Office of the Trust Special Administrator

Appendix D

Operational efficiency opportunities within South London Healthcare NHS Trust

Securing sustainable NHS services

Introduction

1. This appendix to the final report of the Trust Special Administrator (TSA) appointed to South London Healthcare NHS Trust relates particularly to chapter 4 of the report. It provides an overview of the detailed work that has been undertaken by the TSA and his team to identify potential operational efficiency improvements that could be made to the services provided by South London Healthcare NHS Trust.

2. South London Healthcare NHS Trust incurs significantly more cost in the way it provides services than the income it receives from its commissioners. As a result of these higher costs the Trust is in a very poor financial position, spending in excess of £1m more each week than it receives in income. For the year 2012/13 South London Healthcare NHS Trust is forecast to have a normalised deficit of £59.5m.

3. To understand better the reasons for these high operational costs, a programme of detailed work has been undertaken with the aim of identifying how much of the financial challenge faced by South London Healthcare NHS Trust could be resolved by improving the efficiency of the current services. This work has been completed in two phases.

4. Phase one was undertaken prior to the publication of the TSA's draft report on 29 October 2012 and concluded that a significant proportion of the Trust's financial problems could be solved through improved productivity and efficiency gains of £79m over a three-year period.

5. Phase two took place over a five-week period between November and December 2012. The work validated the findings of phase one by converting the identified productivity and efficiency opportunity into detailed cost improvement programme schemes (CIPs). This process generated £74.9m of CIPs, which form the recommended three-year operational efficiency programme outlined in chapter 4 of the final report. It also identified £7.7m of efficiencies which could be realised through merger synergies, outlined in chapter 6 of the final report. These opportunities are a fundamental requirement for achieving financially sustainable services in south east London.

6. This appendix outlines:

   - the approach used in phase one to determine the size of the operational efficiency improvement that could be made within the Trust's services;
   - the identified operational efficiency opportunity and the specific areas with the greatest opportunity for improvement;
   - the approach taken in phase two to develop detailed plans to close the existing efficiency 'gap' over a three-year period and the impact of this on the cost base of the services;
   - the assessment of what South London Healthcare NHS Trust can deliver as it is currently constituted; and
   - what is recommended to ensure that the full efficiency opportunity is captured.

Phase one approach: determining the operational efficiency improvement opportunity

7. Over a six-week period, a team of senior leaders and clinicians from within South London Healthcare NHS Trust worked with external consultancy advisors to review the Trust's current operational efficiency to identify the potential size of the improvement opportunity. The involvement of internal and external leads in this work was deemed essential to the identification of credible opportunities based on innovative best practice.

8. An executive-led working group was established, with the remit to bring together senior leaders and clinicians to assess, challenge and validate the findings of the work.

9. To strengthen further the clinical involvement in the operational efficiency workstream and the above working group, a workshop was held during the process with clinical leads, directors and heads of nursing to provide additional challenge to the process.

10. Two different methods of analysis were used to identify the operational efficiency opportunity: an external benchmarking in which the Trust was compared to 18 similar NHS organisations; and a detailed, internally focused review of the current cost base of the Trust.

Benchmarking

11. In benchmarking South London Healthcare NHS Trust, a similar approach was taken to that used by NHS London in its recent report *Acute Hospitals in London: Sustainable and Financially Effective*[1] *(SaFE)*. The methodology compared the Trust with a peer group of 18 multi-site trusts of a similar size with a similar income and a similar mix of elective and non-elective workload. The peer group of 18 trusts was selected and agreed by the operational working group.

1 http://www.london.nhs.uk/webfiles/SaFE%20repoer/SaFE%20report%20February%202012.pdf

12. Figure 1 shows the 18 trusts - and their relative size, income, case mix and quality of services - against which the Trust was compared.

Figure 1: Peer group of 18 trusts against which South London Healthcare NHS Trust was benchmarked

Trust Name	FT	Trust Type	Trust income £m	Number of spells '000	Non elective spells %	Total beds	Income per bed £000	Quality Score	Monitor FRR
South London Healthcare NHS Trust	N	Large	438	173	50.0%	1,444	303	55%	n/a
Barking Havering and Redbridge University Hospitals NHS Trust	N	Large	407	119	58.9%	1,152	405	29%	n/a
Calderdale and Huddersfield NHS Foundation Trust	Y	Large	321	114	55.1%	837	384	80%	4
County Durham and Darlington NHS Foundation Trust	Y	Large	341	134	57.0%	944	361	74%	4
Derby Hospitals NHS Foundation Trust	Y	Large	423	145	44.3%	1,139	371	54%	3
East Kent University Hospitals NHS Foundation Trust	Y	Large	490	151	50.3%	1,165	421	53%	4
Gloucestershire Hospitals NHS Foundation Trust	Y	Large	423	154	40.5%	1,042	406	43%	3
Heart of England NHS Foundation Trust	Y	Large	561	221	59.8%	1,543	364	14%	3
Mid Yorkshire Hospitals NHS Trust	N	Large	430	140	55.8%	1,152	373	34%	n/a
North Bristol NHS Trust	N	Large	493	112	46.9%	1,114	443	71%	n/a
North West London Hospitals NHS Trust	N	Large	370	101	57.0%	641	577	18%	n/a
Northumbria Healthcare NHS Foundation Trust	N	Large	320	113	55.0%	1,263	253	88%	4
Pennine Acute Hospitals NHS Trust	N	Large	557	210	52.8%	1,626	343	41%	n/a
Portsmouth Hospitals NHS Trust	N	Large	446	122	55.0%	961	464	51%	n/a
Sandwell and West Birmingham NHS Trust	N	Large	388	133	50.5%	912	425	27%	n/a
South Tees Hospitals NHS Foundation Trust	Y	Large	474	147	47.0%	1,127	421	73%	3
United Lincolnshire Hospitals NHS Trust	N	Large	392	156	49.0%	1,350	290	32%	n/a
University Hospital of North Stafford NHS Trust	N	Large	418	139	52.1%	1,054	397	23%	n/a
Western Sussex Hospitals NHS Trust	N	Large	362	121	53.5%	997	363	35%	n/a

13. This benchmarking analysis compared the Trust against the peer group operational efficiency measures within the key cost categories outlined in the NHS Costing Manual[2]. To identify the improvement opportunity for each category, the Trust's performance was initially compared with a peer on the top quartile threshold.

14. In further developing the methodology the TSA team were keen to ensure that benchmark comparisons were made between South London Healthcare NHS Trust and other whole and comparable acute NHS trusts or foundation trusts, rather than by seeking to benchmark performance on each cost element and performance metric with a different trust. This was deemed essential to ensuring the credibility of the benchmarking work with clinical teams and removed the potential for variation in other trusts' cost apportionment approaches to skew the findings. To ensure sufficient ambition in the benchmarking, it was agreed that the Trust would be compared with the average of the top three highest performing peer trusts overall - which are Mid Yorkshire Hospitals NHS Trust, County Durham and Darlington NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust - on their operational efficiency.

15. Operational efficiency is one contributor to overall financial performance, which is also influenced by other factors such as income, fixed costs and capacity and therefore may not always directly correlate to a trust's in-year I&E.

16. In keeping with this approach, the final benchmarking considered what the cost base of the Trust would be if it were able to provide its services as productively as at the average level of these top three highest performing peer Trusts.

17. In undertaking the benchmarking, South London Healthcare NHS Trust's operational efficiency in 2011/12 was compared with that of its peers for 2010/11. This was because a full set of 2011/12 public data on other trusts was not available for all metrics across the peer group. It was noted that the opportunity identified using this approach was likely to be conservative, as many of the peers (and particularly the top performers) would have further improved their performance between 2010/11 and 2011/12. An exception to this was clinical supplies, where 2010/11 data was used for the Trust as well as the peer group, because the Department of Health changed the definition of clinical supplies in 2011/12.

