Carter Efficiency Guidance
Introduction

This document has been prepared by the specialist teams in NHS Improvement’s Operational Productivity Directorate to help identify recurrent CIP opportunities for you to develop and deliver effective, robust and comprehensive 2019/20 CIP plans. In each of the 11 programmes included, you will find:

• Recent trends including pointers to where the most significant efficiencies have been secured by trusts over the past 18 months. You can use the case studies throughout the guidance which demonstrate the approach to identification and delivery;

• Key success factors and barriers, with examples of how to harness and overcome these respectively; and

• Links to existing guidance materials and tools in each programme.

Please don’t hesitate to contact your Regional Productivity Teams if you wish to discuss any information included in this guide. Contact details are as follows:

North Region: nhsi.northproductivityteam@nhs.net
Midlands and East Region: nhsi.midlandsandeastopprod@nhs.net
London Region: nhsi.londonproductivity@nhs.net
South Region: nhsi.southproductivity@nhs.net
Medical Workforce

Recent Trends

• The current year (grey line in chart) is already more costly than the previous years (red and blue) and the trend is that it will continue in this manner. Year to date (YTD) position is driven by an overspend of trainee grades pay of £99m and consultants pay of £62m through WLI’s (Waiting List Initiatives) and utilisation of temporary staffing.

• YTD medical overspend is understated due to the phasing of the medical pay award in 18/19.

• Medical workforce CIPs have been poorly recorded over the last few years and Trusts are beginning to recognise and own this. This is in part to trusts not having a handle over their demand and capacity and therefore unable to identify the required establishment needed to meet demand. Job planning is the direction that trusts need to be moving and are moving to in order to get to grips with this.

Medical Workforce Operational Development Opportunities for 19/20

Establishment setting tools

• An establishment setting tool should be utilised by trusts, to enable them to identify “what good looks like”.

• Tier systems that have been demonstrated in trusts should be available in conjunction with the optimisation of e-rostering functionality for different professional groups to be co-rostered together.

• Trusts need to consider a workforce model which would describe the capabilities of both doctors and newer roles such as PAs, ACP, ENP, ANP etc.

• Trusts should be utilising a suite of metrics that enables unwarranted variation in productivity and efficiency to be identified

Optimisation of e-job planning and e-rostering

• Trusts should use e-rostering to deliver team e-job plans. Be able to measure that against the Meaningful Use Standards and Levels of Attainment framework.

• Team job planning should reflect the workforce requirements.

• There needs to be a clear link between productivity metrics, workforce planning and quality outcomes identified in facilitating good quality care.

• Trusts should use the establishment tools to convert clinical demand to workforce requirements.
Medical Workforce

Key successes and barriers

• A self-assessment framework (SAF) toolkit has been successful in identifying / confirming the areas of intervention that trusts need to focus on.

• For a copy of the SAF please email nhsiclinicalworkforce@nhs.net

Data cleansing of ESR data

• Working with trusts and the Model Hospital team to firstly understand how the data is entered onto ESR and to be able to reduce the amount of options available on ESR, this therefore steers the trust to be more disciplined in the choices that they make. This work has already commenced and the charts below highlights how important good quality data is. The data is submitted to NHSI via the medical workforce template and this is then compared against the data included on ESR.

• Trusts focusing on improving the quality of data on ESR not only reduces the burden on trusts from the task of endlessly completing spreadsheets, which is an exhausting task, but by using ESR data will provide them with a true reflection of how the trust is performing.

![Chart showing ESR vs Template FTE and Expenditure]
Medical Workforce

Supporting resources provided by NHSI / E

- Establishment Setting
  https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing

  https://www.rcem.ac.uk/docs/Workforce/RCEM%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf

- E-job planning & e-rostering

<table>
<thead>
<tr>
<th>Job Planning</th>
<th>Medium / Longer Term</th>
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<tbody>
<tr>
<td><strong>In year Consideration</strong></td>
<td><strong>Leave Management System</strong></td>
</tr>
<tr>
<td>• All consultant and permanent non-consultant grade (NCG) doctors have a current signed-off job plan aligned with the Trust’s strategic objectives and designed to ensure the delivery of a high quality, 7-day clinical service which is consistent across all trust sites:</td>
<td>• Job planning, e-rostering and Leave management systems should be integrated to allow maximum transparency of where gaps are appearing due to leave and sickness.</td>
</tr>
<tr>
<td>• Planned activity is captured broken down to Direct Clinical Care (DCC) &amp; Supporting Professional Activity (SPA).</td>
<td>• Enforce 6 week minimum notice for annual leave to avoid unnecessary cancellation of clinical activity.</td>
</tr>
<tr>
<td>• Establish percentage of consultants with an active, signed-off job plan.</td>
<td>• Trust to utilise 4 week rotas, published at least 6 weeks in advance, to ensure timely sign off to reduce the use of agency and better accommodate staff requests for flexibility.</td>
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<tr>
<td>- Maintain, or increase, to the 90% benchmark that NHS Improvement has set.</td>
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<tr>
<td>- Annual job planning review in place.</td>
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<tr>
<td>- Job Planning Consistency Committee meet on a monthly basis.</td>
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<tr>
<td>• Annualised team job planning review in place.</td>
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<tr>
<td>• Job plan is aligned to GIRFT (Getting It Right First Time).</td>
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<table>
<thead>
<tr>
<th>E-rostering</th>
<th>Appraisal System</th>
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<tr>
<td><strong>Medium / Longer Term</strong></td>
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<tr>
<td>• All medical rotas (Non-consultant grade and Consultants) are managed using an e-rostering system to ensure visibility of workforce deployment and rota gaps.</td>
<td>• Robust appraisal system is in place to ensure all the workforce have achieved the goals for the year, and allow goal setting for the next year, including expected levels of clinical activity (e.g. OPAs, Theatre cases etc) for each DCC session.</td>
</tr>
<tr>
<td>• Ensure effective rostering is in place and demonstrate that its use can ensure the right team/personnel with the correct skill are available to patients when and where they are needed i.e. a rota is provided timely and job plan is in place for NCG doctors.</td>
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<table>
<thead>
<tr>
<th>Productivity</th>
<th>Establishment Setting</th>
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<tbody>
<tr>
<td><strong>In year Consideration</strong></td>
<td></td>
</tr>
<tr>
<td>• Review medical staffing efficiencies using Model Hospital metrics such as WAU/DCC, DCC/FTE and Cost/WAU.</td>
<td>• Medical CIPs plan are identified and signed off by medical director. Monthly validation of CIP delivery against plan and ensure Medical CIPs are categorised correctly.</td>
</tr>
<tr>
<td>• Investigate negative variation to determine if it is warranted which may present an potential opportunity for efficiency gains.</td>
<td>• Medical rotas are reviewed regularly and identify areas for focus by the highest use of temporary staff.</td>
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<table>
<thead>
<tr>
<th>Extra Duty Payments</th>
<th>Agency &amp; Bank</th>
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<tr>
<td><strong>In year Consideration</strong></td>
<td><strong>Medium / Longer Term</strong></td>
</tr>
<tr>
<td>• Review level of payment offered for extra-contractual sessions, and align with other trusts in your STP.</td>
<td>• Planned activities (DCC and SPA) are reported to ensure the clinical services are met with no or minimum use of Locum and agency staff.</td>
</tr>
<tr>
<td>• Ensure no EDP payments are made unless additional hours are worked i.e. no EDP payments for undertaking clinical activity during timetabled SPA sessions.</td>
<td>• Review recruitment processes, establish and promote internal banks. Improve fill rate of vacant shifts through in-house medical bank.</td>
</tr>
<tr>
<td>• Establish appropriate governance for approval of EDP payments (likely to be &gt;£100 p.h.).</td>
<td>• Review pay rates for bank shifts to ensure they adequately incentivise bank over agency.</td>
</tr>
<tr>
<td>• A robust plan in place to reduce Extra Duty Payments across the Trust for both consultants and NCG.</td>
<td>• Ensure board accountability for temporary staffs spend is clearly defined and adequate management resources are allocated.</td>
</tr>
</tbody>
</table>
Recent Trends
The national picture over the last 12 months shows continued overspend on nursing pay, in the region of £280m above plan. There is a need to ensure the permanent workforce is deployed productively to maximise availability and ensure additional spend on temporary staff is reduced. Over the last 12 months this has continued to rise with a circa £104m increase from previous year. It is widely recognised that the overspend is caused by high vacancy rates, with over 40,000 nursing roles being vacant, as well as the impact of the 18/19 Agenda for Change pay award. Therefore focus on retention of existing staff and optimum use of e-rostering and e-job Planning is crucial. The use of evidenced based safe staffing establishment settings and the metric of Care Hours Per Patient Day (CHPPD) should be used to regulate and manage deployment.

