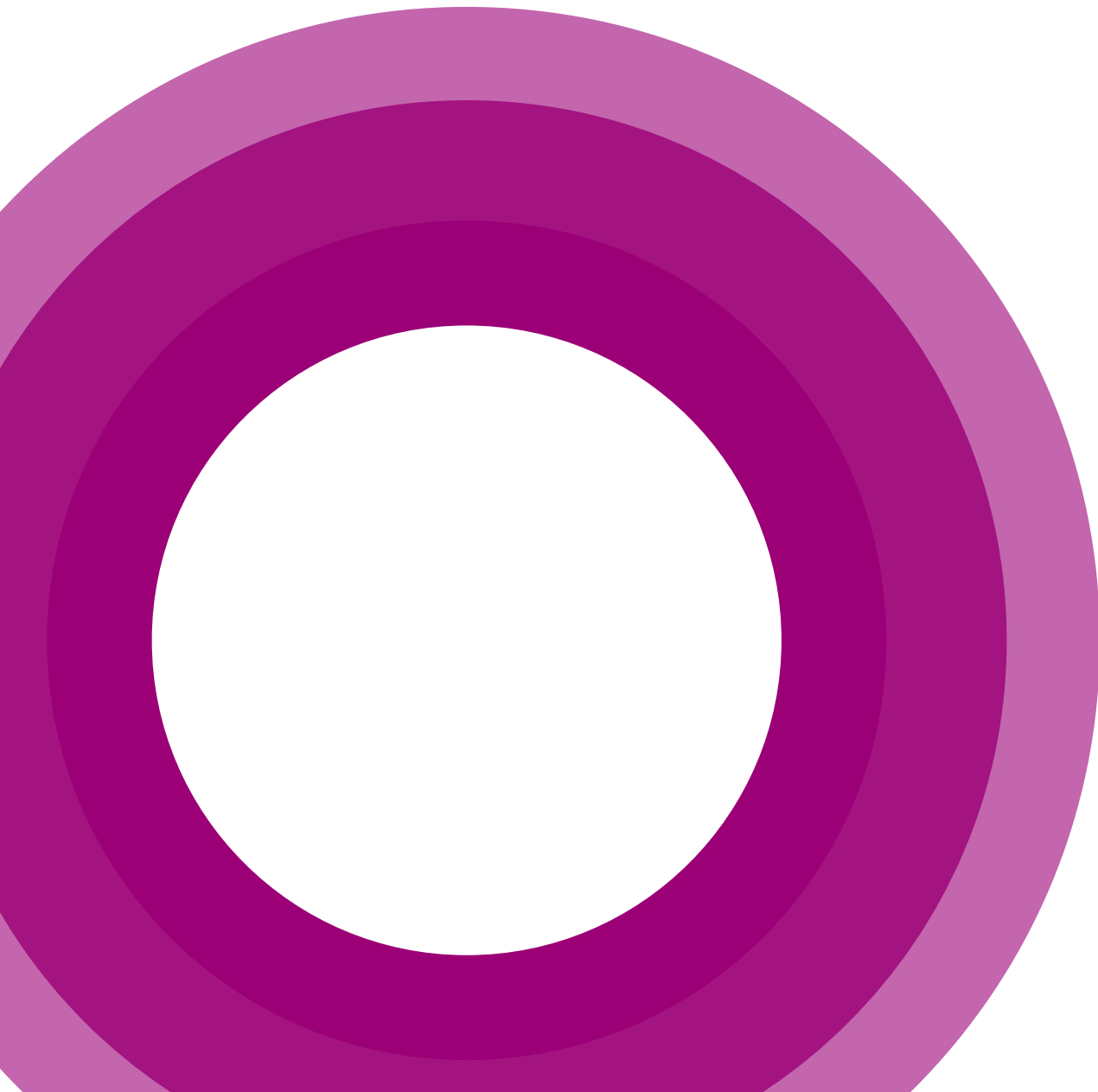




# Delivering sustainable cost improvement programmes

January 2012





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**The Commission appoints auditors to councils, NHS bodies (excluding NHS Foundation trusts), police authorities and other local public services in England, and oversees their work. The auditors we appoint are either Audit Commission employees (our in-house Audit Practice) or one of the private audit firms. Our Audit Practice also audits NHS foundation trusts under separate arrangements.**

**We also help public bodies manage the financial challenges they face by providing authoritative, unbiased, evidence-based analysis and advice.**



**Monitor, the independent regulator of NHS foundation trusts, was established in January 2004 to authorise and regulate NHS foundation trusts. Monitor is independent of central government and directly accountable to Parliament. Monitor's functions and powers are set out in the National Health Service Act 2006.**

**There are three main strands to our work:**

- determining whether NHS trusts are ready to attain NHS foundation trust status;**
- ensuring that NHS foundation trusts comply with the conditions of their authorisation – that they are well-managed and financially viable in order to deliver high quality healthcare for patients; and**
- supporting NHS foundation trust development.**

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## Summary

- 1 This guide is relevant to acute, ambulance, mental health and specialist NHS trusts and foundation trusts (collectively referred to as trusts). It should be read by executive and non-executive directors (NEDs), finance staff and those with responsibility for delivering cost improvement programmes (CIPs). It aims to better equip staff at all levels to ask challenging questions about aspects of the CIP process and to review their approach against the good practice identified. We have included a checklist of questions for this purpose in Appendix 1. Questions aimed at finance staff, medical directors, clinical and general managers are also available at: [www.audit-commission.gov.uk/cips](http://www.audit-commission.gov.uk/cips) and [www.monitor-nhsft.gov.uk/cips](http://www.monitor-nhsft.gov.uk/cips).
- 2 Some trusts are moving away from using the term CIP because they feel it does not help to engage clinical staff. Instead they use terms such as ‘transformational change programmes’ and ‘improvement programmes’. In this briefing the term CIP encompasses all efficiency and transformation programmes. We have used it because there is a wide understanding of what the term means.
- 3 The guide is based on interviews with board members, and key senior finance, clinical and project staff at 16 organisations (five NHS trusts, ten NHS foundation trusts and one primary care trust). The organisations range in size and are a cross-section of trusts from across England. The list is at Appendix 2. We are grateful to these organisations for sparing the time to contribute to the guide and for being willing to share their experiences.
- 4 CIPs are integral to all trusts’ financial planning and require good, sustained performance in order to be achieved. The NHS needs to save up to £20 billion by 2015, an average of 5% per year, the biggest efficiency challenge it has faced. Trusts will encounter a national tariff with built-in efficiency savings, reducing contract volumes with primary care trusts (PCTs) and rising inflation. There will also be fewer opportunities to use income generation to offset savings requirements. To succeed in making sustained annual savings of 5%, boards will need plans for significant transformation programmes and all will face difficult choices about the services they provide.
- 5 CIP success varies among trusts and no single approach works for all organisations. However, several factors are common in organisations performing well in CIP planning, delivery and sustainability. A successful CIP is not simply a scheme that saves money. The most successful organisations have developed long-term plans to transform clinical and non-clinical services that not only result in permanent cost savings, but also improve patient care, satisfaction and safety.
- 6 Figure 1 shows how successful organisations support CIP planning, delivery and sustainability.

