources in the community

About 70% of mental health and community trusts' clinical work is delivered in the community, including in people's homes, general practices, clinics and residential care homes. There are about 80 common services, including community nursing, therapy services, community mental health services, health visiting and school nursing, which support people across different care pathways. They range from smaller services worth tens of thousands of pounds per year to multimillion pound services employing hundreds of staff. We estimate that over 90,000 clinical staff work in these services across England<sup>76</sup>.

We analysed and validated over 37 million lines of data and worked with our cohort trusts to compare similar services and understand:

- **The total time clinicians spend with patients each day**, which tells us how effectively we are using clinical capacity to provide the best care for patients. This 'direct care time' can be face-to-face, over the telephone or using other media such as video calling.
- **The number of patient contacts a clinician has each day**, which tells us how many individual cases a staff member deals with each day.
- **The average duration of individual contacts**, which tells us how long a typical contact takes.
- **The number of contacts per patient over the reporting period**, which tells us how much care is delivered to each patient seen by the service.

Taken together, these measures provide a good basis to evaluate the productivity of a service delivered in the community, and the pattern of care it provides. This chapter focuses on two of the largest service areas, community nursing and adult community mental health. The findings, however, are representative of other services we examined, including larger local authority commissioned services such as school nursing and health visiting.

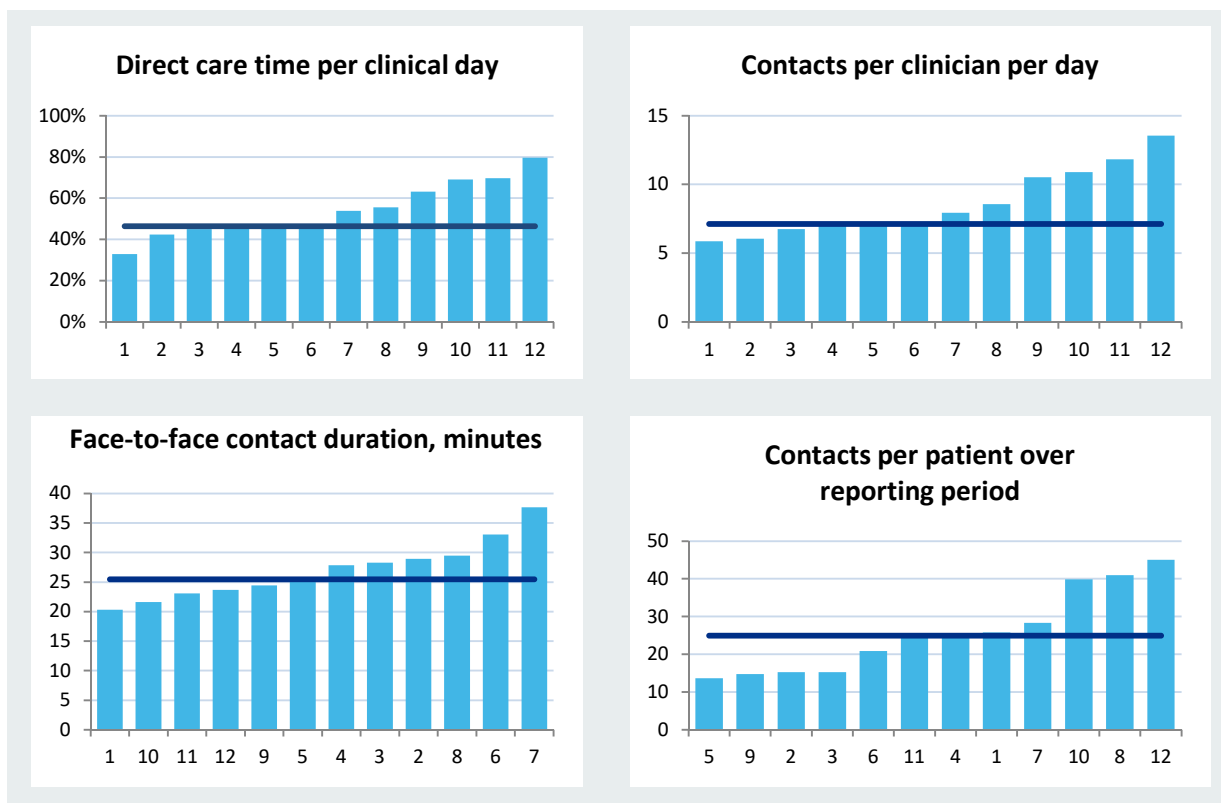
### Community nursing

Community nursing is a core community health service and accounts for about a third of total spend and about 16% of clinical activity delivered by community trusts<sup>77</sup>. These services typically support areas such as bowel care, continence management, wound care, palliative care, end-of-life care, health education, administration of medicines, and nutrition management. Community nursing teams have traditionally comprised nurses and healthcare assistants, but newer integrated teams increasingly include allied health professionals and social workers. The work these teams undertake is varied and often highly complex. Community nursing services will play a fundamental role in supporting the uptake of new care models, and moving care out of hospitals and closer to people's homes. Improving their efficiency is therefore of paramount importance for the efficiency of the whole system of care. Figure 4.1 shows the key productivity measures described above for community nursing.

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<sup>76</sup> Estimate based on total whole time equivalents reported in trust consolidated annual accounts for 2016/17.

<sup>77</sup> Service line data from cohort trusts.



**Figure 4.1 – the productivity of community nursing services in 12 trusts. Dark blue line represents the median; each number represents a unique, anonymised trust.**

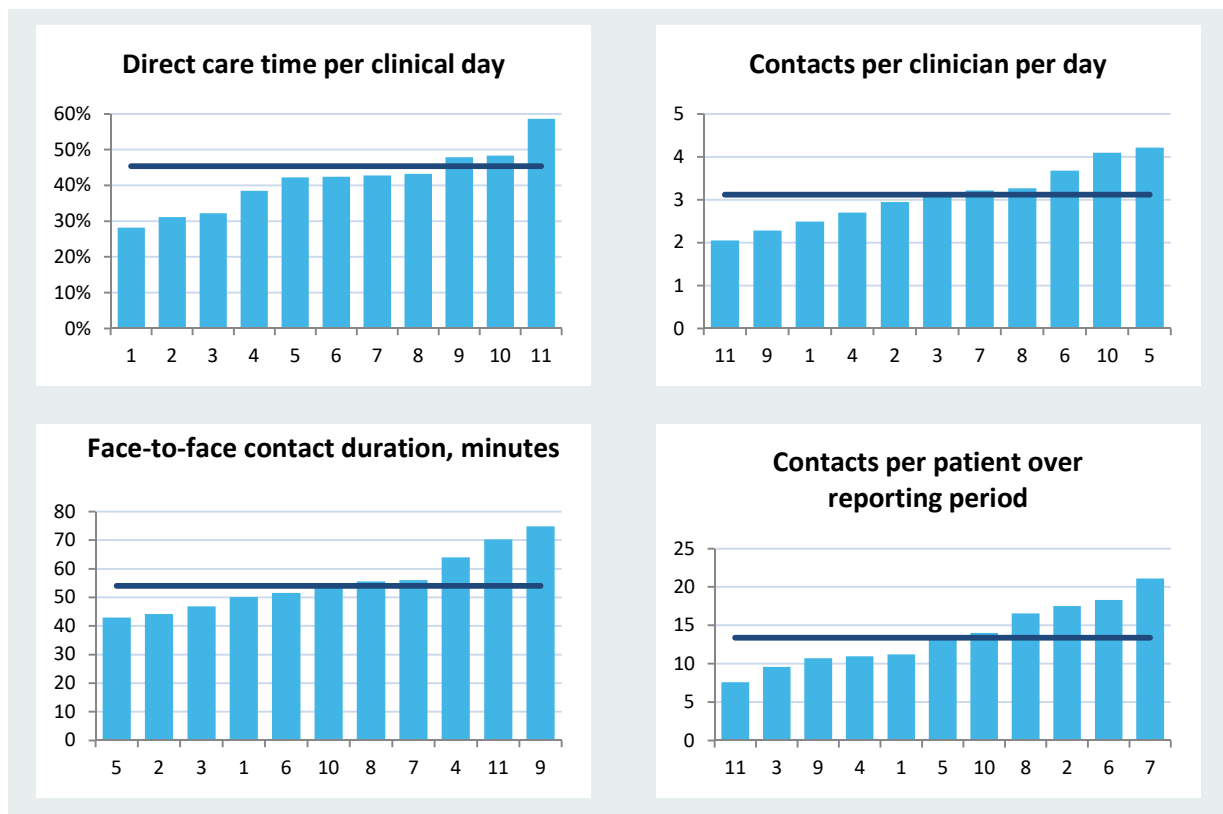
The findings show significant variation in productivity across trusts. The average time clinicians spend delivering care to patients ranges from 33% to 80% with some services delivering twice as many contacts per clinician per day compared to others. There is a 75% difference in the average duration of face-to-face contacts, and the number of contacts per patient over the reporting period ranges from 14 to 45. Trusts told us that some variation may be explained by differences in case complexity, geographies and the way services are commissioned. However, we have also seen significant differences in how individual trusts manage the productivity of their services and have concluded that variation of this scale is unwarranted. Reducing this variation could significantly improve access to care. If the direct care time for all community nursing services were improved to the median, nationally this would free capacity of nearly 300,000 days per year and allow these services to support nearly 90,000 more patients. It would be the equivalent to having an additional 1,600 staff.

This analysis raises important questions. Services that focus on enabling people to independently manage their own care – for instance, by teaching them to self-administer medication – may have longer average contact times but fewer total contacts per patient. Trusts need to ensure that in driving productivity, the effectiveness of clinical interventions and patient experience are maintained or improved.

### **Adult community mental health services**

Adult community mental health teams (CMHTs) are typically multi-disciplinary teams supporting adults with mental health problems in the community. They provide services that include psychological therapies such as cognitive behavioural therapy, care co-ordination, medication support and referrals to other services such as employment and housing. These are sometimes complemented by specialist services such as personality disorder

services. The delivery of the Five Year Forward View for Mental Health objectives are predicated on robust and high-functioning CMHTs. Figure 4.2 shows the variation in productivity of adult community mental health services.



**Figure 4.2 – the productivity of adult community mental health services in 11 trusts. Dark blue line represents the median; each number represents a unique, anonymised trust.**

The direct care time per clinical day in adult CMHTs ranges from 28% to 59% and the average length of contacts varies significantly from 43 minutes to over 70 minutes. Patients are seen three times more often in some services than others, and some teams are delivering twice as many contacts per clinician per day compared to others. Again we conclude that variation at this scale is unwarranted. We estimate that if the direct care time for all adult CMHT services were improved to the median, nationally this would free capacity of more than 90,000 days per year and allow these services to support over 20,000 more service users. It would be the equivalent to having an additional 500 staff.

### ***Unwarranted variation in services delivered in the community***

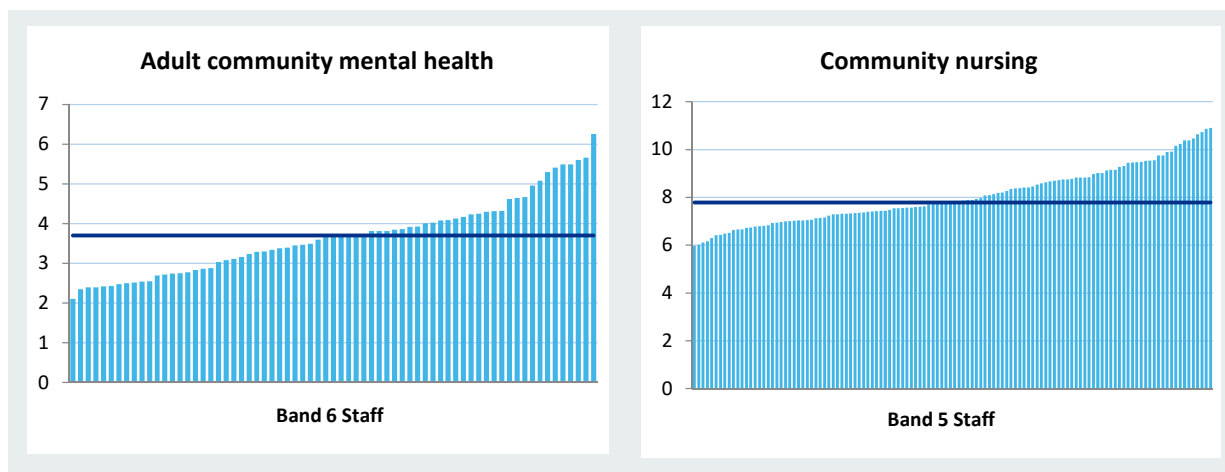
We have analysed a range of services delivered in the community and have found similar unwarranted variation in all of them. There is significant unmet need in accessing children and adolescent mental health services (CAMHS). NHS England is committed to a significant expansion in access to high quality mental healthcare for children and young people with an initial step of ensuring at least 70,000 more children and young people each year receive evidence-based treatment. However, the proportion of direct care time in CAMHS ranged from 35% to 85%, and the average contacts per patient over the reporting period ranged from seven to 15. If the direct care time for all CAMHS were improved to the median, nationally this would free capacity for these services to support over 6,000 more



people and would be the equivalent to having an additional 140 staff. Improving productivity will need to be part of how this gap is closed.

### Managing productivity

We found that most trusts do not routinely review data on their clinical workforce productivity. Performance reports typically focus on volumes of activity without relating them to the resources delivering them, making it difficult for boards and managers to understand whether services are good value for money. We examined individual clinicians' productivity within trusts and found significant variation in the average number of contacts per day for members of staff.



**Figure 4.3 – average number of contacts per day for individual clinical staff in adult community mental health and community nursing services within a single trust**

We found an almost twofold difference in the number of contacts made per day by Band 5 staff working in this trust's community nursing services. For Band 6 staff in the trust's adult CMHTs there is a threefold difference in the number of contacts made per day. Many trusts did not review and manage the productivity of individual staff effectively, particularly in mental health services. Derbyshire Community Health Services NHS Foundation Trust has developed a solution to allow a more detailed understanding of the way clinical capacity is used<sup>78</sup>, and The Queen's Nursing Institute has published clear advice to help trusts understand safe caseloads and the use of demand management<sup>79</sup>.

We visited some trusts where individual staff contacts per day and caseload size were shared and discussed in frontline team meetings. We found this to be associated with higher productivity, stronger working relationships and better team morale. This enables teams to have an open dialogue about the fair allocation of work, helps managers prioritise support their teams, and informs the flexible use of capacity across teams to meet patient demand.