<table>
<thead>
<tr>
<th>Optimal use of E-Rostering and E-Job Planning Tools</th>
<th>Use of Model Hospital and Productivity Metrics Cost per WAU and CHPPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensuring 4-week rota is approved and published 6-8 weeks in advance, with aim to extend to 12 weeks, KPIs and e-rostering metrics should be reviewed monthly and reported at Board level.</td>
<td>• Consider Nursing and Midwifery cost per WAU on Model Hospital compared to national averages as well as at ward level with selected comparable units. Unexplained negative variation will need investigation to determine if this is warranted. If found to be unwarranted, this may present a potential opportunity for efficiency gains.</td>
</tr>
<tr>
<td>• Net Hours - Ensure systems and processes are in place to regularly track and monitor the contracted hours worked over or not worked, with transparent process and policy for follows-on actions e.g. recovery, restriction on bank shifts or overtime payments where hours are owed.</td>
<td>• Consider Model Hospital CHPPD data at ward level and capture the CHPPD available on the roster against budgeted CHPPD (per establishment) and also required CHPPD (using evidence-based patient acuity / dependency models) on a daily and basis as a transparent basis for levelling and redeploying staff across wards in response to safety and quality of care.</td>
</tr>
<tr>
<td>• Monitoring the unavailability of staff in relation to additional spend on temporary staff to fill gaps and in addition flexible patterns to support work life balance. This should also be reviewed at 6 monthly intervals.</td>
<td>Management of Enhanced Care Additional Staffing</td>
</tr>
<tr>
<td>• CNS e-job planning should demonstrate efficiencies across services and pathways and complement other professional groups e-rostering or e-job plans. Job planning related CIPs are more likely to be as a result of improved tariff remuneration and increased clinical capacity as opposed to any pay reducing activity.</td>
<td>• Ensure systems and processes such as enhanced care needs assessments are in place to ensure evidence-based assessment of clinical need and workforce deployment required.</td>
</tr>
<tr>
<td>• Assessment of use of both e-rostering and e-job Planning should be measured against the Meaningful Use Standards and Levels of Attainment framework.</td>
<td>• Robust early approvals process for additional staffing and to optimise deployment opportunities.</td>
</tr>
<tr>
<td></td>
<td>• Monitoring of demand and types of enhanced care additional staffing required to inform establishment reviews and local workforce deployment arrangements.</td>
</tr>
</tbody>
</table>
Nursing Workforce

Key success factors and barriers
- Evidence based establishment setting (safe staffing) is paramount to ensure e-rostering templates ultimately reflect the patient acuity and dependency, ESR and the financial resource required to ensure staffing is available to meet clinical demand, to ensure CHPPD can be used effectively as a metric to support workforce deployment.
- E-rostering KPIs need to be understood and embedded from ward to board to maximise the efficiency of the clinical workforce.
- Converting the use of temporary staffing from agency to bank offers significant improvement to patient safety, staff wellbeing and workforce retention, whilst reducing excessive financial spend.
- CHPPD needs to be understood and embedded particularly at ward level to provide assurance at board level of variation between wards, clinical specialties and peer trusts.
- CHPPD should be used alongside clinical quality and safety outcomes measures.

Nursing Productivity Opportunities for 2019/20
- Reduction in bank and agency spend through effective workforce deployment created by optimal use of e-rostering and e-job planning tools.
- Alignment of non-ward-based roles to better understand how roles such as Advanced Nurse Practitioner, ACPs, APs, CNSs fit into care pathways, how they provide value and explore how job planning can optimise these roles.

Long Term Plan
NHS Improvement’s Retention Collaborative has already delivered substantial measurable improvements through targeted support for trusts with high turnover. We will extend this support to all NHS employers, and NHS Improvement is committed to improving staff retention by at least 2% by 2025, the equivalent of 12,400 additional nurses.

Over the next two years we will focus on ten priority areas as part of a strengthened efficiency and productivity programme by improving the availability and deployment of the clinical workforce to ensure the right clinicians are available to patients at all times and further reducing bank and agency costs. By 2021, all clinical staff working in the NHS will be deployed using an e-roster or e-job plan. By 2023, all providers will be able to use evidence-based approaches to determine how many staff they need on wards and in other care settings. This will provide staff with opportunities for flexible working while helping reduce unwarranted variation and improve safety.
Nursing Workforce

Supporting resources provided by NHSI / E

- CHPPD
  https://improvement.nhs.uk/resources/care-hours-patient-day-guides/

- E-rostering
  https://improvement.nhs.uk/resources/rostering-good-practice/

- Model Hospital Webinars
  http://feedback.model.nhs.uk/knowledgebase/articles/1846981

- Retention Programme
  https://improvement.nhs.uk/resources/improving-staff-retention/
Allied Health Professionals Workforce

**Productivity Opportunities**

- **Integrating acute Physio and OT services** should be a priority for trusts that have not yet done this.
- **Caution must be exercised** when identifying opportunities from the Model Hospital AHP data – reasons for high AHP spend could be:
  1. Advanced AHPs are already deployed into consultant clinics,
  2. the trust hosts AHP services on behalf of another trust (often this is the case for Speech & Language therapists that incidentally are more expensive than other AHP professions as they did well out of AfC review / banding).
  3. trusts have already ‘invested’ in AHPs to create gain share CIPs across divisions. E.g. creating front of house AHP teams to prevent unnecessary admissions.