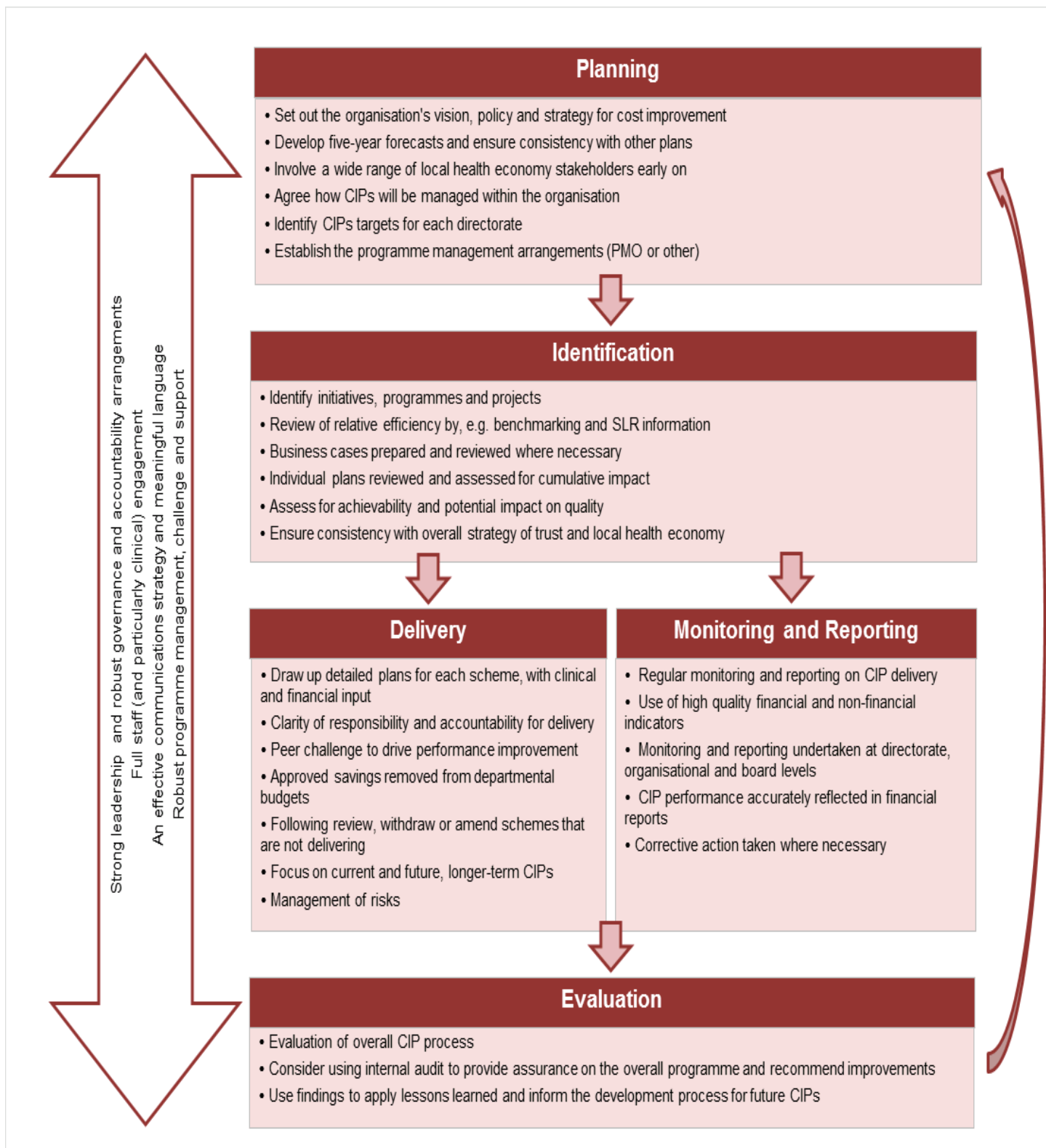
**Figure 1: Key factors in delivering sustainable CIPs**



*Source: Audit Commission and Monitor*

- 7 Despite finding nothing 'new' in delivering CIPs we did find a significant variation in approach and success. Even the most successful trusts will find CIP delivery challenging in the future and all should review their approach to managing these programmes. The consistency of the messages from higher performing organisations regarding the need for significant transformational change suggests that adopting certain ways of working can deliver planned CIPs without reducing quality and safety.
- 8 There are some generic issues and areas for improvement that all boards should consider and certain aspects of good practice that will be new to some organisations. Figure 2 shows the key elements of the CIP process. We have also included practical examples throughout the report that may be helpful.

**Figure 2: Flowchart of the CIP process in a high-performing organisation**



Source: Audit Commission and Monitor

## Introduction

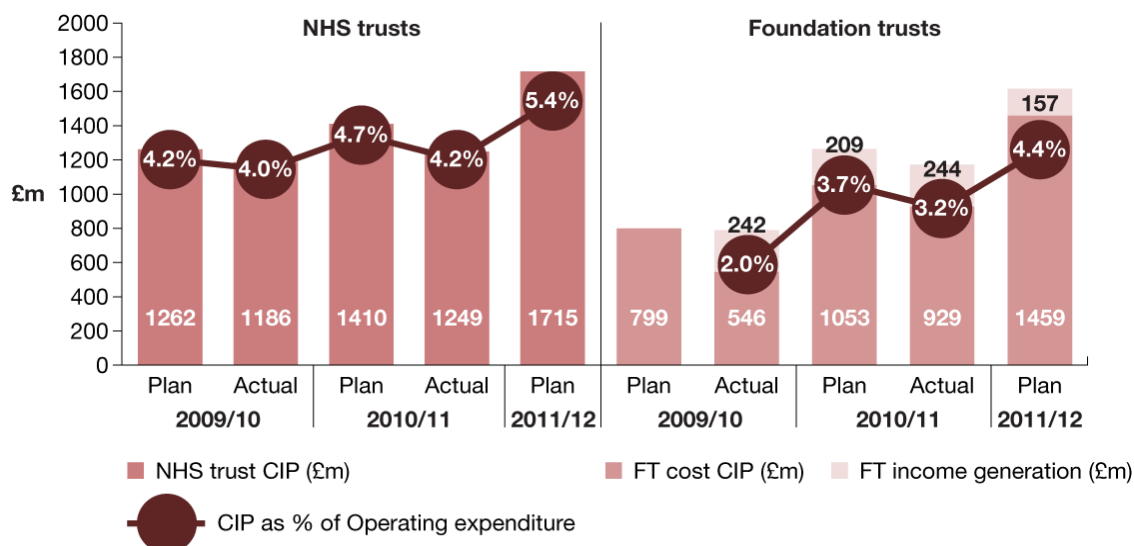
- 9 The NHS faces the largest efficiency challenge in its history. NHS organisations have used CIPs for many years to deliver and plan the savings they intend to make. However, funding growth over the last ten years has meant reduced pressure on some organisations to deliver CIPs but this is no longer the case. From 2011/12, there will be no significant real terms increase in the resources available to the NHS despite growth in demand for services, new technologies and the continuing need for quality improvement.
- 10 The 2011/12 Operating Framework (Ref. 1) set out an effective price reduction for payments to trusts of 1.5% and continued reductions in pricing for some activity, which together are expected to have a material effect on trust income. This will also apply for 2012/13 (Ref. 2). To achieve the required savings of up to £20 billion by 2015, about 5% of the NHS budget every year, NHS organisations will need to increase the size of their CIPs to make sure that savings are delivered. They are unlikely to be able to generate significant increases in income to reduce the need for savings and offset any slippage.
- 11 Monitor's experience shows that 'a well developed CIP has been the cornerstone of recent successful applications for NHS foundation trust status' (Ref. 3). CIPs are also important for existing foundation trusts to continue delivering finance targets in a tougher financial climate.
- 12 Historically, CIPs have included both recurrent and non-recurrent savings. Straightforward CIP schemes, such as vacancy freezes and a cut in use of agency staff for example, have already been carried out in most organisations. Now a more strategic approach is needed.
- 13 Trusts need to have sufficient capacity and capability within the organisation to deliver significant change at the managerial, clinical and service delivery levels. Without fundamentally transforming service delivery, which requires a determined effort and strong leadership to make larger savings, CIPs will become increasingly difficult to deliver (Ref. 4).
- 14 Organisations we spoke to frequently cited the importance of a strong, stable board and senior management team underpinned by a strong governance and accountability structure that is widely understood, as a key factor in the successful delivery of CIPs. This includes a structure to identify, manage and monitor the risks associated with implementing CIPs. In addition, it is important to have a communications plan that involves a wide range of internal and external stakeholders. These factors are considered further in this guide.

## CIP delivery 2009/10 to 2011/12

- 15** Total planned and achieved savings are increasing year-on-year in cash terms. In percentage terms both NHS trust and foundation trust 2010/11 plans were more ambitious and, in some trusts, less realistic, than for 2009/10. As a result, the achievement of plans deteriorated in 2010/11. NHS trusts' planned CIPs in 2010/11 totalled £1.4 billion and 89% of this target (£1.2 billion) was achieved. Foundation trusts' planned CIPs (relating to cost) totalled £1.1 billion and 88% of this target (£0.9 billion) was achieved (Figure 3). The percentage of foundation trusts' plans relying on income generation schemes is reducing year-on-year as a proportion of the total CIP. This is a positive trend that reflects foundation trusts' improved understanding of sustainable cost saving programmes.
- 16** Foundation trusts plan to deliver CIP savings of 4.4% of operating costs (£1.6 billion) in 2011/12, the highest level in the past five years. This is over one third more than delivered in 2010/11. NHS trusts are planning to make CIP savings of 5.4% of operating costs (£1.7 billion) in 2011/12. This is 37% more than the savings achieved in 2010/11.

**Figure 3 – Foundation trust and NHS trust CIPs from 2009/10 to 2011/12<sup>1</sup>**

The columns show the total planned and actual CIP each year. The lines show the size of the CIP as a proportion of controllable operating expenditure.



