Title: Summary of Lord Carter recommendations – Operational productivity and performance in English acute hospitals

Action: FOR NOTING

Meeting: Date of meeting

Purpose:

The purpose of this report is to inform the CCS Board of the 15 recommendations made in Lord Carter’s report the Department of Health titled “Operational productivity and performance in English NHS acute hospitals”, and CCS’s proposed actions taken in response.

This report was informed by centrally gathered spend data from acute hospitals across England, and Lord Carter engaging with 136 of these acute hospitals, sharing specific areas of data that identified opportunities for efficiency when compared to NHS averages of their peers.

It is acknowledged that although his report is acute hospital focussed, the methodology and tools developed are transferable to the non-acute sector.

Recommendation:

The Trust Board are asked to acknowledge the CCS Executives responses to the recommendations in Lord Carter’s report.

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<th>Name</th>
<th>Title</th>
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<tr>
<td>Author &amp; Executive Sponsor</td>
<td>Mark Robbins</td>
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## Trust Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>How the report supports achievement of the Trust objectives:</th>
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<tr>
<td>Provide outstanding care</td>
<td>Efficiency opportunities will not be introduced if they do not pass the Trust's Quality Assurance processes</td>
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<tr>
<td>Collaborate with other organisations</td>
<td>Collaboration is key to support the implantation and maximise efficiency opportunities included in Lord Carter's recommendations</td>
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<td>Be an excellent employer</td>
<td>The Trust will ensure that when implementing these recommendations it is not at the detriment to its valued workforce</td>
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<tr>
<td>Be a sustainable organisation</td>
<td>Implementing these recommendations will further support the Trust being financial sustainable</td>
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### Trust risk register

*There are no current risks relating to this paper on the Corporate Risk Register*

### Legal and Regulatory requirements:

*N/A to this paper*

### Equality and Diversity implications:

*This report does not include any specific Equality and Diversity implications.*

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<tr>
<th>Objective</th>
<th>How the report supports achievement of objectives:</th>
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<tr>
<td>Achieve an improvement in the percentage of service users who report that they are able to access the Trust services that they require</td>
<td>Not covered in this report</td>
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<td>Enhance our approach to involving and capturing the experience of hard to reach / seldom heard / varied community groups</td>
<td>Not covered in this report</td>
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<td>Achieve an improvement in the percentage of staff who report that they are able to access training and education opportunities</td>
<td>Not covered in this report</td>
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<td>Ensure that the Race Equality Standard is embedded and undertake proactive work around any areas of under-representation identified</td>
<td>Not covered in this report</td>
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**Are any of the following protected characteristics impacted by items covered in the paper**

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<tr>
<th>Age</th>
<th>Disability</th>
<th>Gender Reassignment</th>
<th>Marriage and Civil Partnership</th>
<th>Pregnancy and Maternity</th>
<th>Race</th>
<th>Religion and Belief</th>
<th>Sex</th>
<th>Sexual Orientation</th>
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Background

In June 2014, Lord Carter was asked by the Secretary of State for Health to look at what could be done to improve efficiency in hospitals in England. In Lord Carter’s interim report from June 2015 he described the widely varying resource utilisation across the NHS, and estimated that there could be a £5bn reduction in cost linked to the unwarranted variation across acute Trusts from the £55.6bn spent annually by acute hospitals. The final report published in February 2016, details how these efficiencies can be achieved between now and 2020, and it makes 15 recommendations designed to tackle this variation and help acute trusts improve their performance to match the best.

This Board briefing is not to explain the findings in detail from his report, as these are based on acute hospital activities, but the recommendations in some cases can and do reflect activities CCS currently engage and lead on.

The 15 recommendations

The recommendations are listed below, and included is a brief summary of the CCS Action where applicable, to implement these recommendations.

1. NHS Improvement should develop a national people strategy and implementation plan by October 2016 that sets a timetable for simplifying system structures, raising people management capacity, building greater engagement and creates an engaged and inclusive environment for all colleagues by significantly improving leadership capability from “ward to board”, so that transformational change can be planned more effectively, managed and sustained in all trusts;

   **CCS Action** - Anita Pisani is a member of the East of England’s Workforce Development Board, and this Board is currently drafting its internal Leadership Strategy Plan in May 2016, and CCS will review this for implantation where applicable.

2. NHS Improvement should develop and implement measures for analysing staff deployment during 2016, including metrics such as Care Hours Per Patient Day (CHPPD) and consultant job planning analysis, so that the right teams are in the right place at the right time collaborating to deliver high quality, efficient patient care;

   **CCS Action** – During 2015/16 CCS agreed Consultants Job Planning guidance and during 2016/17 begin to review and implement service by service.