18. In comparing the Trust's operational efficiency and using this as a basis to determine potential levels of savings that could be made, the operations working group wished to understand the relative quality of care in those other organisations.

19. A quality score was calculated for each of the 18 Trusts in the peer group, which is a composite measure of 20 clinical indicators of quality of services that are collected nationally. Each of these indicators is weighted and shown in figure 2 (see overleaf).

2 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132398.pdf

Figure 2: Metrics included in Diagnostics, which make up the quality score

Dimension	Sub-dimension	Sub-dimension weight	Metric	Units	Metric weight	Source	Period
Quality	**Safety**	1	Litigation claims rate	Claims per 10,000 bed days	1	NHSLA	2010/11
			Rate of written complaints	Cases per 1,000 bed days	1	NHS IC	2010/11
			Medication errors	Claims per 1,000 bed days	1	NPSA	2010/11
			Patient accidents	Cases per 1,000 bed days	1	NPSA	2010/11
			Treatment procedure	Cases per 10,000 bed days	1	NPSA	2010/11
			All other categories	Cases per 1,000 bed days	1	NPSA	2010/11
			C.diff infection rate	Cases per 1,000 bed days	1	HPA	2010/11
			MRSA infection rate	Cases per 10,000 bed days	1	HPA	2010/11
			Rate of surgical site infections	Cases per 10,000 bed days	1	HES	2010/11
			SHMI	Ratio	1	NHS IC	2010/11
Quality	**Patient Experience**	1	Overall IP experience	Rating	1	Patient Survey	2012
			Overall OP experience	Rating	1	Patient Survey	2011
			Overall A&E experience	Rating	1	Patient Survey	2012
			Mother's satisfaction	Rating	0.5	Patient Survey	2010
			Mixed sex accommodation breach	Rate	0.5	DH	2010/11
			18 week target	%	0.5	DH	2010/11
			Delayed transfer of care	Patients per 1,000 spells	0.5	DH	2010/11
			Delayed transfer of care	Days per 1,000 spells	0.5	DH	2010/11
Quality	**Clinical outcome**	1	Readmission rate for elective spells	%	0.5	HES	2010/11
			Emergency readmission of Babies within 30 days of birth	%	0.5	HES	2010/11
			Readmission rate for non-elective spells	%	0.5	HES	2010/11
			Emergency readmission Total	%	0	HES	2010/11
			% patients discharged to usual place of residence	%	0.5	HES	2010/11
			Stroke patients spending >90% time in stroke unit	%	0.25	National Stroke Audit	2011
			Stroke patients receiving CT scan within 24 hours	%	0.25	National Stroke Audit	2011
			Patients receiving #NOF surgery within 48 hours	%	1	HES	2010/11
			Admitted patients risk assessed for VTE	%	0.5	DH	2010/11
			C-sections	%	0	HES	2010/11
			Mothers with 3rd/4th degree tear	%	0.5	HES	2010/11
Quality	**Patient reported outcome**	1	PROMS: Groin hernia	Score	1	HES online	2010/11
			PROMS: Hip replacement	Score	0.5	HES online	2010/11
			PROMS: Knee replacement	Score	0.5	HES online	2010/11
			PROMS: Varicose vein	Score	1	HES online	2010/11
			Pre-op Questionnaires Participation rate: All Procedures	%	0	HES online	2010/11
			Post-op Questionnaires Issue rate: All Procedures	%	0	HES online	2010/11

Note:	NHSLA	NHS Litigation Authority
	NHS IC	NHS Information Centre
	NPSA	National Patient Safety Agency
	HPA	Health Protection Agency
	HES	Hospital Episode Statistics
	DH	Department of Health
	HES online	Hospital Episode Statistics online

20. The quality score for each of the 18 peer Trusts is shown in figure 1. The score describes the position of the Trust relative to all other acute trusts in England. South London Healthcare NHS Trust was assessed across the weighted 20 measures as being at the 55th percentile. This means that 45% of trusts perform better than South London Healthcare NHS Trust across these quality indicators, whilst 55% of trusts perform less well.

21. As shown in figure 1, a number of Trusts perform either similarly, or better, to the Trust on the quality score. Importantly, two of the top three highest performing peer Trusts overall – County Durham and Darlington NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust – both have quality scores that are much higher than the Trust. This is evidence that the services offered by the Trust can be delivered at a reduced cost, whilst maintaining or improving quality of care.

22. Having benchmarked the Trust against the average of the top three highest performing peer Trusts and having ensured that these peer Trusts were of sufficient quality to be considered appropriate comparators, the phase one benchmarking identified a total cost gap of £57m with the largest opportunities in medical spend (£12m), nursing spend (£17) and clinical supplies (£14m). This is described in further detail later.

23. There are limitations to this type of analysis, not least the different mix of clinical work between peers, the quality and accuracy of the data as reported and the potential for discrepancies in income to skew the analysis. A second assessment of the operational efficiency opportunity was therefore undertaken to supplement and validate the benchmarking.

Internal review and validation of benchmarking

24. The second methodology used to identify the opportunities within the Trust was a more detailed internally-driven bottom-up analysis that reviewed the variable cost base and looked to validate the benchmarking using internal data.

25. Having identified a cost gap to peers of £57m, the next step was to validate this figure by identifying specific savings opportunities within the Trust based on a bottom-up analysis that reviewed individual categories comprising the variable cost base. These categories included: medical pay; nursing pay; scientific, therapeutic and technical staff (ST&T) pay; non-clinical pay; clinical supplies cost; costs attributable to length of stay; and other variable costs (eg. catering and cleaning).

26. The analysis made use of internal data, on-site interviews and direct observations of ways of working. For example, under medical pay, the Trust was found to have the lowest income per consultant in its peer group, a high ratio of junior doctors to consultant staff, and a greater proportion of locums and agency personnel than its peers. The opportunity in this area was broken down into two components: one, savings from aligning clinical income per permanent medical full time equivalent at the Trust with top-quartile peer performance (by specialty), and two, savings from aligning the Trust's locums / agency spend (obtained from payroll and the finance department) with that of top-quartile London trusts.

27. In the case of nursing pay, the Trust was discovered to have high nursing spend relative to its number of occupied bed days, with a £12m opportunity from raising operational efficiency (including of temporary staff) to that of top-quartile peer levels. At the suggestion of key stakeholders, analysis was also undertaken to demonstrate that other hospitals manage to combine high nursing efficiency with good outcomes and patient experience. The Trust was found to have a more senior nursing skill mix than its peers (even accounting for the Trust's latest establishment / vacancy figures), with an additional estimated £2m savings from aligning nursing paybands with peer median distribution.

28. The benchmarking and internal analysis were reviewed on a weekly basis by the operations working group composed of senior leaders of the four Care Groups of the Trust, including clinicians and managers. This group provided input and challenge to the work, which took account of feedback received and suggestions that were put forward. As mentioned above, analyses and conclusions were further tested and validated through conversations with relevant staff and key stakeholders during on-site interviews. The operations working group meetings also considered the most recent internal Trust data (2012/13) to look for any potential departures from earlier-year benchmarking and trends.

The size of the operational efficiency opportunity

29. In benchmarking the operational efficiency improvement opportunity for South London Healthcare NHS Trust, three possible models were identified and considered. The first was based on comparing the Trust with the Trust at the top quartile threshold of all 18 peer Trusts. The second was based on comparing the Trust with the average of the top three performing Trusts. The third involved determining the opportunity by matching the Trust's performance to the top quartile performing Trust on each individual metric.

30. As described above, it was deemed that the second of these models was the most appropriate as it increased the credibility of the benchmarking with clinical teams and removed the potential for variation in other Trusts' cost apportionment approaches to skew the findings.

31. Matching the Trust's level of operational efficiency to the average of the top three highest performing peer Trusts and by providing services in a similar way to them offers the opportunity to reduce costs in the Trust by £57m. Matching the different levels of productivity in these three organisations offered a range of efficiency opportunities of between £56m and £67m. The detailed breakdown of the £57m opportunity is shown in figure 3.