**Source: Audit Commission and Monitor**

<sup>1</sup> Notes: Formula for calculating CIP savings percentage is: Total CIPs divided by the sum of controllable operating expenditure (fixed expenditure for PFI payments is ignored) and the CIP target. Separate cost and income CIP data is not available for all years and 2011/12 planned PFI spend for NHS trusts is not available.



## Planning the CIP

There is no single approach to developing a CIP. However, organisations that develop, deliver and sustain CIPs have several factors in common. They have effective, coordinated and well-executed leadership and management which impacts positively on organisational culture and means that organisational performance is strong and consistent. A successful organisation:

- sets out clearly its overall vision, improvement strategy and philosophy;
- commits to ensuring that the organisational culture facilitates the transformation of services and improves patient experience;
- develops a five-year forecast that supports the need to plan longer-term transformation programmes;
- involves all local health economy stakeholders at an early stage;
- identifies suitable, tailored CIP targets for each division or department that reflect their relative efficiency, using benchmarking data; and
- sets up a programme management office to oversee the CIP, or define clear governance and lines of accountability.

### Planning

- 17 CIP planning should be viewed as a continual process. Successful organisations consistently highlighted the need for CIP development to start as early as possible and to approach CIP planning and delivery as a continual process, rather than as a short-term, in-year project.
- 18 Engagement from the wider directorate team is necessary at the start of the process. This ensures the schemes are realistic and owned by the directorate teams.
- 19 For most trusts, the CIP process starts in the finance department. Finance staff produce a five-year, long-term financial plan that models the forecast activity, income and expenditure, taking into account inflation and capital plans. The financial plan will identify the scale of cost savings required each year to meet financial targets and the trust's strategic plans. The proportion of savings required will vary between trusts – some will be starting from a position of having made significant savings already while others will be in more challenging positions. The finance department will allocate individual savings targets to each department. Some trusts simply apply the same percentage savings target to each department, whereas others use service line reporting and other techniques to flex targets depending on the current cost-effectiveness of individual services. All organisations should make full use of the information available to them and consider whether having the same CIP target for each department is appropriate.

- 20 University Hospitals Birmingham NHS Foundation Trust's CIP plan varies the target among divisions, with the clinical support divisions having a lower target. Each division understands the reasons and logic behind the different CIP targets. The plan more realistically reflects what is achievable, and is fairer, than having the same target across the divisions.
- 21 There are three important aspects to planning:
- *Information:* Organisations need good quality data on costs, cost drivers and comparative costs for planning and making decisions about service delivery. Assumptions should be realistic and based on accurate information. Long-term financial planning and an in-depth understanding of costs are both important elements at an early stage. West Midlands Ambulance Service NHS Trust has developed a custom-made way of collecting and monitoring performance data for forecasting both short-term changes in demand and predicting longer-term trends. Developing a sophisticated forecasting model enables the trust to use the information generated as the basis of their long-term financial plan that feeds into their CIP. The trust also shares its forecasts with other local providers.
  - *Consistency and collaboration with local partners:* Providers should not plan to increase activity in an area where, for example, the PCT is putting in place demand management plans. Similarly, providers should not plan to close a service where there is no alternative option. Ideally, responsibility for delivering Quality, Innovation, Productivity and Prevention (QIPP) schemes should be shared between PCTs and providers. However, some of the trust CIPs we looked at did not use the local QIPP plan as the starting point for their own assumptions. Some trusts felt that PCTs were not doing enough to provide alternative settings for the activity that they proposed to remove from providers.
  - *Building in contingency:* Organisations are more likely to be successful if they identify more schemes than required to meet the CIP target. South London and Maudsley NHS Foundation Trust found that starting the process earlier in the year, together with building in contingencies at the beginning, helps with delivery of the CIP. This is because there is always slippage in delivery of schemes and the process usually takes longer than originally planned to agree and finalise.

## **Governance and accountability**

- 22 While CIP planning often starts in the finance department, more detailed service planning should be led by directorates or divisions. The finance department can act as a facilitator by providing data, analysis, training and financial literacy, but CIPs should have corporate ownership and clinical input and be given high priority within the organisation. Organisations that deliver realistic and successful CIPs involve all staff groups in the CIP process and have clear communications plans in place to ensure the message is recognised and well understood throughout the organisation. Some organisations have initiated poster campaigns

in non-patient areas to help spread the message. These will typically include details of the large schemes, updates on achievements so far and how to get involved or share ideas. North East Ambulance Service NHS Foundation Trust has introduced a staff suggestion scheme called the Big Idea and several of the ideas put forward have developed into CIP schemes. Although not all the suggestions are large in value or realistic in scope, a major benefit is to engage staff in a debate about why savings are required and what they can do to help.

## **Quality**

- 23** Boards have an obligation to maintain or improve quality. Quality and efficiency should go hand in hand and improved services often cost less. The potential risks that cost savings schemes can have on quality of services must be assessed. To do this effectively, the right information is needed in order to understand the potential risks to quality and plans need to be put in place to ensure action is taken before quality deteriorates. If there is a negative impact on quality, the board should be made aware as soon as it occurs.
- 24** Organisations that are successful in delivering CIPs have clear governance and accountability arrangements in place that are fully embedded within the organisational culture. Case study 1 shows how one trust has developed a management structure to secure clinical engagement.

## Case study 1

### Brighton and Sussex University Hospitals NHS Trust: Improving clinical engagement

In 2010 the trust recognised the need to strengthen clinical engagement to help improve the efficiency and quality of the services they deliver. As a result, they created a new Clinical Chief of Finance role to support the directorate clinical leads. This role provides a clear link between finance staff and clinicians and plays a key role in:

- challenging clinical directorates about opportunities for savings, for example by identifying use of expensive drugs, considering list management and theatre use;
- supporting the evaluation of the financial and qualitative impact of proposed business cases;
- supporting and challenging the directorates at all stages of the CIP process; and
- assessing the potential impact on quality and safety of individual CIP schemes.

Specific responsibilities assigned to the role include leading the trust's service line reporting<sup>2</sup> (SLR) programme, chairing the trust's Business Case and Investment Group and acting as Clinical Director for the Finance and Business Support Division and Programme Management Office Director.

This role has had a very positive impact in the trust, bridging the gap between finance and clinical services. Examples of key benefits include:

- reduced re-admissions through improved monitoring;
- an increase in coded procedures per episode since implementing changes to the clinical coding process;
- clinically informed scrutiny of new investment business cases;
- clinically-led SLR, which has increased ownership of data by clinicians and helped them to challenge their cost base and use of support services; and
- increased focus on quality improvement resulting in efficiency, for example, unnecessary testing and prescribing resulting in £1million savings in urology.

This novel approach to clinical engagement has received national recognition. The trust's Clinical Chief of Finance, Philip Thomas, was awarded the Healthcare Financial Management Association's Working with Finance – Clinician of the Year award in 2010.

*Source: Audit Commission and Monitor*

- 25 A clear message is needed to highlight to the organisation the importance of the CIP process, including monitoring the potential impact on quality. The Board at University Hospitals Birmingham NHS Foundation Trust, for example, is clear that poor quality costs more. Their message to staff is that improving quality

<sup>2</sup> SLR gives a clear picture of how each service is working, at both an operational and financial level.

should drive all their activities and that this approach will also increase efficiency and save money.

- 26** Many organisations are moving towards a stronger clinical management structure with clinical leads holding responsibility for service delivery. This enables quality improvement and efficiency to be considered together. Northumbria Healthcare NHS Foundation Trust has moved to a structure where clinicians are accountable for services and case study 2 shows how the trust devolves responsibility for CIPs through the organisation.

## Case study 2

### Northumbria Healthcare NHS Foundation Trust: The implementation of a service line structure

Northumbria Healthcare NHS Foundation Trust has been operating within a service line management (SLM) structure for some time. The trust is organised into five business units with a Business Unit Director (BUD) heading each one, with one BUD GP leading community services. The BUD role is held by a consultant. Half of each BUD's time is spent on the management role and half on clinical commitments to ensure they remain connected to their respective service areas. Each BUD works in partnership with a divisional director and lead nurse with HR, finance and information managers providing dedicated support.

The BUDs are held to account by the Board and are operationally responsible for all aspects of service delivery. They are integral to the CIP process as they lead the planning on behalf of the business unit and manage the process to ensure subsequent delivery to plan and timescale. The trust understands that in order to achieve sustainable service transformation clinicians need to be fully engaged and have an active leadership role in the business. The benefits of this approach are:

- clinicians have a better understanding of the organisation and consequently feel more involved;
- any potential negative impact on quality and safety is considered at the CIP planning stage, with these schemes ruled out early;
- clinicians understand their services and know what can and what cannot be achieved safely; and
- the BUDs welcome the devolved responsibility and feel as though they can influence the process.

