In February 2009 McKinsey was instructed by the Department to provide advice on how commissioners might achieve world class NHS productivity to inform the second year of the world class commissioning assurance system and future commissioner development. The advice from McKinsey, in the form of the following slides, was provided in March 2009.

Department of Health, May 2010

Achieving World Class Productivity in the NHS 2009/10 – 2013/14: Detailing the Size of the Opportunity

March 2009

Summary

- The next spending review may well result in significantly lower rates of growth in NHS spending than has been the case for the last 8 years, resulting in a possible funding gap of £10-15bn in 2013/14 or ~ 10% of spend.

- The NHS in England could potentially capture efficiencies in health and healthcare services by between 15 and 22% of current spend, or £13–20bn, over the next 3-5 years.

- This reduction could come from
  - technical efficiency savings of £6.0 - 9.2bn found from provider costs
  - allocative efficiency savings of £4.7 - 6.6bn due to no longer commissioning low value added healthcare interventions and ensuring compliance with commissioners' standards
  - savings of £2.7 - 4.1bn from a shift in the management of care away from hospitals towards more cost effective out-of-hospital alternatives.

- Further savings could come from a greater focus on prevention resulting in lower demand for healthcare services but this would likely not be realised within the next 3-5 years.

- Achieving a step change in spend on health and healthcare services will require a compelling case for change; the use of formal mechanisms to drive through efficiency gains; deployment of WCC structures and processes; removal of national barriers to change; introduction of incentives schemes; and an increase in skills and capabilities to drive out costs.

- We recommend a nationally-enabled programme delivered through the SHAs and PCTs to drive through efficiency savings. The DH should take direct actions to capture some opportunities e.g. lowering tariffs. And should enable delivery by creating a compelling story, removing barriers, developing frameworks/tools and embedding the drive for efficiency gains within existing mechanisms e.g. WCC.

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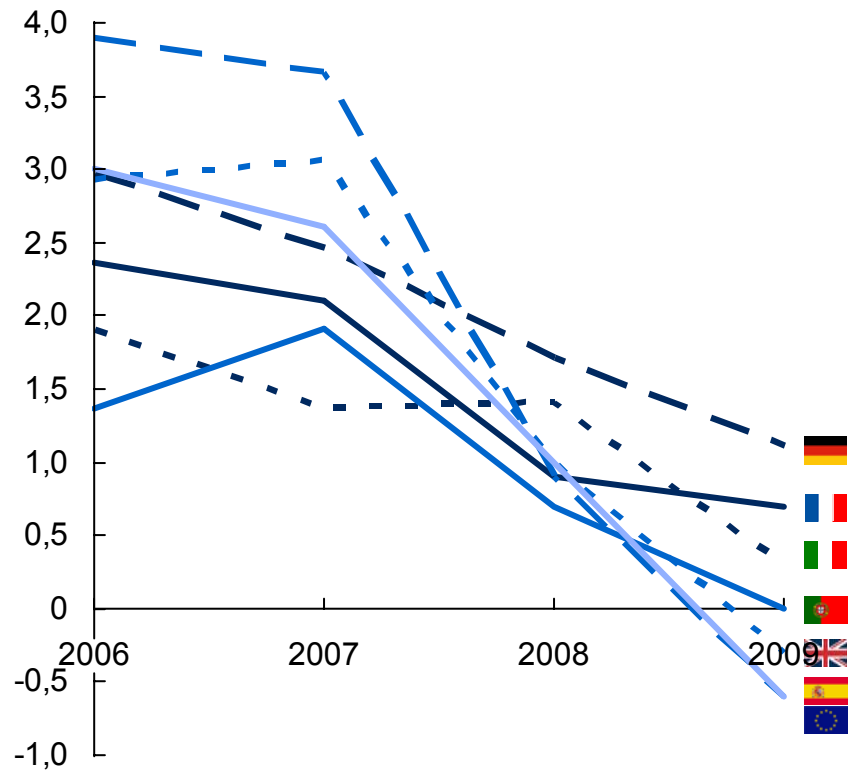
Macroeconomic context has dramatically worsened in the last 12 months

Bad news is everywhere …

… and the numbers confirm the crisis in the real economy

Real GDP growth
Percent



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Source: BEA, McKinsey analysis

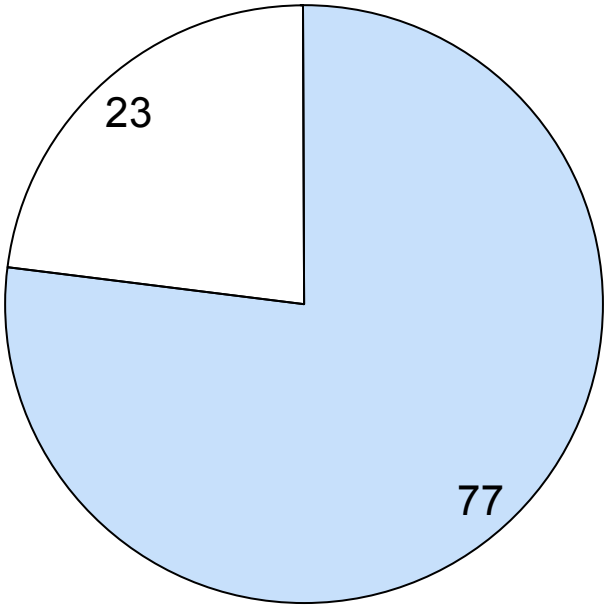
Declines in health care spend are typically observed after a crisis across European countries

Negative year-on-year health care growth within two years

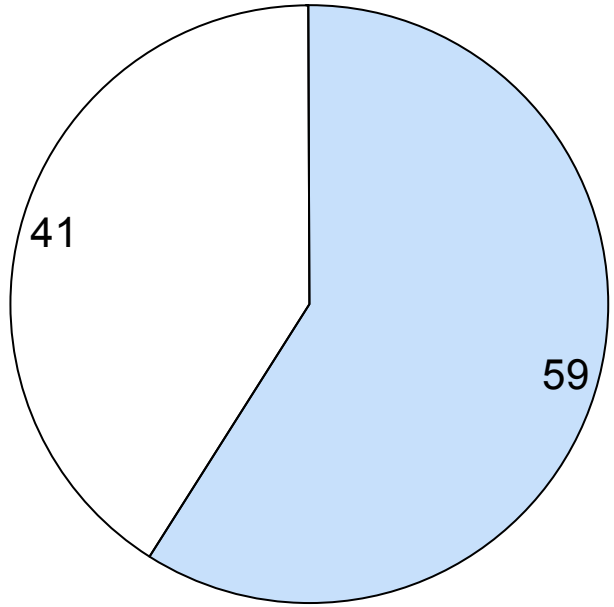
Share of European countries experiencing negative year-on-year health care growth within 2 years of negative GDP growth

As percentage

Oil crisis[1] (1980-83)



Post-Soviet destabilization[2] (1988-93)



1 Austria, Belgium, Denmark, Germany, Iceland, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland and UK
2 Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Norway, Poland, Portugal, Spain, Sweden, Switzerland, UK