Figure 3: Operational efficiency opportunities by cost category based on benchmarking

Cost category	2011/12 cost base (£m)	Matching peer at top quartile threshold (£m)	Matching average of top three peers (£m)	Matching peer at top quartile for category of spend (£m)
ALOS[1]	N/A	0	**0**	0
Medical pay	90	-11 (-13%)	**-12 (-13%)**	-23 (-25%)
Nursing pay	98	-18 (-19%)	**-17 (-18%)**	-14 (-14%)
ST&T pay	37	-2 (-4%)	**-2 (-5%)**	-9 (-23%)
Non clinical pay (back and middle office)	50	-7 (-15%)	**-8 (-17%)**	-12 (-23%)
Supplies[2]	72	0	**-14 (-19%)**	-11 (-16%)
Other variable costs[3]	15	-7 (-46%)	**-4 (-26%)**	-7 (-44%)
Costs not benchmarked[4]	164	n/a	**n/a**	n/a
Total	526	-46 (-9%)	**-57 (-11%)**	-75 (-14%)

Trust analysis performed using 2011/12 data, but benchmarked to peer analysis performance using 2010/11 data. Opportunity for Trust (gap to peers) is even greater if peer Trusts made efficiency improvements themselves between 2010/11 and 2011/12.

[1] Bed day opportunity estimated at £150/day. Note that average length of stay (ALOS) is assumed to stay at current rate or move to target, whichever is shorter.
[2] Clinical supplies opportunity calculated using 2010/11 data for South London Healthcare NHS Trust as well as peers, given differences in definitions of "Clinical supplies" between 2010/11 and 2011/12 FIMS returns
[3] Other variable costs include catering, cleaning and laundry
[4] Cost categories not benchmarked include: other clinical income (due to inconsistency in reporting), premises, establishment cost and non-operating costs (ie. PDC, interest, depreciation, etc.)

32. The analysis undertaken internally to validate the benchmarking and identify specific operational savings came up with a slightly larger savings profile, with a total savings opportunity of £62m. The breakdown of this is shown in figure 4. As with the initial benchmarking the greatest opportunities were identified to be in medical pay, nursing pay and clinical supplies.

Figure 4: Productivity opportunity identified through internal review of the cost base

Cost category	2011/12 cost base (£m)	Improvement opportunity identified from internal review (£m)
ALOS	-	**-6**
Medical pay	90	**-20 (-22%)**
Nursing pay	98	**-14 (-14%)**
ST&T pay	37	**-4 (-11%)**
Non clinical pay (back and middle office)	50	**-4 (-8%)**
Supplies	72	**-9 (-12.5%)**
Other variable costs	15	**-5 (-34%)**
Total	526	**-62 (-11.8%)**

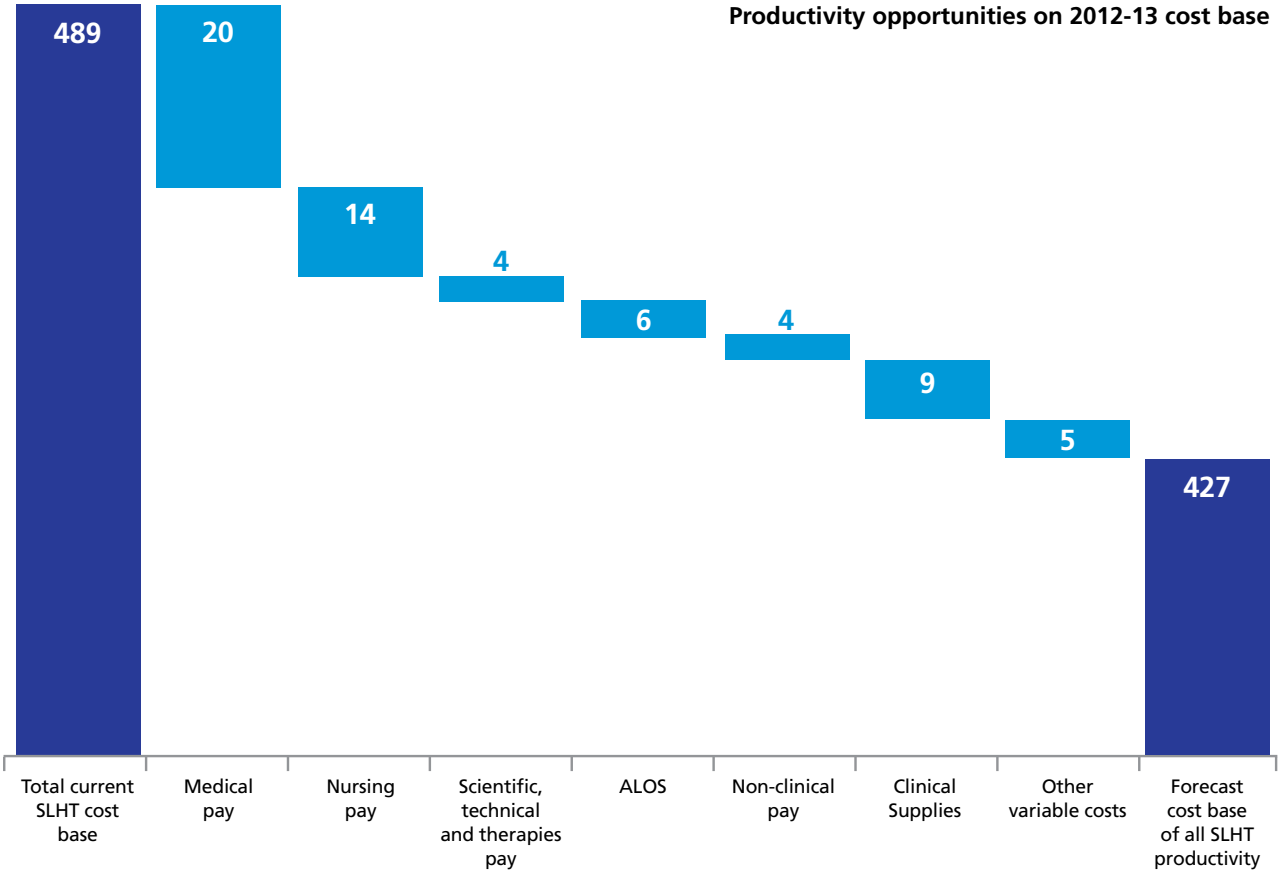
33. Figure 5 compares the benchmarking assessment and the outcome of the internal review.

Figure 5: Comparison of operational efficiency opportunity identified through benchmarking and the internal review of the cost base

Cost category	2011/12 cost base (£m)	Improvement opportunity identified from benchmarking (£m)	Improvement opportunity identified from internal review (£m)
ALOS	N/A	0	**6**
Medical pay	90	12	**20**
Nursing pay	98	17	**14**
ST&T pay	37	2	**4**
Non clinical pay (back and middle office)	50	8	**4**
Supplies	72	14	**9**
Other variable costs	15	4	**5**
Total	526	57	**62**

34. Having considered the current improvement opportunities identified by both the benchmarking (£57m) and the detailed internal review (£62m), the operational efficiency working group recommended that the size of the current improvement opportunity for the Trust was £62m. This is shown in figure 6.

Figure 6: Breakdown of cost savings by type (£m on 2012/13 cost base) from detailed internal review



35. It is implausible to deliver £62m of efficiency improvement in a single year. The TSA team has, therefore, assumed improvements should be made over a three-year period. Alongside this an assumption has been set that the Trust should not only improve to the level of high performing peers as they were in 2010/11, but also recognise that all trusts will need to continue to improve performance.