The trust runs a Clinical Policy Group that meets monthly. All CIP schemes are discussed at this meeting on a quarterly basis, with the focus on quality impact of CIPs. The BUDs present the CIP plans on behalf of their business unit. There is a healthy degree of challenge from other BUDs, lead clinicians and external parties (GPs representatives are also on the group). Progress against CIP delivery is reported to the group during the year. The meeting provides a mix of clinical support and challenge as the BUDs are openly held to account and challenged by clinical colleagues.

*Source: Audit Commission and Monitor*

## Identifying CIP schemes

Trusts have different approaches for identifying CIP schemes. Most will know where they need to make changes, but there should be supporting evidence and involvement from all staff. Seeking input from stakeholders, including PCTs, GPs, social care and third sector providers is also beneficial.

Successful organisations:

- build in dedicated time to enable all staff, clinical and non-clinical, to step back from their day jobs and produce new ideas for service change;
- use benchmarking performance data to help identify saving opportunities and engage clinicians;
- rigorously appraise potential schemes for achievability and impact on quality;
- check that schemes are consistent with the overall strategic direction of the organisation and the plans of partners; and
- fully engage clinicians and other staff to achieve change that is both transformational and genuinely produces realistic, sustainable cost savings.

## Identifying individual CIP schemes

27 Well-managed, well-informed trusts recognise the need to provide support to budget holders where required. There is much variation in the methods employed and we found that no one system fits all. There are several consistent factors and these include:

- developing annual savings targets for each division or department. The identification of plans to meet that target then becomes the responsibility of each budget holder;
  - developing schemes that are balanced between trust-wide corporate schemes, large transformational schemes and smaller departmental schemes;
  - the finance department providing budget holders with the right information to identify savings and protect or invest in profitable services. Appendix 3 lists various sources of benchmarking data available to the NHS; and
  - holding specific sessions for producing ideas through brainstorming using benchmarking data, clinical data and service line reporting information that results in viable ideas that can be followed up in more detail by individual teams.
- 28 Learning from what has worked and what has not should be key part of the process. For example, Sherwood Forest NHS Foundation Trust reviewed

directorate-based CIP schemes that had been successfully delivered to see whether similar schemes could be implemented in other directorates. They also reviewed previously rejected schemes to verify whether factors had changed sufficiently to enable successful implementation.

- 29 SLR and benchmarking information helps budget holders to identify savings, transform services and present evidence to staff to help engage them in the change process. It highlights variation within services which supports teams to identify the inefficiencies and areas for improvement. Several organisations had encouraged staff to identify potential CIP schemes through using SLR data.
- 30 All successful organisations plan and identify CIP schemes over the short and long-term. By planning in good time and making inroads into years three to five of the CIP, delivery is much more likely. This is necessary where schemes are transformational and require lengthy consultation or investment. Case study 3 describes the approach taken by University Hospital Southampton NHS Foundation Trust.



## Case study 3

### University Hospital Southampton NHS Foundation Trust: The production of a five-year CIP plan

The trust recognises that it needs to make continuous efficiency improvements to maintain patient-focused, high-quality, safe care. The trust sees delivery of its five-year rolling CIP plan as a key enabler for real cost reduction and continued achievement of financial balance.

The trust has had its five-year CIP plan in place for two years and the plan is revised annually. Top-down and bottom-up approaches are taken to ensure that schemes identified are strategic and transformational as well as realistic and supported at the operational level.

At a strategic level the trust develops key savings themes in line with the transformational change programme planned over the next five years. Examples of this are reductions in length of stay and reforming the outpatient booking process. The trust Board communicates these themes widely.

Following this, directorate operational teams develop plans under these key themes with clinicians and front line staff. The executive team provide both a support and challenge function. All staff have the opportunity to feed suggestions and ideas into the process and are encouraged to look for opportunities within their own areas.

The trust has found that this approach has shifted the emphasis and culture from traditional savings towards quality improvement.

The introduction of the five-year plan, and trust-wide rules around CIP definitions, has helped to focus the trust on earlier identification of recurrent schemes and encouraged a medium to long-term view to be taken in the identification of schemes.

The trust has developed schemes up to a minimum value level of 65% of the total for the years up to 2015/16. Further identification of savings schemes will continue, driven by the trust's programme management office (PMO).

*Source: Audit Commission and Monitor*

## Assessing individual CIP schemes

- 31 Early scrutiny makes it easier to remove unrealistic or unsafe schemes before committing time and resources. Finance departments have a clear role to play in supporting staff to identify and quantify potential savings, their achievability and risks. Organisations may rank savings schemes, especially where they require investment and involvement of other parts of the organisations such as HR, IT and estates.
- 32 All organisations assess CIP schemes for the potential impact on quality and safety and there are different models for this. For example, all CIP schemes at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust are

assessed for the impact on quality by the PMO. Northumbria Healthcare NHS Foundation Trust focuses on those schemes that are higher risk because the trust works within an established SLM structure with all business units being led by a consultant who manages the entire CIP process.

- 33** Most organisations have a system in place for formal sign off of clinical CIP schemes. The Operating Framework 2012/13 requires NHS trust CIPs to be agreed by medical directors and directors of nursing and include in-built assurance of patient safety and quality (Ref. 2). Trusts should also be aware of non-clinical schemes that could have a quality impact, for instance, changes to the frequency of ward cleaning.
- 34** In organisations where service line leads manage the CIP process, an impact assessment on quality and safety will be completed in the planning stage and schemes that are considered unrealistic or that pose a risk to quality will not be put forward. In trusts where the CIP is not clinically led, this impact assessment should take place once the CIP long list has been drawn up and clinicians must be involved in this process. In challenging financial times it is increasingly likely that all CIP schemes will need some form of quality impact assessment. In addition to doing this assessment at the planning stage, organisations should also do this during delivery, at key milestones and post-implementation to ensure sustainability.
- 35** Developing safe, realistic CIPs requires clinical leadership and engagement. Organisations with a culture of strong clinical leadership develop more rounded CIPs as the individuals leading the service are also those delivering the care. Organisations that have adopted a service line management approach with access to service line data appear to be stronger at CIP delivery.
- 36** A comprehensive delivery plan for all the schemes is necessary once an organisation has identified the individual CIP saving schemes. This will set out the details of the scheme, the milestones, a risk assessment if appropriate, a lead officer and how to measure success. A number of the organisations we visited had a PMO or similar to support this, but other organisations had internal structures and methods of accountability to ensure CIPs were appropriately managed.
- 37** The cumulative impact of CIPs should be assessed. Individual schemes at a directorate or divisional level might not appear high-risk but the overall impact might result in risks to delivery. For example, if a directorate closes some beds the impact at a directorate level might be minimal, but significant for the organisation if other directorates are also closing beds. It may impact on staffing across the organisation, with staff needing to be moved to other areas.
- 38** Monitor's guide for foundation trust applicants (Ref. 5) highlights good practice and suggestions for identifying, planning, managing, delivering and assessing CIPs and can be found at Appendix 4. Nottinghamshire Healthcare NHS Trust assesses the impact of its transformation programme on quality and based its approach on Monitor's guidance (case study 4).

## Case study 4

### Nottinghamshire Healthcare NHS Trust: Quality assurance process and use of clinical panels

The trust has a transformation programme that will result in significant changes to the way healthcare is delivered. The trust and its Divisional Leadership Group wants assurance that it can maintain patient safety and outcomes. It has set up an independent panel to assess the clinical impact of the CIP, including risk management. The remit of the panel is to:

- examine in detail the proposed divisional cost improvements, analysing potential risk in relation to the delivery of clinical services; and
- report and make recommendations to the divisional leadership group.

The panel holds a preparatory meeting once a year and then meets again over several days to consider each directorate's plans in detail. The standing membership consists of specifically selected clinicians from ward manager level to associate director and several invited doctors, representing the directorate being considered.

The format of the panel is to consider a detailed analysis of the CIP against the trust's own risk assessment tool. The Clinical Director and General Manager also attend to advise the panel and to provide assurances against concerns raised.

Clinical panels are advisory but provide a view on all quality issues including patient safety, experience and clinical effectiveness. The panels contribute while the transformation takes place, rather than just during the identification of savings schemes. Directors consider any risks, which the panels feed into risk registers.

The trust feels that the panels have resulted in:

- improved clinical engagement,
- an embedded culture of quality throughout the organisation;
- improved clinician buy-in to the CIP schemes; and
- extra scrutiny and board assurance.

