

NHS operational productivity: unwarranted variations in mental health and community health services

This briefing provides a summary of the key findings and recommendations of *NHS operational productivity: unwarranted variations – mental health and community health services*. The review, led by Lord Carter, covers the operational productivity of English NHS community^[1] and mental health^[2] services. Since early 2017, Lord Carter's review team has been working with a cohort of 23 mental health and community trusts¹, who account for over 20% of total expenditure in the sectors. The final report makes 16 recommendations and indicates productivity benefits worth £1bn can be achieved by 2020/21. It is expected that around 80% of this will be achieved in clinical and workforce productivity, including through the Getting it Right First Time Initiative (GIRFT). This briefing contains:

- The key findings and recommendations of the review
- NHS Providers view of the report and our press statement.

Mental health and community health services

The review team found a disparity in leadership capacity and focus from the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) between mental health and community health services. While the Five Year Forward View (5YFV) for mental health services has engendered a clear ambition, delivery programme and strong leadership, there is a **lack of national work and evidence base on community services**. The report suggests that NHSI and NHSE should do more to recognise and strengthen the role of community health services. This should bring together existing national work streams within a single delivery plan and support local areas to achieve it.

Recommendations

- 1 Learning from new models of care.** NHSE 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. This will involve identifying how to work across STPs and ICSs.

^[1] The review team defined community health services as physical health services delivered in community settings and community hospitals, but not by general practice or acute inpatient services. It includes health services commissioned by local authorities.

^[2] Mental health services were defined as all mental health services including those for children, delivered in the community and in mental health inpatient wards. The review team did not look at learning disability services, but thinks the recommendations can be applied to some of these services.

¹ 2gether NHS FT; Barnet, Enfield and Haringey Mental Health NHS Trust; Birmingham Community Healthcare NHS FT; Central and North West London NHS FT; Central London Community Healthcare NHS Trust; Derbyshire Community Health Services NHS FT; East London NHS FT; Hertfordshire Community NHS Trust; Hertfordshire Partnership University NHS FT; Kent Community Health NHS FT; Lancashire Care NHS FT; Leeds Community Healthcare NHS Trust; Leicestershire Partnership NHS FT; Lincolnshire Partnership NHS FT; Norfolk Community Health and Care NHS Trust; Northumberland Tyne and Wear NHS FT; North West Boroughs Healthcare NHS FT; Nottinghamshire Healthcare NHS FT; Oxford Health NHS FT; South West London and St George's Mental Health NHS Trust; Sussex Partnership NHS FT; Torbay and South Devon NHS FT; Wirral Community NHS FT; other partner trusts.

Quality and efficiency across the pathway

The GIRFT programme will be extended to community health services, in addition to mental health services.

The report recommends that local commissioners, overseen by NHSE, should specify standard response times, including at weekends, for community health providers to support hospital discharges and avoidable admissions. While the implementation of the 5YFV for mental health is developing outcomes standards for a range of mental health conditions, there is a lack of consistent and comparable patient outcomes data for community health services.

The review team believes there is scope to simplify existing commissioning and contracting arrangements, and to standardise service specifications (while some will need to be locally sensitive). NHSI and NHSE should support the development of more contracts with activity or outcome based payment mechanisms, and further develop currencies and payment systems for mental health and community health services.

The review found significant variation in the nursing cost on wards in community hospitals. Greater costs are associated with small and isolated wards. The data indicates that nearly half of patients could have been managed at home with one quarter of beds freed up. Generally, there is a lack of information and clear definition of community hospitals, which raises questions about their role in the system.

Recommendations

- 2 Quality of care and GIRFT.** The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress on 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'.** NHSE should help strengthen commissioning and contracting mechanisms. This should include supporting STPs to work together to develop model frameworks for specifications of community services.
- 4 Restricted patients.** The DHSC, Ministry of Justice and their arm's length bodies should work more closely to improve the administrative management of restricted patients.

Workforce

The report is clear that **workforce is a key driver for efficiency improvements in mental health and community services**, and emphasises the link between productivity and the culture, leadership and staff engagement of organisations.

