LORD CARTER REVIEW OF ACUTE TRUSTS' OPERATIONAL PRODUCTIVITY: ON THE DAY BRIEFING

Lord Carter was asked in the summer of 2014 by the health secretary to assess what efficiency improvements could be generated in hospitals across England. He provided an interim report on his work in June 2015, in which he outlined that potentially £5bn of operational efficiency savings could be delivered in the acute sector by 2020 by improving workforce costs, hospital pharmacy medicines optimisation, and estates and procurement management.

Today, Lord Carter has published his final report into hospital efficiency. The scope of his work to date has been focussed on the acute sector, and we have strongly urged consideration of similar support for mental health, community and ambulance providers in due course. Having started by working with a cohort of 22, extended to 32 acute trusts, he has now looked at the efficiency of all 136 acute trusts in England to come to a target savings figure. He still estimates that if 'unwarranted variation' is removed from trust spend, that £5bn of savings could be saved by 2020. His final report gives a more detailed breakdown of how that figure could be achieved, as well as providing a range of recommendations in order to get there.

This briefing covers:

- The work to date that Lord Carter has undertaken
- The methodology behind the savings calculations
- An overview the final report's findings and recommendations
- Our view on the proposals
- Our press release on the proposals
- An annex with all the recommendations and sub recommendations

If you have any questions arsing from this briefing, please contact Edward.Cornick@nhsproviders.org

THE WORK TO DATE

Lord Carter was asked by the secretary of state to investigate how acute trusts across England could become more efficient. To do this he initially carried out detailed work with 22 trusts from across England. They were broadly representative of different types and sizes of acute hospital ranging from large inner-city teaching hospitals to rural district general hospitals. Following this initial work and ahead of his final report published today, he provided an update on his progress in his 2015 summer interim report - *Review of Operational Productivity in NHS Providers* . In this he outlined the following

- Based on engagement and assessment of the 22 trusts, the NHS has the ability to achieve £5bn per annum of savings through improvements to operational productivity by 2019/20 provided there is political and managerial commitment to take the necessary steps and funding to achieve these efficiencies. The savings breakdown could be delivered, approximately, in the following way:
    - Improving workflow and containing workforce costs, including having a stronger management grip on non-productive time, better management of rosters and improved guidance on appropriate staffing levels and skill mix = £2bn
    - Improved hospital pharmacy and medicines optimisation = £1bn
    - Better estates management and optimisation = £1bn
    - Better procurement management = £500m-£1bn

- To achieve this, he recommended 8 different actions:
    1. Develop an efficiency metric for NHS providers to use to review performance against their peers and create a baseline for improvement.
    2. Develop a 'model NHS hospital' data set and group of case studies to help providers aspire to best practice across all areas of productivity.

3. In workforce, establish standards and best practice policies on productive time, rostering, enhanced care ("specialling") and skill range.
4. In hospital pharmacy and medicines optimisation, design a model approach to the delivery of hospital pharmacy services and the supporting infrastructure.
5. In estates, develop a package of support to help providers improve their efficiency to at least the average of their peers.
6. In procurement, develop product specification and a single national electronic catalogue for products used in the delivery of healthcare.
7. Create national 'productivity collaboratives' to share best practice around the four categories of workforce, pharmacy and medicines optimisation, estates and procurement.
8. Further investigate areas such as diagnostics (radiology and pathology), IT, clinical IT and moving into primary care areas such as community pharmacy.

Some of these recommendations have been developed or amended in the final report published today, with some new recommendations added as well (predominately around how the advice of the report will be implemented in practice).

Since the publication of the interim report, the Carter team has extended its detailed analysis work to an extra ten trusts (32 in total) to refine its methodology. Following this, it then engaged with all 136 acute trusts across the country in the autumn of 2015, presenting what they thought were the high level savings opportunity for each trust based on the detailed analysis work, before entering into discussion with each trust to come to an agreed savings figure.

METRICS BEHIND THE SAVINGS

In order to calculate the savings figures for the 136 providers, the team, in line with the first recommendation in the interim report, devised and used a standardised efficiency metric – initially called the ATI (Adjusted Treatment Index), now called the Adjusted Treatment Cost' (ATC) as it now provides a comparison by cost rather than an indexed score. It provides an overall measure of trust efficiency as well as a breakdown by specialities and other areas of spend. It was refined through working with the cohort of 32 trusts, and following that the Carter team shared with all 136 acute providers what they believed the potential cost saving opportunity was for each organisation based in the main on the ATC calculation.

The ATC is calculated using audited, publicly available data. The main data set it uses is the NHS Reference Cost collection (2014/15), using it to assess both activity volume and costs. Calculation of the ATC is a two-step process. Firstly, to find the expected cost for delivering a volume of a particular activity; the national average cost for an activity at a service and department code level is multiplied by the volume of that activity delivered by the provider. This expected cost for delivering a volume of activity is called the Cost Weighted Output (CWO). The Market Forces Factor (MFF) is applied across all activity taken from the source reference cost data and is incorporated into the mean calculation.

