Managing delivery of cost savings

Planning cost improvements over the medium term can deliver significant benefits. Steven Bliss looks at how one mental health trust is managing its five-year savings programme

The *NHS efficiency map* is designed to help NHS provider organisations to deliver their savings plans. As well as looking at areas where significant savings are known to be possible, such as managing the clinical workforce or estates or procurement, it is also about good practice in managing a savings programme. The experience of a large and successful mental healthcare trust shows this in action.

Mersey Care NHS Foundation Trust, in and around Liverpool, has 32 sites. It became a foundation trust in June 2016, acquiring Calderstones Partnership NHS FT on 1 July 2016. Its accounts for 2015/16, when still an NHS trust, show total income of £213m and a total headcount of 4,104 staff (3,580 full-time equivalent). Its services essentially split in two divisions: local services, which provides a full range of mental health services to the local population; and secure services, serving the North West of England, and also Wales for high secure services. Local services is the larger division, with more than 40% of the trust's staff, many of whom are community-based.

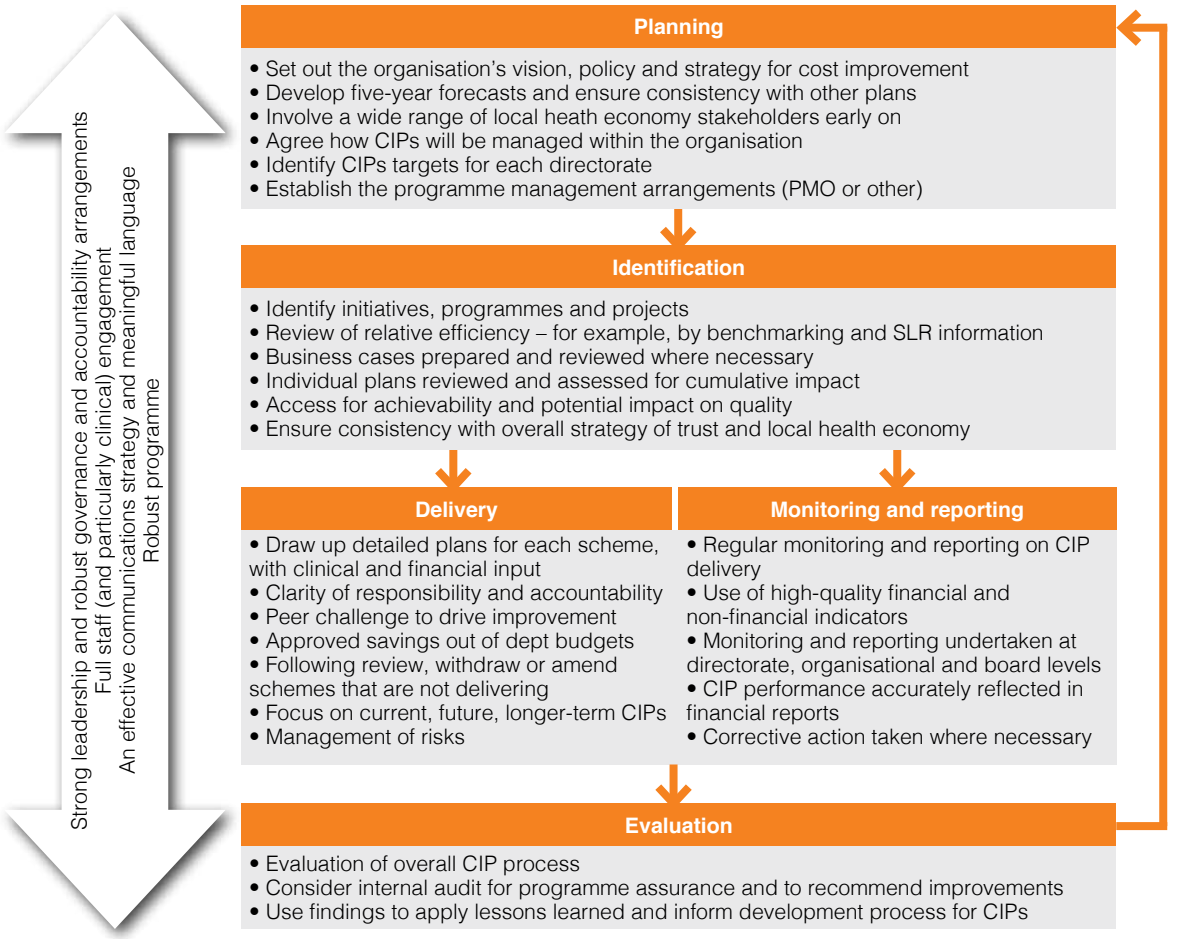
Leadership for savings

The trust has a good record in delivering savings plans. But it became clear when starting on a six-year financial plan for 2015/16 to 2020/21 that the approach used successfully in the past would not be good enough for the years ahead. Savings averaging 3% a year would be required, and only a more robust and proactive approach would deliver that. All divisions would have to make major changes to how they delivered services.