<sup>78</sup> [https://improvement.nhs.uk/documents/2334/Safer\\_staffing\\_District\\_nursing\\_appendices\\_final.pdf](https://improvement.nhs.uk/documents/2334/Safer_staffing_District_nursing_appendices_final.pdf)

<sup>79</sup> [https://www.qni.org.uk/wp-content/uploads/2017/02/Understanding\\_Safe\\_Caseloads\\_in\\_District\\_Nursing\\_Service\\_V1.0.pdf](https://www.qni.org.uk/wp-content/uploads/2017/02/Understanding_Safe_Caseloads_in_District_Nursing_Service_V1.0.pdf)



### **Case study – Quality and performance reporting**

In 2016, Wirral Community NHS Foundation Trust invested in a tool to improve reporting and provide quality and performance information to all staff. The system shows activity and cost data, and helps clinical leads identify activities that are not clinically justified and do not result in improved outcomes for patients. With improved internal benchmarking, this has contributed towards cost improvement plan savings of £2.8 million in 2017/18.

We believe that all providers of services delivered in the community would benefit from having access to reliable, regular and transparent national benchmarking. NHS Improvement should develop the Model Hospital to enable this. This should build on expertise from these sectors and work from organisations such as NHS Benchmarking, and use available data to present information on productivity, caseload management, and patient outcomes and experience. The Model Hospital should evolve to reflect the needs of the community and mental health sectors. Metrics will need to be driven by the national data sets for mental health and community services (the Mental Health Services Data Set and the Community Services Data Set). For robust analysis using these data sets, further standardisation may be needed, including defining services. In the longer term, introducing patient-level costing in mental health and community health will make it possible to generate increasingly robust comparisons between services delivered by different providers.

### **Recommendation 6 – Strengthening the oversight of workforce productivity for services delivered in the community**

**With support from NHS Improvement and NHS Digital, and using the Model Hospital as a national benchmarking dashboard, providers should improve their understanding and management of productivity at organisational, service and individual level.**

Delivered by:

- NHS Improvement designing and delivering Model Hospital compartments for selected service lines by April 2019 and other main services delivered in the community by April 2020.
- NHS England and NHS Improvement supporting providers and commissioners to work together within sustainability and transformation partnerships to develop model frameworks for specifications of services (see also recommendation 3).
- NHS Improvement together with NHS Digital standardising key activity definitions used in national data collections by April 2019.
- Providers ensuring they report all required and mandatory fields to the relevant national data collections by April 2019.
- Providers reviewing how they oversee and manage the productivity of services delivered in the community, including business intelligence capability, and providing a report and improvement plans to their boards by April 2019.

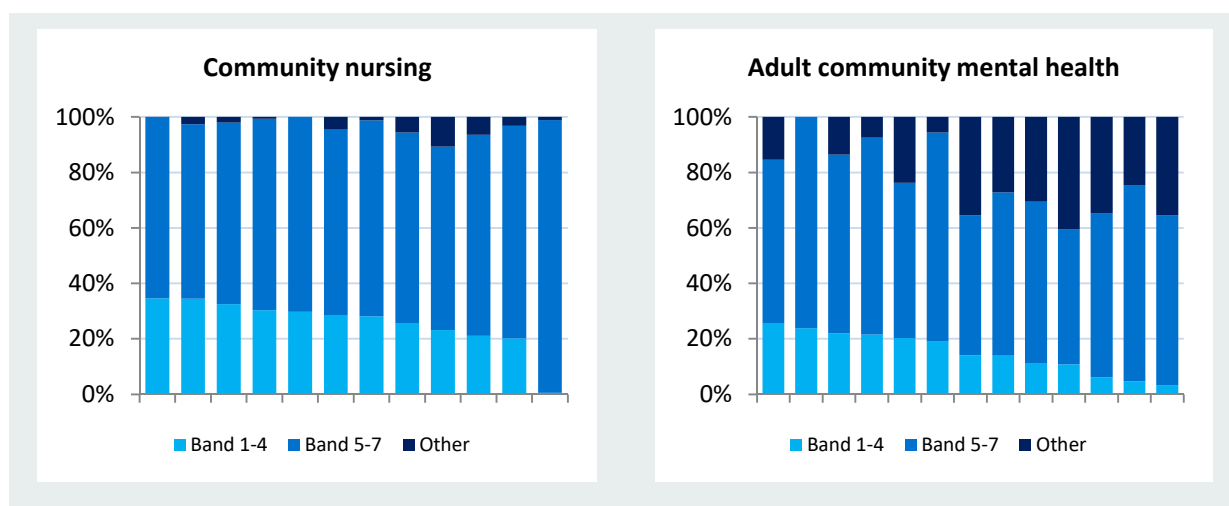
## Improving the way services are delivered

Everywhere we visited we saw how hard staff work to deliver high quality healthcare to the people they support. However, organisations' operating systems and processes do not always help them do this efficiently. While service models should reflect the different needs of the populations they support, more can be done to improve the way in which services are delivered. Where this is done well, staff are able to spend more time delivering care and trusts are better able to meet demand.

Improving workforce productivity for services delivered in the community is about achieving better outcomes through the optimal use of clinical resources. We saw excellent examples of how trusts have improved their capacity through optimising team structure and composition, improving referral and case management, managing appointments to reduce non-attendance, and changing how services are delivered to minimise travel and maximise effectiveness. Providers should review all these areas to ensure clinicians are able to spend as much time as possible supporting service users. Despite the innovative approaches, all trusts felt scope remained to make further improvements. Achieving these improvements requires strong, transformative leadership as outlined in chapter 3, and innovative use of digital technology. If all trusts adopted practice from the best, significant improvement could be made across these sectors.

### Composition and resilience of teams

We saw significant variation in the structure and composition of teams even in comparable services. Figure 4.4 shows the variation in team composition for community nursing and adult community mental health services.



**Figure 4.4 – variation in team composition as a proportion of whole-time equivalents, across 12 community nursing services and 13 adult community mental health services**

There was significant variation in the skill mix of community nursing services. While some trusts use healthcare assistants for activities like taking blood or administering insulin, in others nurses delivered the same care, resulting in higher costs and reduced productivity. Services using a high proportion of healthcare assistants tended to have better developed competency training and delegation schemes. We found differences in mental health

services where non-clinical colleagues supported healthcare workers to free their time and increase productivity, for instance by co-ordinating aspects of care.

We also observed that many community teams were not resilient. We saw how small teams can make a service vulnerable to staff absence without proper processes for managing this. For example, we spoke to a community nursing team where senior team members were covering long-term sickness absence for a Band 3 healthcare assistant and observed mental health teams that had a significant number of long-term agency staff. Trusts should actively review their skills mix and resilience.

### ***Referral pathways and case management***

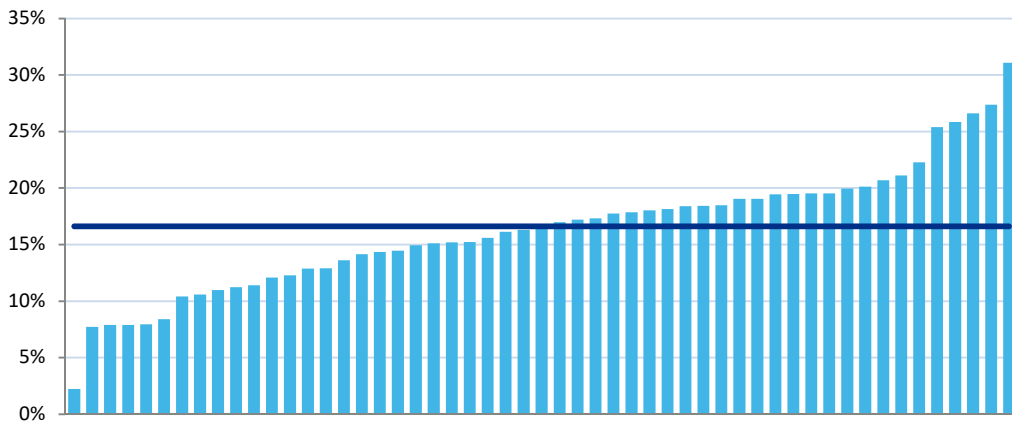
Efficient referral pathways have a direct impact on the use of clinical capacity and patient outcomes. Good referral pathways can reduce waiting times and allow rapid interventions by the right services and clinical staff. Timely and effective interventions reduce the risk of deterioration and the need for more complex care. Many trusts have implemented a single point of access (SPA), which simplifies and streamlines referral processes. Best practice is to have the SPA covering all services provided in a local area however we found that most providers still maintain a range of access routes into their services, resulting in increased administration and poorer communication. Managing access to services well is important in ensuring clinical resources are used to support those individuals who need them most. In many services, discharging someone after a single appointment may suggest this person's needs would be more appropriately met by a different service. Robust management of demand and monitoring of service delivery has allowed <sup>2</sup>gether NHS Foundation Trust to achieve significant improvements in productivity and outcomes.



#### **Case study – Management of demand and access**

<sup>2</sup>gether NHS Foundation Trust implemented a programme of measures encompassing service delivery, clinical practice and demand management, which contributed to it having some of the best outcomes nationally for its Improving Access to Psychological Therapies service. Only 9% of patients are discharged after a single appointment, compared to 29% nationally, meaning that the right people are being seen by the service and getting the right treatment. In addition, recovery rates are consistently above target and the service has improved data quality from 53% to 90%.

It is also important to ensure the timely discharge of people at the end of an episode of care so a service can respond to fluctuating demand. This requires active management of caseloads and effective joint working arrangements with primary care. We saw significant unwarranted variation in all aspects of case management across different services. For example, there are significant variations in the proportion of patients discharged from mental health services each month, as shown in Figure 4.5.

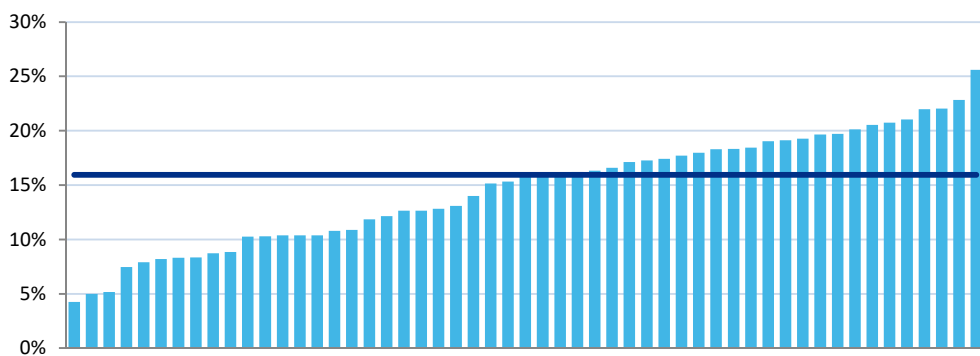


**Figure 4.5 – proportion of cases discharged each month across 53 mental health trusts**

This variation indicates that people are not discharged from mental health services in a consistent manner across the country. This is in line with what we heard from trusts about discharge practices, including how a lack of policies specifying when patients should be discharged can increase caseload sizes and create difficulties in understanding service capacity and prioritisation, and the dependency on primary care services. While it is appropriate that practices reflect specific service and patient needs – for instance, prioritising the continuity of a patient-clinician relationship may be more important in some services – an approach for robust caseload management is needed in all services.

**Reducing non-attendance**

Missed appointments result in the significant waste of clinical capacity and compromised outcomes for patients. Figure 4.6 presents the proportion of missed contacts reported by mental health trusts.



**Figure 4.6 – missed care contacts across 53 mental health trusts**

It is unacceptable that on average 16% of mental health appointments are missed. Trusts that have successfully reduced non-attendance rates have done so through a good balance of effective administrative processes and use of technology. We saw examples of proactive methods, including use of administrative resources to contact patients and service users by phone before appointment, automated text messages and creating online portals for interaction with clinicians and self-management of appointments. By improving staff understanding, data capture and understanding patient experience, <sup>2</sup>gether NHS Foundation Trust has reduced non-attendance in its Gloucestershire IAPT service from

29% to 13% (see case study earlier in this chapter). All trusts should actively learn from good practice models and embrace technology to reduce non-attendance.

### ***How services are delivered***

Services delivered in the community provide a broad range of interventions in varied settings and locations. The changing nature of need, the shift towards prevention and advances in technology create both a necessity and an opportunity to change how services are delivered. A current example of such a change is the use of clinics and groups to provide services that might traditionally be provided at home, often supported by patient transport services using optimised route planning. Some trusts have successfully introduced leg ulcer clinics and clozapine clinics that increase staff productivity and provide care centred more closely around a person's care needs.



#### **Case study – Clozapine clinics**

Northumberland, Tyne and Wear NHS Foundation Trust changed its model for administering clozapine to service users to a pharmacy technician-led clinic. This helped to improve patient experience by supporting service users in need of clozapine to access their treatment more easily and in a way that better suits their service needs. The new model combines blood monitoring with medicines supply, and has halved the number of required visits and improved the levels of missed appointments. The new model has reduced the cost of an initiation from £3,000 to £300, and avoided costs of about £100,000 during the first two years of operation.

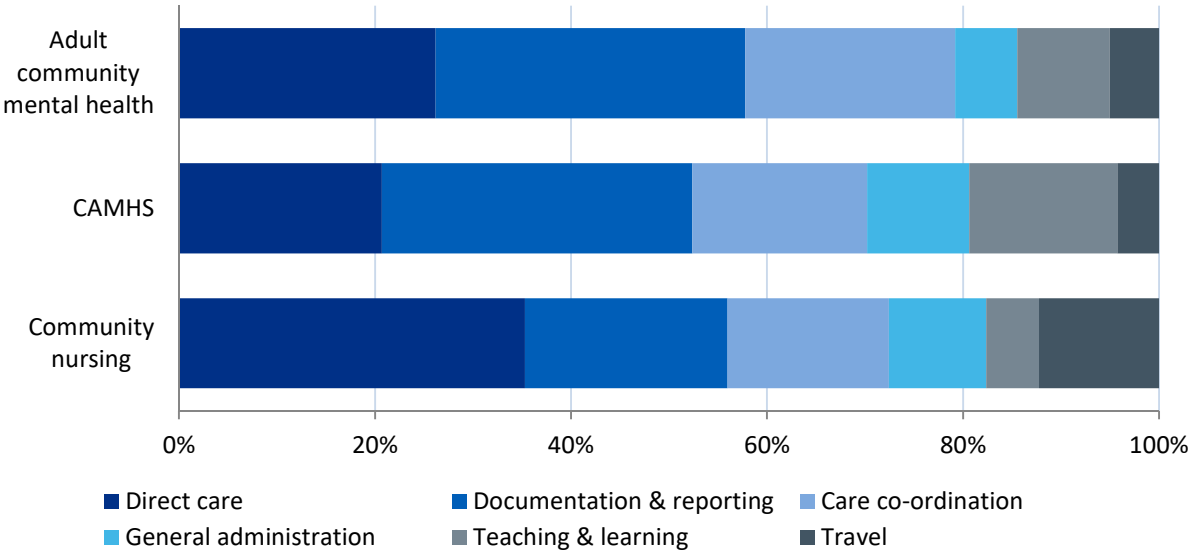
We also saw how some organisations are using technology to deliver care through digital clinics, where clinicians are connected to patients and carers via a video link. These represent significant opportunities to improve staff productivity and patient outcomes for many services. However, despite available technology, these have not been widely implemented. The 'Teleswallowing' model, developed by speech and language therapists in Lancashire, enables the remote assessment of care home residents with feeding and swallowing difficulties. This significantly improved both the productivity of the clinical staff and patient outcomes. In mental health, Turning Point, a social enterprise, uses video calling in its IAPT services to supplement care delivery or as an alternative to face-to-face or telephone treatment sessions. Alongside this, the organisation has introduced an online platform with interactive treatment and support modules that patients can access from their mobile devices.