National Average Cost of Activity x Provider's Volume of Activity = Cost Weighted Output

Secondly, the actual costs the provider incurred in delivering the activity divided by the CWO. This generates an ATC to enable comparison between providers.

Actual Cost ÷ Cost Weighted Output = ATC

Since this method is based on the reference cost data, it can be used to drill down to the individual service level and specialty level, as well as providing a full trust level ATC score.

The ATC is expressed by comparing a trust's per £ of spend against the average. So if a trust performs an activity, service, speciality or all specialities (trust level) at say 95% of the cost of the national average, its ATC rating for any of those categories will be £0.95 indicating it is above average in efficiency in that area(s) . An indicative example of a trust level ATC score is below

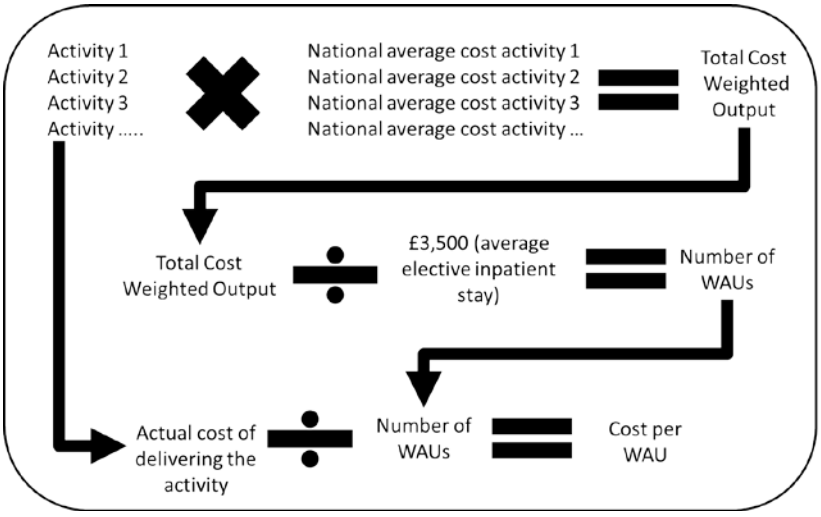
XXXX HOSPITALS NHS TRUST/PROVIDER	
2014/15 Reference Cost Expenditure (MFF adjusted)* £420,00,00	Cost Weighted Output (CWO) £450,000,000
ATC for provider £0.93	

So for this provider, the national average cost of performing all the activities it does would be £450m, but the trust only spends £420m to do them. £420m is 93% of 450m, so the trust's overall ATC score is £0.93 – it spends £0.93 against the average of £1.

Savings are initially calculated by taking away actual costs minus the average activity costs (the cost weighted output) so for the speciality below for example, the savings would potentially equal £4m.

XXXX HOSPITALS NHS TRUST/PROVIDER: OBSTETRICS AND GYNAECOLOGY	
2014/15 Expenditure (MFF adjusted) £29,000,000	Cost Weighted Output (CWO) £25,000,000
ATC for specialty £1.17	

To build on this further, following the interim report the Carter team developed a common currency to measure hospital output - the Weighted Activity Unit (WAU).



To calculate WAUs, each unit of activity reported by a trust is multiplied by the national average cost for that activity (calculated via reference cost data at currency, department, and service code level. All types of activity counted in reference costs are included e.g. non-elective work, outpatients and diagnostic tests as well as elective admissions).

This is then summed to create the total amount of cost-weighted clinical output that a trust delivered. This is then divided by £3,500 (equivalent to the cost of the average elective inpatient stay) to express this in a number of WAUs.

It is then possible to divide the trust's actual costs of providing that activity by the number of WAUs to get a cost per WAU – which can be used as a comparable metric of efficiency. This can be used as an overall measure of the efficiency for each trust, or be drilled down to provide efficiency measures for certain areas of activity

Finally, these figures were also triangulated against providers' costs per FTE across different staff grades and specialities compared against national averages, as well as looking at trusts' clinical output against FTE costs compared to national averages. The basis for this was drawn from Electronic Staff Record (ESR) data submissions (and then improved upon when engaging with all the acute trusts to get more accurate figures for each trust's staff numbers and types) with staff costs in four groups: doctors, registered nurses, AHPs, and admin and managerial. Below again as an indicative example of trust staff spend in a specialty, benchmarked against national averages.