36. Therefore, the TSA has applied an additional 2% savings per annum to the £62m opportunity identified by the operational efficiency working group to reflect the continuing improvement of the Trust's peer group. This is consistent with the methodology used in *SaFE*. Application of this 2% figure identifies an additional £17m of savings, making a total operational efficiency requirement of £79m. This reflects the expectation that there will be a spread of performance compared to the average, with the highest performing trusts having less scope to improve as they have already delivered reductions in their cost base in recent years.

37. The key areas where the operational efficiency opportunity can be realised, as shown in figure 6, are considered to be:

- *Medical productivity (£20m):* the Trust has the highest spend on medical staff relative to total clinical income compared to its peer group, which means it spends much more on medical staff than other trusts would to do the same level of work. This suggests that the level of activity currently delivered by the Trust could be achieved with a lower number of medical staff, if the productivity of other trusts was matched. The Trust also has a very high proportion of non-consultant doctors (for every consultant there are three non-consultant grade doctors) and has a high use of locum and agency staff. Bringing the number of medical staff in line with high performing comparator trusts, by redesigning the way in which services are provided, will reduce costs, with a 16% reduction in the size of the workforce and a reduction in the level of locum and agency use.

- *Nursing productivity (£14m):* the Trust has a high nursing spend relative to the number of occupied bed-days (the sum of all the days spent in hospital by patients), which indicates the efficiency of nursing could be improved. The Trust also has an expensive skill mix compared with peers, with a higher proportion of senior staff and a high spend on bank and agency staff – specifically within theatres and A&E. High-level analysis has also shown that, compared with peers, the Trust has a lower number of A&E attendances per A&E nurse and does fewer operations per theatre nurse, supporting the view that there is a productivity opportunity.

38. Given the size of the opportunity in medical and nursing productivity and the fact that doctors and nurses spend a high proportion of their time working in 'settings of care' – such as outpatients and in theatres – consideration was given to the level of productivity in each of these areas. In particular, improving the efficiency of the overall operations within outpatients or theatres will improve both medical and nursing productivity. This work provided additional insight into how to improve efficiency in the cost categories of medical and nursing productivity.

- *Outpatients:* In total across the Trust nearly 75,000 appointment slots are unused due to patients not attending. Two-thirds of specialities within the Trust have 'did-not-attend' (DNA) rates in the worst 25% of trusts in the country and none are in the best 25% of Trusts. Nearly 30,000 fewer outpatient slots would be needed if the average DNA rate were achieved. In other words, the Trust could treat the same number of patients with many fewer clinics if outpatient slots were better utilised compared to how they currently are and the number of patients seen per clinic matched the top performing trusts. Reducing the DNA rate will mean fewer clinics are required and could save the Trust up to £2m.

- *Theatres:* The Trust's utilisation of staffed theatre time (the amount of time spent operating on patients) currently ranges from 67% to 76%. The main drivers of this are shown in figure 7.

Figure 7: Drivers of active theatre utilisation in South London Healthcare NHS Trust

Site	% of time lost due to late starts	% of time lost due to early finishes	% of time lost to turnaround between cases	% Active theatre time/utilisation
QMS	6	12	7	76
PRUH	8	16	9	67
QEH	13	10	5	72

Late starts and early finishes (indicating that lists are not fully booked or are not staffed in a way that matches staff time to the required operating time) result in significant amounts of time being paid for but not used.

There is also considerable variation between consultants in the average time it takes them to complete the same procedures (eg. the variation in the time taken to carry out a knee operation ranges from 103 to 200 minutes). Achieving 85% utilisation of theatres and improving the number of cases on theatre lists by reducing the procedure time by 10% would unlock significant capacity by reducing the number of paid theatre hours required by approximately 8,000 per year. This would save at least £2m across medical and nursing spend, while still allowing the same number of patients to be treated. This would also reduce the amount of premium spend the Trust incurs on waiting list initiatives. The work has identified three key specialities that have the greatest scope for improvement - general surgery, gynaecology and trauma and orthopaedics - which account for 62% of the potential opportunity as shown in figure 8.

Figure 8: Opportunity by specialty arising from improved theatre productivity

Specialty	Current utilisation % (and hours)	Potential hours freed up per annum	Equivalent theatre sessions per annum
Cardiology	25 (180)	50	16
ENT	58 (1,074)	662	120
General Surgery	75 (7,959)	1,945	382
Gynaecology	75 (4,344)	1,085	248
Ophthalmology	74 (3,094)	819	203
Oral Surgery	58 (593)	266	89
Pain Management	69 (959)	341	86
Plastic Surgery	59 (122)	72	18
Orthopaedics	73 (7,353)	2,109	417
Urology	62 (1,886)	960	160

39. Improving the way in which services are delivered in these settings of care will have a significant impact on the medical and nursing productivity in particular, although other changes are also needed to the overall workforce structure within these professional groups to close the total efficiency gap.

40. The areas of identified opportunity in other categories of spend are detailed below:

- *Average length of stay (ALOS) in in-patient wards (£6m):* in many areas the Trust performs in line with, or even above, the average of its peers. However, there is still opportunity for improvement. Comparisons of overall length of stay can be misleading, given differences in case-mix between Trusts. To estimate the opportunity in this area,

the ALOS for individual groups of patients (HRGs) in each specialty were benchmarked to peer values. The work found that, at a more detailed level, there is an opportunity to improve care for patients with specific conditions and to reduce the amount of time patients need to stay in hospital. Matching peer median average length of stay, for example by making a small improvement for longer-stay patients, would reduce the number of beds the Trust needs to treat the current number of patients. This would allow the Trust to operate with up to 100 fewer beds. The main specialities where there is the potential for improvement are general and elderly medicine, paediatrics, trauma and orthopaedics and general surgery.

This opportunity in ALOS is supported by the work that showed the significant variation in patient length of stay between consultants in the same specialty and for the same condition (HRG), and by estimating the considerable impact of mild reductions in ALOS for longer-stay patients. Realising this opportunity will require changes both to the internal medical model as well as improved joint working across the wider health system, to reduce the time patients spend in hospital. The aspirations for this are set out in the Community Based Care Strategy (see appendix O).

- *Scientific, therapeutic & technical (ST&T) productivity (£4m):* The Trust has a high number of permanent ST&T full-time equivalent staff relative to the clinical income in multiple professional groups. These include pharmacy, speech and language therapy and various sub-specialities of pathology. By bringing the number of full time equivalent staff in line with top performing peers, the Trust could realise around £2m in savings. As with other areas of the Trust, there is also a high bank and agency spend on ST&T staff, specifically within pathology and pharmacy.

- *Non-clinical pay (£4m):* The £50m non-clinical pay spent on 'back office' staff (eg. HR, IT and procurement) and 'middle office' staff (eg. medical secretaries, ward clerks and receptionists) was reviewed. This cost base represents approximately 1,300 full time equivalents. Opportunities for more efficient and effective running of the processes performed by these staff groups have been assessed, using outsourcing as the primary alternative. This assessment took account of the areas that can be most easily addressed and used benchmarks for outsourcing benefits achieved in other hospitals, public sector bodies and private sector organisations. Discussions were held with potential suppliers (both on- and off-shore) for outsourced services.

- *Supplies (£9m):* A detailed review of addressable non-pay spend at category level (eg. prosthetics, laboratory reagents and other consumables) was undertaken and concluded that there was the potential for a saving of £9m across the Trust. This could be achieved through a combination of supplier consolidation, better negotiation, managing demand and reducing stock levels. In order to realise this saving, a significant strengthening of the capacity and capability of the in-house procurement and contracts management teams, which are responsible for £92.5m of the Trust's spend, is required. Alternatively, this function could be outsourced.

- *Other variable costs (£5m):* A high-level review was carried out to establish the savings potential from outsourcing clinical support functions. Pathology and pharmacy were identified as offering the greatest benefit. An estimate of around £5m - based on current Trust operating volumes - was arrived at by making reference to benchmarks and by having discussions with potential suppliers.