SOURCE: OECD

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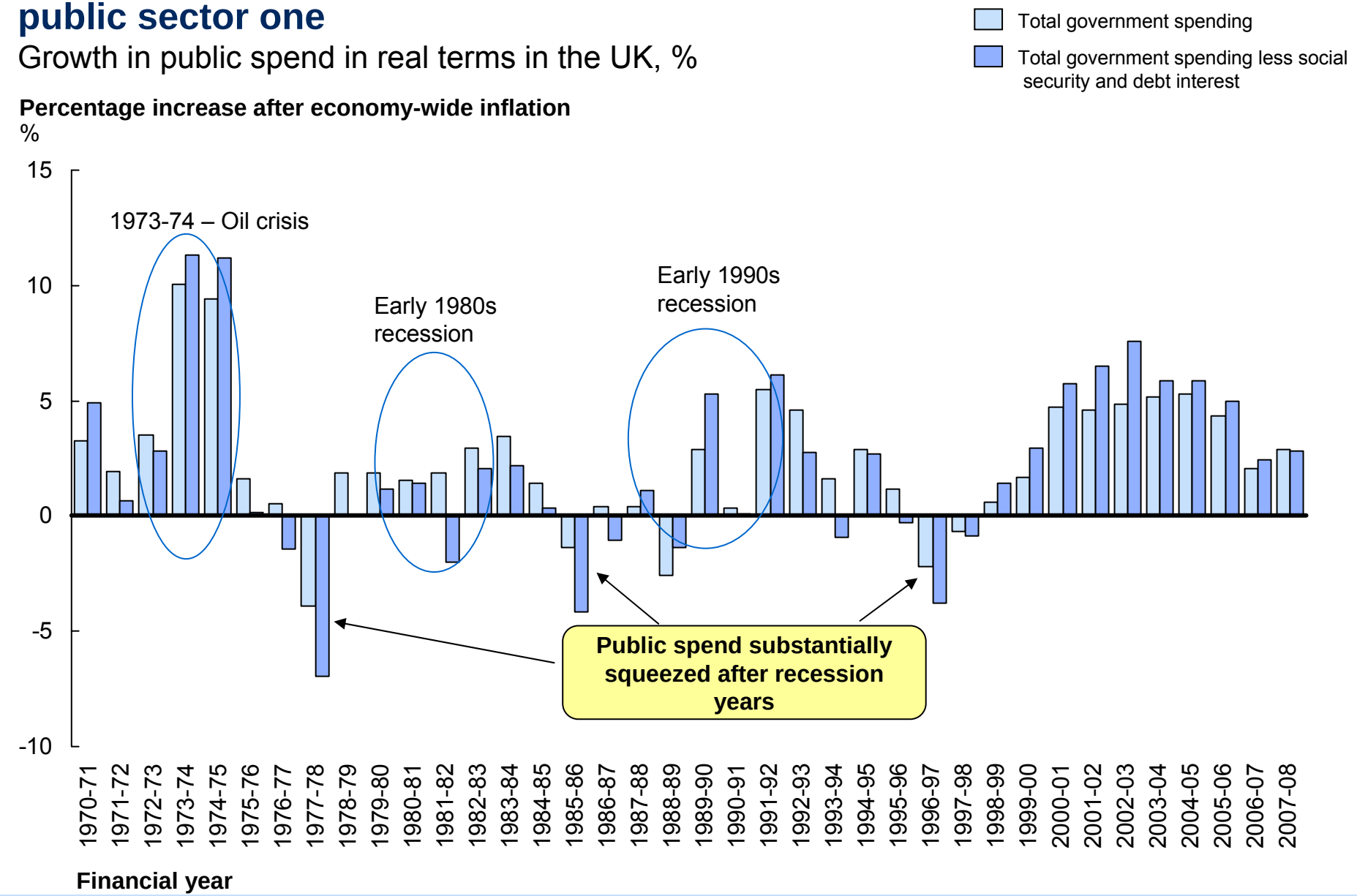
In the UK, after the private sector recession comes the public sector one

Growth in public spend in real terms in the UK, %



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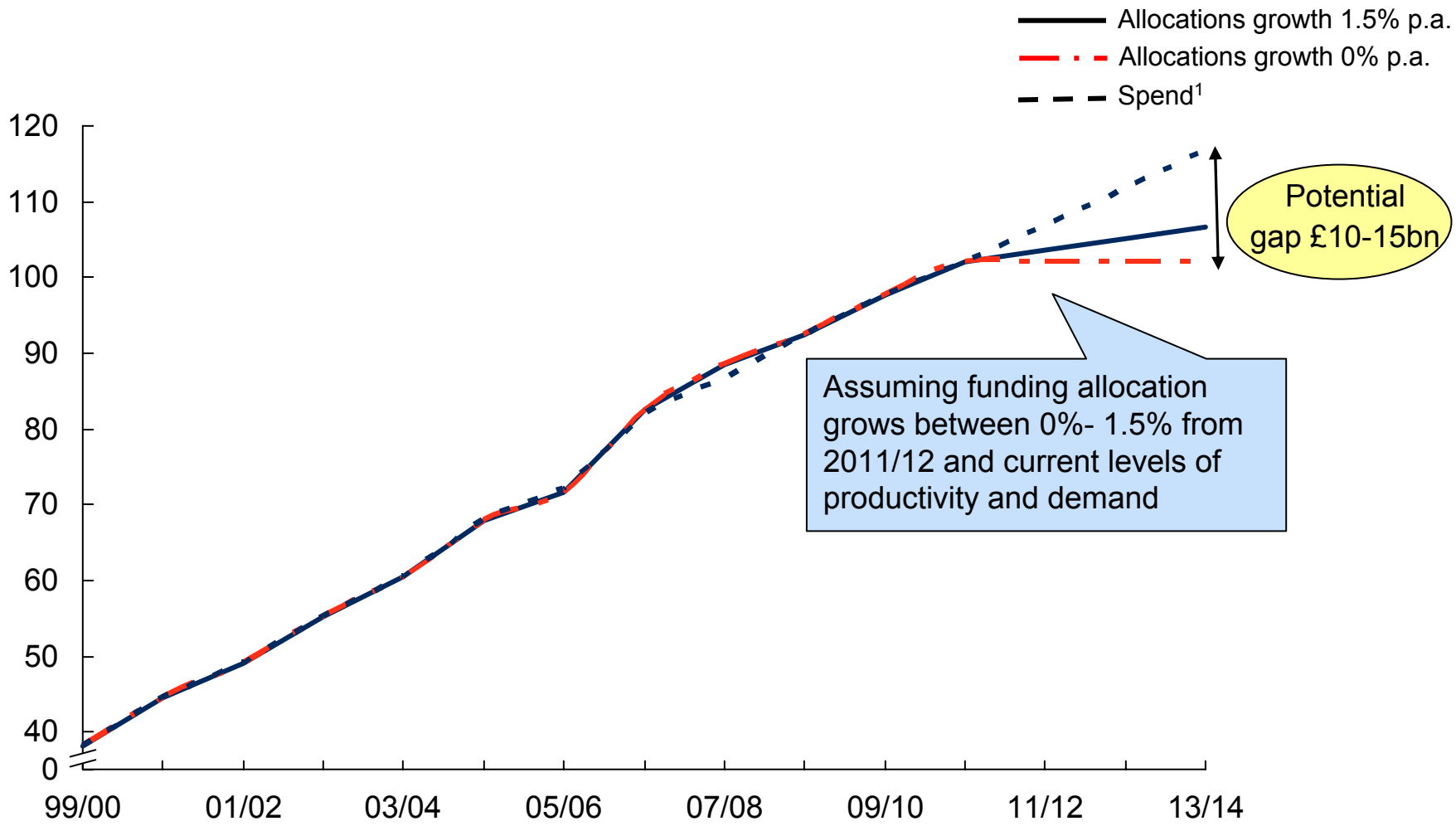
Source: Institute for fiscal studies

The next spending review period from 2011/12 will be much tougher with a potential funding gap of £10-15bn.

£ billion. NHS England allocations and expenditure, 1999/2000 to 2013/14 estimated



[1] 2.5% inflation, except for drugs 5.5%; activity growth based on 98-06 trend. Assumes spend and allocations balanced in 2009/10 and 2010/11

Note: Excludes NHS pensions (£14bn), Capital Expenditure (£4.5bn) and Excludes Personal Social Services (£1.5bn),
Source:Department of Health Annual Reports, Operating Framework 2009/10 and 2010/11, McKinsey analysis