INTENSIVE AND CRITICAL CARE					
Staffing productivity:	TOTAL	DOCTORS	NURSES	AHPs	ADMIN
Total 2014/15 Staff Costs	£7,730,000	£3,000,000	£4,300,000	£350,000	£80,000
Staff cost per £ of specialty activity	£0.43	£0.17	£0.24	£0.02	£0.00
National average across acute trusts	*£0.29*	*£0.04*	*£0.24*	*£0.02*	*£0.01*

Therefore the final savings figures for each trust are measured and benchmarked by ATC, FTE and WAU scores across all major medical specialties, as well as procurement and estates and facilities spend. The final report notes none of these measures is perfect, and they will need to be used in combination to understand trust level productivity overall and to track improvements. The report also recognises these metrics will become more accurate as providers' data reporting becomes more robust over time.

THE FINAL REPORT

Using these metrics and having engaged with all 136 acute trusts, the final report - *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations* - was published today. It outlines again the potential savings opportunity, as well as describing recommendations for how they can be achieved. These recommendations are mixed between what the national bodies – in the main NHS Improvement – need to do and specific actions that providers will be required to take and in some cases be held to account for delivering.

The report breaks down into the following chapter areas:

1. Outline from Lord Carter and introduction
2. Optimisation of clinical resources
3. Optimisation of non clinical resources
4. Quality and efficiency across the patient pathway
5. Creating a 'model hospital' and an integrated performance framework
6. Implementation and further engagement with trusts

Of these, only chapters two and three have 'hard' savings figures attached to them based on the metrics work and engagement with 136 trusts to define their saving figures. The other areas suggest further work and recommendations that could help enable these savings to be realised and will drive the implementation of the programme.

Outline from Lord Carter and introduction

In his letter to the secretary of state prefacing the report, Lord Carter outlines five key points:

1. **The provision of high quality clinical care and good resource management go hand-in-hand**. All trusts should grasp the use of their resources more effectively and strive for quality.
2. **A single reporting framework should be adopted** across all trusts, which pulls together clinical quality and resource performance data and compares it to the 'best in class'. To do this the system must endeavour to reduce and rationalise the plethora of reporting burdens currently placed on providers
3. **Delayed transfers of care have a significant impact on achieving efficiency savings.** Nearly all trusts wrestle with the problem of moving those who are medically fit into settings that are more appropriate - a significant proportion of the £5bn cannot be unlocked unless delays in transfer are managed more effectively, and system wide leadership is needed for that to happen.
4. **The need for genuine local and national collaboration and coordination**. Trusts recognise the efficiency opportunities if they could change the way their clinical services were delivered or could share some supporting services. However, these are rarely realised due to the considerable effort needed to present and explain the benefits to their local partners and communities. National support to address this is critical.

5. **Rapid adoption of the review recommendations is paramount**. Quick implementation of the recommendations by the trust leaders and NHS Improvement when it comes into being is vital if the savings are to be realised by 2020.

The introduction to the report outlines the following points:

- Reiterates the NHS has to deliver the efficiencies of 2-3% per year, effectively placing a 10-15% real terms cost reduction target on trusts to achieve by April 2021. The £5bn of savings identified in the Carter report go some way to achieving this.
- Of the £5bn savings potential, £3bn has been agreed in principle by the 136 acute trusts. The report says "We are confident that as the model hospital work continues and the system issues described later in this report are addressed, all trusts will have greater confidence that £5bn is achievable."
- They have used three primary ways to measure hospital productivity: 1. the ATC, 2. the WAU 3. Specific measures such as revenue per FTE and the Purchasing Prices.
- During the analysis they consistently found imperfections in the data reported by individual trusts, including Electronic Staff Record (ESR), Estates Returns Information Collection (ERIC) or compilation of reference costs
- Two wider system issues impact providers' ability to deliver high quality care and the savings opportunity: delays to transfers of care and the issues of "collaboration, coordination and economies of scale". Trusts needs help tackling these issues but "we do not think [that] absolve[s] trust boards' responsibility to get a tighter grip on the management of their resources".

The report contains 15 main recommendations across the different chapters, each with numerous sub-recommendations. All of the recommendations are listed in full in the Annex and are hyperlinked to throughout the next section of this briefing. Under each recommendation is a breakdown of the key actions for providers to lead on, and which will be taken forward by the national bodies.

Optimisation of clinical resources

Potential savings - Headline figure: Between £3.1bn and £3.8bn
Breakdown of figure: • Optimising staff resource: £1.7bn-£2.7bn. (Figures below relate to top specialities by savings area as released by Department of Health (DH) Oct 15). o General medicine £381m o Obstetrics and gynaecology £362m o Trauma and orthopaedics £286m o Cancer services £255m o Emergency medicine £254m o General surgery £234m o Paediatrics £209m o Intensive and critical care £209m o Cardiology £184m • Pharmacy and medicines: £850m-£1.4bn • Pathology: £200m

- This chapter outlines the thinking behind the savings detailed above. In the main it outlines there is significant variation across trust regarding sickness, staff turnover and morale, and there need to understand why some staff groups have higher sickness levels than others. To address this is recommends the development of a 'national people strategy' (see recommendation 1)

- It also notes a wide variation in how trusts manage annual leave, shift patterns and flexible working, with different approaches to the use of technology and good practice such as e-rostering and the use of information to make decisions about staff utilisation. It therefore proposes 2 main actions to address this (see recommendation 2):
    - Adopting Care Hours Per Patient Day (CHPPD) metric. CHPPD can be used to describe both the staff required and staff available in relation to the number of patients, calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of

in-patient admissions. Using this metric already, they found variation of 144% between the lowest at 6.33 CHPPD and the highest at 15.48 CHPPD which "reinforces the need to benchmark like for like trusts"
    - All trusts adopting e-rostering and its associated best practice and reporting, as well as adopting a guide on the delivery of enhanced care (defined as "specialling" in the report).