As described later in this chapter, providers of services delivered in the community must examine opportunities for changing the traditional way in which care is delivered to patients and maximise use of technology to improve outcomes and productivity.

### ***Use of administrative resources***

Robust administrative processes and efficient use of administrative capacity are fundamentally important for improving the productivity of the clinical workforce. Appropriately trained and supervised administrative staff can successfully carry out a number of delegated tasks in relation to access to services, care coordination and customer support. Failure to provide adequate administrative support means that clinicians

spend less time delivering care. We collected detailed data from 500 staff in three services to understand how they spend their time between direct care, documentation and reporting, care coordination, general administration, teaching and learning, and travel.



**Figure 4.7 – time spent on activities by frontline staff in services delivered in the community**

Figure 4.7 shows that clinical staff spend a significant proportion of their time on non-clinical duties, with CAMHS staff reporting the least direct care time at 21%. This is due to the time required for documentation and reporting, care coordination and teaching and learning (which together make up 65% of the working day). We recognise the differences in the nature of support and service provision, but we found significant variation in the proportion of time taken up by indirect activities even when comparing identical services and teams in the same trust. This is largely due to different administrative capacity and operating processes deployed in individual services and localities.

Trusts told us that administrative support teams have often been reduced as a cost improvement measure without sufficiently considering the impact on the clinical workforce. In many cases this had reduced the effectiveness of frontline teams. We met one senior clinician who spent significant time each week scheduling appointments with patients as the team’s administrative support had been cut. As a result, the team could not see as many patients as before, and the number of missed care contacts had increased. A robust and coherent approach to administrative capacity in trusts can free clinical time and increase engagement in direct care activities.



**Case study – Customer service transformation**

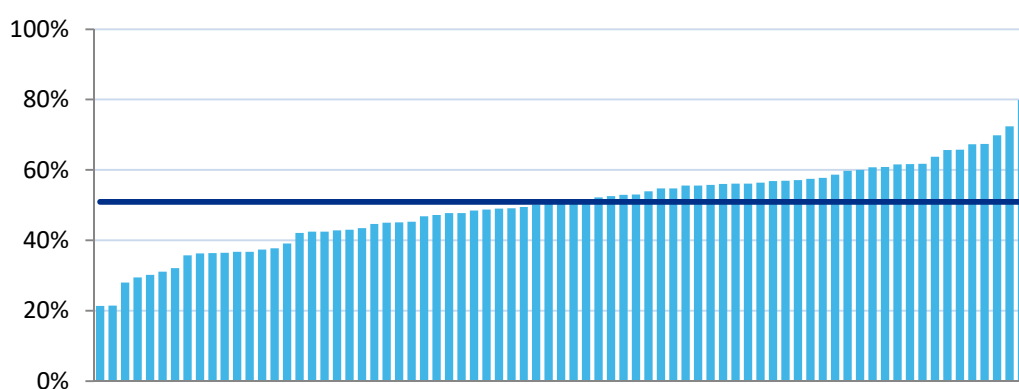
Hertfordshire Community NHS Trust is part-way through a transformation programme focused on improving customer service. This includes restructuring administrative functions to a semi-centralised model based on three contact centres for the county. Through process improvements to free up staff time, expanding the use of technology, better opportunities for progression, and a shift in culture towards customer service the programme is beginning to deliver significant and wide-ranging benefits. The trust is now exploring options for integration with social care partners.



## Digital maturity

Digital technology can be a key enabler for improving workforce productivity for services delivered in the community, both physical and mental health. Mobile technology, remote access to records and automation enable reductions in travel and duplicative clinical recording, better triage and a more efficient allocation of clinical work. The Queen's Nursing Institute report, *Nursing in the digital age*<sup>80</sup> highlights that the use of innovative technological solutions can radically transform the way health and care services are delivered in the community. Our experience shows that these improvements can be maximised when combined with good use of administrative staff and optimised operating processes.

The digital maturity assessment completed in 2015/16 measured the extent to which healthcare services in England are supported by the effective use of digital technology.



**Figure 4.8 – digital maturity assessment score – community and mental health trusts**

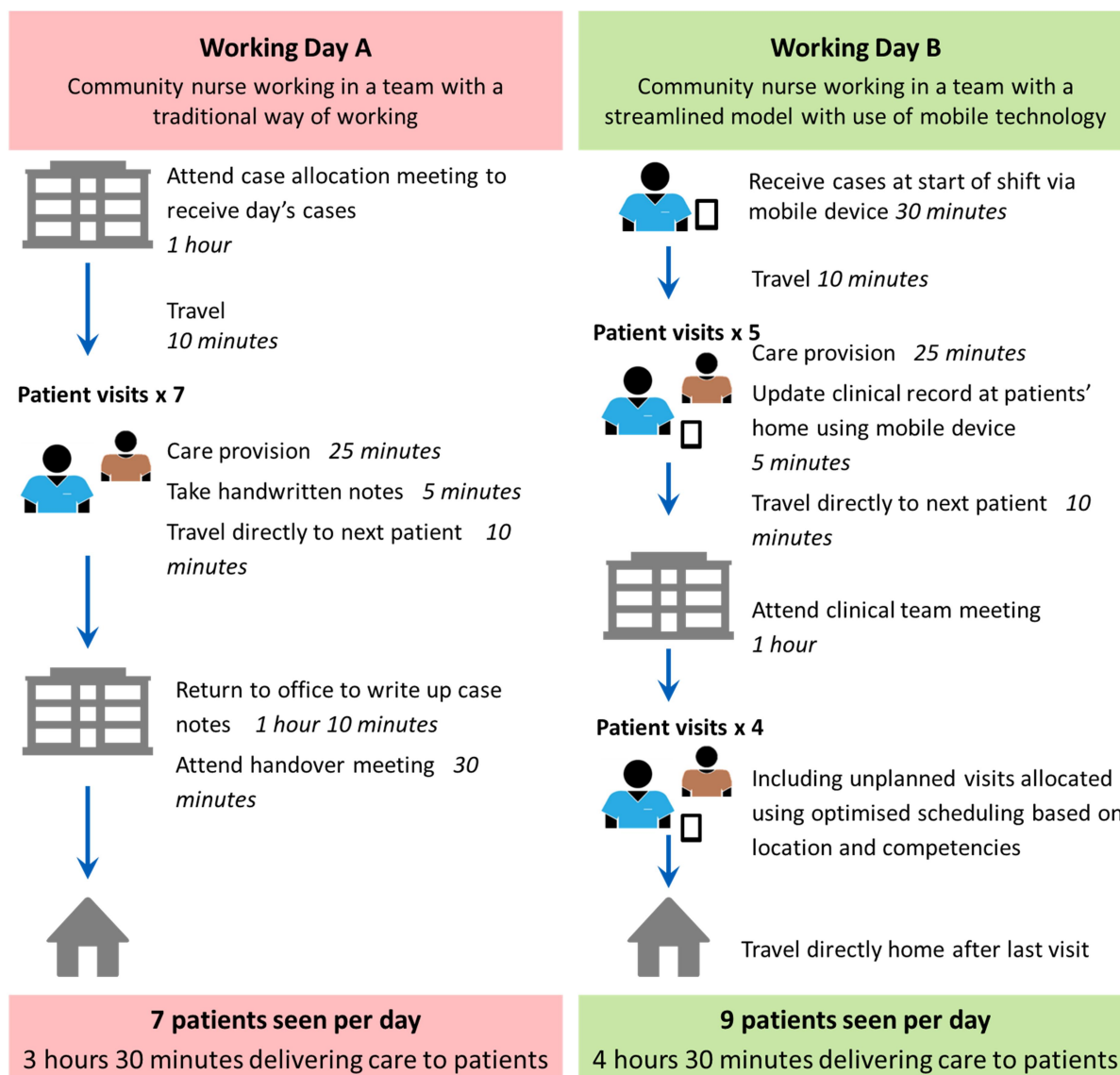
The analysis showed significant variation in digital capabilities and use of technology. The lowest scores were related to trusts' existing capabilities, for records, assessments and plans, transfers of care, orders and results management, medicines management, remote care, resource optimisation and standards.

Many providers have invested in digital technologies, but relatively few have made the necessary changes to working practices to maximise the productivity gains possible from this investment. NHS Improvement and NHS Digital must ensure that good practice is shared so that benefits from the use of digital technology are realised by all. Mental health trusts with advanced digital strategies have already been recognised by NHS England's Global Digital Exemplars programme. These trusts are increasingly being partnered with others to ensure the spread of innovation and good practice. Some trusts, most notably Norfolk Community Health and Care NHS Trust, demonstrated good progress across many areas of digital practice during our review. Their success highlights a significant area of opportunity for other trusts.

Unfortunately, remote access to clinical records and teleconferencing for meetings are still poorly used. Access to and use of mobile technology remains inconsistent. This is unacceptable in 2018 and we anticipate that significant productivity gains can be achieved through technology-enabled change. Figure 4.9 shows the opportunity associated with the use of technology for streamlining case allocation and supporting remote entry into the

<sup>80</sup> <https://www.qni.org.uk/resources/nursing-in-the-digital-age/>

clinical record, enabling clinicians to spend more time delivering care – in this case seeing two extra patients per day and increasing patient-facing time by almost 30%.



**Figure 4.9 – the impact of supporting processes and mobile working on staff productivity**

The benefits from such innovative practices cannot be achieved if organisations or individual services still use paper as their main method of communication, rostering and patient administration. An estimated 29% of district nursing services still use predominantly paper-based processes<sup>81</sup>. Additionally, electronic patient record systems are often cumbersome and difficult to use, and increase the burden of clinical documentation on staff. This is particularly the case in mental health, where we saw clinicians having to re-enter information into the system even when there was no change in underlying presentation or identified risks.

Trusts told us they needed stronger central guidance and support for maximising the benefit of digital technology, identifying and choosing between potential solutions, understanding best practice for configuring and implementing these, and in engaging with

<sup>81</sup> <https://www.qni.org.uk/resources/nursing-in-the-digital-age/>

suppliers. In particular, we heard that often products are not designed for services delivered in the community, and therefore need to be modified to work for these services. This often limits their functionality.

There is a clear role for NHS Improvement, working with NHS Digital, to provide this support in a more active and strategic manner. This must be a central part of NHS Improvement's response to the productivity and efficiency challenges faced by providers of services delivered in the community.

**Recommendation 7 – Improving the productivity of the clinical workforce for services delivered in the community**

**Providers of services delivered in the community should increase the productivity of their clinical workforce by improving and modernising their delivery models, in particular through better use of digital solutions and mobile working.**

Delivered by:

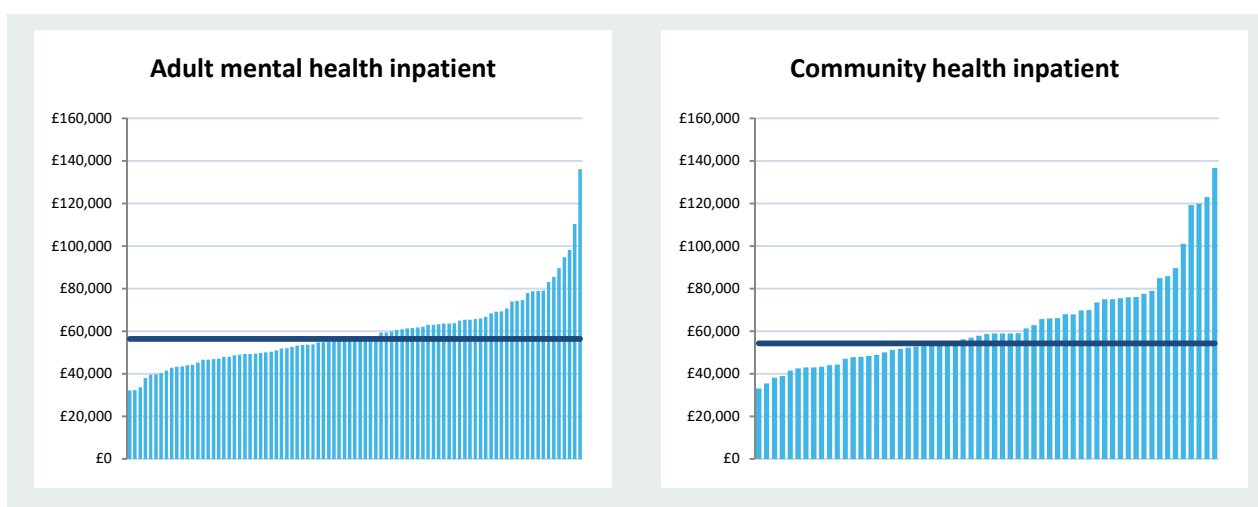
- NHS Improvement developing guidance on good operating practice for services delivered in the community, starting with community health services, by autumn 2018.
- Using this guidance, all providers of services delivered in the community developing plans by April 2019 for how to improve service delivery models. This should include specific productivity improvements regarding information technology and mobile working.
- All providers of services delivered in the community should benchmark their service delivery models against Model Hospital metrics (see recommendation 6) by summer 2019.
- NHS Improvement, supported by NHS Digital, outlining and sharing best practice, and providing support to trusts with both procurement and deployment of digital solutions.

## Chapter 5: Optimising inpatient services and other clinical resources

The remaining 30% of clinical spend is on inpatient services, with more in mental health trusts. A wide range of factors influence the productivity of these services including management of the clinical pathway.

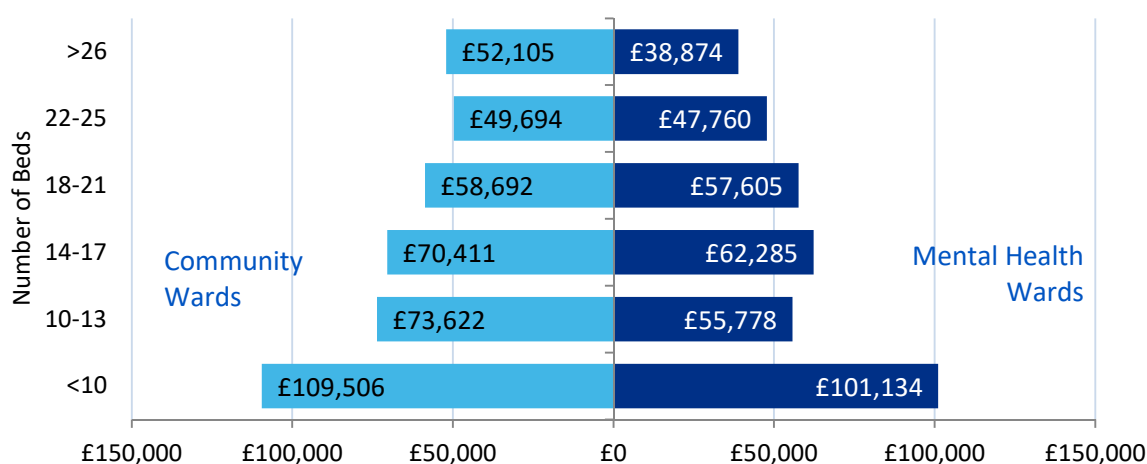
### Nursing cost per bed

Using the data collected from cohort trusts we were able to calculate the nursing cost per occupied inpatient bed per year for a range of service lines. Figure 5.1 shows this for adult mental health and community health inpatient units and highlights significant levels of variation in nursing spend per occupied bed. This variation is replicated across all service lines collected from cohort trusts.