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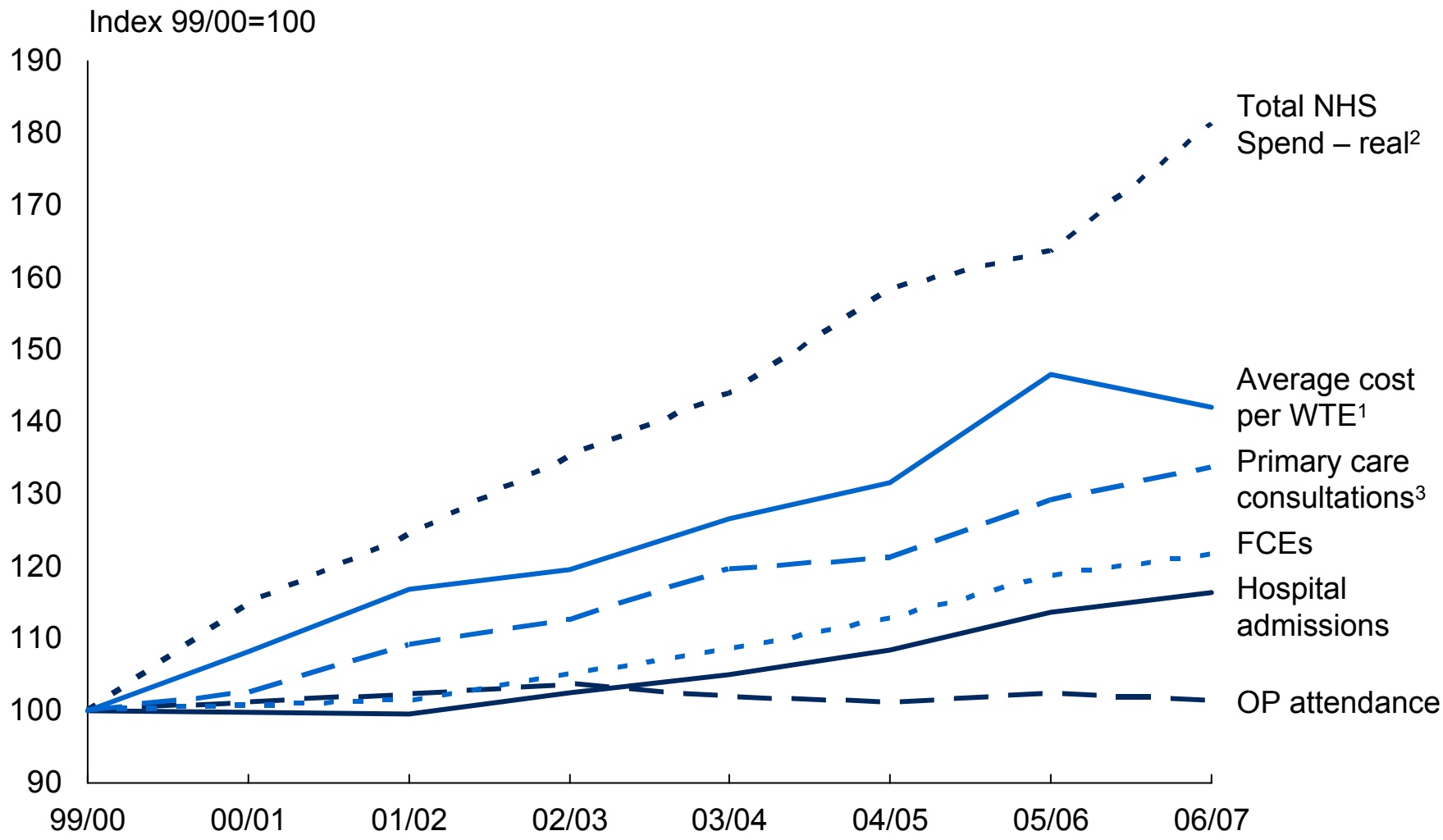
Historically, activity has lagged spend largely due to the labour costs pressure both in acute care and primary care



1 Includes acute and mental health care NHS trusts
2 GPD deflator used
3 Includes GPs and nurses

SOURCE: HES online; Hospital activity statistics; Information centre; IMF; Q-Research, McKinsey analysis

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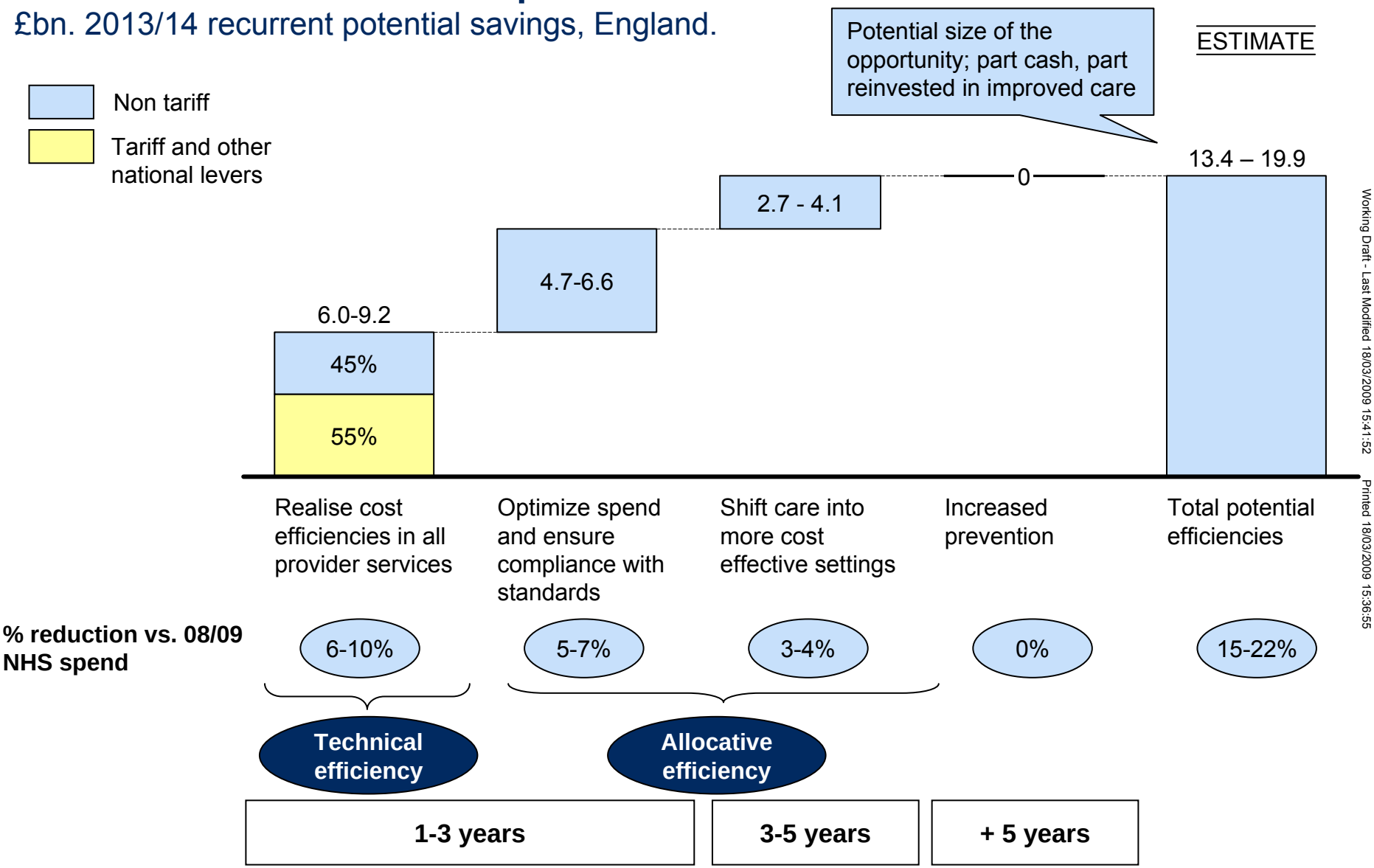
Potential scope for improvement (on a recurrent basis) of £13-20bn or 15-22% of the current NHS spend

£bn. 2013/14 recurrent potential savings, England.