Mental health and community trust staff report poorer levels of overall satisfaction compared with the acute hospital sector. The report points to good examples of staff innovation within trusts, but accepts that NHSI must speed up shared learning and deliver more support at a national level. The report makes

clear that trusts should have leadership strategies, with trust boards drawing on experience from across the public and private sectors. Training also needs to be offered to staff that move into management.

The review team was struck by levels of bullying, harassment, sickness absence and vacancy rates in these services. Community and mental health trusts on average lose an extra two days per staff member per year to sickness compared to the acute sector. The intensity of work, varied geography, work-life balance and levels of patient acuity are identified as reasons for this disparity. NHSI is now reviewing sickness absence policies and scoping a programme to reduce sickness and absence rates by 1% across the sector.

Staff working in mental health trusts in particular are more likely to experience physical abuse, bullying or harassment. NHSE and NHSI have also set up a pilot programme to reduce violent incidents against staff.

In terms of staff turnover rates, the mental health and community sector performs worse than the acute, with **turnover rates ranging from 9% to 45%**. The report highlights several factors behind these high rates, such as an ageing workforce, national pay policy and access to continuous professional development. NHSI and NHS Employers will be rolling out their retention programme to all mental health and community trusts with high turnover rates. The report recommends that all community and mental health trusts should also have a fully developed retention strategy.

Recommendations

- 5 Optimising workforce wellbeing and engagement:** NHSI should work with all mental health and community trust boards to help improve the engagement, retention and wellbeing of their staff. The report notes that trusts should be reviewing their training offer to explore whether they can adopt more efficient processes to improve staff productivity by spring 2019.

Optimising clinical resources in the community

The report estimates that 70% of mental health and community trusts' clinical work is delivered in the community. It focuses on the productivity of community nursing and adult community mental health services, but states they are representative of other services they examined.

The review found significant unwarranted variation in productivity across trusts, such as the average time clinicians spend with patients ranging from 33% to 80% in community nursing and the number of contacts ranging between 14 to 45 during the reporting period.

Managing productivity

- The review team believes **all providers of community services would benefit from having access to reliable, regular and transparent national benchmarking on workforce productivity.** NHSI should develop the Model Hospital to achieve this. **Further standardisation of the mental health services data set and the community services data set will be needed**, including defining services.

- The report recommends that trusts should ensure they report to all relevant mandatory national data collections by April 2019 and review how they oversee and manage the productivity of community services, and report to their boards by April 2019.

Improving the way services are delivered

- **The review found significant variation in the structure, composition and skill mix of community nursing and adult community mental health teams.** Trusts should review these areas, including referral management and maximise the use of digital technology. The review team estimated that 29% of district nursing services still use predominantly paper-based processes, and electronic patient record systems are often cumbersome.
- The review also found that most **providers still maintain a range of access routes into their services**, resulting in increased administration and poor communication and that on average 16% of mental health appointments are missed, leading to significant waste of clinical capacity and compromised patient outcomes.
- The report recommends that **NHSI should develop guidance on good operating models for services delivered in the community**, starting with community health services, by autumn 2018. All providers should then deliver plans by April 2019 for how to improve service delivery models, including technological improvements and mobile working. **All providers should benchmark their service delivery models against Model Hospital metrics by summer 2019.**

Recommendations

- 6 Strengthening the oversight of workforce productivity for services delivered in the community.** With support from NHSI and NHS Digital, and using the Model Hospital, 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.** Community service providers should increase the productivity of their clinical workforce by improving and modernising their delivery models, through better use of digital solutions and mobile working.

Optimising inpatient services and other clinical resources

Around 30% of clinical spend is on inpatient services in mental health and community services. The report found significant levels of variation in nursing spend per occupied bed across all service lines. **Smaller, more isolated wards have increased safe staffing costs and challenges with recruitment and retention.** While local services play a critical role, the report concludes that they need to be delivered on an appropriate scale.

The care hours per patient day metric (CHPPD) for inpatient services provides a consistent means of interpreting productivity and efficiency. The review team recognises that further work is needed to develop CHPPD to provide a useful resource for trusts, but states their **initial analysis showed no correlation between outcomes (e.g. DTOCs) and staffing levels**, but will continue to review this. The review team also intends to explore acuity further to enhance CHPPD and the analysis of variations.