**Figure 5.1 – variation in average nursing cost per occupied bed per year for adult mental health inpatient and community health inpatient units in cohort trusts**

We also examined the relationship between nursing cost and the ward size. Figure 5.2 shows the variation in average nursing spend per occupied bed per year for adult mental health inpatient wards and community hospital wards by ward size.



**Figure 5.2 – variation in average nursing cost per occupied bed per year for adult acute mental wards and community wards in cohort trusts by ward size.**

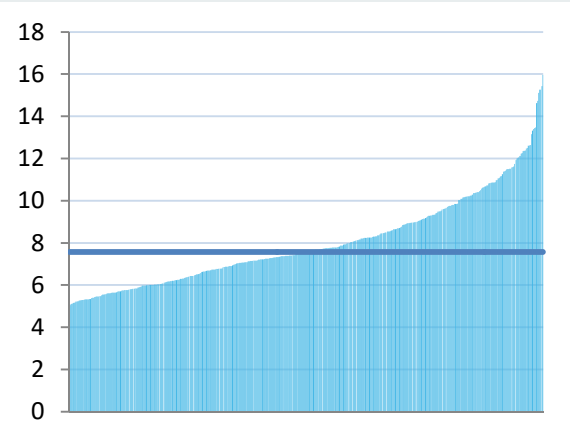
We discussed the findings with trusts and they highlighted that smaller wards were often isolated from other health facilities and on stand-alone sites. This increases the costs of staffing wards safely and presents challenges with recruitment and retention of staff, particularly registered nurses. These wards often had higher bank and agency staffing levels and higher sickness levels. We recognise the critical role of local services in providing care, but we need to ensure it is on an appropriate scale. Some trusts in the cohort are looking at innovative ways of restructuring their inpatient services as part of a wider transformation of their service offer with their local sustainability and transformation partnerships (STPs). To build on this data we collected cost per care hour from mental health and community trusts from September 2017. These metrics are intended to be examined alongside others to understand where variation is unwarranted. We do this further in this chapter through inpatient workforce utilisation and also in chapter 6.

**Care hours per patient day (CHPPD)**

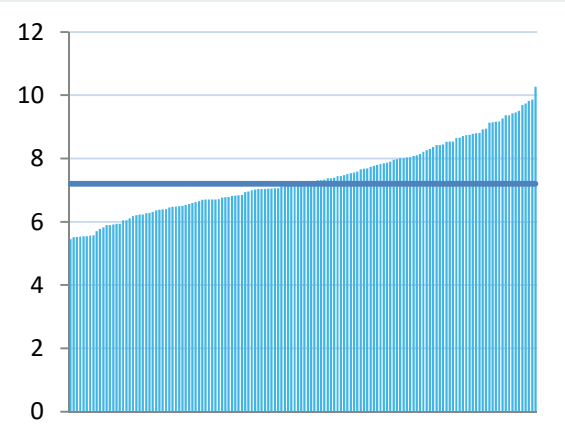
We developed the care hours per patient day (CHPPD) metric for inpatient services to examine nursing and healthcare support worker deployment in inpatient settings. This measure represents the number of nursing care hours available to patients, and allows inpatient units of a similar size, specialty and patient group to be benchmarked:

$$\text{Care Hours Per Patient Day} = \frac{\text{Hours of registered nurses} + \text{Hours of healthcare support workers}}{\text{Total number of patients}}$$

CHPPD can be used to describe both the staff required and staff available in relation to the number of patients. CHPPD also splits registered nurses from healthcare support workers to reflect skill mix needs. Following an initial CHPPD pilot data collection with cohort trusts we collected national data in autumn 2017 from over 1,500 wards in 69 mental health and community health trusts. To reflect the multi-disciplinary nature of working in mental health and community wards we included the care hours provided by allied health professionals (AHPs) rostered and working as part of ward teams. The data showed significant variation across the cohort.



**Figure 5.3 – average daily CHPPD for 455 adult acute mental health wards**



**Figure 5.4 – average daily CHPPD for 141 rehabilitation (physical health) wards**

CHPPD can be used for improvement conversations, and to provide a consistent means of interpreting productivity and efficiency alongside clinical quality and safety outcome measures. Where wards have similar specialty, length of stay, layout and patient acuity or dependency, trusts can compare wards' CHPPD on a like-for-like basis to determine whether variation is unwarranted. A higher CHPPD between wards with similar attributes may suggest that too much staffing resource is being deployed for the number of patients on that ward. Many of our cohort trusts identified significant variation in similar wards within their organisation and agreed that in some areas this was unwarranted. Figure 5.3 illustrates this with the range of CHPPD from 5 to 16. Taking into account patient acuity, environment challenges and demographics, this still represents significant levels of unwarranted variation. Equally, a low CHPPD may suggest too few staff to care for the patients on that ward. Analysing variation across similar wards in the same trust and between organisations can help staff from ward to board understand workforce productivity, improve operational efficiency and reduce costs.

### **Developing CHPPD and cost per care hour**

We recognise that further work is needed to develop CHPPD to provide an increasingly useful resource for trusts. Many trusts highlighted the need to be able to see outcomes in relation to staffing levels. In response to this we reviewed the association between higher levels of CHPPD and readmission rates, delayed transfers of care and reduced lengths of stay. Our initial analysis showed no correlation between these factors. We will continue to review this relationship as we collect more data and work with trusts to understand these issues.

One area we plan to explore further is acuity, defined as a measurement of the severity of patients' needs and the amount or intensity of care they require. We know this can be very varied between patients on the same ward. Trusts reported that they are developing acuity and dependency tools or working together in small groups to develop them. Developing national acuity tools and guidance was recognised as a priority to enhance CHPPD and the analysis of variations it supports.

AHP data was submitted for about one-third of wards and accounted for 10% of the total rostered ward hours. The ward specialties that employed the highest number of AHPs were child and adolescent, forensics, rehabilitation for mental health and step-up for community health. We identified variation in AHP deployment between wards of the same specialty. Further work is required to understand the importance and value of AHPs in wards and how they are best deployed.

One of the recommendations from the review of acute hospital trusts was to develop a measure looking at the cost of inpatient care. This led to the development of cost per care hour, which measures the average cost of an hour of care provided by staff on an inpatient ward. It can be broken down between registered nursing and health support staff, and between substantive, bank and agency staff to understand some of the expenditure drivers. It is also possible to calculate the cost per patient day for each ward, which can be used to highlight the element of cost that is driven by either registered nurses or healthcare support workers.

To undertake a similar process and extend the learning from the acute programme, data has been collected from mental health and community trusts since September 2017. The early data returns show a wide variation across both mental health and community wards but further work needs to be undertaken to assess the quality of this data and the extent to which this variation is correctly specified.

### **Recommendation 8 – Cost of inpatient care and care hours per patient day**

**NHS Improvement should develop and implement measures for analysing workforce deployment, and trusts should use these to report on the cost and efficiency of their inpatient services to their boards during 2018/19.**

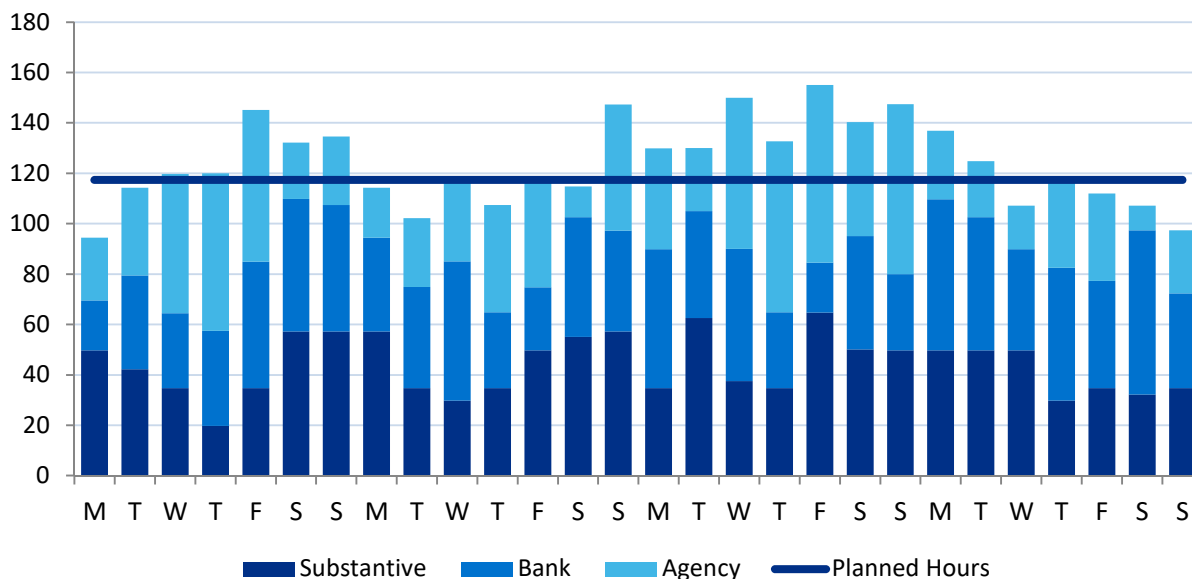
Delivered by:

- Trusts reviewing their existing ward structures as part of their wider strategies to reduce the cost of inpatient care.
- NHS Improvement developing Model Hospital inpatient metrics to support the benchmarking of services, particularly for multi-site facilities and stand-alone wards/units, and sharing of good practice. This will include cost per care hour.
- CHPPD being collected monthly (beginning April 2018) across all community and mental health inpatient wards so it becomes the principal measure of nursing and healthcare support worker deployment for all sectors.
- AHP CHPPD being collected monthly from September 2018 in all community and mental health inpatient wards where AHPs are rostered as part of the team to deliver care to patients.
- Trust boards regularly reviewing CHPPD against patient outcomes metrics.
- NHS Improvement developing acuity and dependency tools. Those for mental health and learning disability inpatient services will be launched by autumn 2018 and for community services by spring 2019.

### **E-rostering**

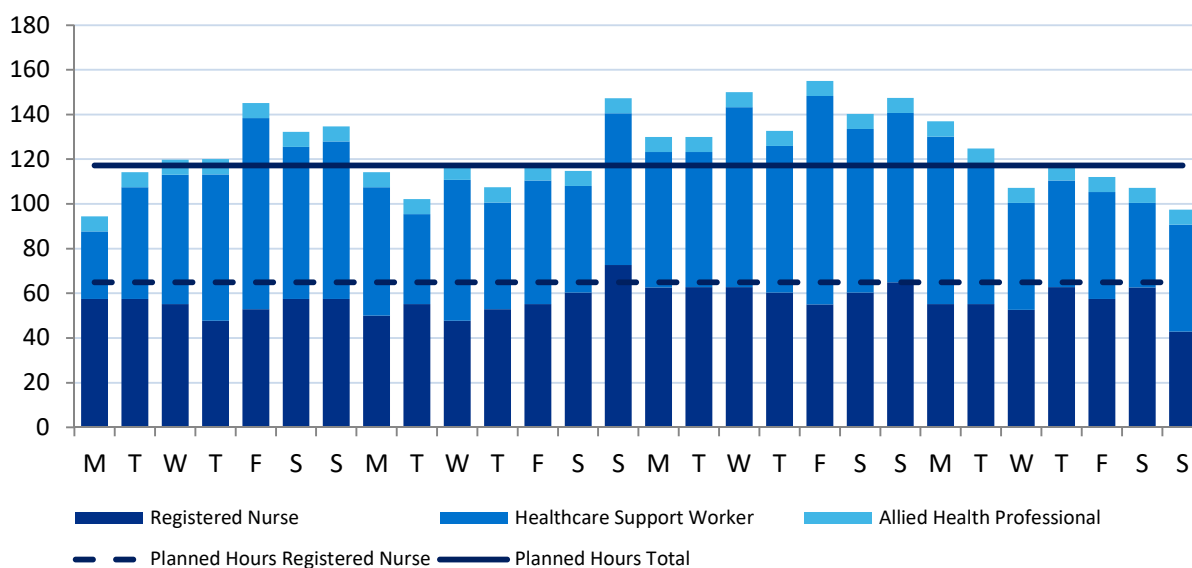
CHPPD data can be used to show how different staff groups are deployed on a ward across days of the week, helping us to understand rostering practice. Analysing variations in staff deployment across trusts and ward types led us to conclude that rostering is an area where productivity improvements could be made, particularly in the use of bank and agency staff, use of headroom (unavailability time) and skill mix.





**Figure 5.5 – hours worked by contract type, showing split of bank, agency and substantive staff by days of the week**

Figure 5.5 shows the split of bank, agency and substantive staff working on an adult mental health inpatient ward during September 2017. The total planned hours of staffing for that month are highlighted by the horizontal line. We can see that for almost one-third of the days the ward was understaffed and on almost half the days it appears overstaffed. On every overstaffed day the trust was paying for agency staff (often working more expensive weekend shifts) and on some days the proportion of hours from substantive workers was as low as 17%. On only two days was the proportion of substantive staff above 50%. The ward reported significant recruitment problems and was not approving rosters until two weeks before they were worked which affected the ward’s ability to get bank staff in a timely manner, contributing to the high levels of agency staff.



**Figure 5.6 – hours worked by contract type, showing split of registered nurse, healthcare support worker and allied health professional staff by days of the week**

Figure 5.6 shows the breakdown in the hours worked by registered nurses, healthcare support workers and AHPs for the same ward. This allows us to examine skill mix. The ward was generally working with fewer than its planned registered nurse hours across the month (compared to the dotted line), despite using bank and agency staff. On only a few days is it above the planned level. The ward was rostering healthcare support workers to cover registered nurse hours during the month. Spreading the substantive staff over the month would ensure a better skill mix and optimisation across all days. Further investigation with the trust identified that staff annual leave was not being appropriately managed across the month.

While Figures 5.5 and 5.6 may be extreme examples, the data we collected showed many other wards in trusts facing similar issues. Trusts said that viewing the data in this format helped them quickly identify where further investigation was required. To examine this further we reviewed rostering data with cohort trusts as part of a tailored collaborative improvement programme. We used methodologies from the Institute of Healthcare Improvement and worked with trusts to identify specific improvement goals. We provided targeted support to meet these over the following five months.

The collaborative programme confirmed that headroom, unused hours and roster approval times were critical factors to ensure substantive staff are used effectively across the year to provide consistency of care and decrease use of bank and agency staff.