The trust believes that a good assurance framework allows clinicians to create a good CIP. By embedding this culture now, the trust considers it will be in a stronger position to deliver CIPs in future years when savings will become harder to achieve.

*Source: Audit Commission and Monitor*

## Approving schemes

- 39 Some organisations use a series of gateways for approving CIP schemes. This may also involve rating or scoring schemes to ensure they meet basic requirements. This should take place before the schemes are started and money removed from the budget. Mid Essex Hospital Services NHS Trust uses a gateway process to provide rigour to its CIP development (case study 5).

### Case study 5

#### Mid Essex Hospital Services NHS Trust: Developing the gateway process to evaluate individual CIP schemes

To add rigour to the CIP, the trust developed three stages or gateways each individual CIP scheme must go through. Each gateway links to key questions and decisions, required inputs and outputs:

**Gate 1** occurs after the generation of CIP ideas and includes clearly defining the potential scheme and a high-level review of the costs and benefits. Schemes that are unlikely to deliver, or are not consistent with the organisation's strategic objectives, are rejected at this stage.

**Gate 2** is the validation of schemes and involves a review of the detailed business case, including a full costing and quality impact assessment and risk assessment.

**Gate 3** involves the review of implementation plans and only schemes that have reached and passed Gate 3 are carried out and included in operational and financial plans. All schemes have to be approved by the Medical Director and Chief Nurse before moving through Gate 3.

While it is in the early stages of implementation, early indications of the benefits of the gateways are:

- time is not wasted on schemes that are unlikely to be successful. Only those schemes that will deliver savings without having a negative impact on the quality of services are implemented;
- formalising the approach means there is documentation supporting each stage, which is essential from a governance and reporting perspective; and
- the removal of savings from the budget only takes place when they are certain to be delivered.

Additional details of the gateway can be found at: [www.audit-commission.gov.uk/cips](http://www.audit-commission.gov.uk/cips).

*Source: Audit Commission and Monitor*

## Delivering the CIP

**Delivery of approved savings plans is the responsibility of individual managers or clinicians but they will not succeed without the support of others.**

**Successful organisations:**

- **have strong leaders who are capable of driving sustained change;**
- **set up a PMO, or establish an alternative reporting and accountability structure, to keep delivery on track, provide challenge when needed and support staff to manage delivery risks;**
- **write detailed plans, in language that increases clinical and front-line support through an emphasis on service transformation and improvement rather than cost saving;**
- **focus heavily on reinforcing an organisational culture that promotes the interest of patients as well as financial and performance targets;**
- **clearly identify who is responsible for delivering each CIP scheme and how they are accountable for quality, finance and performance; and**
- **withdraw CIPs that are not having a positive impact on these areas.**

**As well as concentrating on delivering the current year CIP, trusts should take action at an early stage to support delivery in future years.**

### **Project documentation**

**40** Delivery of CIPs is most likely when there is a good project plan, especially for larger value, high-risk or complex CIPs. A good project plan includes:

- financial savings and how they will be measured;
- quality impact assessment;
- key performance indicators to measure improvements;
- a risk log with a named senior risk officer;
- interdependency with other CIPs;
- dependency on other organisational work streams and strategies;
- project milestones;
- major work required, such as staff and public consultations; and
- a communications plan.

## Project management

- 41 Most PMOs will, by definition, be expert in project management. As outlined in case study 6, PMOs provide support to staff to keep savings plans on track and meet milestones. Many organisations choose not to have a PMO and have alternative plans in place to provide support and ensure savings are delivered.

### Case study 6:

#### The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust's Programme Management Office (PMO)

Eight clinical directors are accountable for operational delivery, including taking the lead on service transformation and CIP planning, development and delivery.

Three years ago, the trust recognised the significant challenges facing the NHS and the need to coordinate the management of the transformation projects. This required a formal approach to project management and a PMO was established. The PMO provides project management expertise and delivers evidence-based assurance of progress against plan. It also supports directorates to generate new ideas through the use of tools and techniques supplied by the Institute of Innovation and Improvement and via networking and sharing good practice with other organisations both in and outside the NHS.

The PMO coordinates all CIP schemes and supports directorates to develop schemes to deliver agreed annual savings targets. Directorates then provide evidence of progress against plan and are held accountable for delivery against target. All directorate schemes are detailed in a directorate-owned CIP tracker. Crucially, this document is owned, updated and verified by the directorate, with financial management support. The PMO adds value, not only by ensuring schemes are delivering to plan and timescale, but also in ensuring any cumulative impact of CIPs are identified, monitored and managed.

Individual initiatives are assigned a green, amber or red status depending on the level of risk to delivery. This provides a holistic picture that supports directorates to understand performance against plan and the need for corrective or alternative action.

The PMO is not a finance-led function. It is managed through the chief operating officer. It follows PRINCE2 methodology for all corporate projects and provides assurance to the Board that the Transformation Programme is delivering the corporate objectives of improving patient care, while contributing to the savings targets. All projects are managed so patient care quality indicators are maintained or improved before making any budget adjustments.

*Source: Audit Commission and Monitor*

- 42 Some organisations with a PMO consider that it balances support and challenge with the added benefit of being objective.

- 43 One clear benefit of a PMO is the coordination and review of all schemes across the trust. This enables the cumulative impact of schemes to be assessed. This is sometimes not the case with structures that are more directorate-based.
- 44 Our research highlighted that if the organisational structure is clear, with accountability arrangements in place and working, a PMO function is not always needed. This depends on individual trust circumstances and the challenges they face, including the complexity, interdependency and volume of CIP schemes, together with the effectiveness of the organisational structure. Some organisations operating within a SLM structure did not feel a PMO would offer them any further benefits because the function of the PMO is carried out between the trust board and divisional teams.
- 45 Trusts often use external consultants to establish a PMO. It is important to get best value from such arrangements and retain learning and expertise once the consultants have left. External consultants cannot be a substitute for developing an organisational culture that promotes patient experience while seeking transformation cost savings. Establishing a PMO will not itself deliver sustainable, safe CIPs.

### **Building understanding**

- 46 Effective CIP delivery requires staff engagement at all levels. It is important to be honest about the need for savings and the delivery challenge. Organisations should consider how to communicate this effectively to teams.
- 47 Many organisations we visited spoke of the importance of building consensus for change at all levels and of giving clinicians and staff a lead role. Actions taken include distribution of information through staff briefings, intranet sites and using clinical policy forums to debate changes. After communicating with staff about the need for savings, it is important that they know about significant individual schemes and how successful they have been. One trust made a communications plan a specific requirement of CIP documentation.
- 48 Organisations also reinforced the importance of staff training. In some organisations finance training, including CIP management, is mandatory for service and clinical leads. Coventry and Warwickshire Partnership NHS Trust's finance department provides specific CIP management training for all budget holders (case study 7).

## Case study 7

### Coventry and Warwickshire Partnership NHS Trust: Benefits of effective communication

The trust is clear that its transformation programme will be delivered by the whole organisation. Its strap line is 'making every contact count', which aims to ensure that staff avoid unnecessary duplication of work with patients and hence become more efficient.

The trust's top 40 or so managers meet as the leadership team and then communicate a consistent message about CIPs to staff across the trust. The trust believes this helps achieve CIP delivery through 'ratifying' the plans by demonstrating there is no hidden agenda. Through improving awareness of the plans and harnessing the 'rumour principle' (by getting people talking about plans) the leadership team can energise and motivate staff until they are fully committed to delivering the trust's transformation programme.

The finance department also plays a key role by providing training for all budget holders on all aspects of the CIP. For the trust, the benefit of embedding a culture of financial literacy is that clinicians and other staff are far more aware of the costs attached to their decisions. Staff also understand more clearly the link between the trust's statutory financial duties and savings requirements.

A copy of the trust's training presentation can be found at:

[www.audit-commission.gov.uk/cips](http://www.audit-commission.gov.uk/cips)

*Source: Audit Commission and Monitor*

## Ensuring success

- 49 The continuous nature of CIPs and the scale of the challenge over the next four years and beyond means that success can only come when an entire organisation is committed, from senior managers to front-line staff. Many organisations that have adopted, or are starting to adopt, an SLM approach with devolved responsibility and accountability into service lines tend to have embedded models of clinical leadership. Organisations that work within an SLM structure feel the benefits are significant in ensuring CIPs do not negatively impact on quality and in delivering true, clinically led transformational change.
- 50 Some organisations are starting to consider how best to incentivise CIP delivery. This was not well-developed, but our research participants saw it as increasingly important. Organisations are considering the use of service line reporting to incentivise or reward profitable services with reduced CIP targets and, where CIP targets are over achieved, to make some of the excess available for reinvestment.