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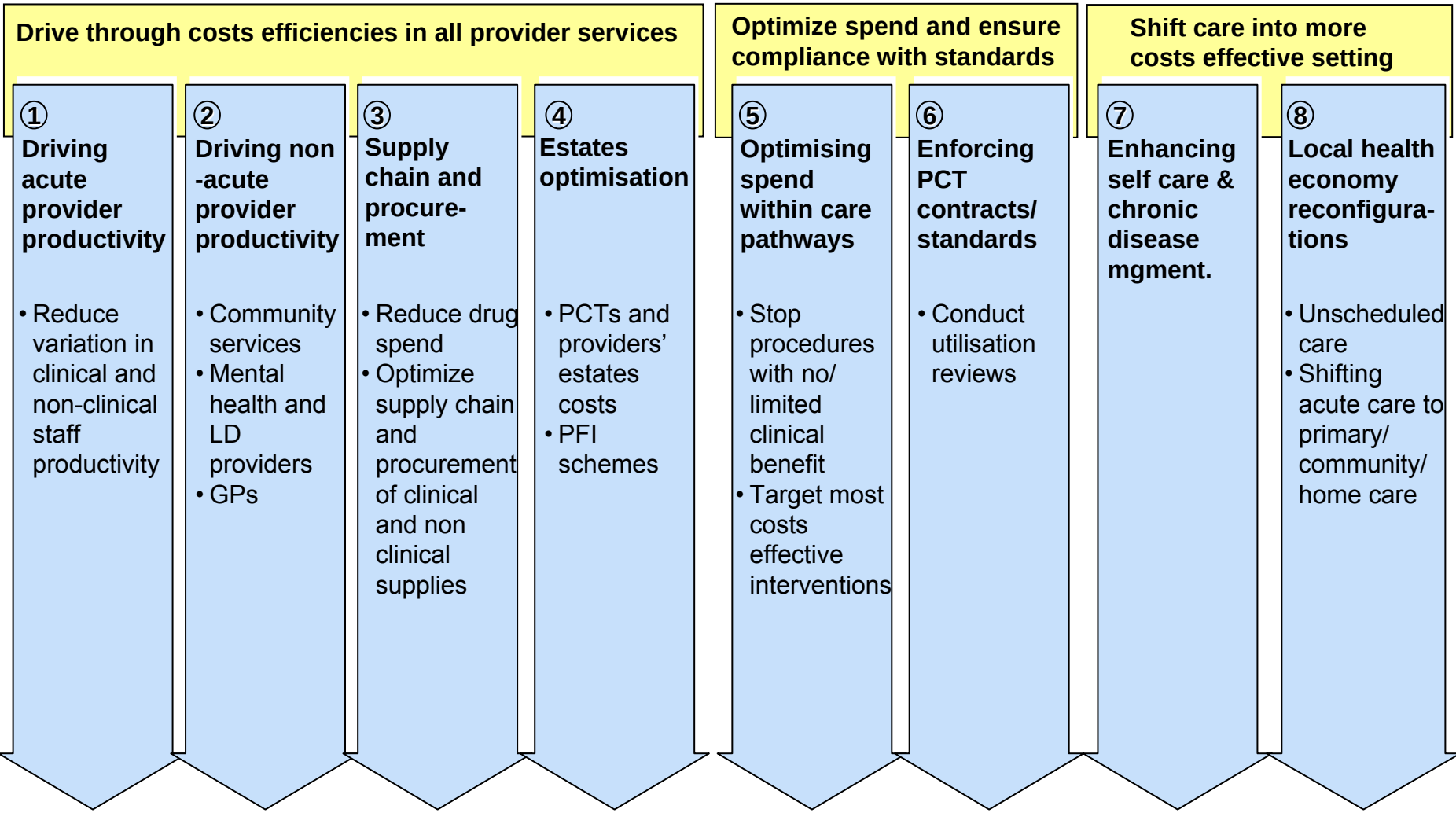
The specific opportunities for improvement include the following



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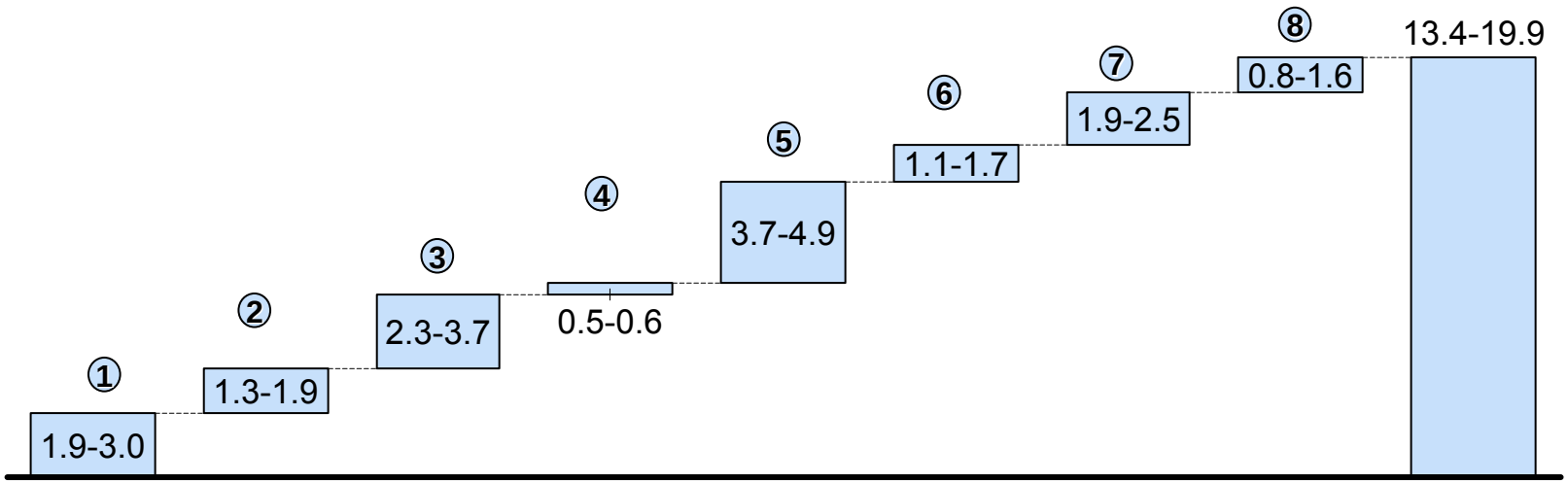
Breakdown of the potential through the implementation of the identified opportunities

ESTIMATE

£bn. 2013/14 recurrent potential savings. England

Programme number



Programme	Drive acute providers' productivity	Driving non-acute providers' productivity	Supply Chain/ procure-ment	Estates optimisa-tion	Optimising spend within care pathways	Enforcing PCTs contracts/ standards	Enhancing self care and chronic diseases mgment	Local health economy reconfigur-ations	Total potential
Current spend £bn	22	15	29	5	63	56	19	24	92
% reduction vs. 2008/09 spend	9-14%	8-12%	8-13%	11-14%	6-8%	2-3%	10-13%	4-7%	15-22%

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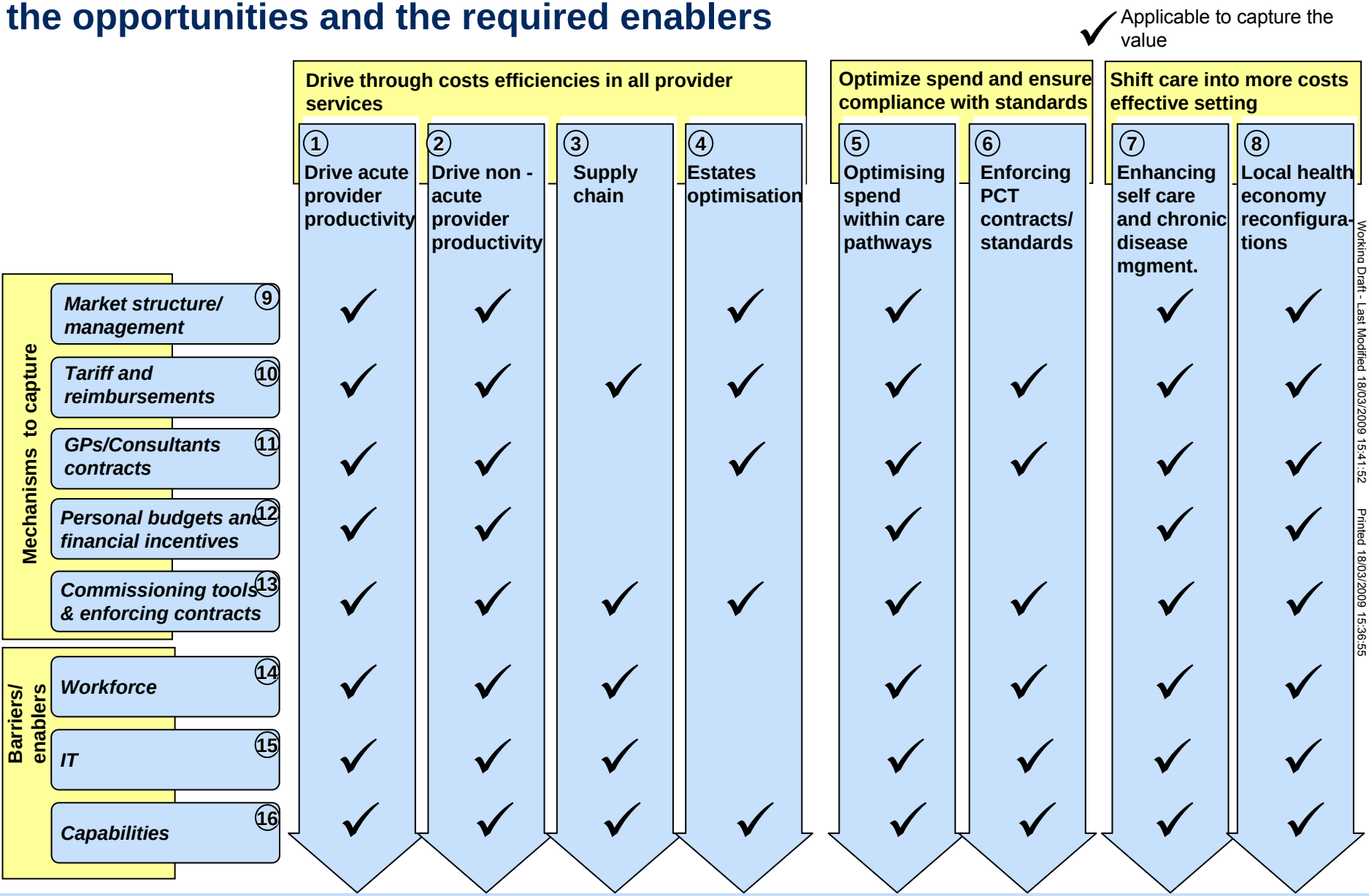
The overall effort can be structured around 16 programmes to include both the opportunities and the required enablers