- Trusts should consider their AHP CIPs in the context of workforce redesign rather than cutting workforce (e.g. not filling vacancies). There are examples of successful ‘gainshare’ CIPs where AHP services have been invested in to reduce overall length of stay, or to substitute consultant / doctor time.
- Trusts should be looking at reviewing capacity and demand for diagnostic image reporting and using Radiographers and Sonographers to supplement Radiologist reporting where they have suitably trained staff. This may enable a cash-releasing saving through reduction in requirements to outsource excess demand or reducing medical agency or premium cost WLI spend.
- Trusts should look at the options to deploy Assistant Practitioners to support the acquisition of diagnostic images, releasing registered Radiographers to work at the top of their licence.
- All AHPs services should implement job planning to their AHP services. Early examples of trusts that have done this shows that efficiencies have been found which increased clinical capacity (and therefore has potential to reduce (AHP) unmet need and reduce LoS)
Recent Trends
The cost of delivering pathology in trusts that have not networked services continues to be higher than what can be expected from a fully consolidated network service. Networks that have fully consolidated services have seen the overall cost per test drop considerably as the benefits of consolidation are realised. There continues to be pressure upon the workforce leading to activity being outsourced to other providers, normally at a higher rate. Nationally, agency spend is high and Trust bank is under-utilised in this area, with an estimated £20m savings possible by removing agency spend and converting staff onto an internal staff bank. Trusts are making progress:
- The first tranche of networks are in operation.
- Almost half of the proposed networks have delivered to NHS Improvement Strategic Outline Cases and over a third are working up Outline Business Cases as they progress towards forming pathology networks.
- Networks that are in the process of conducting joint procurement activities are anticipating significant recurrent savings delivered to each partner, together with other efficiencies driven through use of the same equipment across the network that will be delivered through common SOPs and training pathways for staff. In one example we have seen circa £350,000 savings per annum with an overall saving of £25m over the life of the contract.

Networking
Networking is a multiyear programme however there are a number of areas that trusts can concentrate on that do not detract from networking and proactively drive forward this strategic direction (see Productivity Opportunities for 2019/20 – Grip and Control).
- Reviewing staff skill mix, including looking at advanced and extended roles.
- Working with network partners to harmonise contracts and vendors to buy at scale.
- Review services provided against long term strategy to understand investment versus efficiency opportunities.

Key success factors and barriers
The main success criteria for ensuring pathology services deliver the long term strategic and the short term efficiency is executive engagement.
- The most important factor for trusts to remember is that cost improvements can be realised in year as services progress toward consolidated networked services, however, these need to be aligned to the networking agenda and not focus on short-term plans that will ultimately elongate the timeline for delivering a network. It is important that trusts work collaboratively with network partners.
- Approximately 40% of acute trusts in England do not report pathology CIPs. Regional leads report that all the Acute pathology services have CIPs based on visits to laboratories. This is a classification issue that needs rectifying and trusts to report all their pathology CIPs for FY 2019/2020.
### Pathology – Efficiency Actions (Jan ‘19)

#### In year consideration

<table>
<thead>
<tr>
<th>Rapid actions</th>
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<tbody>
<tr>
<td>- Consolidate referral activity to a single diagnostic provider.</td>
</tr>
<tr>
<td>- Review service contracts – Level of cover versus clinical requirement.</td>
</tr>
<tr>
<td>- Review logistics - operational delivery and contracting arrangements.</td>
</tr>
<tr>
<td>- Business cases and Capex review.</td>
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<tr>
<td>- Demand management of testing – RCPath/IBMS/ACB guidance.</td>
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#### Governance & comms

<table>
<thead>
<tr>
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<td>- Ensure all R&amp;D activities are funded and appropriately priced.</td>
</tr>
<tr>
<td>- Sale of old equipment.</td>
</tr>
<tr>
<td>- Asset review. Consolidation on technology type across disciplines.</td>
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#### Inventory Management

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<th>Pay cost actions</th>
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<tbody>
<tr>
<td>- Reduce reliance on agency / locums.</td>
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<tr>
<td>- Review Out of hours arrangements where they are outside of AFC.</td>
</tr>
<tr>
<td>- Review sample delivery time to reduce out of hour staffing requirements.</td>
</tr>
<tr>
<td>- Review Consultant Job plans.</td>
</tr>
<tr>
<td>- Increase staff availability – remote and flexible working.</td>
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<tr>
<td>- Improve staff retention – Training &amp; Development.</td>
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<th>Non-pay / all cost actions</th>
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#### Procurement

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<tr>
<th>Networking</th>
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<tbody>
<tr>
<td>- Consolidaing pathology services allows for the most consistent, clinically appropriate turnaround times, ensuring the right test is available at the right time. It also makes better use of our highly skilled workforce to deliver improved, earlier diagnostic services supporting better patient outcomes.</td>
</tr>
<tr>
<td>- Taking a hub and spoke approach to this consolidation can ensure an appropriate critical mass to support specialist diagnostics, so that patients have equal access to key tests and services are sustainable.</td>
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### Networking / Collaborative Opportunities

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#### Pay cost actions

<table>
<thead>
<tr>
<th>Cash Management</th>
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</thead>
<tbody>
<tr>
<td>- Governance and cash management – PO or approved testing request route only.</td>
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<tr>
<td>- Capital and assets opportunities.</td>
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</table>

#### Non-pay / all cost actions

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>- Adoption of just in time stock management.</td>
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<tr>
<td>- Introduction of automated stock management systems to meet accreditation requirements and reduce staff time.</td>
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<tr>
<td>- Removal of ad-hoc deliveries via improved stock management.</td>
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#### Governance & comms

<table>
<thead>
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<tbody>
<tr>
<td>- Clear delivery plan on and around consolidation.</td>
</tr>
<tr>
<td>- Engage staff and key stakeholders, particularly Clinical users.</td>
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<tr>
<td>- Clinical need rather than clinical want.</td>
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</table>
Supporting resources provided by NHSI / E
The NHS Improvement Pathology programme have produced a number of resources that can support trusts and networks in understanding where opportunities can be derived.

- Pathology programme Detailed Guidance
  [https://improvement.nhs.uk/resources/pathology-networks/](https://improvement.nhs.uk/resources/pathology-networks/)

- Emerging Network Toolkits
  [https://improvement.nhs.uk/resources/pathology-networks-toolkit/](https://improvement.nhs.uk/resources/pathology-networks-toolkit/)

- National & Regional Teams
  Regional and National pathology teams are on hand to support trusts in reviewing plans to ensure they are appropriate which will increase chance of successful delivery.
Recent Trends
Delivering imaging services in trusts continues to rely on an increasing spend on ‘outsourcing’ (Independent sector providers) and ‘insourcing’ (use of extra sessional payments), to meet the capacity shortfall. This increasing spend is not sustainable in the longer-term due to increasing costs, with vacancy rates remaining high (12.5% Consultant Radiologists, 15% radiographers).