Conclusion from phase one

41. The first phase of work concluded that operational efficiency improvements totaling £79m could be made over the three years 2013/14 to 2015/16, which is equivalent to 5.4% a year. The expected site split of the savings was £34m at Princess Royal University Hospital, £34m at Queen Elizabeth Hospital and £11m at Queen Mary's Hospital.

42. However, a risk assessment of capability within South London Healthcare NHS Trust assessed the Trust as only being able to deliver 55% of these savings with the current clinical and managerial leadership. Further detail on this is set out in paragraphs 63 to 68.

43. This formed the basis for the draft recommendation that the operational efficiency of the services provided by South London Healthcare NHS Trust should be improved over a three-year period such that costs were reduced by £79m by the end of 2015/16 and that, to achieve this, enhanced leadership capability would be required to drive it forward.

Phase two approach: developing detailed plans to realise the identified operational efficiency improvement opportunity

44. Following the publication of the draft report a second phase of work was undertaken in which detailed CIPs were developed to test and validate the £79m total operational efficiency improvement expectation for the three-year period 2013/14 to 2015/16 as outlined in the draft report.

45. To aid the focus of the development of the CIPs, the £79m of opportunity was allocated to each of the care groups as a target by each of the cost categories used in phase one. This ensured that CIPs broadly reflected the main areas of opportunity identified and thus would be credible.

46. All of the cost improvement schemes were developed over an intensive five-week period in which the external advisors from phase one continued to work with the leadership teams of the four care groups and corporate services. Dedicated finance, workforce and information management resources were provided to work alongside each group to develop and validate all CIPs.

47. The governance arrangements for this phase of the work included the following weekly pattern of development and review:

- a weekly meeting of the operational working group to review progress, test and challenge the work completed;
- internal Trust leads were identified and freed up to match the external consultancy support on a one-to-one basis. The external advisors and the Trust leads also met twice a week to co-ordinate the programme of work;
- a weekly internal leads meeting to ensure schemes that cut across care groups were coordinated;

- three meetings per week between the care group team and the consultancy support team; and
- throughout the five-week period there was clinical and finance engagement to ensure clinical rigour was applied and finance input incorporated.

48. In the fourth and fifth weeks the process included a review of the schemes by the Medical Director, Chief Nurse and Deputy Director of Finance to provide executive review and sign off. The CIPs were also reviewed by an independent firm who undertook a due diligence exercise on the proposed schemes and the underlying analysis.

49. The process for developing the CIPs was driven by a number of principles:

- the scale and location of improvement opportunities should be based on the cost categories identified in phase one;
- senior management and clinical engagement throughout, so that schemes would be credible and deliverable;
- internal and external clinical assessment of proposed schemes, so that patient safety and quality of care can be maintained and, where possible, improved; and
- robust internal governance processes, so that the work is undertaken with sufficient quality, scale and pace to meet the needs of the TSA process.

50. Teams from each of the four clinical care groups and corporate services developed detailed CIPs to full business case standard for year one (2013/14) and to outline business case standard for years two and three (2014/15 and 2015/16). This level of detailed planning over a three-year time period is considered to be excellent practice and beyond that routinely done in other NHS organisations.

51. The year one full business case standard CIPs all follow a similar very detailed format showing:

- the cost category that the CIP will reduce, and by how much in each of the three years;
- how costs will be reduced through specific actions in each of the three years;
- the underlying analysis that details the feasibility of the scheme;
- the impact on headcount and spend over the three years; and
- the implementation costs of the schemes, a site level split and an assessment of risk.

52. All CIPs were developed at hospital site level on the basis of the clinical and non-clinical services that are currently provided by the Trust. They therefore focus on improving the efficiency of the services as they are currently configured within the Trust. The implications of other recommendations are addressed in the relevant sections elsewhere in the report and build on the position for the Trust post this CIP work.

53. In total, £74.9m of CIPs were developed during phase two, covering the three-year period 2013/14 to 2015/16 (see figure 9). This represents 95% of the £79m total operational efficiency improvement expectation set out in the draft report.

54. In addition to CIPs developed to reduce costs based on the current configuration of South London Healthcare NHS Trust, a high-level piece of work was undertaken to assess the potential further cost savings that could be made to corporate services within the Trust if the proposed new organisational arrangements (see chapter 6 of the final report and appendix F) were implemented. This work identified £7.7m of savings could be achieved in corporate services by streamlining functions and shaping and sizing the workforce in line with the corporate services of other merged high-performing NHS trusts.

Figure 9: Total CIPs 2013/14 – 2015/16

		Improvement opportunity (phase one)		Cost Improvement Programme Schemes developed (phase two)			
Cost category	2011/12 cost base (£m)	Improvement opportunity identified from external benchmarking (£m)	Improvement opportunity identified from internal review (£m)	CIP identified year 1 (£'000)	CIP identified year 2 (£'000)	CIP identified year 3(£'000)	Total CIP identified (£'000)
ALOS	N/A	0	**6**	1.9	1.4	0	**3.3**
Medical pay	90	12	**20**	6.1	6.1	2.6	**14.8**
Nursing pay	98	17	**14**	7.3	2.5	3.9	**13.7**
ST&T pay	37	2	**4**	0.9	1.4	2.0	**4.3**
Non-clinical pay (back and middle office)	50	8	**4**	1.9	2.6	5.7	**10.2**
Supplies	72	14	**9**	4.9	5.1	5.0	**15.0**
Other variable costs	15	4	**5**	3.4	5.7	4.5	**13.6**
Total	**526**	**57**	**62**	**26.4**	**24.8**	**23.7**	**74.9**

55. Figure 9 outlines the major elements of the CIPs for the three-year period. The key components of this are:

Average length of stay (ALOS): £3.3m of CIPs developed against an identified improvement opportunity of £6m

- Inpatient bed capacity should be reduced over the three-year period as the Trust reduces its current ALOS. This should be achieved through improvements in internal working, consolidation of key inpatient areas into single geographical spaces and maximising the opportunity to reduce the number of people who stay in hospital after they are fit for discharge.

- The provision of beds should be matched to the demand, through further use of day-case wards and with bed capacity in high cost areas better aligned to patterns of demand, so that there are not more beds being staffed than are needed.

- Inpatient capacity should be reduced by approximately 90 beds across the sites over the three-year period.

Medical productivity: £14.8m of CIPs developed against an identified improvement opportunity of £20m

- The medical workforce should be redesigned to match the number of consultants to the workload, ensuring that appropriate numbers of patients are treated in each session.

- A significant component of this should be achieved by improving elective theatre utilisation to 90% over the three-year period and by increasing the number of cases per list. This will mean fewer expensive theatre sessions are needed.

- A redesign of the number of non-consultant doctors and their working patterns will realise further reductions in cost.

- Several schemes reduce the reliance on waiting list initiatives and premium spend in areas such as theatres, endoscopy and radiology and, as changes are made to working patterns, expensive locum and agency spend will reduce.

- Most of the apparent remaining opportunity in medical productivity relates to clinical income opportunities, which are captured under the non-clinical pay section (see below).

Nursing productivity: £13.7m of CIPs developed against an identified improvement opportunity of £14m

- Improved rostering control and improved management of sickness should further reduce the requirement for expensive bank and agency staff.

- The current model of nursing in theatres and wards should change, and over the three-year period a number of elements should come together, resulting in a differently structured nursing workforce.

- A different model of staffing theatres should be introduced, alongside a reduction in the number of theatre lists.

- The senior nursing structure that supports inpatient wards should be redesigned and there should be a reduction in the number of non-ward based senior posts.

- A change to the model and skill mix within midwifery should be introduced over the period.

Scientific, therapeutic & technical (ST&T) productivity: £4.3m of CIPs developed against an identified improvement opportunity of £4m

- A coherent programme of automation should enable the size of the workforce to be reduced over the three-year period, alongside the use of outsourcing of areas such as outpatient dispensing.

- The replacement of expensive on-call systems with standard terms and conditions and a modernised way of working in pathology and radiology should take place.