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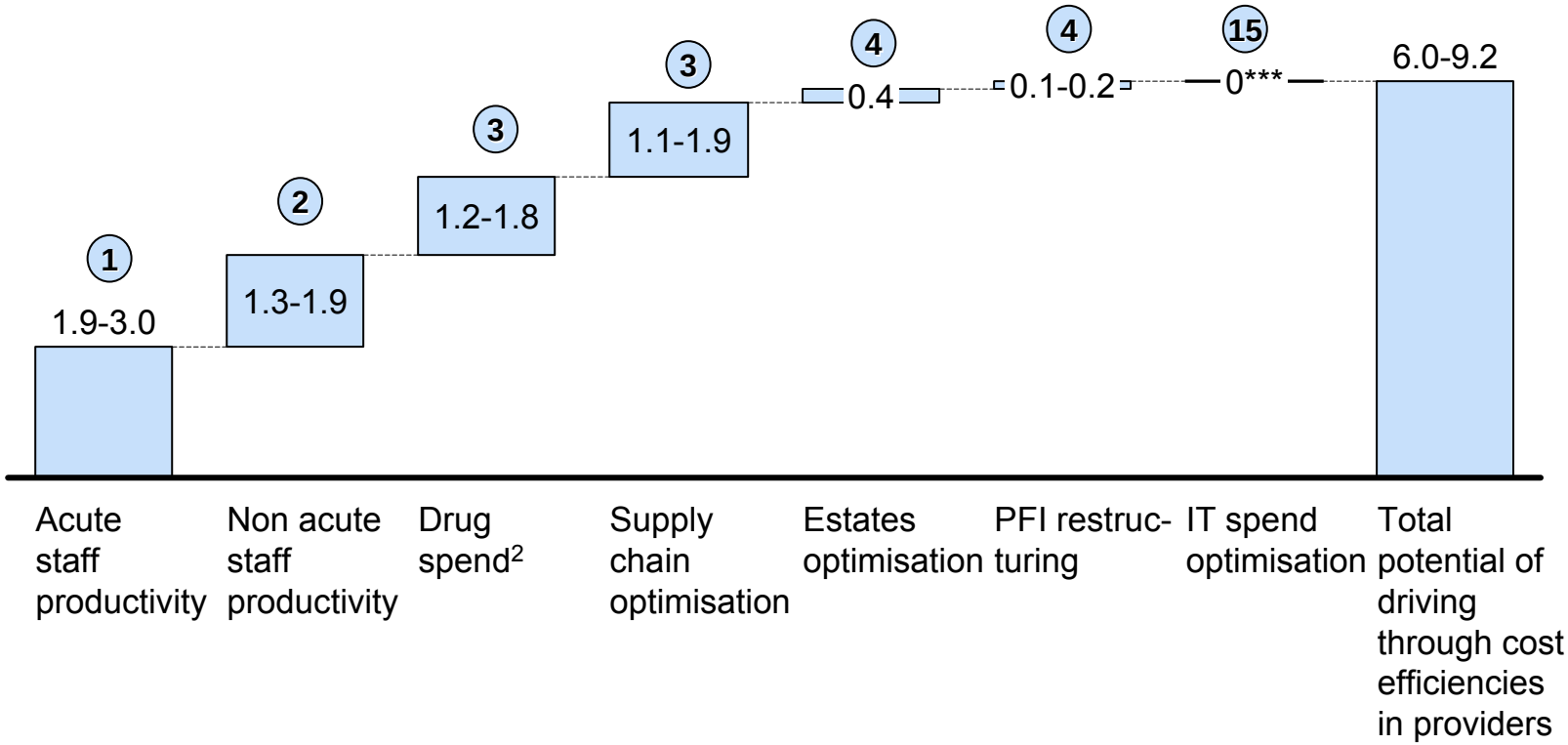
Break-down of potential opportunities to drive-through cost efficiencies in all provider services

ESTIMATE

£bn. 2013/14 recurrent potential savings. England



	Acute staff productivity	Non acute staff productivity	Drug spend[2]	Supply chain optimisation	Estates optimisation	PFI restruc-turing	IT spend optimisation	Total potential of driving through cost efficiencies in providers
Current spend £bn	22	15	12	17	3.3	1.3	2.6	92
% reduction vs. 2008/09 spend	9-14%	8-12%[1]	10-15%	6-11%	11-13%	11-17%	n/a [3]	6-10%

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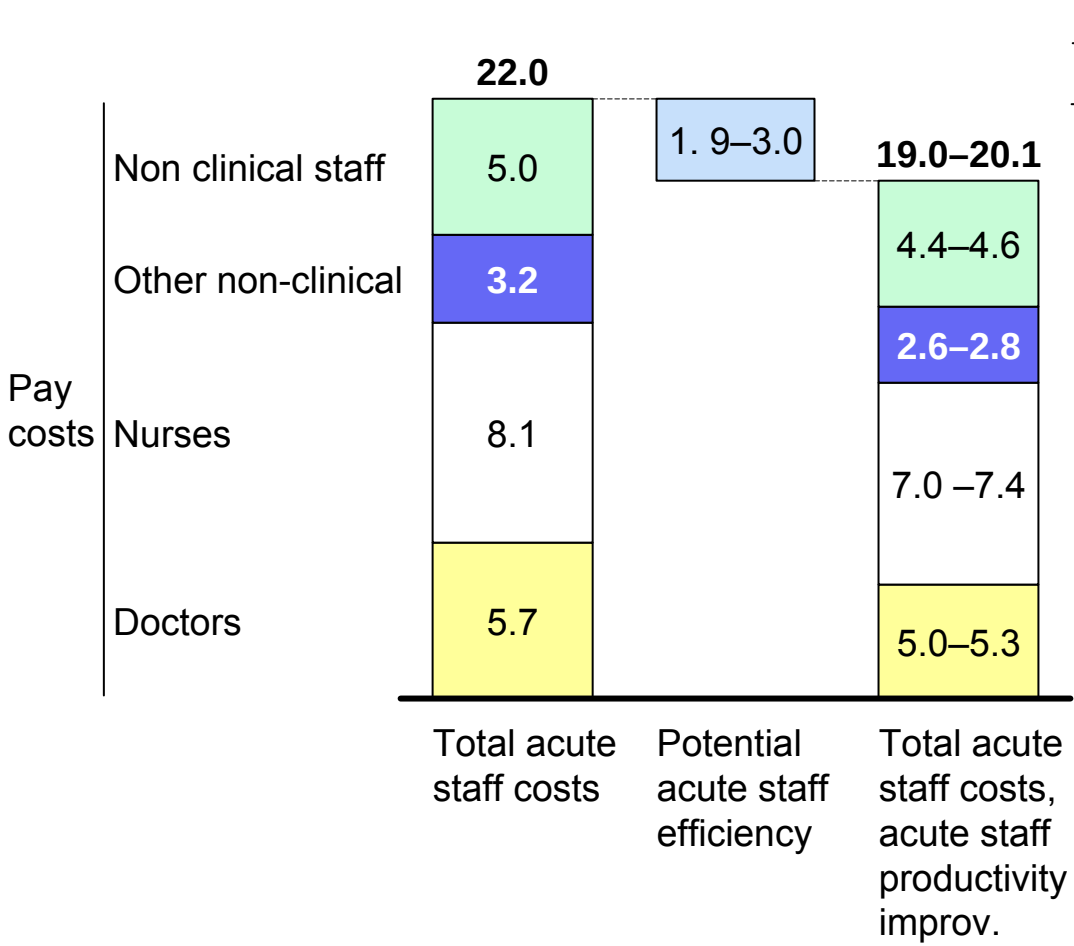
1 It includes 11-15% for community services, 8-12% for mental health care and 5-9% for primary care
2 Includes £450m savings from the already negotiated PPRS scheme
3 Although potential efficiencies exist, it is assumed that savings will be reinvested (key enabler and low IT spend)