- Some imaging departments are beginning to organise themselves into Imaging Networks, setting up programme structures and rudimentary governance structures to begin working as a network and gain benefits. Most networks have come together to gain benefits from a joint procurement, to replace their existing PACS systems and have started to recognise and look for wider benefits of working together across a number of areas (Workforce, Capital Equipment, Training opportunities, ISAS accreditation). Some networks have been successful in gaining funding for an IT platform that will allow image sharing and offer them the opportunity of joint backlog reporting or shared reporting gains. Most of this funding has been secured through either Cancer Transformation Funds or STP Transformation Funds, however, this funding is not universal and large parts of England do not have funds to procure a technical solution. Where technical solutions have been acquired, there have been some benefits of joint backlog reporting securing savings over outsourcing solutions.

- NHS Digital are developing a Toolkit to support networks through the technical procurement process to ensure an optimum image sharing solution, based on the experience of networks to date. This is due for completion in Spring 2019.

- There continues to be significant workforce challenges, with high vacancy rates, however skill mix remains variable with the percentage of plain x-rays being reported by advanced practice radiographers varying from 80% to 0%. Backfill to replace radiographers undertaking advanced roles remains a challenge and Assistant Practitioner roles remain low. Challenges accessing appropriate training for this staff group, and access to funding for training remain an issue. The apprenticeship levy may offer some opportunity.

- Radiography academies / multidisciplinary radiology academies have offered opportunities to increase skill mix by training cohorts of staff to develop reporting skills as Advanced Practitioners. Innovation in new pathways for suspected lung cancer have had success in some trusts and are starting to be adopted in others.

- Some networks have started to work together on shared reporting networks for on call, to increase the availability of radiologists available during the day and to increase training opportunities.
### Networking

Networking is a long-term, multiyear programme however there are a number of areas that trusts can concentrate on that do not detract from networking and proactively drive forward this strategic direction (see Productivity Opportunities for 2019/20)

- Reviewing staff skill mix, including looking at advanced and extended roles.
- Working with network partners to agree clinical pathways and protocols (and reduce duplication / repeats).
- Reviewing capital replacement requirements and understand where ‘economies of scale’ can be leveraged (utilising Category Tower 7 – NHS Supply Chain).
- Negotiating ‘outsourcing’ contracts at scale, by agreeing multisite deals and planning for known capacity shortfalls.

### Key success factors and barriers

The main success criteria for ensuring imaging services deliver the long term strategic direction of imaging networks and the short-term efficiency gains is executive engagement. The Strategic Plan for Imaging is yet to be published, however, there is a commitment to Imaging Networks by 2023 in the NHS Long-Term Plan.

- Trusts will be able to deliver cost improvements in year as services progress towards imaging networks, with ‘economies of scale’ being offered by collaborative working, procurement and training. Any local CIPs will need to be aligned to the networking agenda and not short-term plans that could cause challenges for delivering a network. It is important that trusts work collaboratively with network partners, particularly when considering PACS / RIS and image sharing solutions for the next 10 years.

- Classification of CIPs for Imaging are not yet clear with pathology and imaging opportunities only being identified separately this year. Work needs to be done in identifying where imaging spend is accounted for in ‘outsourcing’ and ‘insourcing’ budgets, so that these can be transparent.

- Information submitted for national data collections such as the DID (Diagnostic Imaging Dataset) and the DM01 through information departments should be ratified with imaging departments to improve data accuracy.
# Imaging - CIP opportunities (Jan ‘19)

## Cash releasing / In year consideration

- Understand where sourcing / outsourcing spend is accounted in your budget and track alongside demand (overtime, locum, WUJ).
- Implement an annual leave policy (monitor compliance).
- Review “on call” or out of hours arrangements (could shift systems offer improved cover).
- Review staff availability and flexible working arrangements (e.g. 3 long days, reporting from home).
- Use “retire and return” to retain skilled staff at the end of their career.
- Review job plans for Consultant Radiologists and advance practice radiographers to ensure any shortfall in reporting capacity is understood and planned for.
- Re-negotiate outsourcing contracts in a planned / effective way. Utilise economies of scale across sites.
- Review use of advanced practice radiographers to ensure appropriate utilisation of their skill set and attendance at appropriate MDT, audit etc.
- Encourage multidisciplinary working to ensure advance practice skills are developed and maintained while appropriate review and supervision is undertaken.
- Consider tasks and opportunities for assistant practitioners to release radiographers for advanced practice roles (some plain x-ray or theatre). Scope of practice and supervision must be clear.
- Access the apprenticeship levy to support the development of assistant practitioners and new support roles.

## Longer Term Considerations

- Offer patients a choice of appointments (not next available slot) by partial booking.
- Offer pre-assessment or telephone triage/ support for more complex procedures (IR) or complex conditions.
- Consider having x-ray booking clerks in high volume clinics (to agree appointments before the patient leaves clinic and minimise DNA rates).
- Consider dedicated lists for patients with high DNA rates or incomplete studies (anxiety to MRI).

## Networking / Collaborative Opportunities

- Review opportunities for cost effective replacement through NHS Supply Chain to gain economies of scale or cheaper financing options.
- Optimise capital replacement opportunities across multiple trusts in an imaging network (incl PACS / RIS).

## Protocols & Pathway Management

- Agree referral protocols for defined care pathways and use clinical decision support to improve the appropriateness of referrals.
- Monitor inappropriate referrals and provide feedback.
- Agree standardised scanning protocols for the same type of scans both within the organisation and for tertiary transfers e.g. Neuro, cancer.
- Work with commissioners to review opportunities to deliver system wide efficiencies.
- Agree network wide protocols to enable easier shared reporting and reduced repeats, reduce risk.

## Booking & Admin Procedures

- Use intelligent reminder services (txt, appropriate calls, artificial intelligence for those most likely to DNA).
- Use appropriately trained staff to protocol and vet requests (justification must follow IR/(ME)R guidance).
- Make a decision on who will manage the booking and protocol.

## Pay Cost

- Ensure that savings on consumables and contrast agents are attributed to Imaging departments.
- Ensure staff groups such as “sonographers”, “mammographers” are appropriately coded to imaging where they are not obviously radiographic posts.
- Ensure staff are accurately coded within ESR to ensure financial and workforce planning is informed by accurate workforce data including support staff.
- Work with information departments to agree and sign off DID and DM01 returns. Be clear on how activity data is counted.

## Coding & Classification of CIP

- Ensure the age of capital assets (asset register) is understood by the trust board and any risks of using older equipment are documented.
- Have a capital replacement plan agreed and contingency plans for sudden outage.
- Review opportunities for cost effective replacement through NHS Supply Chain to gain economies of scale or cheaper financing options.