- The report notes significant variation in total pharmacy and medicines costs across acute trusts, and that there is scope for improving supply chain management in this area though more effective collaboration at local, regional and national levels to help all trusts achieve the what they consider 'model hospital' benchmarks. To do this they propose a national Hospital Pharmacy Transformation Programme (HPTP) should be developed (see recommendation 3).

- The report outlines that the Carter team gathered data and information from the cohort of 32 trusts directly to establish a set of benchmarks for efficiency opportunities in diagnostic services such as pathology and imaging. The report notes that their analysis confirmed that consolidated pathology organisations are the most efficient, and therefore requires trusts to plan towards achieving benchmarks or move towards a consolidated or outsourced solution (see recommendation 4).

Optimisation of non clinical resources

Potential savings - Headline figure: Between £2.1bn and £2.4bn
Breakdown of figure: • Optimising procurement: £750m - £1bn • Estates and facilities management improvements: £1bn – including, cleaning £93m, energy savings £36m and food services £52m • Back office, admin and management rationalisation: £350m-450m

This chapter outlines issues with procurement, estates and facilities management and back office costs.

- On procurement, it outlines how most trusts still do not know what they buy, how much they buy, and what they pay for goods and services. Furthermore, there continues to be a systematic failure to capitalise on the national nature of the NHS. They therefore recommend implementation of a new purchasing price index with immediate effect for the 100 most commonly purchased items (trusts will have to submit their individual lists so NHS Improvement can create an aggregate list with average prices), with NHS Improvement holding trusts to account on their performance against the index from April 2016 (see recommendation 5) and with more items being added to the index over the coming years to help NHS Improvement develop a national procurement reporting system.

- On estates and facilities, the Carter team outlines it has developed a dashboard that provides each trust with a clear understanding of their costs as well as pointers for efficiency opportunities, including an indication of what they could potentially save by improving their performance in line with their peers In areas such as energy consumption, patient food, cleaning and linen and laundry services. To realise these savings, it wants all trusts to produce estate management plans, and more prescriptively, a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 (see recommendation 6).

- The report highlights it found "inexplicable" variation in corporate and administration costs across trusts ranging from 6%-11% (with a mean of 8%) spend of trust income. It therefore recommends where a trust's corporate/administration workforce costs are above 7% of their income they should submit a plan for reducing it to NHS Improvement by April 2016, and want trusts to 'rigorously' test if they can make savings through shared service models (see recommendation 7).

Quality and efficiency across the patient pathway

- Unlike the two previous chapters, this chapter does not outline any specific savings opportunities to be attained, although it does mention a potential headline figure related to delayed transfers of care. Rather it outlines a diverse range of recommendations, looking at:
    - Rationalising reporting on clinical quality and variation
    - National IT funding for IT measures mentioned elsewhere in the report
    - Alignment with other current national policy initiatives and addressing system wide issues

- On the first of these, the report notes the different partners in the health economy look at care through their own lenses. There is a need to create a single version of the truth on best quality care. Building on the trauma and orthopaedics *Getting it Right First Time* initiative, the team has pulled together a number of data sources that to provide a picture of most of the patient pathway for other medical specialties, including: spinal, general surgery, urology and renal, vascular, ear nose and throat, cardiothoracic, ophthalmology, oral and maxillofacial, neurosurgery, paediatric surgery, and obstetrics and gynaecology. It proposes having a joint governance structure to review this information going forward (see recommendation 8).

- On the second point, it notes that in the spending review government said it will "invest £1 billion in new technology over the next 5 years to deliver better connected services for patients and ensure that doctors and nurses have the information they need at their fingertips". The report explicitly links some of this funding to delivering IT solutions mentioned elsewhere in the report such as e-rostering and stock management, so trusts have them in place for October 2018 (see recommendation 9).

- Thirdly, it recognises that there are systemic issues with delayed transfers of care, as well as highlighting a need for greater system wide collaboration to unlock economies of scale. Its estimates that on any given day as many as 8,500 beds in acute trusts are blocked with patients who are medically fit to be transferred and that the cost of these delays to providers could be around £900m per year. It notes the national bodies as well as trusts have a key role in helping to address this and other system wide issues, and lessons should also be drawn from current Sustainability and Transformation plans as well as the Vanguards programme (see recommendations 10 and 11).