Mersey Care has an unusual, but effective, way of leading savings programmes within the trust. They are not led by the finance director but by the medical director.

David Fearnley, who has been medical director for 11 years, has led the cost improvement programmes (CIPs) for the past six years. This, together with his work on mental health clustering for tariff purposes, earned him the 2013 HFMA

Figure 1: CIP forward planning process



Working with Finance – Clinician of the Year Award.

The strong medical involvement in cost improvement has helped to get all staff in the trust working together, valuing what each function can contribute. Doctors realised they needed their human resources and finance departments if they were to restructure their services, and day-to-day working improved as a result.

The trust's overriding aim is to find a better way to deliver care. A key initiative is the Perfect Care programme, part of which – its No Force First policy – has won a national patient safety award.

All savings schemes are assessed as part of the Perfect Care programme, and are then subject to ongoing review by a quality assurance committee. No scheme gets into the overall savings programme without rigorous assessment of quality and money. This early scrutiny ensures that unviable schemes are removed before time and resources are devoted to them.

Planning framework

The local services planning framework, introduced in February 2016, follows the sort of forward planning process set out in the *Audit Commission/Monitor report on CIPs* (see Figure 1, previous page).

A great deal of good practice is condensed into one simple diagram, and it proved very helpful in the trust's own planning. As Mr Fearnley says, much of this is the sort of good practice the trust was undertaking already, but the framework helps the trust to think differently when necessary.

A key factor at the outset was the determination to use benchmarking to improve performance.

Benchmarking, however, only takes a trust so far, even when the information is reliable – which isn't always the case. It records how much a trust's costs or performance deviate from the norm or from best performance, but it rarely indicates why the trust is different or what it should change. Mersey Care used brainstorming sessions to identify what it might change, and where good ideas emerged, they were worked up into proper schemes.

Savings requirement

Much of what is shown above might be applied to a typical one-year savings programme, but this sort of systematic planning becomes far more important when looking at a major five-year programme. Figure 2 (above), taken from a trust board paper approving the 2016/17 budgets, shows the scale of savings required and what at first may seem an unusual phasing of the planned savings.

As can be seen, these are big figures for a trust with an income of £213m – a 15% reduction in total costs. They are also ambitious in the early years – the local services division aims to save £5.5m in 2017/18, leaving only £1.9m of its five-year target for later years.

As the trust says, you don't make radical change gradually over five years: once you know what to do, you do it in the first two years. Pay makes up about three quarters of the trust's costs, so inevitably the redesign of how care is delivered produces reductions in overall headcount, especially for nursing staff. A two-year timescale for most of the savings is long enough to manage the staffing implications.

Figure 2: Phasing of planned savings

Division	2016/17 (£m)	2017/18 to 2020/21 (£m)	Total (£m)
Local services	6.0	7.4	13.4
Secure services	5.0	6.4	11.4
Corporate	1.7	3.8	5.5
TOTAL	12.7	17.6	30.3

Community services redesign

The biggest savings scheme is community redesign, which was targeted to produce nearly half of the local services savings in 2016/17.

The scheme aims to ensure that services are more integrated, co-located, productive and standardised. It will see a reduction in overall caseloads, with safe and appropriate discharge back to primary care. Workloads and working practices will be redesigned.

It is typical of the trust's approach to redesigning services, and very refreshing, that the transformation plan for local services begins with a statement by one of its service users:

'New and seemingly radical alternatives come to mind. Does a psychiatrist really have to be physically present to expedite a prescription, for instance, or is electronic prescribing a viable option? Can an advanced practitioner or nurse practitioner perform ward-based roles that free consultants to listen to us, the service users? Why should I not be able to phone my consultant for a telephone appointment when I am so well that I feel almost embarrassed turning up at clinic f or my quarterly review?

Nor had I known that high-street pharmacies can take over responsibility for my prescription such that I never have to worry about repeat prescriptions getting lost or delayed in the post again.'

The plan goes on to summarise the main changes proposed:

- A new model of care for personality disorders (where a typical service user might have months of inpatient care and dozens of other contacts with the trust)
- Better management of outpatient clinics, leading to a reduction in the number of clinics and hence staffing needed
- Improving the productivity of mental

health practitioners, partly through better use of technology
- Skill mix changes that will free consultants' time
- Comprehensive and standardised assessment of service users, with less duplication of work, better care plans and less need for inpatient admission.

Key measures are required so that the trust knows, early on, whether the plan is being achieved – reductions in the number of service users in certain clusters; reduced inpatient admissions for certain conditions; reductions in delayed discharges; reducing the number of patients not attending booked appointments at outpatients; and a range of health performance indicators.