## Monitoring and reporting

Monitoring and reporting arrangements vary according to an organisation's governance and accountability framework and the risk associated with delivery of CIPs. Successful organisations:

- monitor CIP delivery weekly and also according to the risk associated with delivery of the overall CIP target and to individual schemes;
- monitor quality continually, as an essential part of corporate risk management;
- select informative key performance indicators (KPIs) and effective controls to ensure the quality of underlying data are reliable for effective monitoring and reporting;
- produce tailored reports that meet the differing needs of users in the governance chain;
- accurately reflect CIP performance in finance reports; and
- take timely, corrective action where necessary.

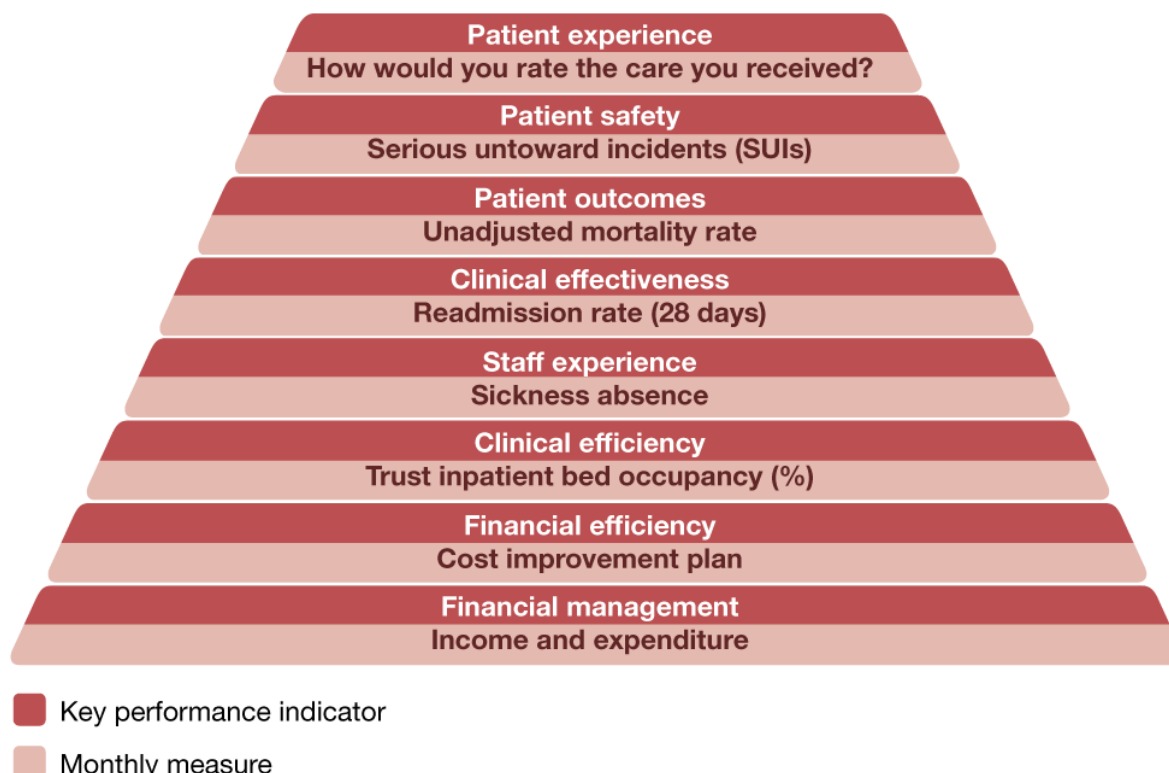
### Arrangements for monitoring CIP performance

- 51 Better performing organisations have good arrangements for regularly monitoring CIP delivery. This allows for timely action to deal with slippage on plans or any unanticipated adverse impact on patient experience or quality of services. In such organisations, the PMO (if used), finance and other senior managers consider CIP performance weekly or every other week and will review schemes that are on track as well as those that are underperforming.
- 52 The organisations we visited all agreed that effective communications are needed to ensure that individuals' responsibilities are clear and that staff are aware and understand what is required of them. Teams need to know what is expected and be signed up to delivering the CIP - they also need clear roles and responsibilities for governance arrangements to work effectively.
- 53 Flowcharts are a useful visual representation of governance arrangements, particularly where responsibilities overlap, for example, where CIPs cover several departments or specialties. Many trusts use performance management arrangements to hold individuals to account for their CIP responsibilities.

### Ongoing measurement of impact on quality

- 54 A quality impact assessment should be made when both developing and monitoring CIPs during delivery. Quality is usually measured in terms of patient experience, patient safety and clinical quality. KPIs and risk ratings should be assigned and agreed by sponsoring individuals and departments. The example in Figure 4 is from University Hospital Southampton NHS Foundation Trust.

**Figure 4: Quality Indicator Pyramid (QIP)**



*Source: University Hospital Southampton NHS Foundation Trust*

**55** For many organisations, regular reassessment of the quality impact of CIP schemes is an integral part of monitoring arrangements. Trusts should have clear escalation procedures in place for when they identify quality issues and risk ratings worsen. This includes taking remedial action to manage risks to an acceptable level which may involve tighter management to bring the risk under control or, if necessary, abandoning a scheme.

### **Internal and external performance reporting**

**56** Trusts use different types of report to monitor CIP schemes depending on the organisation and the size of the CIP. Reports for individual departments will be tailored to meet specific requirements and reports used by the PMO or finance team will be much more detailed than the information reported to the board. A suite of reports available at individual scheme, directorate and service level are a necessary part of effective monitoring, however all levels of reporting should include a consistent message about performance.

- 57** At the trusts we visited, PMOs, finance teams and budget holders made use of detailed databases and CIP trackers to prepare monitoring reports. These reports typically include:
- description of individual CIP schemes;
  - a named responsible officer;
  - savings profiled over the year and longer;
  - a risk rating;
  - split of recurrent or non-recurrent savings, and part and full year effects;
  - split of pay and non-pay costs;
  - performance against quality and productivity KPIs;
  - separately identified income generation schemes, so as not to allow efficiency savings targets to be masked by additional income;
  - review dates; and
  - summary narrative and action plans.
- 58** Good quality underlying data is important for management and the board to identify appropriate actions and check whether priorities are being delivered.
- 59** We found that most trusts present summary board reports which flag key issues and risks. Dashboard reports that focus on priority areas and include risk assessed KPIs are a good visual representation of performance, but these vary significantly across organisations. Case study 9 shows University College London Hospitals NHS Foundation Trust's approach.

## Case study 8

### University College London Hospitals NHS Foundation Trust: CIP monitoring arrangements

The Quality, Efficiency and Productivity (QEP) programme at University College London Hospitals NHS Foundation Trust is monitored through a programme office with clear reporting lines from the Executive Board, via the QEP Programme Board, to the clinical services.

A monthly pack is produced that identifies savings by budget and by the trust's five transformational strands. The trust finance team has produced guidance on what can be counted as an efficiency to ensure that the organisation delivers recurrent, sustainable costs savings. Financial performance is linked to operational performance and quality. Each programme has operational and quality measures such as utilisation and patient experience to ensure there is no adverse impact on the quality of services.

An example pack produce by the trust is available at [www.monitor-nhsft.gov.uk/cips](http://www.monitor-nhsft.gov.uk/cips).

*Source: Audit Commission and Monitor*

- 60 Board reports should be sufficiently detailed and highlight high risk areas to allow NEDs to provide proper challenge. Some trusts found brief explanations for the CIP risk assessments prompted focused board discussion. Where there is slippage on schemes or emerging quality issues the board should be made aware of the actions planned and taken to improve the position.
- 61 Trusts should consider the risk to the organisation of not delivering schemes when considering the level at which monitoring reports are considered. Higher value corporate and transformational schemes should be a high priority in the board's strategic risk register, as well as part of the CIP monitoring process. Departmental schemes may be monitored by the PMO, or alternative, and on an exception basis by the board. Lower value, lower risk schemes may be monitored either at departmental level, or less frequently, to allow senior management to focus on the most important areas.

### Reconciliation to the ledger

- 62 Trusts should reconcile their CIP to the ledger and ensure financial forecasts fully reflect CIP performance. Some organisations have databases that allow them to drill down into CIPs from workstreams through to ledger codes. Other organisations built up the CIP from ledger codes. This provides a hard measurement of achievement and trusts with this information are able to remove the full year recurrent saving from the following year's budget line with confidence.
- 63 Finance departments should also have a clear audit trail providing assurance that savings are being made. In many trusts, finance staff work with divisional staff to identify the data sources to validate cost savings. Management

accountants would then review invoices, payroll feeds and other documents each month to ensure reported savings were measured and be seen in a reduction to expenditure coded to the general ledger.