Creating the model hospital and an integrated performance framework

- One of the key recommendations of the interim report was to create a 'model hospital' dashboard, to set out a clear, consistent approach to setting expected standards that a good hospital should meet. The report says within this key performance metrics should be available for comparison against both internal plans and peer benchmark. This will allow definitions of good performance to be cascaded down through organisations with metrics appropriate at each level so that everyone knows what good looks like in their own area of responsibility. This dashboard will look to include:
    - clearly defined performance metrics, encompassing patient outcomes, people productivity and financial sustainability;
    - the ability for organisations to compare performance against their internal plans, peer benchmarks and the views of NHS experts; and
    - good practice checklists to guides for improvement actions, including links to detailed guidance and knowledge sharing by top performers.

- The report states the metrics should be presented in a systematic way, according to the needs of a broad audience, and come together in dashboards intended to support Board, senior and operational management levels. The dashboard will include the metrics mentioned throughout the final report so it holds a single view of all the items that providers are reporting on and are expected to be held to account against. This will be known as an integrated performance framework for use across the acute sector, covering quality and efficiency and serving regulators, commissioners and inspectors (see recommendations 12 and 13 on how this will be achieved).

Implementation and further engagement with trusts

- The final chapter in the report starts to assess what practical steps both providers and national bodies will have to take the actions throughout the report into implementation. Its recommendations, 14 and 15, outline the individual direct responsibilities for trust directors and groups within the DH and NHS Improvement for taking the work forward.

NHS PROVIDERS VIEW

NHS Providers recognises that there is scope to deliver significant efficiency savings across the sector, and welcomes the approach that Lord Carter and his team have taken in seeking to identify these efficiencies. Working in depth with cohort of 22, then 32 trusts to really understand the productivity challenges they face was a refreshing and correct approach, allowing the DH to see what trusts are doing well already to become more productive as well as identifying where practices could be improved. Similarly, using this detailed work to engage with the entire acute sector and negotiate, rather than impose savings targets should act as a benchmark for how central bodies engage with trusts in future national level policy discussions. It is also welcome that the report places a premium on all parties to move at pace with the proposals.

It is also encouraging to see that many of the report's recommendations acknowledge the vital role that NHS Improvement and other national arms length bodies (ALBs) will have in helping trusts realise the savings identified. System wide issues such as delayed transfers of care cannot be addressed by trusts alone, and it is indeed the national bodies' responsibility, not a local concern, to reduce and simplify the onerous reporting burden that trusts currently bear. The integrated performance framework is very welcome progress in this regard.

However, there are still some areas of concern which emerge from this report, in particular proposed measures which contradict the 'bottom up' basis of the work described above or which contravene foundation trust decision making freedoms. The mandating of 7% back office costs and 35% non clinical floor space are both examples of such measures, and the report does not provide enough evidence that variation in these areas is unwarranted to the extent that all trusts should have to achieve the suggested benchmarks. Also whilst recognising the importance of central alignment to help providers address issues, the report mandates numerous separate plans that trusts have to submit to NHS Improvement across topics as diverse as HR practices, estates management, medicine procurement, data cleansing and back office staffing amongst others. The deadlines for submitting these plans are as diverse as the topics they cover. How they relate to one another, and as importantly how they join up with other national directives that providers are currently undertaking is not yet effectively explained.

NHS Providers looks forward to continuing to engage with this work programme as it transitions to NHS Improvement for implementation. In particular, having the correct governance arrangements will be key to ensuring the correct balance between provider board's own grip, support from the centre and intervention if agreed targets are not met. The thinking on this at a high level is outlined in recommendation 15 of the report, but in the coming months NHS Improvement will have to provide more detail on how they can, within the same single process, hold providers correctly to account but at the same time provide the right support for delivery of the new savings targets. It also needs to show it will have the skills and expertise to be able to distinguish between legitimate and illegitimate under delivery, particularly early in the implementation of the programme when the metrics used are still being refined to improve their accuracy. To do this, having appropriate provider representation on any body overseeing the work programme is vital. We also note that in the recommendations for implementation there is no specific mention of how the work will be expanded into specialist and non acute providers beyond ensuring the model hospital metrics are applicable to them by April 2017. It is essential the next steps of the work programme therefore

puts adequate focus on these trusts, and that these providers are properly engaged to ensure that their version of devised metrics are properly applicable and robust.

NHS PROVIDERS PRESS STATEMENT

Commenting on today's publication of the final Carter Review, Chris Hopson, chief executive of NHS Providers, said:

"In the last parliament, NHS providers met the Nicholson Challenge of finding an unprecedented £20 billion of NHS wide efficiency savings. The NHS now faces an even greater challenge this parliament – finding £23.5 billion of savings. Our members tell us that doing more of the same simply won't work – finding new ways of improving efficiency and productivity are required and these can only be realised if NHS system leaders provide unprecedented levels of support to the frontline leaders who have to actually make the savings.