## Capital Equipment

- Review opportunities for cost effective replacement through NHS Supply Chain to gain economies of scale or cheaper financing options.
Supporting resources provided by NHSI / E

The NHS Improvement Imaging programme will be publishing the proposed Strategy for Imaging (including Imaging Networks) in Spring 2019. The resources to support its adoption will be:

- A Toolkit for procuring an Image Sharing Solution (In development with NHS Digital)
- A resource plan for Imaging Networks (to support set-up and infrastructure)
- A proposed programme of supportive workshops to share best practice and identify ‘barriers to change’ – A National Development Programme
- A Leadership Development Programme (for identified network leads)
- Regional and National imaging teams are on hand to support trusts in reviewing plans to ensure they are appropriate and will increase their chance of successful delivery
- Case studies can be found below.
Hospital Pharmacy & Medicines Optimisation

Recent Trends
The significant volume of CIP delivery is routinely from medicines management, with the data tracked in the Model Hospital via the Top 10 Medicines metrics. However, several additional CIP initiatives are delivered by provider trusts (see CIP Opportunities slide below) these can be split into cash releasing, longer term and workforce related initiatives.

Key success factors and barriers
- Trusts achieve best success through detailed and tracked 'CIP Pipeline' work.
- Collaboration with finance and clinical teams is crucial.
- Exec oversight and reporting lines provide the necessary scrutiny and accountability. Assessment of use of both e-rostering and e-job Planning should be measured against the Meaningful Use Standards and Levels of Attainment framework.

Productivity Opportunities for 2019/20
- The slide below sets out the CIP initiatives we believe are prudent for 2019/20 these are categorised into the following areas:
  - Price & Coding
  - Stakeholder Management & Comms
  - Pay cost actions
  - R&D and Aseptics
  - Contracts & SLAs
  - Medicines
  - Work with Commissioners
  - Cash Management

Supporting Resources
- A template has been developed for trusts to adapt and track each suggested CIP initiative. We have seen this work well in a number of trusts, providing a RAG status for each initiative and highlighting opportunities for CIP pipeline work, the template can be found below.

- The Hospital Pharmacy and Medicines Optimisation Self-Assessment Framework (below) has been developed to help NHS trusts review their approach to medicines optimisation.

- A number of webinars / workshops are being planned during the CIP planning process, hosted by the NHSE-I Regional Pharmacists, further details to follow.
## Hospital Pharmacy and Medicines Optimisation (Jan ‘19) – CIP opportunities

<table>
<thead>
<tr>
<th>Price &amp; Coding</th>
<th>Stakeholder management &amp; comms</th>
<th>Pay cost actions</th>
<th>R&amp;D and aseptics</th>
</tr>
</thead>
</table>
| • Assurance Patient Access Scheme price arrangements in place – reimbursement sought for any overpayment  
• Ensure re-charging for all pass through medicines is robust.  
• Process for monthly tracking of off-contract claims.  
• Accurate coding of medicines. | • Clear monitoring of implementation of Hospital Pharmacy Transformation Plan.  
• Engage pharmacy & organisation staff and key stakeholders (e.g. STP leadership).  
• Senior clinical engagement focusing on prescribing efficiencies. | • Plan to e-rostering workforce.  
• Increase number of prescribing pharmacists.  
• Improve staff retention – Training & Development. | • Ensure all R&D including clinical trials are appropriately priced and fully funded (including non-commercial trials).  
• Purchasing agreements in place for best value consumables including dispensing & aseptics. |

<table>
<thead>
<tr>
<th>Contracts &amp; SLAs</th>
<th>Work with commissioners</th>
<th>Cash management</th>
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</table>
| • Review service contracts in all areas to provide assurance of VFM including supply & educational input.  
• Ensure charging structure in all SLAs covers full costs of service not just salaries.  
• Local purchasing agreements for all medicines not on regional/national contracts. | • Process in place to plan for patent expiries and immediate uptake of new contract waves.  
• Assurance of full coverage of Bluteq prior approvals.  
• Check pharmacy stock levels are appropriate and cannot be reduced.  
• Remove ad-hoc deliveries through improved stock management.  
• Robust oversight of use of unlicensed products. | • Governance and cash management – PO or approved use route only.  
• Monthly tracking of medicines waste and review.  
• Monthly validation of medicines CIP delivery against plan. | • Capital and assets opportunities including review of asset registers & capital charging. |

### Workforce / Pay / On-going work with commissioners

- Clear monitoring of implementation of Hospital Pharmacy Transformation Plan.
- Engage pharmacy & organisation staff and key stakeholders (e.g. STP leadership).
- Senior clinical engagement focusing on prescribing efficiencies.

### Pay cost actions

- Plan to e-rostering workforce.
- Increase number of prescribing pharmacists.
- Improve staff retention – Training & Development.

### R&D and aseptics

- Ensure all R&D including clinical trials are appropriately priced and fully funded (including non-commercial trials).
- Purchasing agreements in place for best value consumables including dispensing & aseptics.

### Contracts & SLAs

- Review service contracts in all areas to provide assurance of VFM including supply & educational input.
- Ensure charging structure in all SLAs covers full costs of service not just salaries.
- Local purchasing agreements for all medicines not on regional/national contracts.

### Work with commissioners

- Process in place to plan for patent expiries and immediate uptake of new contract waves.
- Assurance of full coverage of Bluteq prior approvals.
- Check pharmacy stock levels are appropriate and cannot be reduced.
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### Cash management

- Governance and cash management – PO or approved use route only.
- Monthly tracking of medicines waste and review.
- Monthly validation of medicines CIP delivery against plan.

### R&D and aseptics

- Ensure all R&D including clinical trials are appropriately priced and fully funded (including non-commercial trials).
- Purchasing agreements in place for best value consumables including dispensing & aseptics.
Recent Trends

For 2018/19 year to date, up to and including M08, CIP delivery in the Ambulance Sector for areas related to the Carter work on unwarranted variation equates to £30.2m, £2.4m (7.5%) less than plan, with overall savings for the year planned to be £55m. Although this is still under plan cumulatively, M08 showed a significant improvement in CIP delivery with November savings being 2% above plan.

This improvement was caused by significant savings in Procurement (£1.6m and 76% above plan) and AHP Workforce (£0.98m and 93% above plan). Overall, CIP delivery in the Ambulance sector has been better than in some other sectors. In terms of expenditure, year to date for 2018/19, spend was £1.7bn, £31m (2.0%) more than plan which is broadly in line with expectations. The largest two areas of CIP delivery are in Workforce Other (43% of total), month 8 – under plan by 10% - and Workforce AHP (20% of total), month 8 – over plan by 44%.

Key success factors and barriers

In 2018/19 areas which have enabled trusts to achieve different levels of progress in productivity include:

- Fleet modernisation and upgrade
- Implementation of make ready systems which maximises clinicians time with patients

Implementation Barriers have included:

- Poor staff engagement
- Complex operating models
- Aging fleet and infrastructure
- Lack of system interoperability, e.g. computer aided dispatch (CAD) systems

Unwarranted Variations in the Ambulance Sector


Productivity Opportunities for 2019/20

Some key opportunities for the Ambulance sector outlined in the Long Term Plan include the following:

- “1.22. ... Introduced new standards for ambulance services to ensure that the sickest patients receive the fastest response, and that all patients get the response they need first time and in a clinically appropriate timeframe”
- “1.27. ... We will work with commissioners to put in place timely responses so patients can be treated by skilled paramedics at home or in a more appropriate setting outside of hospital. We will implement the recommendations from Lord Carter’s recent report on operational productivity and performance in ambulance trusts, ensuring that ambulance services are able to offer the most clinically and operationally effective response. We will continue to work with ambulance services to eliminate hospital handover delays. We will also increase specialist ambulance capability to respond to terrorism. Capital investment will continue to be targeted at fleet upgrades, and NHS England will set out a new national framework to overcome the fragmentation that ambulance services have experienced in how they are locally commissioned.”
Productivity Opportunities for 2019/20 cont

- “1.33. … We will develop an equivalent ambulance data set that will, for the first time, bring together data from all ambulance services nationally in order to follow and understand patient journeys from the ambulance service into other urgent and emergency healthcare settings.”