Headroom, defined as the amount of staff time not rostered for care time (which takes account of training, sickness, annual and other leave) varied across the cohort from 17% to 28%. In some wards we found headroom was regularly as high as 32% and therefore temporary staff were required to cover shifts (as highlighted in Figure 5.6). We worked with trusts to monitor total headroom approved in each roster period to keep within agreed limits. This often required amending rostering policies to include headroom percentages as a key performance indicator and developing processes to monitor these on a monthly basis. Improved leave management, through increased visibility and analysis of staff availability, enabled managers to balance and control leave.

The management of 'unused hours', defined as the difference between the number of hours a member of staff is recorded as working and the number of hours they are contracted for, varied considerably across the cohort. The improvement collaborative found that trusts were not always monitoring the number of unused hours on a monthly basis and that e-rostering systems were not always kept up to date. We observed that many staff work more than their contracted hours. However, we also found that on average the cohort trusts lost about 3,800 inpatient staff hours each month. These are hours that the trust has paid staff for, but are not used in the roster. At a national level, using all these hours effectively would be the equivalent of having about 1,100 additional nurses and 600 additional healthcare support workers providing inpatient care to patients. We estimate that these unused hours could be costing trusts as much as £70 million to £80 million per year.



### **Case study – Reducing unused hours**

As part of the rostering improvement collaborative, Lincolnshire Partnership NHS Foundation Trust looked at the number of hours owed by nursing staff on two pilot wards. It offered individual training and review sessions for ward roster creators and approvers to improve understanding of headroom and roster analyser reports. Where staff owed hours, the team met staff to engage them in the process. Repayment of hours was negotiated and the trust saw a reduction of bank and agency costs by 23% in six months across the two wards.

The rostering good practice guidance developed as part of the acute hospital sector review set a target for trusts to ensure that all rosters were approved six weeks in advance. Evidence showed that if rosters are approved less than four weeks ahead there is a higher chance of having to use agency staff to fill the shifts. Working with the cohort we identified high levels of ward approval that were less than four weeks, with examples of one and two weeks. This makes it difficult for trusts to book bank staff in a timely manner, particularly during holiday periods. We supported trusts to review policies, put in place approval calendars, set up meetings to confirm roster approval and develop reporting processes to support wards.



### **Case study – Roster approval**

The improvement goal identified by Hertfordshire Community NHS Trust as part of the rostering improvement collaborative was that 100% of the inpatient units would reach second level approval for their rosters eight weeks before going live; the starting position was 12.5%. To meet its goal the trust focused on five specific objectives. These included reviewing and republishing its rostering policy with approval guidelines – delivering training to second-level approvers to help them understand what they needed to look for, and introducing a new KPI dashboard for each of eight wards alongside monthly roster clinics attached to each ward manager meeting to review rosters. This resulted in 100% of ward rosters being fully approved eight weeks in advance, and bank and agency spend reduced by about 8% in six months.

As a result of the collaborative process trusts have begun to get a better grip of their rostering practices. Learning from the improvement collaborative programme, including case studies and good practice guides, will be shared across mental health and community trusts by summer 2018.

## Recommendation 9 – Inpatient rostering and e-rostering

**All community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practice that require improvement. NHS Improvement should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.**

Delivered by:

- Trusts implementing an effective approval process by publishing rosters at least six weeks in advance, and reviewing regularly against key performance indicators such as the proportions of staff on annual, training, and other leave, and the use of contracted hours. Measurable progress to be made during 2018/19.
- Trusts setting up formal processes to tackle areas that require improvement, with clear escalation processes, action plans and improvement tracking. Measurable progress to be made during 2018/19.
- NHS Improvement undertaking a review of the rostering good practice guidelines<sup>82</sup> to ensure they include all sectors by July 2018.
- NHS Improvement building on the collaborative approach and development of good practice guidance by undertaking further improvement collaboratives or masterclass sessions for trusts and examining the opportunities to extend e-rostering to services delivered in the community by spring 2019.

### Medical staff

Medical staff make up on average about 5% of the workforce for mental health trusts, and about 2% for community trusts<sup>83</sup>. This compares to an average in the acute hospital sector of 13%. Our visits to mental health and community trusts highlighted mixed practice regarding medical job planning. We found variations within and between organisations in medical staff pay spend, medical rostering, use of electronic rostering systems, and leave planning. We discovered potential annual leave discrepancies, and an inconsistent approach being taken across this staff group with multiple manual templates in use. As well as having a negative impact on the workforce, this lack of grip on job planning manifested itself in increased locum agency payments, which in some trusts are higher than nursing agency costs.

There is a lack of metrics that clearly, reliably and meaningfully reflect the use of doctors' time and their deployment. Even in trusts with well-developed job planning processes, we found a lack of connection between agreed job plans and the service/organisation objectives. Developing medical staff productivity metrics would enable trusts to identify and decrease unwarranted variation and improve the quality of care delivered while making efficiency savings.

We undertook a pilot job planning data collection in December 2017. The response rate was about 80% for community trusts and about 70% for mental health trusts. Early findings

<sup>82</sup> <https://improvement.nhs.uk/resources/rostering-good-practice>

<sup>83</sup> These proportions are on average across mental health and community trusts. Source: latest ESR data.

highlighted difficulties collecting data from trust IT systems, as much of the data was not easily accessible. We found that for mental health trusts about 75% of consultants have job plans on average. Two trusts reported that none of their consultants had job plans, and 11 reported that all consultants did. For community trusts about 50% of consultants have job plans on average, with four trusts reporting that none of their consultants had job plans and two where all did.

The pilot indicated that further work is needed to understand the current level of implementation of e-rostering systems for the medical workforce. This would ensure trusts are realising the full benefits of workforce insights and using data they can measure and act on more effectively. In mental health trusts only 8% of wards have e-rostering in place for consultants, with three trusts having fully implemented it. For community trusts only 6% of wards have e-rostering for consultants, and one trust that has fully implemented it.

We recommend that medical directors should co-design and implement a comprehensive data set covering consultant and non-consultant grade job planning. This should build on the pilot data collection. We see this as a first step alongside examining the use of staff banks, extra duty payments, and understanding medical e-rostering systems. This will allow us to help trusts realise efficiency savings and provide good practice guidance and Model Hospital benchmarking information.

#### **Recommendation 10 - Medical job planning**

**NHS Improvement should work with trusts to ensure that the right doctor is available for patients at all times using effective and comprehensive job planning and rostering, and identify improvements in clinical efficiency and productivity.**

Delivered by:

- NHS Improvement developing and collecting a comprehensive consultant and non-consultant grades job planning data set by September 2018.
- NHS Improvement reviewing the use of staff banks and extra duty payments in 2018/19 to ensure staffing efficiency, sharing the learning from the medical bank pilots that are in development.
- NHS Improvement working during 2018/19 to understand in more detail how implementing an e-rostering system could better control use of locum staff and reduce extra duty payments.
- NHS Improvement should provide trusts with good practice guidance (such as e-rostering, recruitment and retention strategies and electronic job planning) and benchmarking information during 2018/19.



It was not surprising to find variation between trusts in the extent that services are being provided either by in-house teams, service level agreements with other NHS providers, commercial providers, or community pharmacy providers. This is reflected in the widely varying numbers of pharmacy staff that trusts directly employ.

We found variation in dispensing practices from our cohort trusts: some made extensive use of homecare and community pharmacy dispensed FP10 prescriptions, with others providing largely in-house services. There was also variation in GPs' involvement in prescribing for community nurses on FP10 prescriptions, which had a significant impact on community nurses' care time with patients. These areas could be streamlined.

As with the acute review, for trusts providing in-house medicines distribution services there is significant variation in stock holding from between eight and 52 days, use of e-commerce from between 0% and 100% for orders and invoices, and average number of deliveries per day – ranging from two to 12.

Providing medicines education and training to pharmacy, nursing and other staff groups is an important role for pharmacy departments. We observed little evidence of collaboration in developing and maintaining teaching materials, with them largely being written in-house. This is despite materials being available from the Centre for Pharmacy Postgraduate Education, developed in partnership with experts from the service.

## **Governance**

Governance accounts for 22% of costs in mental health and 46% of costs in community trusts<sup>86</sup>. We were struck by the number of activities performed to meet medicines governance requirements that are effectively duplicated in each organisation, and the amount of time dedicated to these activities. Such activities include preparing and reviewing patient group directions, formulary management and medicines policies. The new regional medicines optimisation committees, supported by NHS England's Specialised Pharmacy Service as part of the national MVP and the General Practice Forward View, provide an opportunity to introduce a national 'do once' work programme to significantly reduce time spent.

## **Clinical services**

The data from our cohort trusts shows that on average 80% of clinical pharmacy resource is allocated to bed-based care. Evidence demonstrates that involving pharmacy staff in community settings improves access to, and the safety and outcomes of, medicines use at reduced overall costs. Despite this, the provision of clinical services accounts for only 38% of costs in mental health trusts and 30% of costs in community trusts.

However, we found several examples where pharmacy staff were deployed in innovative ways across a wide range of services in mental health trusts, including crisis teams, clozapine clinics, and titration dose clinics to help address short-falls in other professional groups.

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<sup>86</sup> Data collected from cohort trusts.





### **Case study – Sussex Partnership NHS Foundation Trust**

The trust employed a specialist mental health pharmacist in a CAMHS team and achieved a net annual saving on its drug budget of £97,000. This successful change led the trust to expand the example, and placed specialist mental health pharmacists in more of its community teams. The pharmacists help triage referral calls to the team and have been able to keep some patients with their GP with modifications to their treatment to improve care.

We learnt that most community trusts were aware of the need to review and improve the clinical and cost-effective selection and supply chain routes for a number of pathways including wound care, stoma and incontinence, nutritional supplements (SIP feeds), anticoagulation and palliative care. Opportunities exist for clinical pharmacy staff to provide medicines optimisation support to these patients and their clinical teams, including transitions of care.

We found that the rates of prescribing pharmacists as a proportion of total hospital pharmacists vary between 5% and 65% (average 30%) for our cohort trusts. Many trusts would value having more pharmacist prescribers, not only to help improve the quality of prescribing but to address shortfalls in the recruitment of medical and senior nursing staff.

#### ***Use of technology***

We know that electronic prescribing and medicines administration (EPMA) improves medicines safety, but only 26% of mental health trusts have fully implemented it. Only four community trusts have implemented EPMA partially or wholly for inpatients or discharge. Interest in using ward-based medicines automation is growing in the sector.

Northumberland, Tyne and Wear NHS Foundation Trust have used it extensively: a combination of automation on wards and in pharmacy led to the rationalisation of three dispensaries into one with pharmacy staff redeployed to support medicines use on wards. Using ward-based automation, the time nurses spent on medicines rounds on the wards reduced. This trust recently installed a robotic dispensing system for filling multi-dose packs for all 1,700 clozapine patients. It is planning to use the robot's spare capacity to provide services to other trusts locally.

#### ***Medicines and the non-pharmacy clinical workforce***

The prescribing, supply, administration and review of medicines occupies a substantial amount of nursing time in community settings. NHS Benchmarking data shows that 39% of community nurse direct care time is taken up with wound care, with an additional 12% for pressure ulcer prevention and a further 12% for medicines administration. Making better use of pharmacy staff to review medicines choice and optimise both supply and administration of medicines enables trusts to release significant amounts of nursing time back to clinical care.



### **Case study – patient self-administration**

Kent Community NHS Foundation Trust invested £185,000 in additional pharmacy staff to support patients to self-administer medicines, and worked with local GPs and patients to improve the quality of communication with patients about medicines. Through this programme, and by improving the relationships and understanding of medicines optimisation across and with other organisations, the trust estimates annual savings of £1 million from fewer community nurse visits and medicines usage reductions.

Our review demonstrated that pharmacy services are underused in these sectors. Better use of pharmacy staff to support patients and other clinical staff with medicines can offer tremendous value to the NHS and address much unmet need. We believe collaborative working offers opportunities, including the deployment of technology, to release pharmacy staff time. Not only will this improve patients' experience and outcomes, but it represents good value for money.

We recommend that trusts develop plans for their pharmacists and other pharmacy staff to spend more time on patient-facing medicines optimisation, focusing on the current underuse of clinical pharmacy staff, especially in community settings. This should include increasing numbers of pharmacist prescribers and developing current roles to support patients as they transfer between care settings.

### **Recommendation 11 – Medicines and pharmacy optimisation**

**Trusts should develop plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.**

Delivered by:

- Trusts increasing the numbers of specialist pharmacy professionals – including advanced clinical practitioners (pharmacists) – working in multidisciplinary teams to better lead and co-ordinate medicines use for cohorts of patients across health and social care systems by 2020/21.
- Trusts increasing the numbers of pharmacist prescribers to add capacity, expertise and value starting with increased numbers in training in 2018.
- Trusts identifying local opportunities for the innovative use of pharmacy staff, systems and technologies using case studies provided by NHS England and NHS Improvement during 2018/19. This should include reviews into CAMHS, use clozapine and antipsychotics, medicines administration, automation and polypharmacy.
- Health Education England ensuring that workforce plans include capacity to support the development of higher numbers of pre-registration trainee placements, vocational foundation trainees, specialist pharmacists and pharmacy technicians in mental healthcare settings, including increasing the numbers of advanced clinical practitioners (pharmacists) and consultant pharmacists by 2020.
- Trusts reviewing the value for money of all infrastructure activities to release

capacity for patient-facing work. Opportunities to collaborate with other providers should be explored during 2018/19.