"The 32 providers Lord Carter has worked most closely with tell us that they have found his review extremely helpful – the work has identified a significant number of areas where new savings could be realised. They welcomed the genuinely collaborative, bottom-up, approach the review took. It is vital that, as we turn to implementing the plans, we don't lose sight of this collaborative approach and that our members are active partners in finding the right solutions rather than having savings targets imposed on them.

"The report also rightly highlights that high quality patient care is inextricably linked to strong financial management; that appropriate governance and action is needed from the centre to help providers realise the proposed savings; and that sharing best practice, striking a balance between accountability and support, addressing systemic issues such as delayed transfers of care and alignment with other national plans are all key to delivery.

"Our members tell us they are always nervous of central system leaders setting new national standards such as reducing back office costs to 7% of income and requiring all trusts to operate with a maximum of 35% of non-clinical floor space, when there can often be good local reasons for being an outlier against these standards. So they want to understand the detailed rationale for these new standards and how they will be implemented. There is a world of difference between warranted and unwarranted variation and local leaders are usually best placed to make that distinction.

"It's also vital we take a realistic view of how much of the gap the Review will plug: the estimated £5 billion represents less than a quarter of the £23.5 billion of efficiency savings needed by 2020. Our specialist, mental health, ambulance and community members also remain keen to understand how the Review process will affect them".

ANNEX: FULL BREAKDOWN OF RECOMMENDATIONS

Recommendation 1: NHS Improvement should develop a national people strategy and implementation plan by October

2016 that sets targets for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from "ward to board", so that transformational change can be planned more effectively, managed and sustained in all trusts.	
Key items for trusts to lead: • HR polices reviewed to ensure they are clear and simple and transparent • a reduction in the high rates of bullying and harassment with a sustained campaign led personally by each trust Chief Executive • ensuring staff have regular performance reviews. • improving sickness absence	Key items for NHS Improvement/national bodies to lead: • implementing clear set of leadership capabilities used in leader selection and performance management • developing management practices to gain a better understanding of the reasons for high staff attrition • mandating the use of a trust and national level succession planning processes • common definition of sickness absence and improved collection of data

Recommendation 2: NHS Improvement should develop and implement measures for analysing worker deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care.	
Key items for trusts to lead: • improving analysis of consultant job plans and better collaboration within and between specialist teams • All trusts using an e-rostering system, with the following practices being implemented: o publishing rosters six weeks in advance, submitted to NHS Improvement o formal process to tackle areas that require improvement and developing associated cultural change and communication plans o implementing NHS Improvement guide on enhanced care by October 2016, to be monitored by NHS Improvement.	Key items for NHS Improvement/national bodies to lead: • NHS Improvement collecting CHPPD on a monthly basis (beginning April 2016), so that CHPPD becomes the principle measure of nursing and healthcare support worker deployment • improving the understanding of the configuration of the AHP workforce in each trust • national bodies taking a coordinated/proactive approach to managing the supply of staff to improve efficiency in the NHS, including overseas recruitment campaigns.

Recommendation 3: Trusts should, through the Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding, in agreement with NHS Improvement and NHS England by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities.	
Key items for trusts to lead: • developing HPTP plans at a local level, with each trust board nominating a Director to work with their Chief Pharmacist to implement changes. • moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA) • each trust's finance director ensuring that coding of medicines are accurately recorded. • 80% of trusts' pharmacist resource utilised for direct medicines optimisation activities, medicines governance and safety remits. • reduce stock-holding days from 20 to 15, deliveries to less than 5 per day and ensure 90% of orders and invoices are sent and processed electronically	Key items for NHS Improvement/national bodies to lead: • NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for trusts to pursue; • Commercial Medicines Unit (CMU) in the DH undertaking regular benchmarking on an international scale ensuring price competiveness • NHS Improvement identify the true value and scale of the opportunity for rationalisation of hospital pharmacy procurement developing an NHS Manufactured Medicines product catalogue.

Recommendation 4: trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017.	
Key items for trusts to lead: • trusts introducing the Pathology Quality Assurance	Key items for NHS Improvement/national bodies to lead: • HSCIC publishing a definitive list of NHS pathology tests and how they should be counted by October 2016, with NHS Improvement requiring trusts to adopt the

Dashboard (PQAD) by July 2016, with NHS Improvement hosting the dashboard	definitions from April 2017 • NHS Improvement publishing guidance notes for forming collaborative joint ventures by October 2016; • NHS Improvement introducing metrics for imaging departmental productivity by December 2016.