Supporting resources provided by NHSI/E

For support from the Ambulance Productivity team in the Operational Productivity Directorate of NHS Improvement, please contact: nhsi.nhsiambulanceproductivity@nhs.net

For the NHS England Ambulance team please contact: england.ambulance@nhs.net
Recent Trends
For 2018/19 year to date, up to and including M08, CIP delivery in the Mental Health and Community Sector for in areas related to the Carter work on unwarranted variation totalled to £136m, £40m (23%) less than plan overall (£292m). Although this is under plan, this is broadly in line with expectations.

In terms of expenditure, year to date for 2018/19, spend as of M08 was £9.8bn, which is £37m over plan for Community and £168m over plan for Mental Health.

Recent Productivity Gains
The largest areas of productivity gains YTD for both the Mental Health Sector are both in Corporate and Admin (91% YTD cumulative CIP delivery for Mental Health and 99% YTD cumulative CIP delivery for Community).

Key success factors and barriers
In 2018/19 areas which have enabled trusts to achieve different levels of progress in productivity include but are not exhausted to the following:

- Focus on staff well-being and engagement in delivering major transformative projects. Using enabling factors such as technology, mobile working as opportunity to give staff greater flexibility in the way they deliver their work thus not only achieving efficiency objectives but improving engagement scores and reducing sickness absence levels.

- Introducing interventions and making changes that target specific system impact that has to be achieved and can be measured, e.g. changing the way services are delivered to specific cohorts of population/patients/service users and monitoring the effect on key outcomes such as admissions, out of area placements, A&E attendances, etc., and then scaling up success.

- Utilising the potential of analytics and BI for knowing own data and using that to drive identification and monitoring of improvement opportunities, e.g. using e-rostering data analysis to identify unused hours.

Key success factors and barriers cont
- Maximising self-management to reduce demand

Specific barriers
- Avoid unrealistic expectations and pressures for benefits realisation in major transformative projects

- Disconnect and failure to address human factors and change business process when deploying new technologies

- Poor availability and quality of data

- Inadequate capacity in central and regional NHSI structures hinder identification and spread of good practice

Unwarranted Variations
Other factors are outlined in the Carter report on unwarranted variations in the Mental Health and Community sector, published in May 2018:

https://improvement.nhs.uk/documents/2818/20180524_NHS_operational_productivity_-_Unwarranted_variations_-_Mental....pdf
Some key opportunities outlined in the Long Term Plan include the following:

- “3.100. Specific waiting times targets for emergency mental health services will for the first time take effect from 2020”.

- “1.8. Extra investment and productivity reforms in community health services will mean that within five years all parts of the country will be expected to have improved the responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate. In addition, all parts of the country should be delivering reablement care within two days of referral to those patients who are judged to need it. This will help prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital to community”.

- “6.17.iv. The NHS will improve efficiency in community health services, mental health and primary care, which together cost around £27 billion a year. This Long Term Plan sets out the new investment we will make to improve these services. We will also support staff to increase the amount of time they can spend with patients to reduce the unacceptable variation as, for example, documented in Lord Carter’s review of community services. To enable this, over the next three years, we want all staff working in the community to have access to mobile devices and digital services as set out in Chapter Five. Ambulance services will be able to reduce avoidable conveyance to A&E by accessing patients records, alternative services and have the right clinical support and training.

we will also ensure primary care networks can be most effective by introducing extended roles such as physiotherapists, clinical pharmacists and pharmacy technicians as set out in Chapter One. The GIRFT programme has already started work in mental health and will be extended across to community health services and primary care from April 2019”.

**Supporting resources provided by NHSI/E**

For support from the Sector development team in the Operational Productivity Directorate of NHS Improvement, please contact: nhsi.sectordevelopment@nhs.net
### Recent Trends

The 17/18 ERIC data showed that Estates and Facilities (E&F) running costs were £360/m², up by £19/m² from 16/17. Variation is at £617/m² a 29% reduction from previous years with the Max: £769/m² Min: £152/m². For the Carter targets of non-clinical space (35%) and empty space (2.5%), achieved 33.9% for non-clinical space and 2.3% for empty space. Occupied Floor Area is 24.5m sqm and the reported number of sites 8,253 up by 2,572. The cost per Attendance is £73.15/attendance and attendance per sqm at 4.92m². There has been an increase in Critical Infrastructure Risk £3,067M and Non-Critical Infrastructure Risk £2,893M for Back Log Maintenance Model Hospital usages for FY 18/19 (as at Jan) is 6,330 user days, with 400 visits to the E&F opportunity page. Trusts are forecasting E&F cost efficiencies of £199m for FY end 18/19, that is a £10m increase on what was delivered in 17/18, an increase of 5.3%. Trusts are underperforming on recurrent (R) schemes and overperforming on non-recurrent (NR) schemes, with (NR) schemes being used to close the gap on (R) schemes, this may lead to an ongoing problems where trusts need to find recurrent element the following year.

### Key success factors and barriers

#### Success Factors:
- For 17/18 Trusts overachieved on the plan of £162m and achieved £183m. This was determined through evaluation of the programme following its completion, and it is important that future programmes provide the visibility of the plan and achievements in a much clearer way.
- Direct engagement between NHSI Estates and Facilities team and Trusts, with the NHSI team able to support specific initiatives, including looking for alternative CIP options where slippage may be occurring.
- Trusts achieve best success through detailed and tracked ‘CIP Pipeline’ work.
- Collaboration between Finance and Estates teams within trusts is fundamental.
- SDMPs and Estates Strategies in place.
- Proactive involvement of Trusts in using/accessing the EFM Collaboration Hub.
- Regional workshop attendance and focus on sharing learning from best practice.
- Development of Model Hospital site and presentation of data allowing trusts to focus on opportunities.

#### Barriers:
- MEA revaluation instead of DRC – loss of capital to address backlog.
- Lack of capital for invest to save (energy efficiency, backlog reduction).
- Lack of re-investment of some of the revenue savings to pump prime future initiatives.
- Disconnect between EFM and Finance Teams in CIP Setting.
- Incorrect categorisation of schemes both hiding true gains and preventing management of targets.
Estates and Facilities

Productivity Opportunities for 2019/20

The table below shows the opportunity for Trusts based on data benchmarking. This data can be accessed in greater granularity on the Model Hospital opportunities page.