1 Acute providers – Potential savings of £1.9–3.0b if all providers below the median productivity achieve 50–80% of the potential improvement of stepping up to the median

£b, 2008/09. Acute staff costs



Potential savings		
	£b	% of spend
	1.9–3.0	9–14
Non clinical staff	0.4–0.6	7–11
Other non-clinical	0.4–0.6	11–18
Nurses	0.7–1.1	9–14
Doctors	0.4–0.7	8–13

Key opportunities

- Increase nurses patient-facing time
- Increase throughput of diagnostics
- Reduce variability of FCEs per doctor (± 50% difference top and bottom quartile)
- Standardise pathways

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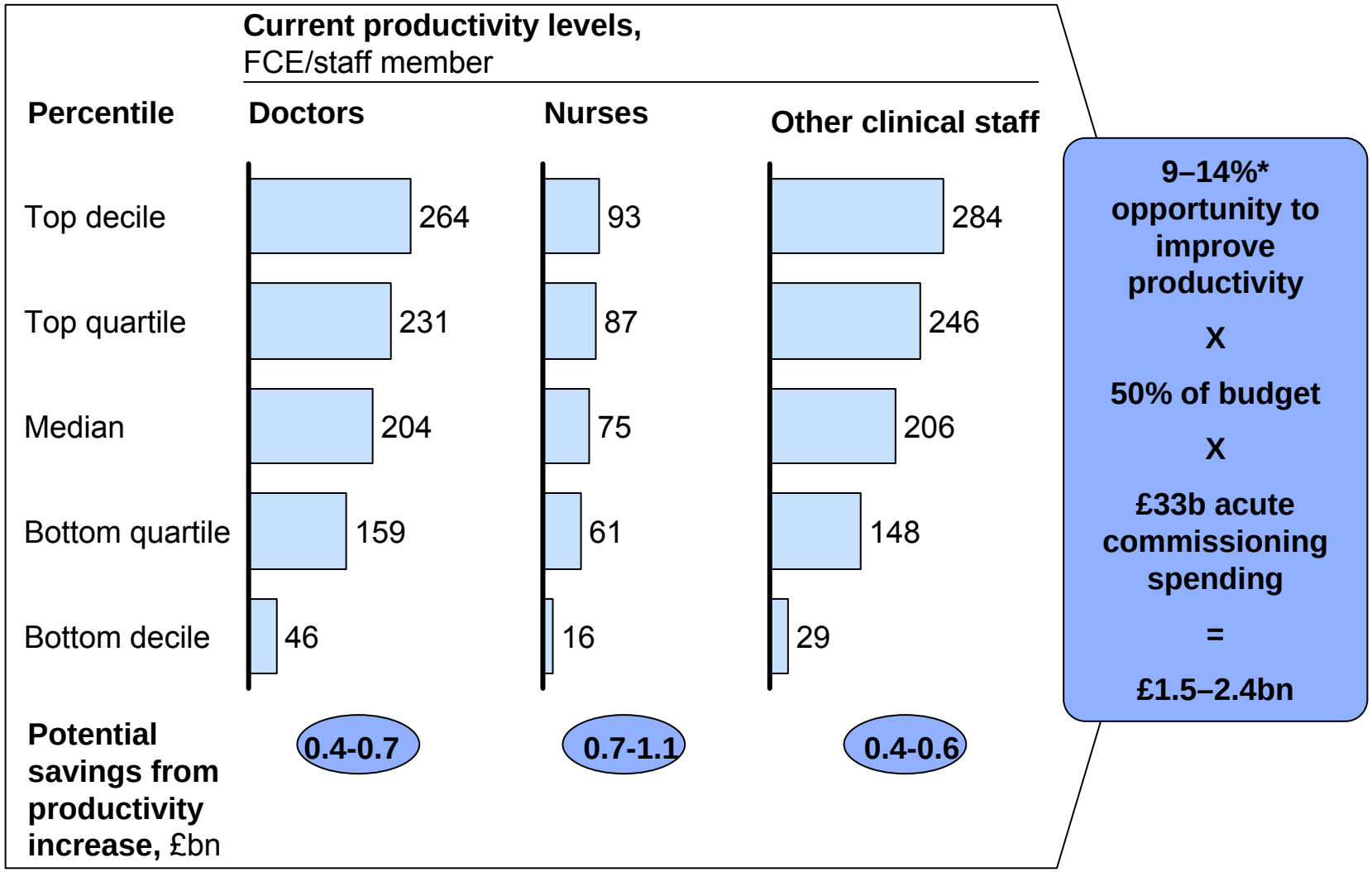
SOURCE: The Information Centre for Health and Social Care 2007 – Workforce Census; National Audit Office – Summarised Accounts Care purchased by PCTs; HES Online; McKinsey analysis

1 Acute providers – £1.5–2.4bn savings if all providers below the median of clinical staff productivity achieve 50–80% of the potential improvement of stepping up to the median



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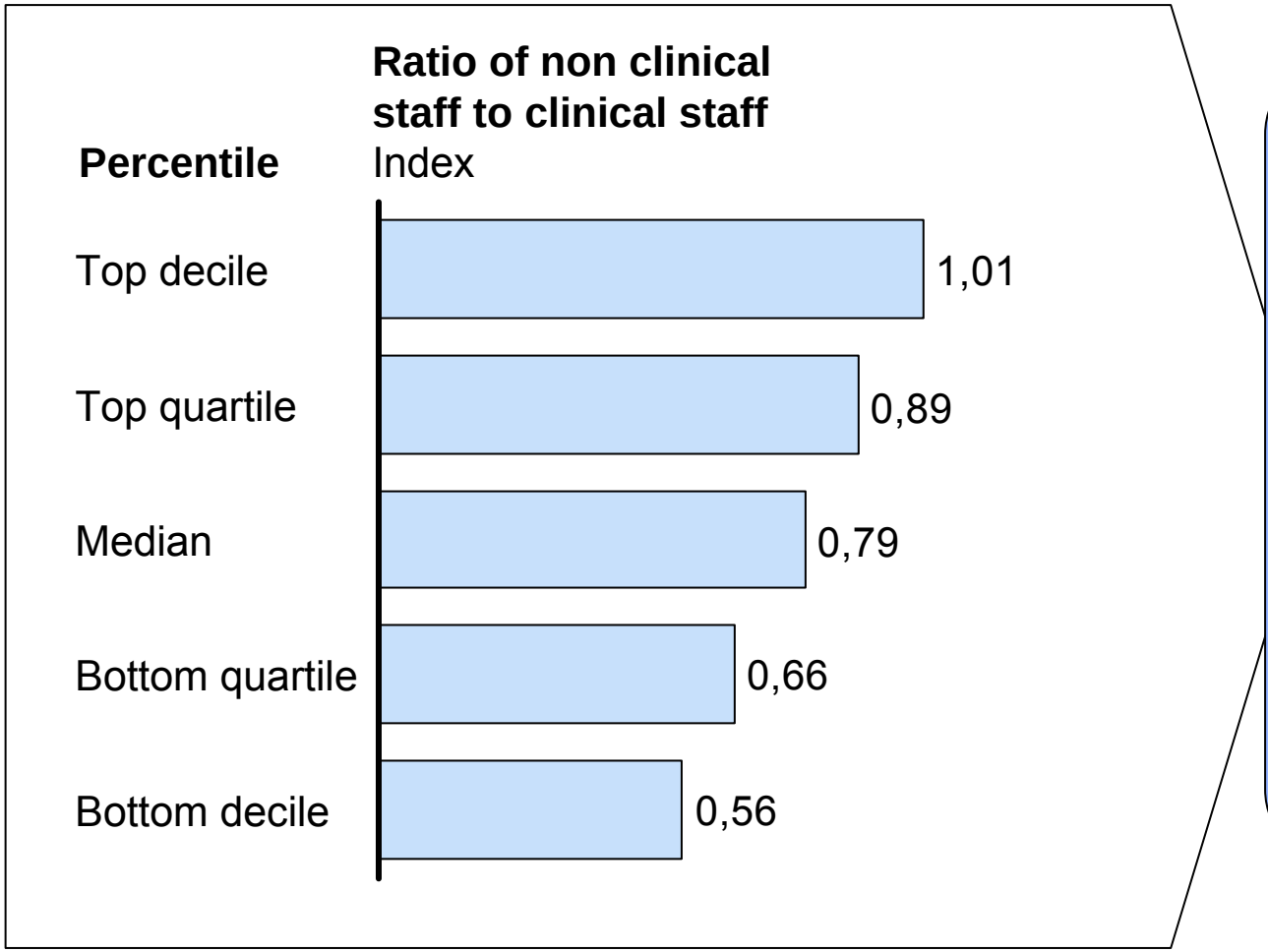
* Top of range: bottom performers stepping up to 80% of the median (e.g., for doctors from 159 to 195). Bottom of the range: bottom performers step up to 50% of the median (e.g., for doctors from 159 to 182)