Non-clinical pay and income based schemes: £10.2m of cost and income schemes developed against an identified cost improvement opportunity of £4m

- The use of technology to replace current manual processes should be introduced in a number of areas across the Trust.
- Corporate services and management costs should be reduced as those functions are 'right-sized' to the activity being undertaken.
- Some of the CIPs in this area relate to income growth across clinical areas and are captured here to ensure that cost and income based schemes are not confused within the main clinical cost groupings.

Clinical supplies: £15.0m of CIPs developed against an identified improvement opportunity of £9m

- Standardising the supplies that are used by the Trust, ranging from less expensive disposable items to expensive prosthetics used in surgery, will result in significant cost savings, whilst better stock control and management should mean that the Trust will be able to carry out its activities by holding and wasting fewer stocks of supplies.
- Drug spend should be reduced through a variety of schemes and contracts for support services should be rationalised.

Other variable costs £13.6m of CIPs developed against an identified improvement opportunity of £5m

- Aligned to the CIPs to automate scientific and technical services, the outsourcing of some clinical support functions should be introduced in certain areas of the Trust.
- A different model of managing the Trust's outpatient dispensing through the provision of a non-NHS supplier should reduce cost while also delivering an improved quality of service and reduced waiting times.
- A revised managed service model for pathology should achieve further cost reductions through strengthened purchasing power.
- Further opportunities have been identified to improve the quality of patient care, which will attract best practice tariff payments.

56. During phase 2, £74.9m of CIPs were identified for the three-year period which represents 95% of the £79m target. The target is composed of a £62m productivity gap identified in phase 1 and an additional £17m of savings required to match the predicted future improvement of top performing trusts during the next three years. Thus, the CIPs identified will deliver the full £62m of productivity gap and £12.9m out of the £17m required to match ongoing improvement of top performing peer trusts. By regularly benchmarking performance and by developing a culture of continuous improvement, further opportunities should be identified over the three-year period.

57. The scale and phasing of the CIP savings for the Trust as a whole are shown in figure 10.

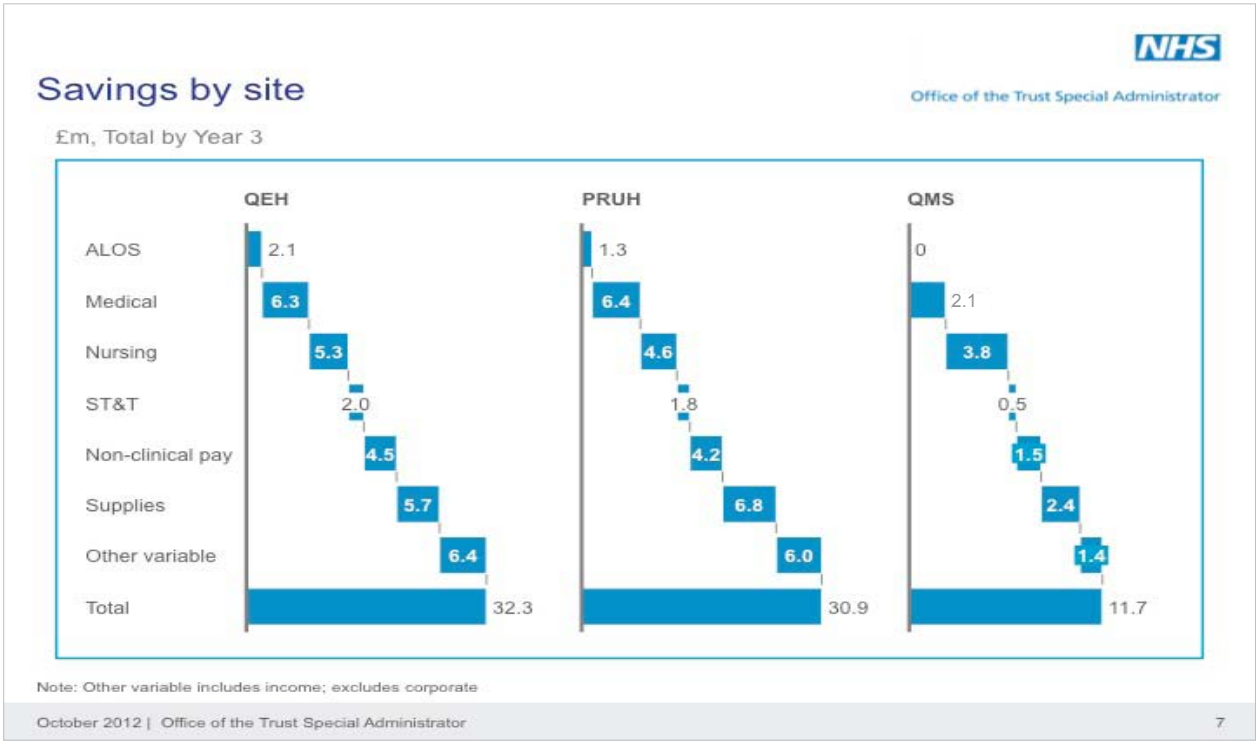
Figure 10: Total planned CIPs by year for South London Healthcare NHS Trust's services overall

Year	CIP (£m)	CIP[2] (%)
2013/14	26.4	5.4%
2014/15	24.8	5.4%
2015/16	23.7	5.4%
Total	**74.9**	**15.3%**

58. Assuming no change in configuration of services and the profile of these opportunities, the cost of operating the services at Queen Elizabeth Hospital will reduce by £32.3m over three years, at Princess Royal University Hospital the reduction will be £30.9m and at Queen Mary's Hospital the reduction will be £11.7m. The profile of the savings across the three years is shown in figure 11.

Figure 11: Planned CIPs by site and year

Year	QEH £m (%)	PRH £m (%)	QMS £m (%)
2013/14	11.2 (5.6%)	10.9 (5.3%)	4.2 (5.1%)
2014/15	10.9 (5.7%)	9.7 (5.0%)	4.3 (5.4%)
2015/16	10.2 (5.6%)	10.3 (5.6%)	3.2 (4.3%)
Total	**32.3 (16.0%)**	**30.9 (15.1%)**	**11.7 (14.1%)**
Equivalent % per annum	**5.6%**	**5.3%**	**5.0%**



2 The CIP % in year relates to the % saving on the forecast cost base at the start of the year.

59. Figures 12 to 14 show the planned CIPs by year for each of South London Healthcare NHS Trust's three main sites and the split of the planned savings across the cost categories in each of the three years.

Figure 12: Total planned CIPs by year at Queen Elizabeth Hospital

Year	CIP	CIP[3] (%)
2013/14	£11.2m	5.6%
2014/15	£10.9m	5.7%
2015/16	£10.2m	5.6%
Total	**£32.3m**	**5.6%[4]**