Energy costs (all energy suppliers) (£ per kWh) 0.049 0.055 0.052 0.047 0.063 0.049 0.074 0.053 0.072 0.055
Water cost (£ per Sqm) 1.65 2.05 1.42 1.77 1.60 1.68 0.85 1.46 0.92 1.31
Sewage cost (£ per Sqm) 2.09 2.11 1.62 1.73 1.56 1.92 0.87 1.29 0.88 1.24
Landfill disposal cost (£ per Sqm) 224 188 237 174 220 234 285 296 312 243
Inoceramic disposal cost (£ per Sqm) 450 447 425 433 414 411 508 536 681 676
Waste recycling cost (£ per Sqm) 145 118 80 125 153 119 224 227 229 174
Other recovery cost (£ per Sqm) 263 196 164 275 267 192 325 184 278 194
Cleaning service cost (£ per Sqm) 42.65 39.30 34.10 38.64 36.64 41.70 14.49 43.88 28.44 37.68
Inpatient food service cost (£ per meal) 4.21 3.53 4.20 3.59 6.39 4.56 - 5.50 5.93 4.39
Laundry and linen service cost (£ per item) 0.325 0.321 0.405 0.332 0.343 0.351 0.679 0.368 0.382 0.398
Portering service cost (£ per Sqm) 17.24 16.87 14.45 18.86 13.08 15.98 - - 3.13 3.82

Long Term Plan

There are some key opportunities for Estates outlined in the Long Term Plan including “Section vii. The NHS will improve the way it uses its land, buildings and equipment”:

- This will mean we improve quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment while supporting the Government’s target to build new homes for staff.
- We will work with all providers to reduce the amount of non-clinical space by a further 5%, freeing up over one million square metres of space for clinical or other activity.
- By 2020, we aim to reduce the NHS carbon footprint by a third from 2007 levels including by improving energy efficiency through widespread implementation of LED lighting and smart energy management.
- We will also improve the way we manage our estate and modernise and standardise our ambulance fleet to help reduce emissions and to improve air quality.
- Much of our estate consists of world leading facilities that enable the NHS to deliver outstanding care for patients. But some of our estate is old, in parts significantly older than the NHS itself, and would not meet the demands of a modern health service even if upgraded.
- Equally, meeting our future aspirations will require our digital capability and diagnostic equipment to be enhanced significantly.
- The Chancellor has confirmed that NHS long-term capital investment will be considered in the 2019 spending review. In return, we will continue to maximise the productivity benefits generated from our estate, through improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency and releasing properties which are no longer needed.
Estates and Facilities

Supporting resources provided by NHSI / E
For support from the Estates and Facilities team in the Operational Productivity Directorate of NHS Improvement, please contact: nhsi.estatesandfacilities@nhs.net or your Estates and Facilities Regional Leads:

- North
  emma.bolton4@nhs.net

- Midlands & East
  tom.myers2@nhs.net

- London
  nancy.silva@nhs.net

- South
  anthony.hickson@nhs.net

On the EFM Hub there are 31 case studies showing several savings opportunities for Trusts including, Car parking, Cleaning, Contract Management, Facilities Task management, Food, Medical records, PFI, P22, Procurement, Strategy and Sustainability. These can be accessed here. Additional support can be found via the Model Hospital and at EFM Regional events.
### Estates & Facilities - CIP opportunities (Jan ‘19)

#### Capital & Commercial

- **Commercial opportunities** - training, retail, conference facilities.
- Review charges for car parking, nursery provision to ensure costs are covered.
- Rates review.
- Review car parking management systems to enable full charging and efficient use.
- Advertising sponsorship opportunities.
- Energy grid opportunities.
- Review of bills (e.g. water and energy).
- Consider opportunities for consolidation in purchasing across organisations.
- Review of contract standards for outsourced services to identify any over specified services.
- Consider collaboration across organisations for more specialist services like contract management.
- Ensure that any benchmarking/market testing due to take place is identified and undertaken in a robust way with appropriate support.
- Trust run private patient units.

#### Strategic Estates Planning

- Estates consolidation.

#### Sustainability

- LED lighting: especially those projects already scoped through NEEF fund.
- Renewable Energy Solutions delivery (see assessment in year) e.g. Solar, battery, CHP.
- Furniture reuse programme.
- PC Power Management.
- Theatre Optimisation (Operating Theatres).
- Energy Bill Validation.
- Renewable Energy Assessments (for further years).
- Energy billing through PFI (if not done) for VAT reclaim @c20%.

#### Operational

- Occupancy – consider use of occupancy sensors to get better data on utilisation to help identify surplus estate.
- Clinical Space booking software.
- New for Old – Standardisation Modular Construction.
- Review of IT equipment.
- Non-clinical space utilisation.
- Agile Working.
- Desk/Space sharing.
- Review of service specifications

- Model Hospital target metrics for Ambulance, Community and Mental Health Trusts.
### Workforce
- Review of skill mix and collaboration across STP.
- Bundling up of PPM procurement.
- Joint back office functions through STP.
- Buying in a trainer for your STP region, rather than sending staff out of the office ad hoc.
- Exploring opportunities to look at job Description changes for current Band 1 & new Band 2 entrant staff incorporating wider duties, assisting in efficiency.

### Data
- Implementation service line reporting.
- Asset management system – Trust and site level.
- ERIC data collection system.

### Policy
- Review of catering/food provision model.
- Review of portering rotas and delivery methods.
- Review of cleaning rotas.
- Review of window cleaning.
- Laundry Review.

### PFMS Guidance
- Guidance on where Trusts categorise CIPs – e.g. E&F CIP need to categorised under E&F and not under Corporate Services.

### In year consideration

### Longer Term

### In year & Longer Term

### Estates & Facilities - CIP opportunities (Jan ’19)
Recent Trends

Provider trusts delivered savings of £270.5m in FY18 and are on track to deliver similar levels in FY19. It is recognised that it is getting harder each year for trusts to negotiate lower prices individually and more collaboration is required to leverage the spending power of the whole NHS. We launched the **Nationally Contracted Products** programme in FY17, which is on track to deliver £15.9m savings recurrently, with an average price reduction of 21% per product. These savings have been achieved on already heavily negotiated products such as syringes and surgical face masks. There are a thousand more products to be rolled out in the next wave with the benefits yet to be determined.

### Ongoing development

- The procurement league table (published via Model Hospital) compares procurement functions’ performance against a range of metrics. The Regional Heads of Procurement are available to support trusts to understand and improve their performance against these metrics.

- The **Purchase Price Index Benchmarking (PPIB)** tool helps trusts to identify savings opportunities. This was the first nationally available product level price comparison tool available to the NHS. Use of this tool has increased over the last two years, supporting trusts to identify savings and challenge supplier behaviour.

- Regional Heads of Procurement are supporting trusts in their efforts to achieve **NHS Standards of Procurement**. So far, 98 trusts have achieved level 1 and twelve have achieved Level 2.