## Assuring and evaluating the CIP

Our research highlighted that not all trusts seek assurance or evaluate their programmes to improve current and future CIPs. Few have formal evaluation frameworks in place. Arrangements do not have to be complex, but should form a natural part of the monitoring and reporting cycle. Successful organisations:

- seek assurance on their arrangements for delivering the CIP by using internal audit, or a similar independent and objective reviewer;
- evaluate their programmes; and
- use the findings to make changes and improve future CIPs.

### Assurance

64 Many trusts have used internal audit to provide their board with assurance about how well their development, implementation and monitoring processes work. Nottinghamshire Healthcare NHS Trust commissioned its internal audit provider to undertake a review of its CIP arrangements. The auditor then benchmarked performance with four other trusts in the local health economy using a red/amber/green rating for key CIP controls.

### Evaluation

- 65 Trusts should define their approach to evaluation at the beginning of the CIP process, including: evaluation within initial objectives; how actions from lessons learned will be taken forward; and how staff members from all levels and departments will feed into the evaluation process. Trusts should evaluate how the project has been carried out, including an assessment of the programme management, and whether any lessons can be learned from each stage.
- 66 Trusts should ask themselves whether they delivered the CIP for the prior year, both in terms of planned savings and whether the schemes worked as intended. It is important to compare the plan against the actual position achieved. Many trusts make non-recurrent savings to balance the books but fail to deliver what they planned.
- 67 Evaluation of management processes has several elements including how schemes were set up, the effectiveness of monitoring and reporting to the board, risk identification and mitigation, and the efficiency and robustness of the accountability and governance arrangements.
- 68 Evaluation should inform future improvements. It can identify where an approach might be replicated internally in another service area or feature as a regular element in future years' programmes. Findings are unlikely to be a surprise where CIP monitoring and reporting has been effective. Case study 9 describes how a mental health trust addressed areas of weakness in its CIP arrangements.

## Case study 9

### South London and Maudsley NHS Foundation Trust: Reviewing the CIP process

During 2010, the trust identified that it would need to adopt a different approach to CIP management. Performance against plan had started to slip and the Board was increasingly aware that the level of CIPs required would need to increase to almost double that of previous years. The trust recognised that smaller efficiency gains had mostly all been identified and that more significant service transformation would be needed to deliver the savings. The Board took this very seriously and reviewed and revised the planning process, method for CIP implementation and the trust-wide governance and accountability structure.

The Board also acknowledged the need to improve the capability and capacity of the organisation to enable improved performance as the financial challenge became harder.

The Board had established seven Clinical Academic Groups (CAGs) in 2010 as the new management structures for bringing together clinical services, research, and education and training to develop care pathways designed around the needs of patients. The transformation into disorder-specific CAGs rather than organisation along purely geographic lines was to put the trust in a strong position to harness innovation for the benefit of patient care, improve the quality of the clinical services and reduce costs through the focus on pathways and economies of scale. The Board:

- empowered clinical teams to be innovative through the establishment of CAGs and by further development of SLM;
- established tripartite CAG leadership teams with a clinical director, academic director and service director to deliver the strategic transformation and operational performance of the CAG;
- strengthened the accountability structure;
- invested in planning and development for staff to ensure the right skills and competencies are in place;
- introduced a PMO type role to provide an objective challenge and support function to the CAGs whilst fitting the culture of the trust to maximise delivery;
- accepted that the CIP process needed to start much earlier than had previously been the case and become a rolling programme; and
- ensured the message from the Board was clear, accessible and constant.

The new structure has enhanced cross-site and cross-boundary working and clearer lines of accountability have improved performance. While the change process created uncertainty and instability in the short term, the trust is clear that the longer term benefits are significant, with CAGs being operationally responsible for delivery and working in a much more devolved way across traditional boundaries. This has enabled the trust to build a strong platform for reducing the costs of service delivery and infrastructure in its plans for the next three years.

*Source: Audit Commission and Monitor*

## Post-evaluation

- 69 From the development stage onwards, boards need to ensure that they give a clear message to the rest of the organisation about the importance of scheme evaluation as well as CIP delivery itself. This shows staff the trust is taking CIP delivery seriously. Achievements and lessons learned about schemes' successful (or otherwise) delivery should be communicated to the wider organisation. This is particularly helpful where trusts have carried out a multi-year programme of savings.



## Conclusions

- 70** All NHS organisations will experience financial pressure in the coming years and how they respond to it will impact on patients. Taking short-term reactive decisions to maintain financial stability risks deterioration in the quality of services and patient safety. Preparing and implementing a CIP that links to the organisation's strategic plan is essential if quality services are to be delivered and financial stability achieved.
- 71** This briefing describes some of the ways that organisations are planning, implementing and monitoring their CIPs. Organisations that deliver CIPs well engage with their staff, plan in detail, have robust monitoring arrangements and continually evaluate both individual CIP schemes and overall performance. Those with more rigour in the structure, clear lines of accountability and performance management processes deliver more to timescale and plan. Organisations that have strong clinical engagement and leadership, for example by working within an SLM structure, tend to deliver more realistic CIP plans.
- 72** We recommend boards use the checklist of questions in Appendix 1 to identify opportunities for improvement. Completing the assessment will also provide additional assurance about the CIP programme. The questions can also be used by staff responsible for CIP delivery.
- 73** Process, structure, governance and accountability are key elements of safe, effective CIP delivery. But the people delivering CIPs on the ground are crucial. Structures and processes, though important, will not deliver unless staff are engaged and have the capability, capacity and competence.

## Appendix 1: Questions for board members

Question	Yes/ No	Link to evidence
<p><b>Governance and accountability (relevant to each stage of the CIP process)</b></p>		
<p>Do we provide visible, constant board leadership to ensure that senior managers and clinicians buy-in to CIP objectives?</p> <p>Do we have assurance that the organisational culture supports CIP delivery? What is our approach to organisational change? Will it give us the best possible chance of success?</p> <p>Are governance structures clear and straightforward with minimal overlap? Are they understood and followed?</p> <p>Do we have CIP programme management arrangements in place? Are roles and responsibilities clearly communicated? Who is accountable for CIP delivery? Do we hold individuals responsible for CIP delivery to account?</p> <p>Do we ensure staff that are responsible for delivering the CIP have the necessary capacity, capability and competence? Are clinicians fully involved in the CIP process?</p> <p>Do we receive assurance that the arrangements for delivery, monitoring, reporting and risk management are appropriate and working effectively?</p> <p>Is the membership of the board and senior management team stable? Do we ensure that learning, experience and organisational memory about CIP delivery is retained throughout the organisation?</p> <p>Do we have the skills needed as a board to support organisational delivery? Are we clear about what the role of the chair and non-executive directors should be? Do we delegate responsibilities effectively and appropriately?</p> <p>Is information about the CIP communicated to staff? Do staff understand and feel engaged in the process? Are they aware of the potential impact? Are they kept up to date with CIP achievement? Has the board considered what language will be meaningful to staff?</p>		

Question	Yes/ No	Link to evidence
<p><b>Planning the CIP</b></p> <p>Is there an agreed strategy for cost improvement? Is it consistent with the trust's strategic aims and objectives? Does it have the support of the entire board? Does it cover a five-year period?</p> <p>Do we ensure CIP plans are consistent with the wider business plan of the trust? Are transformational programmes consistent with the trust's strategic objectives?</p> <p>Are divisional CIP targets determined using a transparent, fair process? Do they take into account relative efficiency? Is there guidance for what does and does not constitute a CIP?</p> <p>Is the plan discussed with local stakeholders?</p> <p>Has a PMO been set up? If not, does the trust ensure that appropriate project management arrangements are in place?</p> <p>If a PMO is not in place are you confident that there is enough objectivity, challenge and support given within the trust? Is the cumulative impact of schemes considered?</p>		
<p><b>Identifying CIP schemes</b></p> <p>Is service efficiency/benchmarking information used to identify saving opportunities? Are clinical staff involved? Is there sufficient clinical engagement and accountability in the CIP process? Does the trust learn from others? Does the CIP contain transformational change schemes?</p> <p>Do we consider the impact of individual CIP schemes on quality and safety? Do we understand the key risks to quality of services?</p> <p>Are the CIP plans consistent with other trust plans, for example the finance, workforce and IT strategies? Is the cumulative impact of the schemes assessed? Are our plans consistent with health economy plans?</p> <p>Do we ensure there is clinical challenge to individual schemes?</p>		