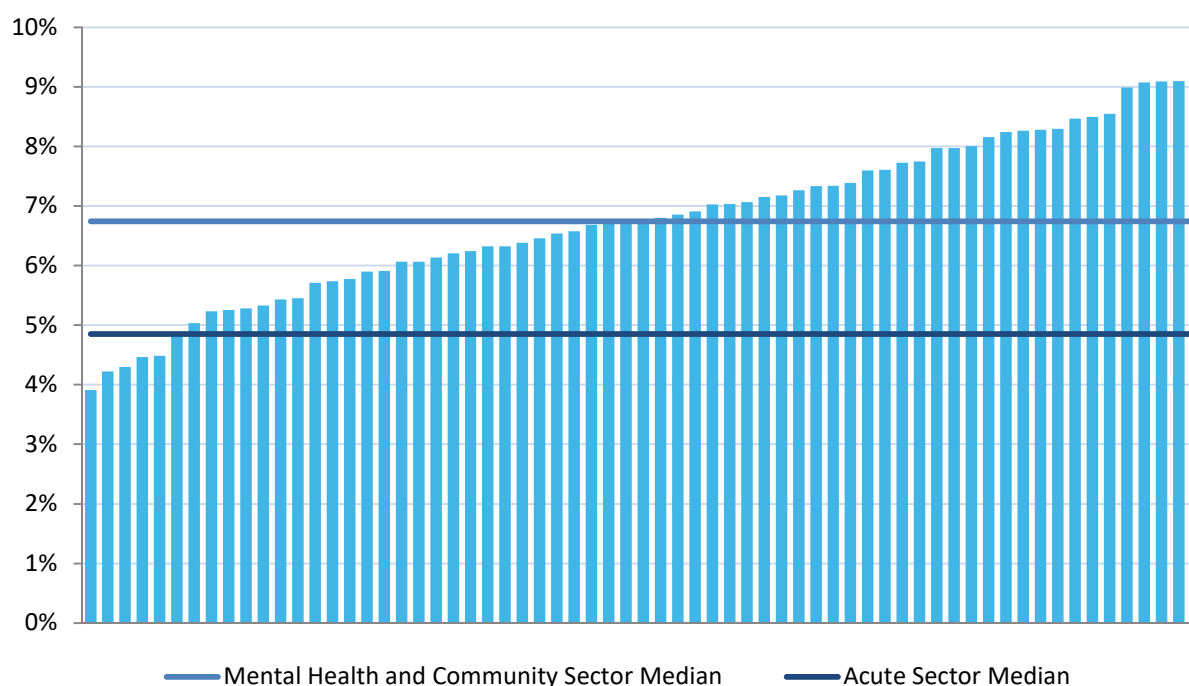
- The Centre for Pharmacy Postgraduate Education developing a system-wide approach to developing medicines teaching materials for mental health and community trusts starting in 2018/19 to release local staff time to education and training delivery.
- NHS England's Specialist Pharmacy Services and the regional medicines optimisation committees developing a national 'do once' system for organisational medicines governance, including national standardised medicines policies, patient group directions and other essential organisational governance documents during 2018/19.
- NHS Improvement and trusts examining the potential to streamline processes for the ordering, approval and delivery of medicines and clinical products to patients receiving services in the community during 2018/19. This should include the use of homecare and FP10s.
- Trusts that provide their own stores and distribution services consolidating medicines stock-holding, and aggregating and rationalising deliveries. This should seek to reduce stock-holding days to a maximum of 15 and deliveries to less than five per day, and ensure 90% of orders and invoices are sent and processed electronically by 2020/21.

## Chapter 6: Optimising non-clinical resources

Clinical staff and resources are by far the biggest area of opportunity for productivity improvements at about 70% of spend<sup>87</sup>. However, the review identified scope for optimising non-clinical productivity in corporate services, procurement, and estates and facilities. These services are sometimes overlooked but are essential to frontline care, and trusts need to take a full view of the impact of improvements in these areas. Our recommendations emphasise decisions, processes and practices across organisations. When implementing them, trusts should consider the appropriate scale of business functions and the degrees of standardisation and aggregation that are possible between organisations, such as across sustainability and transformation partnerships (STPs) or Integrated Care Systems (ICSs). These are particularly relevant for corporate services and estates and facilities management. Although mental health and community trusts are generally smaller corporate entities, spend in these areas benchmarks higher than other organisations.

### Corporate services

Approximately £900 million is spent by mental health and community trusts every year to deliver corporate services at a significantly higher relative cost than in acute trusts<sup>88</sup>.



**Figure 6.1 – corporate services expenditure as a proportion of turnover, 2016/17 data**

Figure 6.1 shows significant unwarranted variation in overall corporate services spend between mental health and community trusts from about 4% to 9%. This unwarranted variation is observed at all levels including accounts payable, recruitment and occupational health. For example, the cost of producing a payslip varies between about £1.70 and £9.10

<sup>87</sup> Spend in mental health and community trusts, consolidated trust accounts 2016/17.

<sup>88</sup> NHS Improvement Corporate Services Benchmarking Return from trusts, 2016/17. Cost covers seven corporate services functions: finance, governance & risks, human resources, information management & technology (IM&T), legal, payroll and procurement.

and the cost of human resources per employee is between about £530 and £1,520. Generally we did not identify significant differences in key performance measures such as the level of salary overpayments, retention or sickness rates and the level of expenditure in these areas. In some cases, where the processes remain paper based, they were both more expensive and offered poor customer experience. This indicates it is possible both to reduce costs and improve performance. The savings potential is significant, if all mental health and community trusts are able to limit expenditure to the median level, the annual savings would be about £140 million per year.

Overall we found there is an efficiency of scale, where larger organisations tend to spend less on corporate services as a proportion of turnover than smaller ones. We found some specific reasons why mental health and community trusts have higher corporate costs in some areas: for example, they respond to a number of tenders each year, which typically impose costs of about 2% of the annual value of the contract. But there are some areas of corporate services that they do not provide, such as counting and coding acute hospital tariff activity.

NHS Improvement established the Corporate Services Programme following the acute hospital sector review. This aims to shift corporate services delivery away from current methods to a modern operating model, moving from labour intensive transactional processes to provide a more efficient service to staff across trusts at a lower cost. Modernising corporate services also includes benefits from automating functions. This could reduce costs as well as releasing time for staff throughout trusts, including general and clinical managers, to allow them to focus on providing care. As a critical enabler to frontline clinical teams, the programme is clear that reduced cost must not result in sub-standard services, or be achieved by adversely affecting clinicians' ability to deliver high quality care.

As part of this, all trusts should examine where they can collaborate to standardise and share corporate services functions, and assess the extent to which this will help them maximise economies of scale and reduce overall costs. Standardising corporate services and collaborating across organisations will enable greater service resilience, especially for smaller trusts that rely on a small number of experienced individuals for service continuity. We saw early examples of this working in practice: for example, Derbyshire Healthcare NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust, who recently merged their HR departments. Work is underway to fully embed and harmonise roles and processes. Savings across both organisations are about £500,000 to date. Based on successful learning across the sector, NHS Improvement has published a list of 40 measures and schemes that trusts can review and take forward, and the Corporate Services Programme will support trusts to do this.

## **Recommendation 12 - Corporate services**

**Trusts should reduce the variation in the cost of their corporate service functions. As part of this, they should examine the opportunities to collaborate and share corporate service functions.**

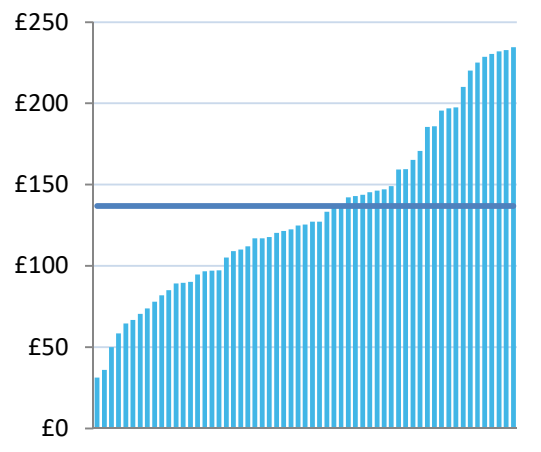
Delivered by:

- NHS Improvement's Corporate Services Programme providing annual benchmarking reports to trusts that identify the areas with the greatest savings opportunity. This will be supplemented by the NHS Improvement's twice-yearly publication of the cost improvement plan (CIP) opportunity list to help trusts identify and increase corporate services CIP delivery.
- NHS Improvement's Corporate Services Programme developing tools and resources to enable trusts, STPs, ICSs or other groups to collaborate and make changes to share their corporate services provision. These will be published from June 2018, with more released during the rest of the year.
- NHS Improvement's Corporate Services Programme highlighting wider savings opportunities by outlining and driving the implementation of collaborative operating models, developing pathways to deliver longer term corporate service models, and testing technological developments to aid the automation of transactional services during 2018/19.
- Trusts completing the corporate services opportunity list self-assessment by October 2018 and using this with their corporate services benchmarking report to identify where to focus capacity.
- Trusts assessing the opportunities to work together across NHS and other organisations to standardise their corporate service functions during 2018/19 and report on these opportunities to NHS Improvement. These opportunities should be taken forward where it is cost effective to do so.

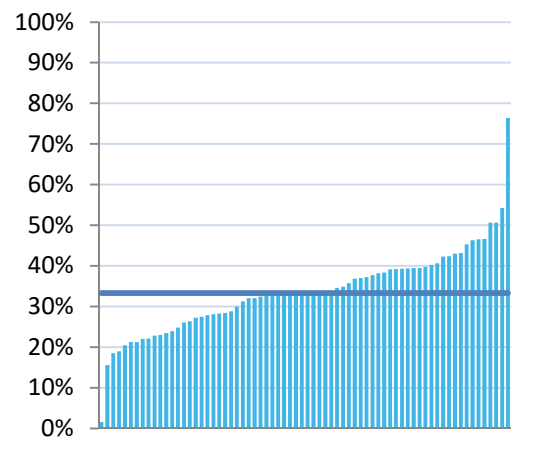
## **Estates and facilities management**

Mental health and community trusts spend £1.3 billion on estates and facilities making it the largest area of non-clinical spend. Trusts typically operate out of several sites, with space used for inpatient units, clinics and office space. Costs range from 5% to 28% of trust turnover, with the average at 10%. The range of services provided by trusts in these sectors and the locations they cover is reflected in their estates<sup>89</sup>.

<sup>89</sup> All data is taken from ERIC and trust consolidated accounts, mental health and community trusts, 2016/17.



**Figure 6.2 – estates and facilities running costs per m<sup>2</sup> of occupied floor space**



**Figure 6.3 – non-clinical space as a proportion of total space**

Some variation is warranted due to the differences in services provided by trusts, level of inpatient provision, location, quality and age of buildings. However, the review also identified significant unwarranted variation in practices and areas for improvement.

### *Estates and facilities management function*

Effective management is critical in controlling costs and ensuring the estate effectively supports staff and patients. However, we found that trusts frequently struggle to fill vacancies for estates and facilities staff and there is limited succession planning for leadership positions. STPs should support this by promoting collaborative estates models between trusts and with other local partners such as local authorities. As with clinical staff, mobile working offers an opportunity to improve the productivity of estates and facilities operational staff. Sir Robert Naylor’s report<sup>90</sup> identified opportunities to invest in the training and development of the estates and facilities workforce, including the development of new roles and career paths. NHS Improvement is currently working to deliver this across the NHS.



### **Case study – Estates corporate function**

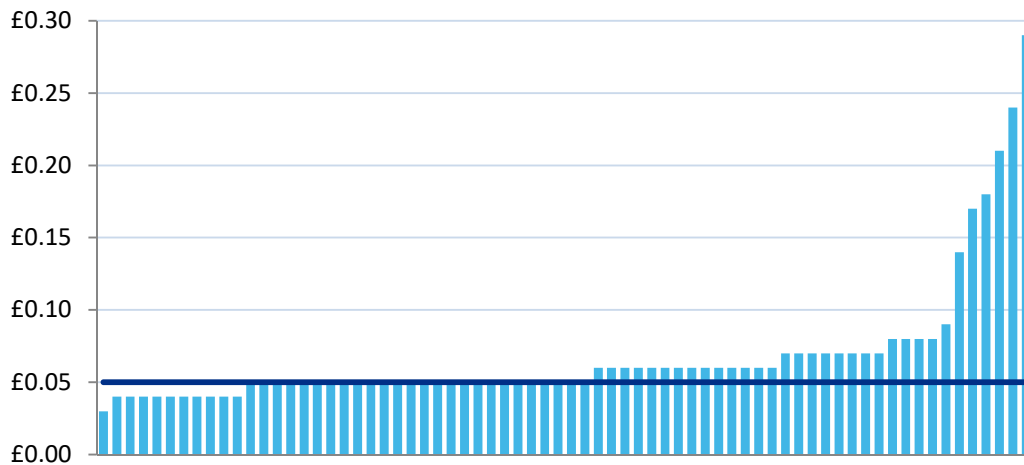
North West Boroughs Healthcare NHS Foundation Trust has restructured its estates and facilities department, saving £540,000 against a budget of £6 million. It also introduced mobile working and live task reporting for engineers, improving responsiveness and productivity.

### *Energy*

Trusts’ energy costs per unit vary across the community and mental health sectors, as shown in Figure 6.4.

<sup>90</sup> NHS property and estates: why the estate matters for patients’, 2017. <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>





clinical and non-clinical staff when proposing hot-desking and shared clinic rooms, with a culture of professional space ownership being a particular challenge. It is therefore essential that trusts' estates and facilities strategies are aligned to clinical strategies, and trust leaders communicate the value of space and modern internal processes to staff.

### ***Leased properties***

Trusts described challenges in vacating leased buildings when rationalising estates. The community sector in particular has a higher proportion of leased buildings than the acute hospital and mental health sectors. Trusts risk incurring costs if another tenant cannot be found within a given time if they vacate a leased property. This does not incentivise the consolidation of these estates. Arrangements with NHS Property Services and Community Health Partnerships, which most of these sites are leased from, should therefore be reviewed to support trusts moving towards a more efficient estates model.



#### **Case study – Estates strategy**

Wirral Community Healthcare NHS Trust saved about £2 million against a budget of £6 million over three years. This involved reviewing site leases, running costs, space utilisation, and assessing future estate requirements. The trust reduced its leased sites from 21 to 13 by relocating services from leased buildings to owned buildings. Other initiatives included reviewing its estates and facilities contracts, which enabled it to reduce spend on contracted services by 22%.

### ***Estates quality***

To clinicians and service users, the quality of a trust's estate is critical. We heard from trusts how the quality of their estate had fallen in recent years, which had raised some safety risks and also meant the estate often did not provide the necessary support for staff. As we recognise earlier in this document, redesigning facilities to support new ways of working is critical, particularly for services delivered in the community. Trusts will need to invest capital funding for this. Starting later in 2018, NHS Improvement will support trusts through the 'new-for-old' estate strategy to address issues for providers of mental health and community health services.

### ***Estates Return Information Collection (ERIC) Dataset***

The current ERIC dataset is limited in its ability to support mental health and community trusts to identify improvement opportunities. For instance, the 2018/19 collection will only collect data on sites above 150m<sup>2</sup> in total area (200m<sup>2</sup> for previous collections) or nine inpatient beds. While data was collected on 3,338 sites for mental health and community trusts last year, 36% of sites were smaller than 200m<sup>2</sup> and therefore not reported. Furthermore, the dataset does not distinguish between inpatient space and outpatient clinic rooms, or whether trusts are using sites on a full or part-time basis, making it difficult to benchmark estates use. Data on sites rented from NHS Property Services and Community Health Partnerships is only captured at a high level. The dataset therefore needs to be developed to find improvement opportunities for these sectors in a way that is proportionate so as not to introduce an unnecessary data collection burden on trusts.