Source: HES data, National Audit Office, McKinsey analysis

1 Acute providers – In addition, £0.4–0.6bn savings if all providers below the median of non clinical staff productivity achieve 50–80% of reaching the median



7–11%* opportunity to improve productivity

X

280,000 non-clinical staff

X

£20,000/FTE/year

=

£0.4–0.6bn

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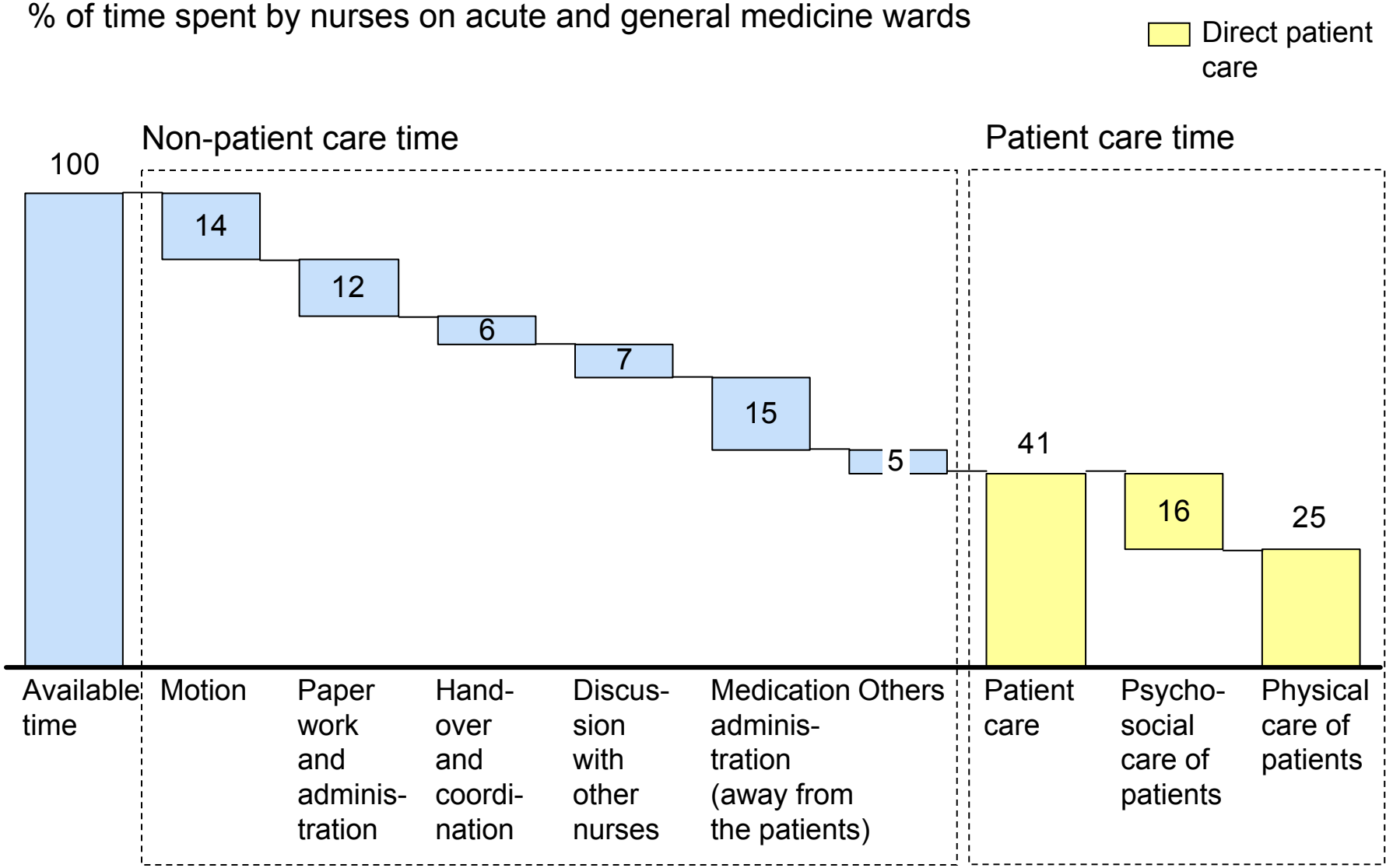
* Top of range: bottom performers stepping up to 80% of the median (e.g., for top quartile from 0,89 to 0,81). Bottom of the range: bottom performers step up to 50% of the median (e.g., for top quartile from 0.89 to 0.84)

Source: HES data, National Audit Office, McKinsey analysis

1 Acute providers – nurses spend only 41% of their time on patient care

% of time spent by nurses on acute and general medicine wards



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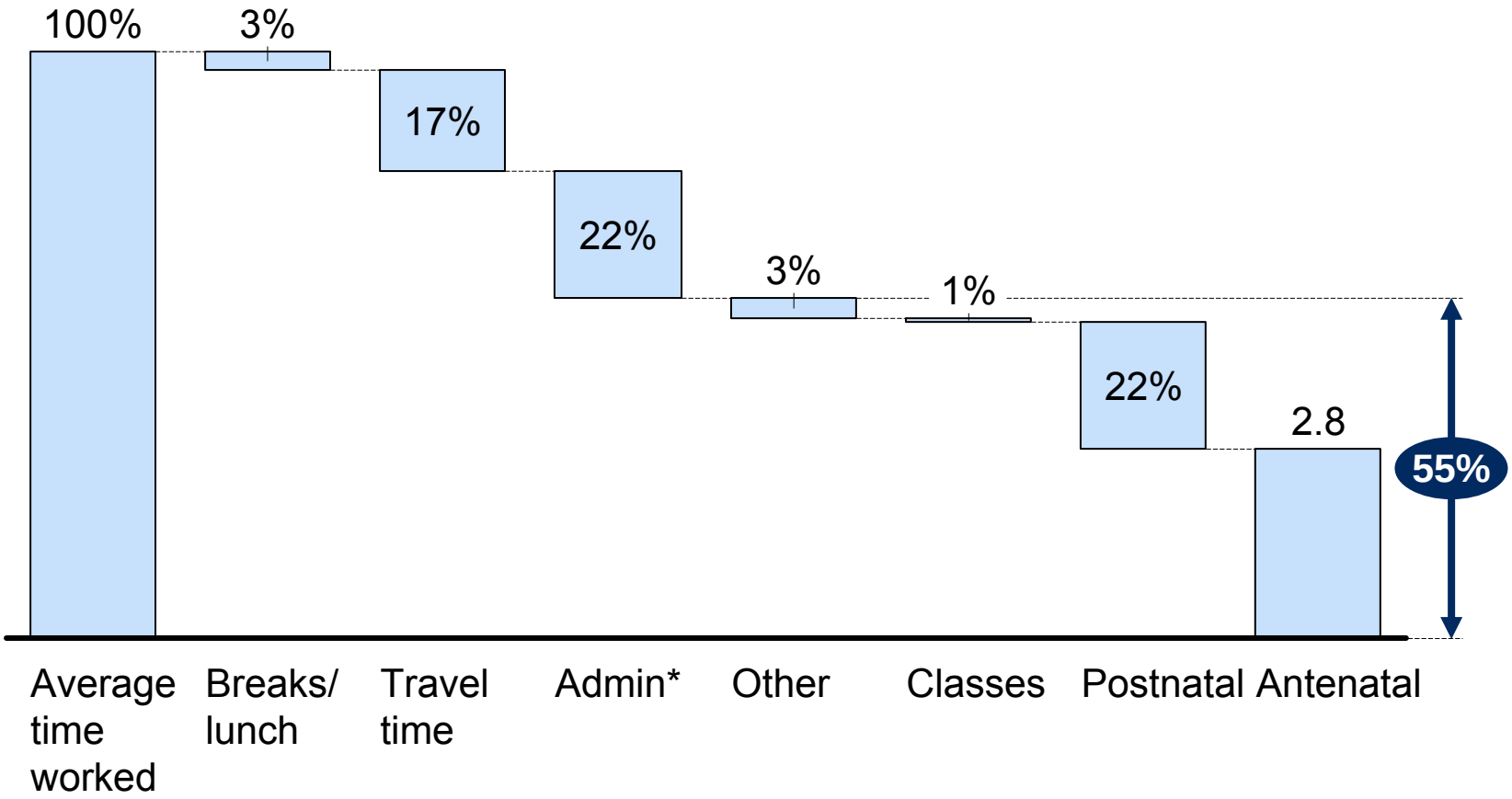
Source: Wards observation