- There is significant unwarranted variation in the way procurement services are provided across the NHS and consequently there is similar variation in the cost to provide these services and the effectiveness of the service delivered. NHSI have begun work on a **Procurement Target Operating Model Design (PTOMD)** which seeks to address this variation by transforming how procurement is delivered within providers to leverage the purchasing power of the NHS, improve data quality to better understanding of spend and how it can be reduced and improve the development of and retention of procurement professionals in the NHS.

### Programme priorities for FY20

- We will work with the GIRFT Programme to support trusts to standardise clinical products.

- We will continue to work with trusts to help them identify and deliver savings. We issued a template to capture CIPs and are currently collating these to prepare an insights report. This will highlight where trusts could work together to increase savings (for example, by renegotiating similar product categories), identify savings areas that others are already focusing on and provide the opportunity to learn about their approach. We will also share the report and collated plans with SCCL and procurement hubs so that they can support the realisation of these savings.

- We will conclude the PTOMD programme and commence its implementation.

- We will continue to develop the PPIB tool and offer training and support to help trust identify further savings.

- We will continue to support trusts to achieve the NHS Standards of Procurement.
Corporate Services

We continue to work with the regional teams to:

• help trusts to deliver sustainable savings through the publication of benchmarking, CIP opportunities and one to one support;
• pilot and enable trusts to adopt new ways of working, and;
• support trusts to work consistently and achieve opportunities from collaboration.

Our programme has active workstreams across all elements detailed in this diagram:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Fundamentals</th>
<th>Standardise &amp; Collaborate</th>
<th>End State</th>
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<tbody>
<tr>
<td>Outcomes</td>
<td>Data Driven Decisions</td>
<td>Improvement actions</td>
<td>Standardised outcomes and processes through RPA or by redesign of function. Consolidate services with other organisations</td>
</tr>
<tr>
<td>Enabling actions or outcomes</td>
<td>• FY18 National benchmarking collection completed</td>
<td>• CIP guidance &amp; self assessment tool issued to trusts</td>
<td>• Three Robotic Process Automation pilots currently being undertaken.</td>
</tr>
<tr>
<td></td>
<td>• Trust benchmarking reports issued</td>
<td>• Hands on support to trusts</td>
<td>• Process mapping and good practice blueprints, initially focused on Finance function developed.</td>
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<td></td>
<td>• Corporate services compartment launched on Model Hospital</td>
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<td>• Series of workshops held and materials developed to support collaboration initiatives.</td>
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<td>• Implementation guides and regional support provided.</td>
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<td>• Toolkits and good practice guidance produced &amp; published for trust use.</td>
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Key achievements:

• 97% of trusts submitted FY18 corporate services data. These trusts now have an individual report and data published on Model Hospital.

• Trusts are using these data to identify and deliver savings, for example:
  • two trusts are now jointly re-procuring their telecoms service, which will save them £1.9m per annum;
  • an internal audit provider has been encouraged to reduce prices to reach the lower cost quartile, saving it’s trust clients over £2m
  • a finance and payroll provider has lowered new contract offers to achieve the lower cost quartile prices (total benefits to be quantified)
  • nineteen trusts in one region have now committed to a single payroll provider and a single financial ledger with potential savings of c.£0.8m

• Trusts are also working together to take advantage of technology:
  • Robotic Process Automation pilots and development of clear approach and guidance to ensure standardisation across corporate services.
  • Trusts are using our data, tools, guidance and support to make savings (continued on next slide)
The Corporate Services Programme has published **CIP opportunities** and a trust **self-assessment tool**, which we encourage all trusts to please review, complete and return to us at nhsi.corpservices@nhs.net

Over a fifth of trusts have told us that they have utilised our CIP opportunities list and the self-assessment tool to improve and enhance their CIP plans and delivery.

Please access these documents at [https://improvement.nhs.uk/resources/corporate-services-productivity-toolkit/#CIP](https://improvement.nhs.uk/resources/corporate-services-productivity-toolkit/#CIP) and then get in touch with your regional team or the central programme for support.

**Examples of how our guidance and support is helping trusts?**

The CIP guidance and self-assessment tool has been worked through with the support of regional colleagues with over forty trusts, helping them to identify and deliver savings in corporate services spend:

- **Another north region trust** undertook a supported self-assessment with the north regional corporate service lead in April 2018. Twenty workstreams were identified of which eleven were prioritised resulting in c.£1.5m total corporate services CIP delivery year to date against an original plan of £0.7m.

- **A south region trust** undertook a supported self-assessment with the central programme team in June 2018. The trust identified thirty schemes across the seven corporate services functions. The programme value was estimated at c.£1.2m and the trust are working with their Turnaround Director to deliver these.

- **Another south region trust** undertook the self-assessment without support and has reported enhancements to their savings profile of over 40%, increasing it to c.£1m.

We are also working with trusts to help them to collaborate:

- **Three Midlands region trusts** are collaborating to deliver opportunities identified following a joint review of the CIP opportunities and completion of the self-assessment tool (benefits to be confirmed, but expected to be in excess of £1.5m).

- **One Northern trust** recognised that they were outliers for accounts payable, accounts receivable, temporary staffing function and payroll. As a result these functions have sought support from the central programme team and have moved to a shared services function with a saving of c.£0.6m.
## Corporate Services – CIP opportunities (Jan ‘19)

**Finance**
- Simplify chart of accounts
- Implement a robust journal policy.
- Consolidating the level at which budget holder support is provided
- Accounts payable automation and e-invoicing to accelerate invoice processing and approval time
- Sharing ledger cost with other neighbouring trusts and renegotiating with the vendor
- Enforcing compliance with policies and procedures
- Review financial reporting ability and systems

**In year consideration**

**Longer Term**

**HR**
- Review spending in learning & development.
- Review learning & development catalogue
- Roll-out of ESR self-service
- Roll-out of alternative systems in recruitment
- Self-service and intranet refresh
- Review of occupational health against demand and forecast
- Implement e-rostering for A&C staff
- Review policies

**Informatics**
- External hosting.
- Direct a shift from calls and emails to web forms to access support.
- Capitalisation of project posts.
- Commoditise technical solutions and review partnership options.
- Review licences and contracts for software and services.
- Team consolidation.
- Annual review of all contracts alongside performance review of VFM.

**Payroll**
- Introduce e-forms for all payroll input data.
- Introduce e-payslips for viewing and personal payroll account to view information.
- Move to e-expenses
- Mandate use of all ESR modules available

**Legal**
- Provide a single point of contact/authorisation for queries to be passed to external legal advisors.
- Develop a frequently asked questions (FAQs) reference point to help reduce avoidable contacts to Legal.
- Standardise operating procedures to collaborate across regional or national footprint.
- Contract reviews

**Procurement**
- Centralise all Procurement roles.
- Create an integrated Procurement and Contract Management function management.
- Clinical procurement specialist.
- Widening access to and adoption of e-catalogues.
- Adoption of electronic P2P solutions.
- Expanded use of e-tendering

**Governance & Risk**
- Sharing of complaints, clinical governance, health and safety and fire officers across partner organisations