Recommendation 5: All trusts should report their procurement information monthly to NHS Improvement to create a NHS Purchasing Price Index commencing April 2016, collaborate with other trusts and NHS Supply Chain with immediate effect, and commit to the DH's NHS Procurement Transformation Programme (PTP), so that there is an increase in transparency and a reduction of at least 10% in non-pay costs is delivered across the NHS by April 2018.

Key items for trusts to lead:	Key items for NHS Improvement/national bodies to lead:
• trusts to send top 100 purchased products list to NHS Improvement • developing PTP plans at a local level with each trust board nominating a director to work with their procurement lead to implement changes • all trusts implementing a spend analytics capability, efficient electronic catalogue, inventory management systems and exploring other back-office opportunities including enhancing current Process to Pay (P2P) systems adopting Global Standard 1 (GS1) and Pan European Public Procurement Online (PEPPOL) standards. • By April 2018 having 80% addressable spend on catalogue, 90% addressable spend under contract, 90% addressable spend with a purchase order; • trusts accelerating collaboration with other trusts to develop aggregated sourcing work plans to reduce variety for 2016-17 and 2017-18, • trusts adopting NHS Standards of Procurement, with those that have already achieved Level 1 achieving Level 2 of the standards by October 2018; and those trusts that are yet to attain Level 1 achieving that level by October 2017. All trusts to produce a self-improvement plan to meet their target standard by March 2017.	• NHS Improvement who will develop and implement a new purchasing price index starting with an initial basket of 100 products with immediate effect. NHS Improvement will hold trusts boards to account in performance against the index from October 2016, and develop the index into a national procurement reporting system by April 2018

Recommendation 6: All trusts estates and facilities departments should operate at or above the median benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016); with all trusts (where appropriate) having a plan to operate with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied or under-used space by April 2017 and delivering this benchmark by April 2020, so that estates and facilities resources are used in a cost effective manner.

Key items for trusts to lead	Key items for NHS Improvement/national bodies to lead:
• every trust has a strategic estates and facilities plan in place, including a cost reduction plan for 2016-17 based on the benchmarks, and in the longer term (by April 2017), a plan for investment and reconfiguration • investing in energy saving schemes such as LED lighting, combined heat and power units, and smart energy management systems, • estates and facilities costs embedded into trusts' patient costing and service line reporting systems.	• new DH 'invest to save energy efficiency fund' set up by April 2017 to help trusts deliver the opportunities for reduced energy consumption • HSCIC and trusts should ensure better data accuracy by improving the governance and assurance of the ERIC data in time for the 2015-16 returns due in July 2016

Recommendation 7: All trusts corporate and administration functions should rationalise to ensure their costs do not exceed 7% of their income by April 2018 and 6% of their income by 2020 (or have plans in place for shared service consolidation with, or outsourcing to, other providers by January 2017), so that resources are used in a cost effective manner.

Key items for trusts to lead:

- submitting a plan to NHS Improvement by October 2016 if their corporate/admin workforce costs are above 7% of their income for the financial year 2015/16, including comparing their functions and services against a national set of benchmarks that NHS Improvement are developing for July 2016 for the key functions of HR, Finance, IM&T, and Procurement with plans to commit to national shared service models. Also should test their existing services against shared service solutions and where comparison highlights savings of 5% or more, work to deliver those savings.

Recommendation 8: NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so

that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway.	
Key items for trusts to lead: • trust boards mandated to review the dashboards for 3 clinical or medical specialties each month, to benchmark themselves against the established metrics and best practice, and routinely track progress by October 2016.	Key items for NHS Improvement/national bodies to lead: • implementing the three-year clinically-led Quality and Efficiency project (GIRFT), Right Care and similar programs currently operated by the DH, NHS England and Monitor by July 2016; • NHS Improvement bringing all existing clinical registries and data source feeds into its new structure in order to establish National and Local dashboards for each clinical specialty by July 2016.

Recommendation 9: All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of 'meaningful use' standards and incentives.	
Key items for trusts to lead: • Trusts having in place by October 2018, fully integrated and utilised e-rostering systems, e-prescribing systems, patient-level costing and accounting systems, e-catalogue and inventory systems for procurement, RFID systems where appropriate, and electronic health records;	Key items for NHS Improvement/national bodies to lead: • DH to make some of the Spending Round investment for IT available for trusts to meet these standards, with a suitable 'meaningful use' clause embedded in contracts

Recommendation 10: DH, NHS England and NHS Improvement, working with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers.
Key items for NHS Improvement/national bodies to lead: • identifying the barriers, such as assessment and funding mechanisms, that prevent patients from being transferred from hospitals; enabling cross organisational IT systems, and developing a model and guidance on when and how to provide new alternative capacity (such as sub-acute step-down facilities) outside of acute hospitals

Recommendation 11: trust boards to work with NHS Improvement and NHS England to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community.
Key items for NHS Improvement/national bodies to lead: • trusts completing their area plans as per the 2016/17 planning guidance; and successful implementation of the New Care Models, Vanguard and Success Regime programmes, and trusts not involved in these programmes learning, adapting and implementing the findings of these programmes as they develop.