The report suggests that trusts should review their existing ward structures, and regularly review CHPPD against patient outcomes metrics, and recommends that CHPPD should be collected monthly (beginning April 2018) across all community and mental health inpatient wards. This will include collections on allied health professional CHPPD should be collected monthly from September 2018.

E-rostering

- The review found that **there is 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.**
- **The review found variation in the management of unused hours.** On average, the cohort trusts lost about 3,800 inpatient staff hours each month that were paid for but 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. The report estimates that these unused hours could be costing trusts as much as £70m to £80m per year.
- Learning from the improvement collaborative programme which focused on rostering practices will be shared across mental health and community trusts by summer 2018.
- Trusts should make measurable progress by 2018/19 on implementing an effective roster approval process and tackling areas that require improvement. NHSI should deliver further improvement collaboratives to extend e-rostering to all community services by spring 2019.

Medical staff

- **The review team found variations within and between organisations in medical staff pay spend, medical rostering,** use of e-rostering systems and leave planning, as well as a lack of medical staff productivity metrics that meaningfully reflect the use of doctors' time and their deployment.

Medicines and pharmacy optimisation

- The review team concluded that **pharmacy services are underused** in both community and mental health services, and identified opportunities for streamlining dispensing practices, more pharmacist prescribers, clinical pharmacy staff to provide medicines optimisation, and the implementation of electronic prescribing and medicines administration.

Recommendations

- 8 Cost of inpatient care and care hours per patient day.** NHSI 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. NHSI should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.
- 10 Medical job planning.** NHSI 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.

Non-clinical resources

Although mental health and community trusts operate smaller corporate entities, the spend in these areas benchmarks higher than other organisations. The report suggests that **trusts consider the most appropriate scale of their business functions** as part of the implementation.

Corporate services

- **Mental health and community trusts spend on corporate services is 2% higher than the acute sector.** There may be some justification for this, as mental health and community trusts respond to a larger number of tenders each year, which cost round 2% of annual contract value. However if all mental health and community trusts were able to limit spend to the median level, the sectors would save around £140m per year.
- The review found clear efficiency of scale, with larger organisations spending less on corporate services as a proportion of turnover, and advise all trusts to examine where they can collaborate to standardise and share corporate services, especially for smaller trusts.

Estates and facilities, energy and rationalising estates

- Spend on estates and facilities is worth £1.3bn a year, with costs ranging from 5% to 28% of trust turnover (average 10%). It represents the largest area of non-clinical spend. Some of this variation is warranted due to the dissimilarities of service provision across the sector.
- The review uncovered **unwarranted variation in terms of estates and facilities staffing**, with limited succession planning and extended staff vacancies. There are also opportunities for trusts to improve sustainability and reduce energy consumption.
- The review found that on average 3.7% of space in the community and mental health sectors is left empty, with a further 2.2% underused. In terms of leasing property, the report recommends that NHS Property Services and Community Health Partnerships arrangements should be reviewed.
- The report states that in later 2018 NHSI will support trusts through a 'new-for-old' estate strategy to address issues around the quality of the existing estate. Work also needs to be done to improve estates data collection, as under the current system some smaller sites are not getting captured in estates return information collection returns.
- The report mentions the need to rationalise the estate, within the STP and ICS footprints but provides limited detail on how to do this.

Procurement

- Mental health and community trust spend on procurement is around £970m per year, about 7% of overall expenditure. The review found few trusts switching to products that are equivalent and more cost-effective and urge trusts to use benchmark data. In addition, the report states trusts are not leveraging their buying power or collaborating to secure better prices.

- The largest variation in terms of procurement spend was for business fees, which may include audio visual service fees, courier services, room hire and other building fees, as well as consulting services.
- The review team believe there are a number of common products that should be added to the NHS Business Services Authority's Nationally Contracted Products programme or prioritised for national procurement via the relevant NHS Category Towers.

