NHS operational productivity: unwarranted variations
Mental health services and community health services
Summary document

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[1], 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,

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[1] OECD, 'Health at a Glance 2017'; https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en

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 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[2]. As Lord Darzi's recent review of health and care[3] 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

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[2] NHS Improvement analysis
[3] The Lord Darzi Review of Health and Care: Interim report: https://www.ippr.org/publications/darzi-review-interim-report

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.

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.
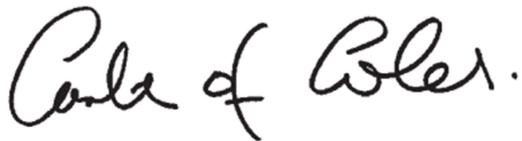
Lord Carter of Coles
May 2018

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.

Summary of Recommendations

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.