Involving commissioners

Something should be said about the role of commissioners. The savings are front-loaded, but the savings passed on to commissioners will be evened out at 2% a year (which is what commissioners expect). The additional savings the trust makes in the first two years, if all goes to plan, will be used for non-recurrent initiatives. Although there is no intention of letting savings slip, the phasing of savings means some slippage would not affect the trust's overall financial viability. Commissioners have reviewed the details of the trust's savings plans and raised various issues without disputing the overall direction of travel.

Annual timetable

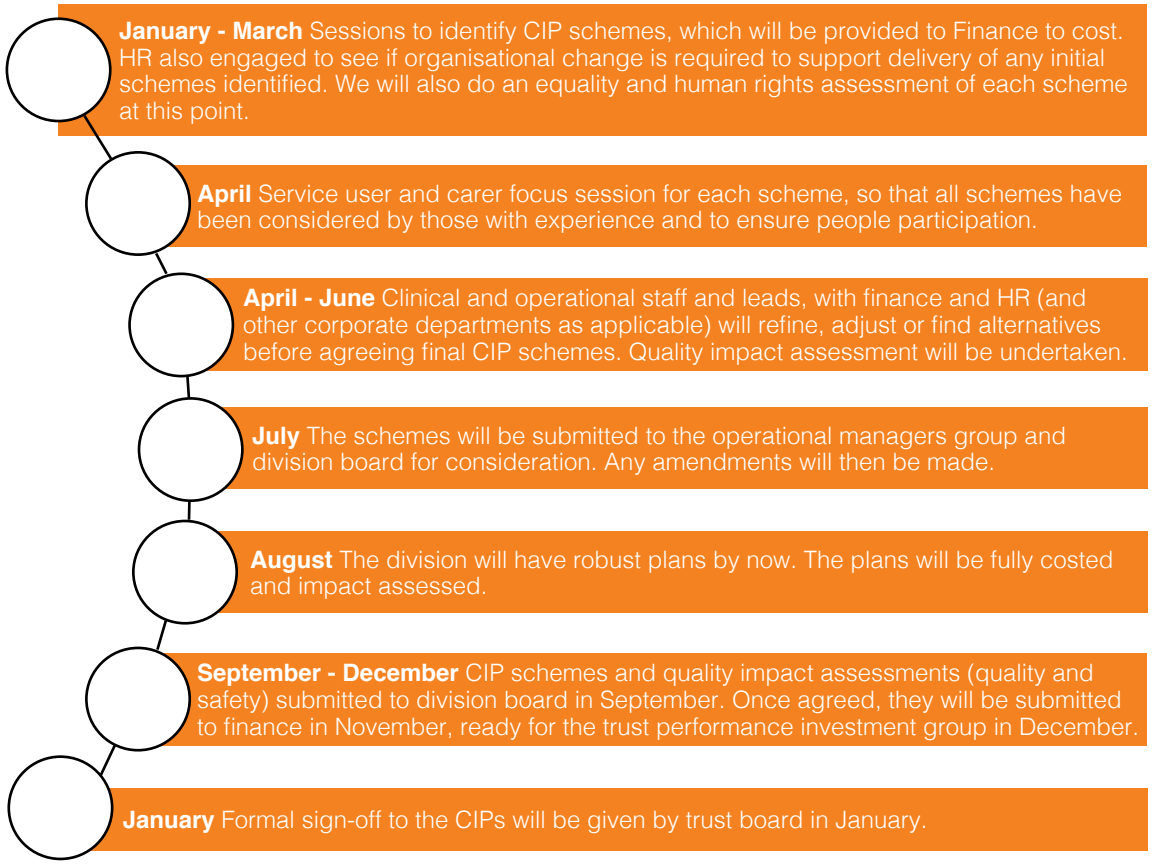
Cost improvement should not be a one-off annual event but an ongoing process (see Figure 3). Mersey Care has a long but robust process: by the time the board is asked to approve plans, they have been rigorously assessed in terms of financial, quality and human resources implications.

Monitoring of plans, once approved, is equally rigorous. They are regularly assessed by a performance investment committee and a quality assurance committee. All schemes are risk-rated. If schemes slip or need redesigning (both of which are rare), the revised schemes are put forward for approval.

Cost improvement has never been easy and is particularly hard for trusts. To save 3% a year, continually over many years, is a big challenge. It is perhaps easier for mental health trusts than for acute hospitals – there may not be so many high-profile performance targets and there may be more scope to remodel community-based services than inpatient hospital services.

That said, however, Mersey Care's approach is an example of good practice from which providers in any sector might learn.

Figure 3: Mersey Care's annual cyclical timetable



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