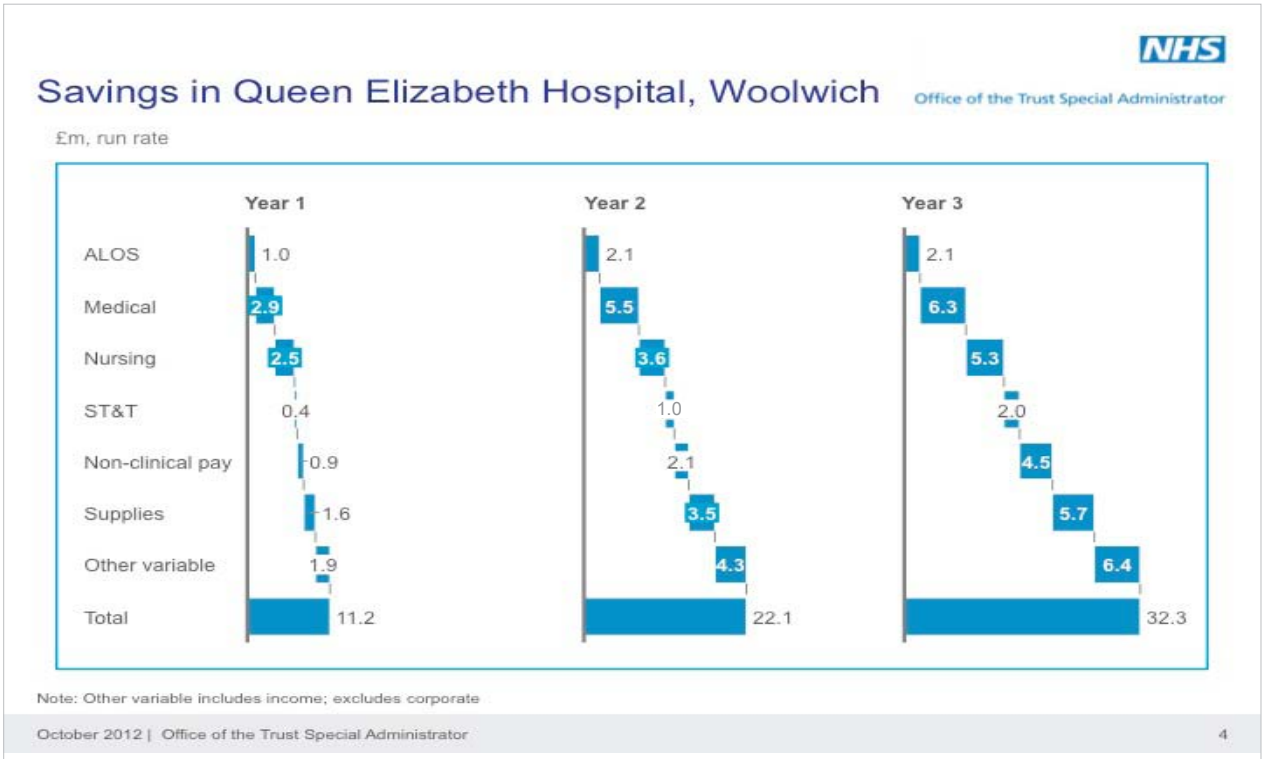


Figure 13: Total planned CIPs by year at Princess Royal University Hospital

Year	CIP	CIP[5] (%)
2013/14	£10.9m	5.3%
2014/15	£9.7m	5.0%
2015/16	£10.3m	5.6%
Total	**£30.9m**	**5.3%[6]**

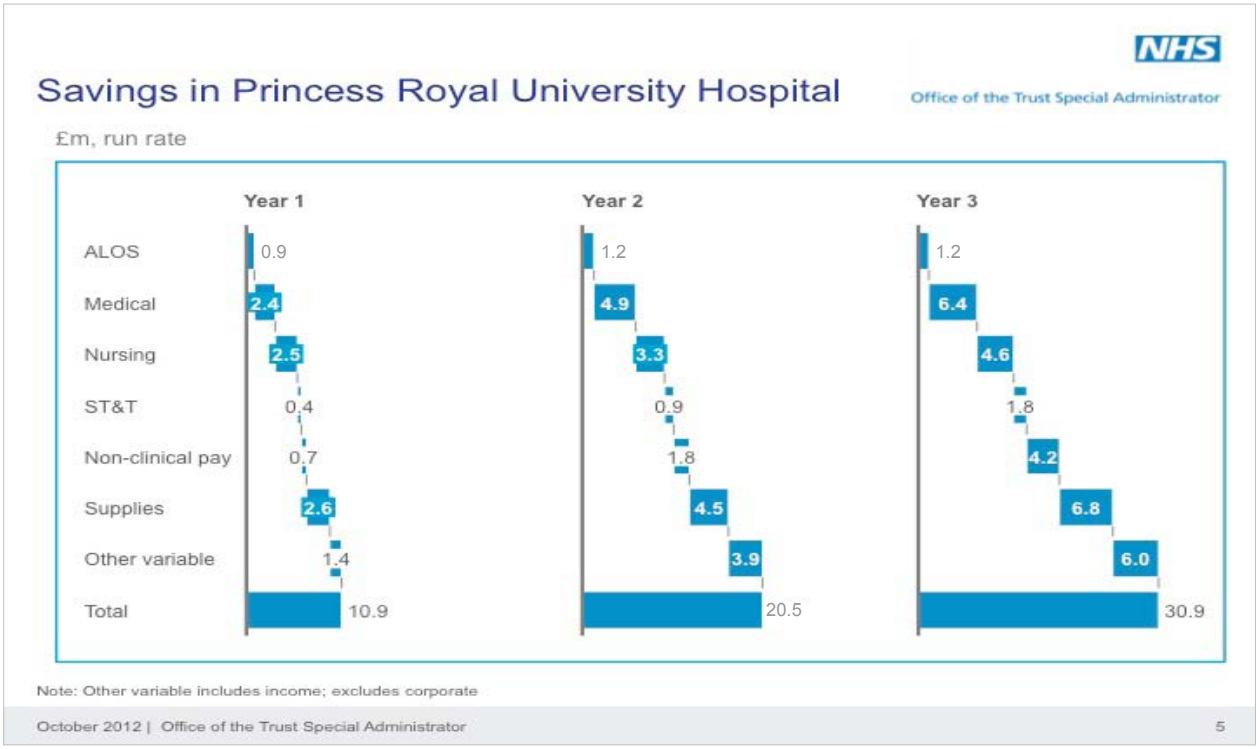
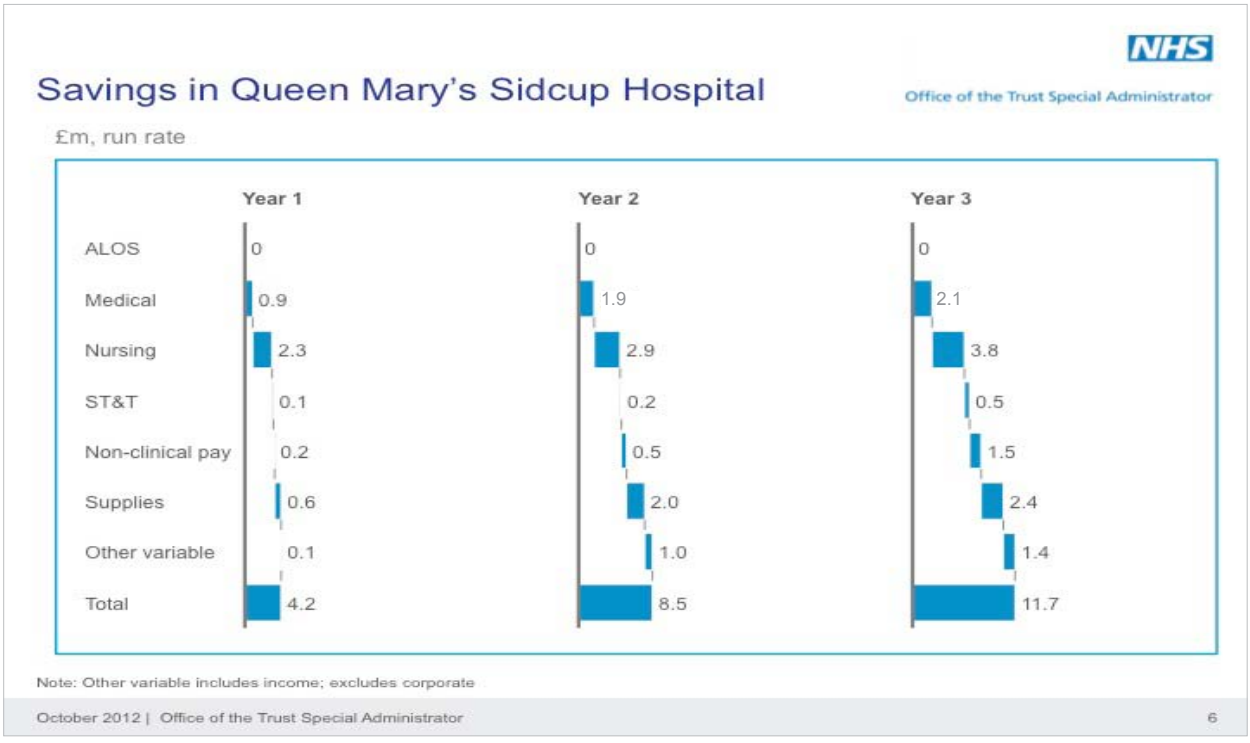