Recommendations

- 12 Corporate services:** Trusts should reduce variation in the cost of their corporate service functions, and should examine the opportunities to collaborate and share corporate service functions. Trusts need to complete the corporate services opportunity list self-assessment by October 2018.
- 13 Estates and facilities management:** NHSI 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 states and facilities and provide a report to their boards by April 2019. Trusts need to review and identify opportunities for estate consolidation and improved data capture by autumn 2018. In addition to this trusts need to have a sustainable development management plan signed off by their boards by winter 2018.
- 14 Procurement:** Trusts should reduce unwarranted price variation in procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking. All trusts should be using the Purchase Price Index and Benchmarking tool during 2018/19 should achieve accreditation of level 1 of the NHS Procurement & Commercial Strategy by March 2019, with level 2 achieved by March 2020.

Implementation, the Model Hospital and next steps

The report recommends that the Model Hospital tool extend its existing data to incorporate mental health and community trusts (particularly for non-clinical services), and be expanded to include data on clinical services beyond acute hospital settings. Work also needs to be undertaken on the branding of the tool as in its current state community and mental health trusts feel it is focused too much on the 'hospital'. Underpinning these expansions will be increased data submissions, via the Mental Health Services Data Set (MHSDS) and the Community Services Data Set (CSDS) collections. NHSI hopes to incorporate additional metrics on the Model Hospital by April 2019.

Implementing the recommendations of the review will rest on genuine support and expertise, over a prolonged period. The review team accept that progress implementing the recommendations of the original review of acute hospitals has been slow because of a lack of capacity and capability. The report acknowledges the recommendations of the Kirkup review and references the changes to the NHSI operating model. Based on this information, the implementation methodology will be extended for trusts, STPs, ICSs and NHSI.

A review implementation team, within the NHSI operational productivity directorate, will be responsible for tracking delivery of all the report's recommendations. **A universal support offer will be made to all mental health and community trusts.** The team will also look to align its work with NHS Digital and

NHSE, in particular the Five Year Forward View for Mental Health programme, the Hospitals to Home and 'vanguards' teams as well as the data development teams looking to introduce the MHDS and CSDS.

Recommendations

- 15 Model Hospital:** NHSI should develop the current Model Hospital and underlying metrics to ensure there is one repository of data benchmarks and good practice so all trusts can identify what good looks like. Trust boards need to ensure that mandatory data fields are submitted to the minimum datasets.
- 16 Implementation:** Trusts, NHSI and NHSE and others should work together to take the action required to implement these recommendations.

NHS Providers view

We support the focus on efficiency in community and mental health services in this report. By highlighting variation in key areas of spend for the first time, this review presents a new opportunity for trusts providing community and mental health services to improve their productivity, and trusts will welcome this focus.

Overall view

The recommendation that NHSE should share learnings from the successful vanguards is sensible. As the vanguard programme was explicitly aimed at testing new models of care and sharing learning across the country, it is important that lessons can be spread as STPs look to find practical ways of transforming care. System-level working provides an opportunity to apply a degree of consistency and standardisation to community services that has been lacking up till now.

Focusing GIRFT on reducing out of area placements for mental health patients is sensible as this is currently a key challenge for trusts and contributes to poor patient experience. The inclusion of community and mental health services in GIRFT is a welcome – if overdue – recognition that the programme has relevant learnings for community and mental health services, as is the recommendation that the Model Hospital be developed to meet the needs of community and mental health services.

The impact of fragmented commissioning on community mental and physical health services impacts their efficiency and productivity. The transaction costs caused by trusts working with many different commissioners must be reduced, along with the number of performance indicators they are being asked to report on. Standardising and simplifying the commissioning landscape is necessary, although it is important that the national bodies recognise that not all community service providers will run comparable bundles of services, often because of tendering behaviours from commissioners dating back several years which disproportionately affect community services. More strategic STP-level commissioning could reduce this wasteful activity.

The findings on workforce wellbeing and engagement in community and mental health trusts are concerning. While trusts are already working hard to improve these results and many have begun to make

progress, the widespread nature of the problems suggests this issue is a national one. Trusts therefore need to be better supported by the national bodies to implement effective retention programmes that are sector-specific. The review's identification of external factors affecting retention, such as national pay policies and the ageing workforce is helpful.