3. Trusts should, through a Hospital Pharmacy Transformation Programme, develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding by April 2020, in agreement with NHS Improvement and NHS England so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities;

   **CCS Action** – This recommendation isn’t entirely relevant to CCS, but we are however developing a Pharmacy Procurement plan which will look at the various options to potential procure in a different way the to the current multiple pharmacy providers.

4. Trusts should ensure their pathology and imaging departments achieve their benchmarks as agreed with NHS Improvement by April 2017, so that there is a consistent approach to the quality and cost of diagnostic services across the NHS. If benchmarks for pathology are unlikely to be achieved, trusts should have agreed plans for consolidation with, or outsourcing to, other providers by January 2017;
CCS Action – This recommendation isn’t entirely relevant to CCS, but we have recently procured a single pathology provider for its Sexual Health pathology service, which has benefitted in an improved quality service, with opportunities for further efficiencies through Trust wide standardisation and practice.

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

CCS Action - This recommendation isn’t entirely relevant at this current time, however we are aware that although the requirement to report this information is currently limited to acute trusts, the assumption is Mental Health and Community providers will eventually be required to provide this information.

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

CCS Action - This recommendation isn’t entirely relevant as it focused on the use of acute hospital settings. CCS has however been reviewing utilisation of clinical and non-clinical space across it estate and has consolidation and co-location plans for a number of sites. Matthew Winn is the Executive sponsor on behalf of the Cambridge & Peterborough locality to discuss and agree opportunities for the Community Estate, and this group has project support from the Transformation Team.

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

CCS Action – The Trust awaits the definition requirements but it is also working with the Cambridge and Peterborough System Transformation programme reviewing back office arrangements to identify opportunities of improved efficiency through collaborative working.

8. NHS Improvement and NHS England should establish joint clinical governance by April 2016 to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway;

CCS Action - This recommendation isn’t entirely relevant, however CCS is already reviewing best practice standards in its acute paediatric and sexual health services, to be implemented during this year, and this will also be informed by recommendations from NHS Improvement and NHSE.

9. All trusts should have the key digital information systems in place, fully integrated and utilised by October 2018, and NHS Improvement should ensure this happens through the use of ‘meaningful use’ standards and incentives;

CCS Action – Again this is very acute focussed as it is in relation to the patient journey through the hospital setting, however we are fully engaged in working towards an intergrade pathway model for adult services in Luton, which will include digitalisation of
data. In addition the Trust is also looking to introduce “E-Rostering” in the children’s services based at Holly and SCBU.

10. The Department of Health, NHS England and NHS Improvement should work with local government representatives, to provide a strategy for trusts to ensure that patient care is focussed equally upon their recovery and how they can leave acute hospitals beds, or transfer to a suitable step down facility as soon as their clinical needs allow so they are cared for in the appropriate setting for themselves, their families and their carers;

**CCS Action** – Not relevant to CCS.

11. NHS England and NHS Improvement should work with trust boards to identify where there are quality and efficiency opportunities for better collaboration and coordination of their clinical services across their local health economies, so that they can better meet the clinical needs of the local community;

**CCS Action** – The Trust is involved in supporting 2 System Transformation workstreams and additionally in Luton, CCS is the lead provider for the Primary Care Home project, engaging GP’s, LA’s and Trust’s to review a select range of care pathways.

12. NHS Improvement should develop the Model Hospital and the underlying metrics, to identify what good looks like, so that there is one source of data, benchmarks and good practice;

**CCS Action** – Not relevant to CCS.

13. NHS Improvement should, in partnership with CQC and NHS England, by July 2016, develop an integrated performance framework to ensure there is one set of metrics and approach to reporting, so that the focus of the NHS is on improvement and the reporting burden is reduced to allow trusts to focus on quality and efficiency;

**CCS Action** – Awaiting further guidance as to whether applicable to community trusts.

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

**CCS Action** – as applicable and will be built into Trust future CIP plans.

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

**CCS Action** – the C&P STP includes organisations sharing efficiency ideas and working together to maximise opportunities.

### Conclusion

The majority of the recommendations could be seen as expected and good practice in the NHS, and CCS has historically been involved in and continually reviews procurement opportunities and efficiencies from collaborative working. However, NHS Improvement have indicated that Trust’s are required to demonstrate implementation of Lord Carter’s recommendation to ensure they can access their System Transformation support funding, and to delivery their control total.

We are still to understand in what form CCS will need to demonstrate it is reviewing and implementing these recommendations, but we feel confident, based on the work already in place, that this will be achievable.