Figure 14: Total planned CIPs by year at Queen Mary's Hospital

Year	CIP	CIP[7] (%)
2013/14	£4.2m	5.1%
2014/15	£4.3m	5.4%
2015/16	£3.2m	4.3%
Total	**£11.7m**	**5.0%[8]**



60. Throughout the work, the importance of safeguarding the quality and safety of service delivery has been recognised and is paramount. A combination of internal clinicians from the key professional groups and external clinicians have been involved in the development of many of the schemes. An initial review of the schemes has been undertaken by the Trust's Chief Nurse and Medical Director and the external clinical panel. It was noted during this process that there is a very significant scale of change proposed in totality when the combined effect of all the schemes is considered. As such, a further review of the timing of the schemes should take place prior to implementation to ensure all the interdependencies, which have been mapped out, are carefully managed.

61. Four key recommendations were made following the internal and external clinical review:

- CIPs that reduce the overall bed base should be phased over two years to mitigate any risk to delivery;
- further work should be undertaken on those individual schemes where they relate to existing local and pan-London service networks;
- a robust implementation programme and safety impact assessment should be developed, to provide assurance during the delivery of schemes; and
- further assurance should be undertaken through the implementation period, so that changes do not compromise other recommendations.

62. Clinical leadership and engagement in implementing schemes will be critical to ensure successful delivery. The CIPs for all three years have been broken down by year, by site and by cost category and have been collated into a single programme plan to describe the recommended sequence for implementation. The further work recommended by the review will take place early in 2013, prior to the implementation of any schemes.

Assessment of current capacity and capability to deliver the required efficiency improvements

63. Based on the work described in the previous section, the TSA's assessment is that the opportunity exists to reduce the cost of South London Healthcare NHS Trust's current services by £79m over a three-year period and that the TSA has identified £74.9m of CIP schemes in the development of this final report.

64. Linked to the identification of the savings that could reasonably be expected by improving the productivity of the services provided by the Trust is the important question of how these improvements could be delivered that, if unanswered, would have meant that the opportunity would not be translated into actual savings. Paragraph 56 of chapter 4 describes the TSA's assessment of the culture, capacity and capability within the Trust, indicating that significant change is likely to be needed.

65. Based on the experience accumulated over the two phases of work, the analysis which underpinned it and the review of the output by the operational efficiency working group, an assessment of what levers would be required to ensure successful delivery of the CIPs has been completed. The major barriers to effective delivery identified within the Trust included:

- inadequate and insufficient consistent clinical leadership, clinical management and a lack of clinical engagement and ownership;
- inadequate consistent general and operational management capability and a lack of senior management leadership within the care groups;
- insufficiently strong board leadership;
- a lack of partnership working between clinicians and managers and a lack of collective responsibility and ownership for the services provided by the Trust; and
- inadequately developed systems and processes to provide timely and accurate information that provides insight into performance and productivity relative to peers.

66. It was therefore considered that the Trust would not be able to deliver the full operational efficiency opportunity identified through the TSA process. The capacity and capability of the Trust to reduce costs in each of the major areas identified was considered and the assessment is shown in figure 15.

Figure 15: Assessment of capacity and capability of South London Healthcare NHS Trust to deliver the required productivity improvement

Cost category	2011/12 Cost base (£m)	Validated estimate of savings (£m)	Trust capability to deliver opportunity	Risk adjusted estimate of delivered savings (£m)*
ALOS	N/A	6	Medium	4
Medical pay	90	20	Low	12
Nursing pay	98	14	Medium	8
ST&T pay	37	4	Medium – High	3
Non clinical pay (back and middle office)	50	4	Low – Medium	2
Supplies	72	9	Low	2
Other variable costs	15	5	Medium	3
Total	**526**	**62**		**34**

* Risk adjusted calculation based on:

Low capability:	20% of opportunity will be delivered
Low – Medium capability:	40% of opportunity will be delivered
Medium capability:	60% of opportunity will be delivered
Medium – High capability:	80% of opportunity will be delivered
High capability:	100% of opportunity will be delivered

67. Figure 16 details the rationale for the level of risk adjustment that was applied to each area of opportunity, based on the specific levers that were associated with each opportunity.

Figure 16: Basis for the risk adjustment to the savings opportunity by category

Cost category	Trust capability to deliver opportunity	Summary rationale for risk assessment
ALOS	Medium	Lower level of clinical engagement in the need to modernise radically the model of care delivery within hospital. Out-of-hospital systems' capacity and capability represents a significant barrier.
Medical pay	Low	Lack of co-ordinated medical management, inconsistent approach to job planning and individual performance review and a lack of clinical engagement and ownership.
Nursing pay	Medium	Lack of previous evidence-based approach has hindered leadership taking this forward. Inability to identify clearly where opportunity exists.
ST&T pay	Medium – High	Willingness amongst workforce to modernise ways of working and take advantage of technology.
Non clinical pay (back and middle office)	Low – Medium	Requires significant commercial capability, which the Trust does not have
Supplies	Low	Detailed review of procurement function showed a low level of clinical engagement in standardisation / non-pay control and a lack of commercial ability within the procurement function.
Other variable costs	Medium	Requires significant commercial capability, which the Trust does not have

68. Based on this detailed consideration, it was concluded that the Trust could deliver 55% of the £79m total opportunity – in other words £43.3m over the three-year period – and the base case was developed on this basis.

Conclusion

69. A significant and validated operational efficiency opportunity exists by improving the way in which South London Healthcare NHS Trust's services are provided. This should reduce costs by at least £74.9m over a three-year period.

70. There are significant barriers to achieving this improvement within the Trust in its current form. The barriers identified during the TSA's assessment do not exist in all trusts or, at least, not to the same extent that has been found in the Trust and, as such, it should remain possible to deliver the full level of CIPs that have been developed.

71. However, to achieve this will require cultural change across the Trust with the following elements being critical to success:

- strong board-level and local management to drive productivity changes at the clinical service line;
- significantly strengthened clinical leadership and clinical management of the medical workforce;
- significantly strengthened general and operational management;
- improved clinical and, specifically, medical engagement;
- stronger partnership working between clinicians and managers;

- strengthened job planning;
- timely and accurate information that provides insight into performance and productivity relative to peers;
- improved systems and processes to support clinicians to perform to their maximum potential; and
- significantly strengthened procurement capability.

72. This will be a challenging task that requires committed leadership. It is, however, essential if the Trust is to provide sustainable services that are value for money. Fundamentally, an engaged and aligned clinical workforce and a capable clinical and managerial leadership structure are the critical success factors. New organisational arrangements will need to facilitate and lead this change. Without this, the scale of transformation that is required will not be achieved.

Footnotes

1 £164m of 2011/12 cost base not benchmarked, including other clinical income (due to inconsistency in reporting), premises, establishment cost and non-operating costs (ie. PDC, interest, depreciation, etc.)

2 The CIP % in-year relates to the % saving on the forecast cost base at the start of the year.

3 The CIP % in-year relates to the % saving on the forecast cost base at the start of the year.

4 The total cost reduction over the three years is 16.0%, which is equivalent to 5.6% per year over the period.

5 The CIP % in-year relates to the % saving on the forecast cost base at the start of the year.

6 The total cost reduction over the three years is 15.1%, which is equivalent to 5.3% per year over the period.

7 The CIP % in year relates to the % saving on the forecast cost base at the start of the year.

8 The total cost reduction over the three years is 14.1%, at a rate of 5.0% per annum over the period.