## **Recommendation 13 – Estates and facilities management**

**NHS Improvement should develop a comprehensive and tailored set of benchmarks for the sector by 2019/20, and all mental health and community trusts should review their existing estates and facilities and provide a report to their boards by April 2019.**

Delivered by:

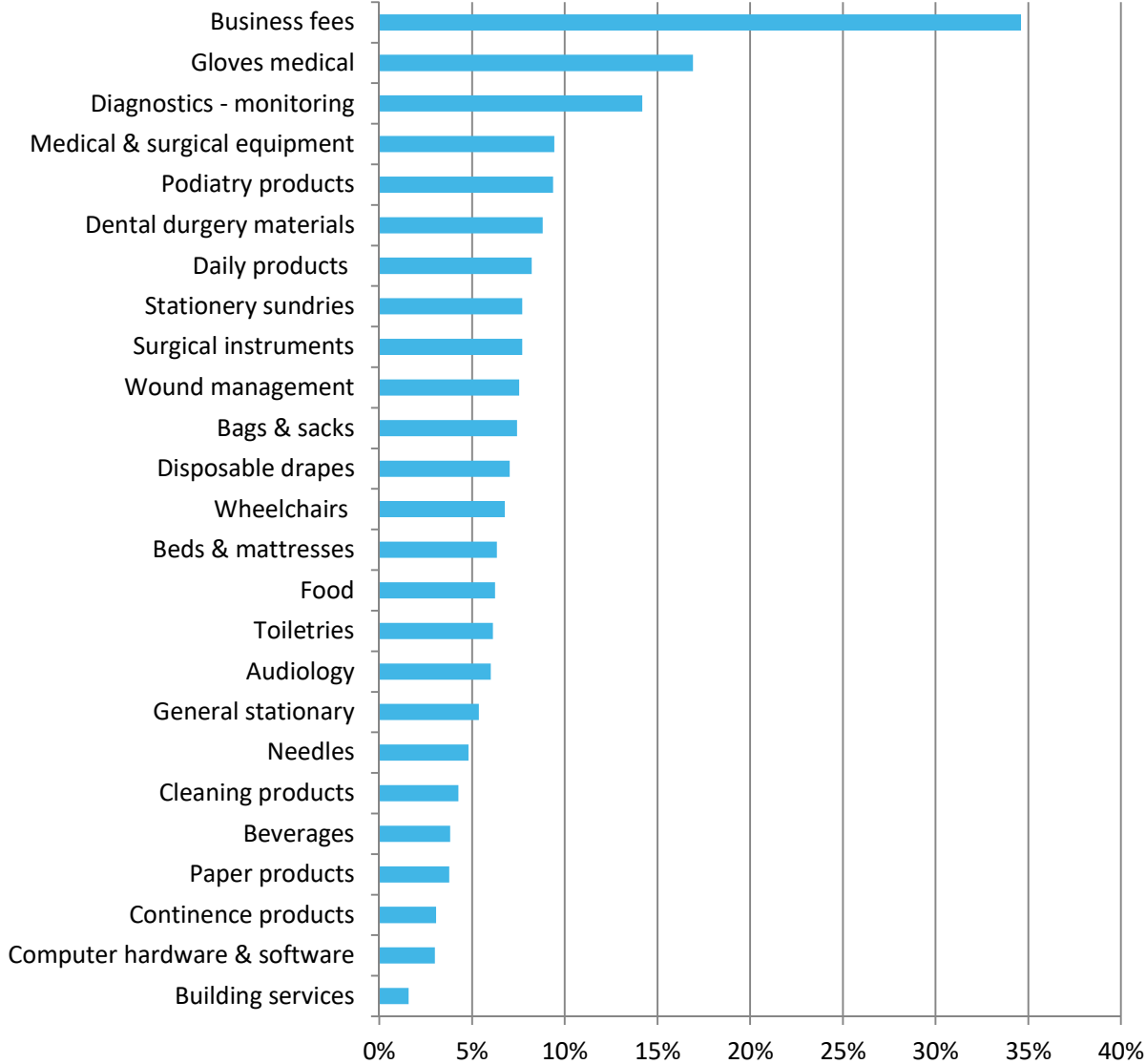
- Trusts reviewing their estate to identify opportunities for consolidation and improved data capture by autumn 2018.
- Trusts ensuring they have a sustainable development management plan approved by their board and are investing in sustainable equipment and hardware such as LED or ultra-low energy-efficient lighting to lower energy costs by winter 2018.
- Trusts ensuring that they are using modern working practices and reporting to improve their space utilisation, by exploring the use of occupancy monitors and developing a culture that supports shared space and agile working by spring 2019.
- Trusts reviewing their estate quality and implement plans that are consistent with local STP and ICS ambitions to bring their estate up to an appropriate standard as quickly as possible.
- NHS Improvement and NHS Digital continuing to engage with representatives from the Community and Mental Health sectors to develop the ERIC data collection so that it supports the implementation of the Model Hospital benchmarking measures by autumn 2018.
- NHS Improvement reviewing the current arrangements for properties leased from NHS Property Services and Community Health Partnerships to support trusts in their aims to rationalise their estates by winter 2018.
- NHS Improvement further developing the measures available on the Model Hospital for the community and mental health sectors, including showing measures at site level to account for providers from these sectors typically operating out of multiple sites by spring 2020.

## **Procurement**

Procurement accounts for £970 million of mental health and community trust spend – about 7% of expenditure overall. Procurement functions are uniquely placed to support frontline services by ensuring critical goods and consumables needed by clinicians are procured in a timely manner. Procurement functions also play a crucial role in identifying and releasing cash savings, which can then be re-invested into frontline services. The core procurement activities for mental health and community trusts are similar to acute hospital trusts in many ways, and include, for example, invoicing and catalogue management. The types of goods procured, however, are often very different to the acute hospital sector.

The review found that trusts are paying very different prices for the same goods. For example, across 43 trusts purchasing the same dressing products the price paid varied from £1.62 per unit to £20.29 per unit. Trusts must use benchmark data to purchase goods at the best possible price. In addition we found that very few trusts are switching to products that are equivalent and more cost-effective. Where they do, there is scope for significant savings. For example, we found one trust that has switched from using laboratory drug test kits costing £20 each to on-site test kits costing £7.50, a saving of over 60% per unit.

To help all trusts identify savings the Purchase Price Index and Benchmarking (PPIB) tool collates information on the prices they pay for procured goods. We analysed the top 25 categories of spend for mental health and community trusts.



**Figure 6.5 – price variation as a proportion of total spend, top 25 categories<sup>92</sup>**

Business fees are administrative and subscription-based fees incurred by trusts. Examples include audio visual service fees, courier services, room hire and other building fees, and consulting services. Figure 6.5 shows that ‘business fees’ represent the largest price variation as a proportion of total spend – trusts could save 35% of this spend if procured at

<sup>92</sup> Data extracted from PPIB tool, covering around 70% of mental health and community trusts.

the minimum NHS price. We observed other significant price variations in categories such as computer software and hardware, for example if trusts purchased at the minimum or median price, in total they could save about £600,000 and £275,000 respectively. The aggregate effect of these variations across the sector equates to up to £7 million of savings<sup>93</sup>. Once all appropriate and addressable non-pay expenditure is benchmarked, mental health and community trusts should be able to identify savings opportunities of about £65 million<sup>94</sup>, which represents between 2% and 7% of procurement spend. These estimates do not include the benefits from switching products or reducing unnecessary demand.

Our engagement with trusts also showed they are not leveraging their buying power or collaborating at full scale to secure the best price. In 42 trusts we sought to understand the savings opportunity and identify economies of scale that may exist for common goods and services specific to the mental health and community sector. We identified 27 common products deemed to deliver the most value if they were procured collaboratively<sup>95</sup>. Although some were identified in our analysis of price variation, such as procurement of wheelchairs and computers, we found other areas such as incontinence supplies and patient transport where collaborative procurement could make savings. We deem that these common products should be added to the NHS Business Services Authority's Nationally Contracted Products programme<sup>96</sup> or prioritised for national procurement via the relevant NHS Category Towers. This will help to leverage trusts' buying power securing the best possible service and price for trusts.

The NHS Procurement & Commercial Standards<sup>97</sup> were launched in 2012 to provide a clear vision of good procurement through trust accreditations against three defined levels. Accreditation levels among community and mental health trusts are lower than all other types of providers. Only four mental health and community trusts (5% of the total) have achieved level 1 accreditation against the standards, and only two trusts (3%) have gone on to achieve level 2 accreditation. While further work is required to understand and evaluate the savings opportunities through reducing price variation and improved collaboration, these levels of accreditation need to improve. We also found that procurement functions in mental health and community trusts are often very small. Some trusts have started to share common resources and procurement functions to address the challenges they face, but all trusts should take steps to consider whether there are potential scale and efficiency gains through resource sharing and collaboration.

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<sup>93</sup> £7 million opportunity is based on movement to the minimum price.

<sup>94</sup> £65 million opportunity is based on movement to the minimum price.

<sup>95</sup> The majority of these are shown in Figure 6.5, but the 27 common products were selected in discussion with heads of procurement from mental health and community trusts.

<sup>96</sup> <https://www.supplychain.nhs.uk/savings/nationally-contracted-products/>

<sup>97</sup> <https://www.gov.uk/government/publications/nhs-procurement-standards>

## **Recommendation 14 – Procurement**

**Trusts should reduce unwarranted price variation in the procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking.**

Delivered by:

- All trusts using the Purchase Price Index and Benchmarking tool in daily procurement and in evaluating prices submitted by suppliers during 2018/19.
- NHS Improvement's National Procurement Programme working with DHSC, NHS Business Services Authority and trusts to leverage sector buying power. They should do this by refining and adding the 27 common goods to the Nationally Contracted Products programme and new NHS Category Towers by April 2019.
- All trusts achieving accreditation of level 1 of the NHS Procurement & Commercial Standards by March 2019 and level 2 by March 2020. This should be supported by the Commercial & Procurement Skills Development Network and NHS Improvement.

## Chapter 7: Expanding the Model Hospital

The Model Hospital was developed to enable boards of non-specialist trusts to better fulfil their responsibility for improving efficiency and productivity and for identifying potential opportunities. It receives over 11,000 page views per working day from about 9,000 unique users benchmarking their trust on a variety of metrics that cover board to ward. The case for developing similar metrics specific to the services mental health and community trusts provide is equally pressing.

As a result, we recommend two programmes of work to ensure that the Model Hospital includes metrics analysing productivity and efficiency across these sectors. These programmes are to:

- extend existing data on the Model Hospital to incorporate mental health and community trusts where applicable, in particular for non-clinical services.
- expand the Model Hospital to include data on clinical services provided beyond acute hospital settings.

Mental health and community trusts have told us that the current Model Hospital branding is focused too closely on the 'hospital' and does not recognise the importance of services delivered in the community. We also recommend that NHS Improvement reviews how it is branded as it expands to cover new sectors.

### Extending the Model Hospital – non-clinical resources

The Model Hospital was opened to all NHS providers in April 2017 and we have seen a number of users in mental health and community trusts sign up. To date, the information available to them has been limited to core functions where the data collection method is the same as for acute trusts. This includes areas such as workforce metrics for nursing and AHP staff, operational metrics in areas such as estates and facilities and corporate services. The extension of metrics into areas such as equality and diversity, procurement and temporary staffing is on track to be completed in this financial year.

For the Model Hospital to be a valuable tool for mental health and community services, it is essential to develop the benchmarking and ensure it appropriately supports all trusts. A longer term goal should be to develop the weighted activity unit (WAU) to take account of services delivered in the community. A robust WAU relies on detailed service line costing and activity data from the sectors, and will be supported by the development of patient-level costing. This will support more direct benchmarking across and between organisations based around the cost of specific services that a patient receives. A tool that allows all trusts to find some 'peer' trusts most similar to itself should be developed and be based on variables including service provision, demography, geography, workforce and infrastructure.

### Expanding the Model Hospital – clinical services and resources

The information and metrics identified in the review will provide the foundation for expanding the Model Hospital. To account for the complex configuration of trusts the



Model Hospital should allow them to benchmark productivity based on service provision regardless of their trust type. For example, a mental health trust, a community trust and an acute trust may all provide community nursing or have an inpatient ward providing musculoskeletal rehabilitation services. It is our aim that each of these trusts should be able to compare the productivity of their services against each other, rather than each being confined to comparators within their designated sector.

Further metrics to those already proposed should be developed with trusts to analyse the quality of service provision and performance against national ambitions, such as those in the Five Year Forward View for Mental Health. This will require significant work on standardising definitions of service lines. All trusts providing mental health and community services must submit increasingly accurate information through the national Mental Health Services Data Set (MHSDS) and Community Services Data Set (CSDS) collections.

Encouraging trusts to make better use of national data collections will lead, we hope, to improved accuracy and quality. We cannot stress strongly enough how important it is for trusts to report data accurately, particularly as this data will be used for a more open and integrated approach to performance management across the NHS. We believe these metrics could fundamentally transform productivity across the mental health and community sectors. As such, their development should be accelerated so NHS Improvement can include them on the Model Hospital by April 2019.

#### **Recommendation 15 – Model Hospital**

**NHS Improvement should develop the current Model Hospital and the underlying metrics to ensure there is one repository of data, benchmarks and good practice so all trusts can identify what good looks like for services they deliver.**

Delivered by:

- NHS Improvement ensuring that the Model Hospital and the metrics in it are expanded to include data at a comparable service level for all trust types by April 2019. NHS Improvement must ensure that these are maintained and updated.
- NHS Improvement working with providers of mental health and community health services to develop a peer finder tool by April 2019.
- NHS Improvement reviewing the overall branding of the Model Hospital as it expands to incorporate different types of provider during 2018/19.
- NHS Improvement working to develop a WAU that considers mental health and community health services in line with the timeline for developing patient-level costing for these services.
- Trust boards ensuring that all the mandatory data fields are submitted to the minimum datasets for mental health and community health services (MHSDS, and CSDS), and that all data submitted is of robust quality to allow for effective benchmarking.