Recommendation 12: NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice.	
Key items for trusts to lead: • trust boards ensuring that the Electronic Staff Record (ESR) is reconciled to the financial ledger on a weekly basis, with a minimum reconciliation of 95% from October 2016; • trusts agreeing with NHS Improvement their peers for each of the ten specialties and functions in which each trust's largest productivity and efficiency gains are to be found	Key items for NHS Improvement/national bodies to lead: • continuous programme of development for the design and maintenance of all the components and benchmarks that make up the Model Hospital, completing 'phase 1' development by April 2017 • NHS Improvement creating benchmarks and guides of best practice to be used as the operating standards of hospital management, • NHS Improvement calculating the ATC, WAU and broader set of productivity metrics for all acute trusts annually starting in April 2016, and developing a mechanism to track total cost per WAU for all 136 non-specialist acute trusts at regular intervals in year. • Ensuring model hospital work and metrics are expanded to cover the non acute trusts by April 2017
Recommendation 13: NHS Improvement should, in partnership with NHS England by July 2016, develop an integrated performance framework to ensure there is one set of metrics and approach to reporting, so that the focus of the NHS is on improvement and the reporting burden is reduced to allow trusts to focus on quality and efficiency.	

Key items for trusts to lead:	Key items for NHS Improvement/national bodies to lead:
• trusts working to improve cleanse and validate their data submissions to ensure that the data is robust enough for benchmarking.	• NHS Improvement creating integrated performance framework based on the Model Hospital work, with a set reporting cycle to drive efficiency and care improvements, aligning with requirements of commissioners and CQC • NHS Improvement engaging with trusts to identify the nature of the reporting burden, demonstrating a reduction in reporting burdens by April 2017

Recommendation 14: All acute trusts should make preparations to implement the recommendations of this report by the dates indicated, so that productivity and efficiency improvement plans for each year until 2020/21 can be expeditiously achieved.

Key items for trusts to lead:

- Chief Executives, having identified the efficiency opportunities that their organisations can deliver on their own and those which require collaboration and cooperation, plan how these will realised over three years;
- Chief Executives ensuring that the management information they will be required for the Model Hospital and Integrated Performance Framework is robust
- Chairs and Chief Executives preparing their Boards to the use the Model Hospital and the Integrated Performance Framework;
- Directors of Nursing or Chief Nurses ensuring that nurse and healthcare support staff are managed using the recommended e-rostering, 'Enhanced Care' and CHPPD recording and reporting arrangements;
- Medical directors ensuring that each Consultant has an up to date accurate Job Plan which clearly sets out the sessions allocated to the performance of clinical procedures, patient/carer facing time and quality improvement; that the Hospital Pharmacy is ready to implement the recommendations on the deployment of pharmacists, the coding of high cost medicines and stock control;
- Medical directors ensuring that the recommendations of the GIRFT report for the hospital are implemented;
- Finance directors using the new purchasing price index of 100 products to optimise value in procurement and work towards the benchmarks of spend against catalogue, under contract and by purchase order
- Chief Executives introducing a lean daily management approach, with metrics that are simple and visible, that non-executive directors understand and by which they hold executive teams to account
- HR directors introducing the nine management practices that strengthen organisational resilience, effectiveness and productivity.

Recommendation 15: National bodies should engage with trusts to develop their timetable of efficiency and productivity improvements up until 2020/21, and overlay a benefits realisation system to track the delivery of savings, so that there is a shared understanding of what needs to be achieved.

Key items for NHS Improvement/national bodies to do:

- the DH continuing to host the development of the Model Hospital and engage with trusts to derive a business plan for activities up until July 2016, until this programme of work fully transitions to NHS Improvement;
- NHS Improvement establishing an Analytical Unit which will provide the capability and capacity to continue the development of the Model Hospital and the systems to collate, interpret and regularly and reliably report performance data as a 'single version of the truth' so as to obviate the need for other routine and ad hoc requests to trusts to report and provide other data;
- NHS Improvement enlisting a Professional Lead for each component of the Model Hospital and other features of the Integrated Performance Framework, to provide the leadership in developing the metrics and benchmarks for each component and feature, and to engage key stakeholders;
- NHS Improvement establishing engagement resources (probably regionally based) to support trusts develop their plans and the professional leads in developing and using both the Model Hospital and the features of the integrated performance framework by engaging with trusts so that their need for external consultancy radically reduced;
- NHS Improvement developing and implementing a phased programme of activities which introduce the full use and functionality of the Model Hospital and the Integrated Performance Framework as early as is practicable; and,
- NHS Improvement convening a series of mandated change implementation mobilisation events for Chairs, Non-Executive directors, CEOs and executive team members in the second quarter of 2016, so that a clear and shared understanding of the challenges is established and targets set for achievement.