It is clear more work need to be done to address the unwarranted variation found in corporate services, estates and facilities management and procurement. But the solution to some of these issues will require national leadership, particularly as smaller community and mental health trusts will struggle to make efficiencies of scale.

The recommendation that NHSI provides "bespoke and intensive support offers" for trusts to implement Lord Carter's findings is sensible and recognises the diverse nature of the issues experienced by individual organisations. Trusts that worked with the Carter team to produce this report have said the experience was very positive and constructive. As the programme rolls out more widely it is important that this is preserved. The recommendation to provide a universal offer to trusts via a dedicated implementation team is encouraging, and we hope it will be resourced adequately to enable widespread progress to be made quickly.

Although the report does not explicitly state this, Lord Carter has separately suggested in an [HSJ interview](#) that trusts which run both acute and community services are inherently more efficient than the alternatives. However, we recognise that there are various organisational forms which currently exist, each with their own benefits, and each capable of delivering seamless care as part of a wider system.

Community services

In our recent report *NHS community services: taking centre stage*, we showed that community services have, for many years, had an insufficient profile and lack of priority at both national and local levels. This means the expansion of care in the community has struggled to gain wider momentum, recognition or investment at a local level. One of our recommendations in the report was for greater national leadership for community services to ensure the Five Year Forward View ambitions are realised, and we are pleased to see that the review has also highlighted this gap. Hopefully our report and now this publication represent the beginning of a shift in attitudes.

We have continued to highlight the lack of robust national data, quality indicators and performance metrics, which means that there is less national focus on, and no national improvement approach for, community services. We are pleased to see that the review team have also flagged that a standardised national dataset is necessary if community providers are to properly monitor changes in demand, activity, funding and quality. While the new community services data set is a welcome development, it needs to be refined further to add real value and not add any additional burden on trusts.

Mental health services

In our [report published last year on the state of the mental health provider sector](#), we welcomed the government and national bodies' commitment to address longstanding inequalities in care for people with mental health needs. The increase in funding has started to improve service provision in the targeted areas, but there remains a disparity between these commitments and the deteriorating state of core mental health services.

We have concerns over the focus on variation in care hours per patient day in inpatient mental health and community health settings. In general there seems to be clear recognition that the metric in the report is only for inpatient services, which by the review team's own admission, makes up only 30% of activity in the community sector. This part of the analysis not yet well enough developed to be safely acted upon: while that CHPPD varies between trusts, the report has not demonstrated the extent to which this is unwarranted. Although the report says there is no correlation between CHPPD and rates of readmission, delayed transfers or length of stay, these are very general measures. There may be more specific outcome indicators which better capture the impact of the care given. Because of the highly specialist nature of some mental health services in particular, we do not feel it is safe to generalise about CHPPD for adult acute mental health as a whole. We also note that this is an inpatient services metric – the lack of an equivalent analysis of care hours in other settings, suggests much more work is needed to understand the impact, quality, and efficiency of community and home based care.

NHS Providers press statement

Responding to the Carter report into operational productivity in mental and community health services. Amber Jabbal said:

"These findings highlight many of the concerns we raised this week in our [report](#) on NHS community services.

"Highlighting unwarranted variation in key areas for the first time presents a new opportunity for trusts to improve their productivity and providers look forward to working with NHS Improvement to implement the recommendations

"The inclusion of mental health services in GIRFT is a welcome – if overdue – recognition that this is as important as acute physical health services, and we strongly support the recommendation to extend this to community health services.

"This report is right to draw attention to the complex commissioning and contracting environment, discrepancies in the way performance is measured, and the importance of harnessing IT to provide better care.

"It is also clear – as this report points out – that we need stronger leadership at national level and within STPs and ICSs, to support the work of community services in bridging barriers and delivering new models of care.

"Above all, these services need adequate funding, and action to address staff shortages.

"We need to seize the opportunities presented by the push for integrated care and the Prime Minister's commitment to increase long term health and care funding to make good on past promises, and bring NHS community services centre stage."