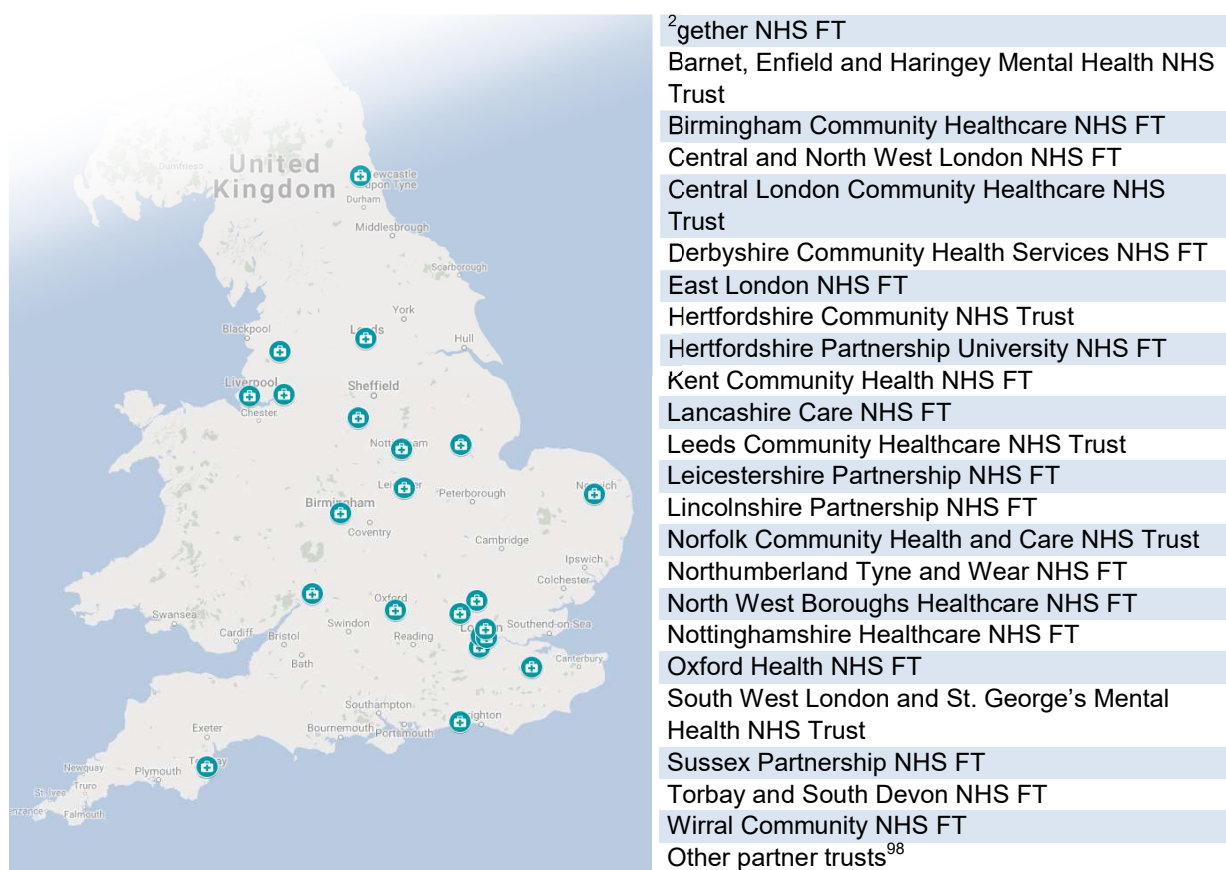
## Chapter 8: Securing effective implementation

Our recommendations in this review will support improvements in productivity, but delivering real change will require more than this. The experience of delivery to date has taught us that many trusts need more than just benchmarking and good practice guidance, important as that is. They need to be able to access genuine support and expertise, sometimes over a prolonged period, to help drive efficiency and improve quality. This will be the challenge for, and test of, effective implementation.

### Engagement

The review team worked with a cohort of volunteer trusts to develop, challenge and improve our emerging findings through the review process. These trusts shared their experience, good practice, challenges and data. We also worked with them on a number of areas, such as identifying how to improve rostering practice, and to test the concept of driving improvement. We are very grateful for their continued support.

The cohort was selected from community and mental health trusts across England, including an integrated care trust.



**Figure 8.1 – cohort trusts**

<sup>98</sup> We included Bradford District Care NHS Foundation Trust and Avon and Wiltshire Partnership NHS Trust in our engagement around inpatient rostering – specifically the rostering improvement collaborative, and other trusts such as Bridgewater Community Health NHS Foundation Trust supported our engagement around estates and facilities management, and procurement.

These trusts account for over 20% of total expenditure in the sectors and so provide a secure base for our work. We visited the executive team of each trust at least once, ran workshops with them and spent many hours discussing the detail of the work.

The trusts helped us pilot and extend CHPPD, and design the analysis of the productivity of services delivered in the community. They also provided us with high-level service line data, which was instrumental in assisting us to understand the scope of mental health and community health services provided by trusts, and the challenges that providers face. We also reached out beyond the cohort trusts and engaged with colleagues across the sectors at a national and local level.

### **Scale of efficiency opportunity**

We found productivity benefits of about £1 billion by 2020/21 can be released and reinvested within these sectors for improved care. Our analysis suggests that most of this benefit, about 80%, is in clinical and workforce productivity, including GIRFT, and the remainder from non-clinical resources. The opportunities identified directly support trusts in achieving their existing recurrent cost improvement programmes, tracked through existing reporting mechanisms and as required in national planning guidance. In 2017/18 trusts reported saving of about £170 million<sup>99</sup> against these. This analysis will be updated as the implementation programme progresses.

### **Implementation in mental health trusts and community services**

Acute hospital trusts have made substantial progress in delivering the recommendations and productivity benefits from the review of acute hospitals in England. This has included, for example, securing £324 million of savings in 2017/18 from switching to clinically effective biosimilar or generic medicines by taking advantage of opportunities published in the Model Hospital. However, progress in other areas has been significantly hampered by the lack of skills and capability to support frontline delivery, particularly with those trusts that need the most help to make changes.

Throughout this review we have also been struck by a strong willingness to learn and appetite for guidance amongst colleagues in trusts we have engaged with. Mental health and community trusts face specific challenges. A lack of available, robust quality metrics creates a challenge for NHS Improvement and trusts in ensuring that cost improvement programmes are not implemented at the expense of quality. The lessons from Dr. Kirkup's review of Liverpool Community Health NHS Trust are fundamental to this<sup>100</sup>. NHS Improvement's response<sup>101</sup> describes the actions it will take for each recommendation, in particular to improve the talent management of trust leaders, ensure that joint working between regulators and oversight organisations is improved, and ensure organisations assess risks more appropriately. NHS Improvement is clear that the actions it will take must have a lasting impact and give confidence that a similar situation will be avoided in future.

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<sup>99</sup> NHS Improvement internal analysis of provider finance returns for month 12, 2017/18.

<sup>100</sup> <https://improvement.nhs.uk/news-alerts/independent-review-liverpool-community-health-nhs-trust-published>

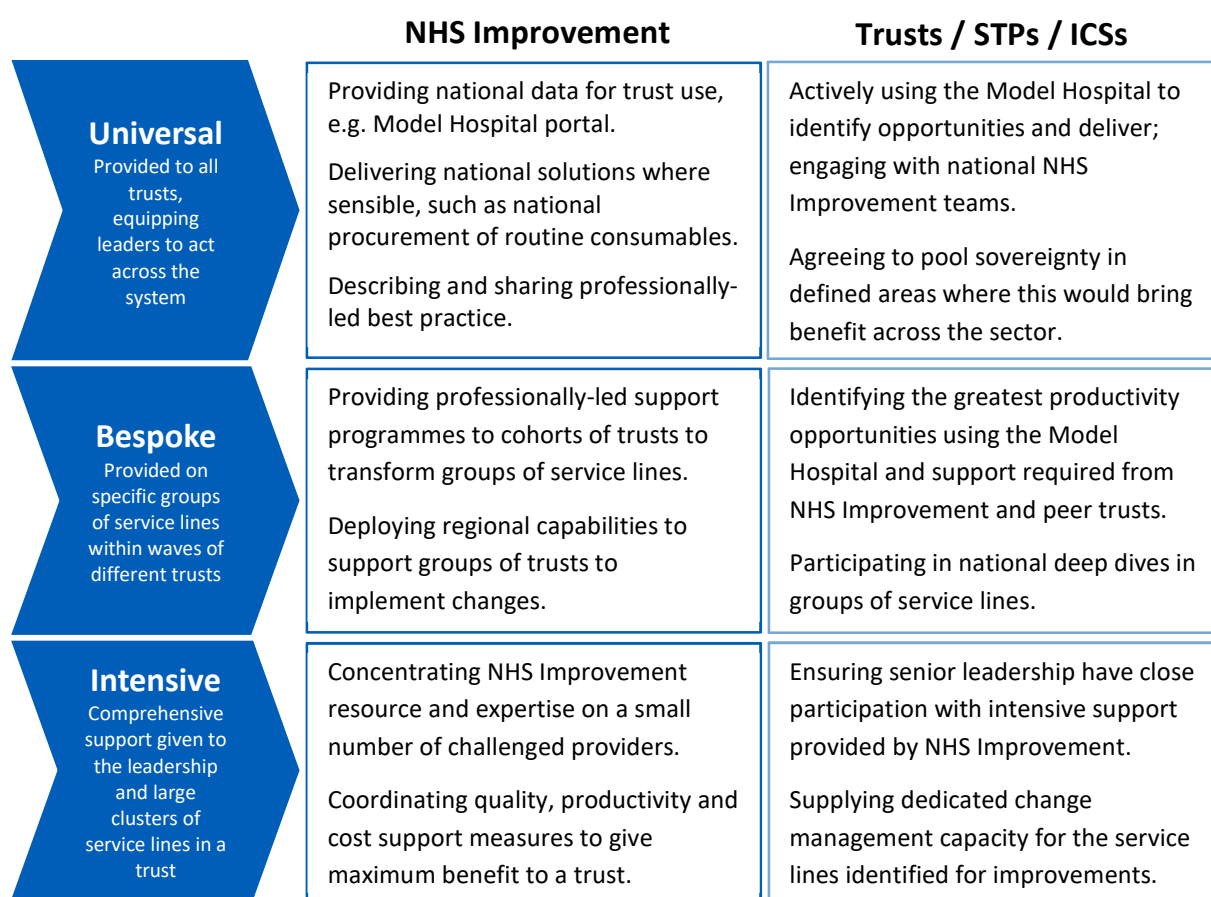
<sup>101</sup> Response published as part of NHS Improvement public board papers on 22 March 2018.

[https://improvement.nhs.uk/documents/2541/Response\\_to\\_recommendations\\_review\\_Liverpool\\_Community\\_Health\\_NHS\\_Trust.pdf](https://improvement.nhs.uk/documents/2541/Response_to_recommendations_review_Liverpool_Community_Health_NHS_Trust.pdf)

These experiences have highlighted the need for NHS Improvement to make changes to improve its operating model to respond to this. NHS Improvement has already started to work with 15 of the most challenged acute trusts to support them more effectively, but this offer needs to be made available at pace and scale and draw on the expertise that is evident across the NHS. NHS Improvement is reviewing its operating model and also identifying where it can work more closely with NHS England. It is critical that these changes respond to the challenges set out in this, and previous, productivity reviews. The effective implementation of these recommendations will require active staff-side involvement, in line with existing collective agreements. Employing Trusts and Foundation Trusts (together with NHS Improvement, NHS England and NHS Employers) should ensure that proper engagement and discussions and, where required, formal consultations take place in a transparent and timely way throughout the implementation process, as per agreements with staff and their representatives.

### Implementation model

The review proposes to extend the methodology currently in use in implementing the acute hospital sector review.



**Figure 8.2 – implementation methodology for NHS Improvement’s operational productivity programme**

A review implementation team in NHS Improvement’s Operational Productivity Directorate will be responsible for tracking the delivery of all recommendations, and work with trusts and other national bodies to do this. This team will also be responsible for

delivering the recommendations allocated to NHS Improvement, and the application of the methodology in Figure 8.2 to trusts providing mental health and community services.

Initially, the principal focus of this team will be to provide the universal offer to all providers of mental health and community services. It will provide productivity data and benchmarking metrics in the Model Hospital for clinical and non-clinical inputs as outlined in Chapters 4 to 7, and share best practice in areas such as rostering practice. Following the publication of this review, the team must engage with trusts to agree the areas where sharing universal best practice would add most benefit, and then develop a proposition to take as many of these forward as possible. This universal offer is critical to providing trusts with the opportunity to identify productivity and efficiency gains and include these in their cost improvement programmes. As this will be subject to risks around data quality and availability, particularly for services delivered in the community, we will work closely with NHS England and NHS Digital to achieve these recommendations.

The team's work must be taken forward through close alignment with NHS Digital and NHS England, in particular the Five Year Forward View for Mental Health programme, the Hospital to Home and 'Vanguards' teams, and the teams developing the Mental Health Services Data Set and Community Services Data Set. As part of this, the design and targeting of bespoke and intensive support offers must also be guided by the joint CQC and NHS Improvement 'Use of Resources' assessment framework which as part of CQC's inspection regime will assess an organisation's quality, productivity and leadership.

#### **Recommendation 16 – Implementation**

**Trusts, NHS Improvement, NHS England and other national bodies must take the action required to implement these recommendations. NHS Improvement must ensure that the best practice observed throughout this review is shared, key benchmarks are specified, and more intensive support is provided.**

Delivered by:

- Trusts, NHS Improvement, NHS England and other national bodies accepting and implementing the recommendations in this review.
- NHS Improvement's Operational Productivity Directorate leading on tracking the implementation of each recommendation, and holding trusts and other national bodies to account for achieving recommendations they are responsible for.
- NHS Improvement ensuring that its future operating model is fit for purpose to allow best practice to be routinely shared with trusts. It must also provide bespoke and intensive support offers to trusts to maximise the benefits from this, and establish the fundamentals of the universal support offer for trusts by April 2019.

## Thanks and acknowledgements

We received a great deal of help and support in undertaking this review and producing this final report. We would like to thank in particular the following people and organisations, whose input has been crucial in guiding and iterating the review over the last 18 months.

Firstly, without the insight, support and data from the cohort of 23 trusts the review would not exist. It would take too long to list the precise pieces of insight from specific individuals here, but we would like to particularly thank the senior executives, non-executives, and all of their staff including directors of nursing, chief pharmacists, directors of estates, heads of procurement, finance directors, operations and strategy directors, as well as all the many frontline staff we met during the course of the review. Their time and knowledge was greatly appreciated.

We are also very grateful for the input and time given to Lord Carter and the review team by many individuals in the main health organisations including NHS Improvement, NHS England, the Department of Health and Social Care, Health Education England, NHS Digital and NHS RightCare. The same goes for the input and guidance from the Secretary of State, Stephen Barclay MP, Simon Stevens, Ian Dalton, Dido Harding, Jeremy Marlow and the NHS Improvement Executive team, and Professor Tim Briggs CBE. We would also particularly like to express our gratitude for the time that Claire Murdoch and her team gave to supporting the review.

We would like to pass on our thanks on behalf of Lord Carter to the members and attendees of his Advisory Board for their steers and support over the last 18 months. This includes, Professor Tim Kendall, Derek Sach, Katy Steward, Andrew Strevens, Professor Chris Gray, Dr. Keith Ridge, Tony McCarthy, Stuart Bell CBE, Alex Lewis, Gary Wilder, Greg Smith, Sir Ian Carruthers, Dr. David Fearnley, Matthew Winn, Ros Alstead OBE, Anthony Marsh, Rod Barnes, Tony Fox, Dr. Simon Eccles, Will Smart, Professor David Oliver, Nigel Burchett, Professor Keith McNeil and Peter Pratt.

We have also received help and guidance from colleagues in national bodies from across the health sector including the Royal College of Psychiatrists, Royal College of Physicians, Royal College of Nursing, Unison, the Chartered Society of Physiotherapists, NHS Employers, the NHS Benchmarking Network, the Healthcare Financial Management Association, Whizz-Kidz and the King's Fund. We would also like to thank Chris Hopson (NHS Providers), Crystal Oldman (Queen's Nursing Institute) and Anita Charlesworth (Health Foundation).

We would also like to thank the many companies we have discussed and worked with in particular James Quinn, Graeme Ratten and Campbell McKerracher and their team from Meridian, Deanna Roepke and her team from Relias, as well as Accenture, Connect Health, and CHS Healthcare.

We are sure that there are many people and organisations that we have not mentioned above, but we would personally like to thank everyone who has helped the review team to compile this report.