Question	Yes/ No	Link to evidence
<b>Delivering the CIP</b>		
<p>Are detailed plans developed for each significant CIP scheme? Is peer challenge used to drive improvement in performance?</p> <p>Are risks that arise during the delivery of trust plans identified and managed?</p> <p>Does the trust have a process to identify slippage against plans and to take remedial action? Are contingency plans in place?</p> <p>Do we support the preparatory work for transformational CIPs that will increase efficiency in the medium to long term?</p>		
<b>Monitoring and reporting</b>		
<p>Does the board have information at the right level to monitor and challenge CIP performance? Do we have evidence that CIPs are being delivered? Are we aware of the corrective action taken to get the CIP back on track?</p> <p>Do the KPIs tell us about the trust's CIP performance? Are they the right indicators? Do they adequately cover patient experience, patient safety and quality of services?</p> <p>Is the information we use to monitor risks to CIP delivery timely and relevant? Are risk identification, management and controls effective?</p> <p>Are arrangements in place to ensure the data that supports reported information is fit for purpose? Is the reported CIP performance consistent with the reported financial position? Does the financial forecast look accurate, when considering the likelihood of achieving the CIP?</p> <p>Does the board receive independent assurance on CIP achievement? Is this sufficient?</p>		
<b>Evaluating the CIP</b>		
<p>Do we evaluate the effectiveness of the CIP scheme, including development, delivery, reporting and monitoring?</p> <p>Have we learned anything from evaluating the CIP scheme or taken action as a result? Has the action been effective?</p>		

## Appendix 2: Acknowledgements

We are grateful to the following organisations for sparing the time to contribute to the briefing and for being willing to share their experiences:

- Brighton & Sussex University Hospitals NHS Trust
- Coventry & Warwickshire Partnership NHS Trust
- Derby Hospitals NHS Foundation Trust
- Dorset Primary Care Trust
- Mid Essex Hospital Services NHS Trust
- North East Ambulance Service NHS Foundation Trust
- North East London NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- West Midlands Ambulance Service NHS Trust

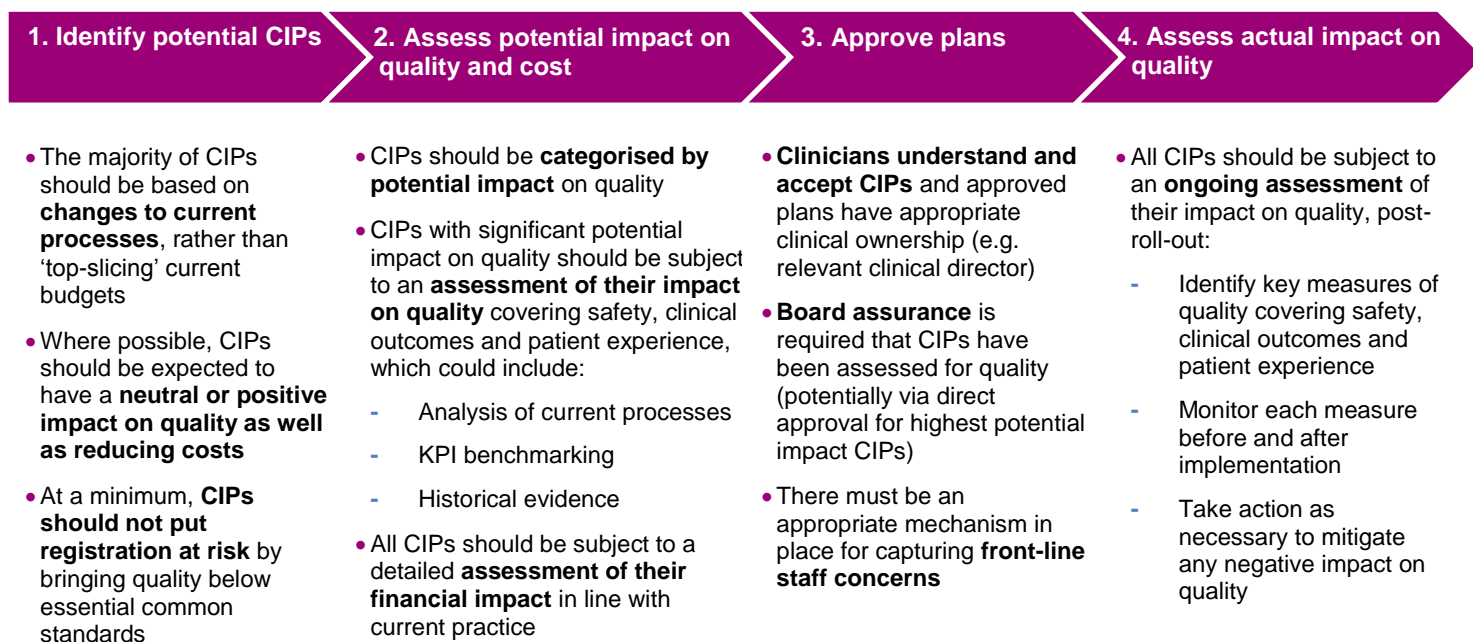
### Appendix 3: Examples of methods for reviewing efficiency to identify potential CIP schemes

Method	Source	Details
PbR Benchmarker	Audit Commission	Online tool that compares acute hospital activity data, clinical coding and Payment by Results related measures with other organisations.
Service line reporting (SLR)	Monitor	SLR gives a clear picture of how each service is working, at both an operational and financial level.
FTN Benchmarking	Foundation Trust Network	Analyses trusts' performance in quality (clinical outcomes and patient experience), cost effectiveness and operational management.
Productive Ward series	NHS Institute for Innovation and Improvement	The Productive Series supports NHS teams to redesign and streamline the way they manage and work.
NHS Benchmarking	NHS Benchmarking	The NHS in-house benchmarking service, hosted by NHS Somerset. Projects cover a range of quality and productivity measures, in clinical and non-clinical areas.
NHS Better Care, Better Value Indicators	NHS Institute for Innovation and Improvement	Better Care Better Value indicators identify potential areas for improvement in efficiency that may include commissioners re-designing and shifting services away from the traditional setting of the hospital and out towards community based care.

*Source: Audit Commission and Monitor*

## Appendix 4: Monitor guidance on CIPs for applicant trusts (July 2010)

### Illustrative action plan for applicants



### Additional guidance on recommended analytical approaches

Approach	Description	Comments
<b>Current processes</b>	<ul style="list-style-type: none"> <li>• Review of current processes to identify where waste exists and how it can be eliminated to reduce costs without compromising quality</li> <li>• Reducing variation is also very powerful</li> </ul>	<ul style="list-style-type: none"> <li>• Could include Lean analysis, time and motion studies, staff interviews</li> <li>• Generally considered to be the most insightful piece of analysis</li> </ul>
<b>KPI benchmarking</b>	<ul style="list-style-type: none"> <li>• Benchmark analysis of relevant operational 'inputs' to quality relative to peers and guidance (e.g. Royal College)</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse/bed ratio, average length of stay<sup>3</sup>, bed occupancy, bed density and doctors/bed are examples of operational efficiency metrics which can be markers of quality</li> <li>• Useful as a prompt for discussions (e.g. 'Is it really feasible to reduce nurse headcount when our nurses/bed ratio is already in the bottom decile relative to our peers?')</li> <li>• However, limitations of this approach must be recognised: no direct link between operational inputs and quality outputs; hard to set peer group; generally poor quality data</li> <li>• Currently, benchmarking data is generally more available and useful for acute trusts than for mental health trusts</li> </ul>
<b>Historical evidence</b>	<ul style="list-style-type: none"> <li>• Analysis linking operational changes (e.g. nurses/bed reductions) to quality outputs</li> </ul>	<ul style="list-style-type: none"> <li>• Analysis could be based on internal evidence (e.g. historical trends or on different wards) or external evidence (e.g. published reports on experience in other trusts/countries)</li> <li>• However, important to recognise limitations of links between operational inputs and quality outputs</li> </ul>

<sup>3</sup> Relevant as an indicator of quality when paired with readmission rates

## References

- 1 Department of Health, *The Operating Framework for the NHS in England 2011/12*, 2010
- 2 Department of Health, *The Operating Framework for the NHS in England 2012/13*, 2011
- 3 Monitor, *Lessons Learnt from Recent NHS Foundation Trust Applications*, 2011
- 4 Audit Commission, *NHS Financial Year 2010/11: A Summary of Auditors' Work*, 2011
- 5 Monitor, *Amendments to Applying for NHS Foundation Trust Status – Guide for Applicants*, 2010



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