1 Acute providers – Study across FTs found only 55% of community midwives time is spent on patient facing activities

Overall mean activity breakdown per day (2006), %
100% = 8.6 hours



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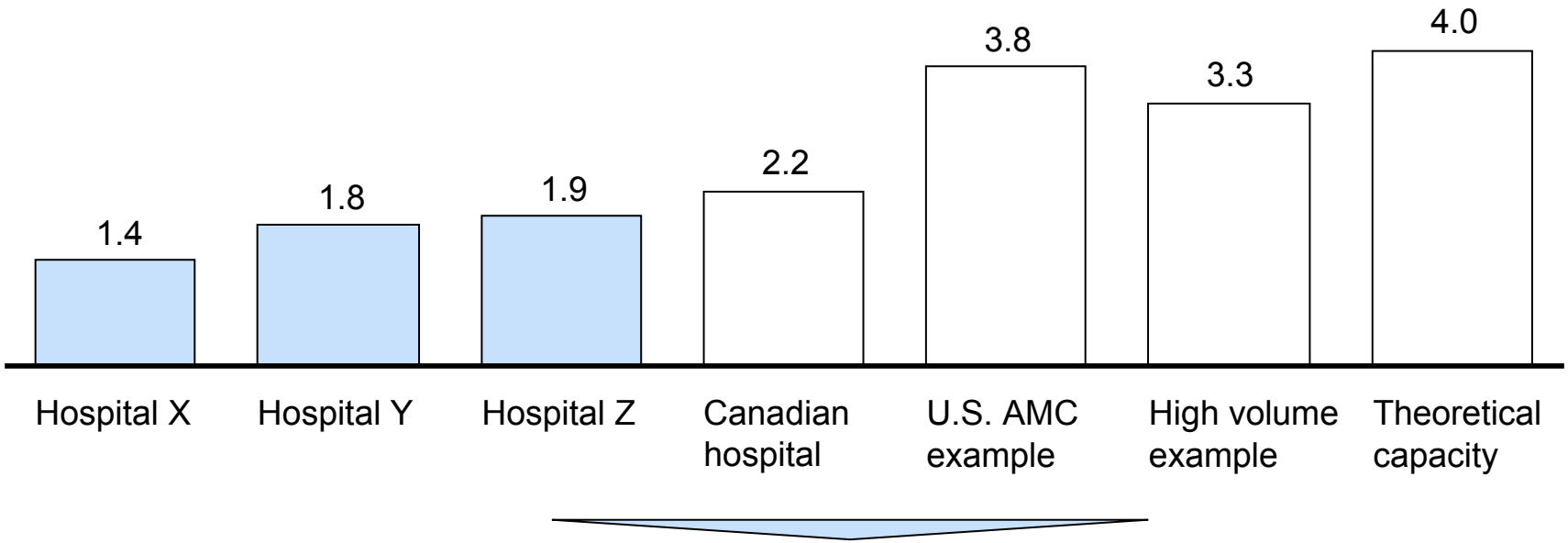
* Admin also includes phone calls, texting, emails, meetings

Source: Benchmark Trusts, Foundation Trust Network

1 Acute providers – potential to increase CT throughput by 50-100%

Number of CT scans per machine per hour of operation. 2006



Key levers to increase throughput

- Reduce downtime e.g., scheduling, patient ready
- Reduce rework
- Standardize process e.g., consistent protocols

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1 Acute providers – Potential to increase usage of the clinical rooms in 80%* of the potential slots

> 80%
50 - 80%
< 50%

Clinical room usage

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Clinic room A	Morning	75%	35%	53%	91%	34%	45%	10%
	Afternoon	80%	60%	85%	45%	56%	45%	15%
	Evening	80%	60%	65%	45%	56%	45%	5%
Clinic room B	Morning	75%	35%	53%	91%	34%	45%	10%
	Afternoon	80%	60%	85%	45%	56%	45%	15%
	Evening	80%	60%	65%	45%	56%	45%	5%
Clinic room C	Morning	75%	35%	53%	91%	34%	45%	10%
	Afternoon	80%	60%	85%	45%	56%	45%	15%
	Evening	80%	60%	65%	45%	56%	45%	5%

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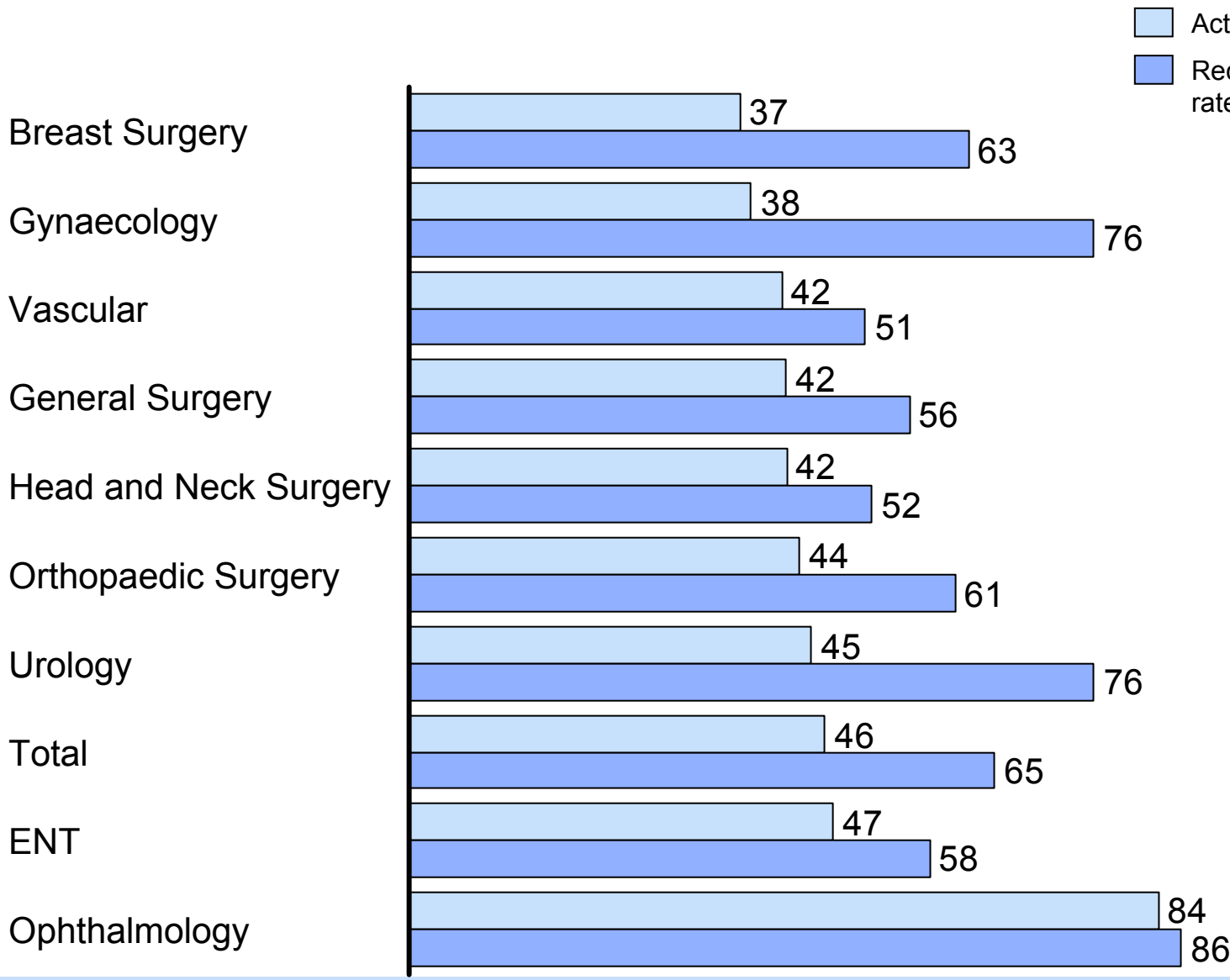
* Assumes target utilisation 80% or more

1 Acute providers – Opportunity to increase day surgery rates

Day cases as proportion of total activity by specialty, %, London



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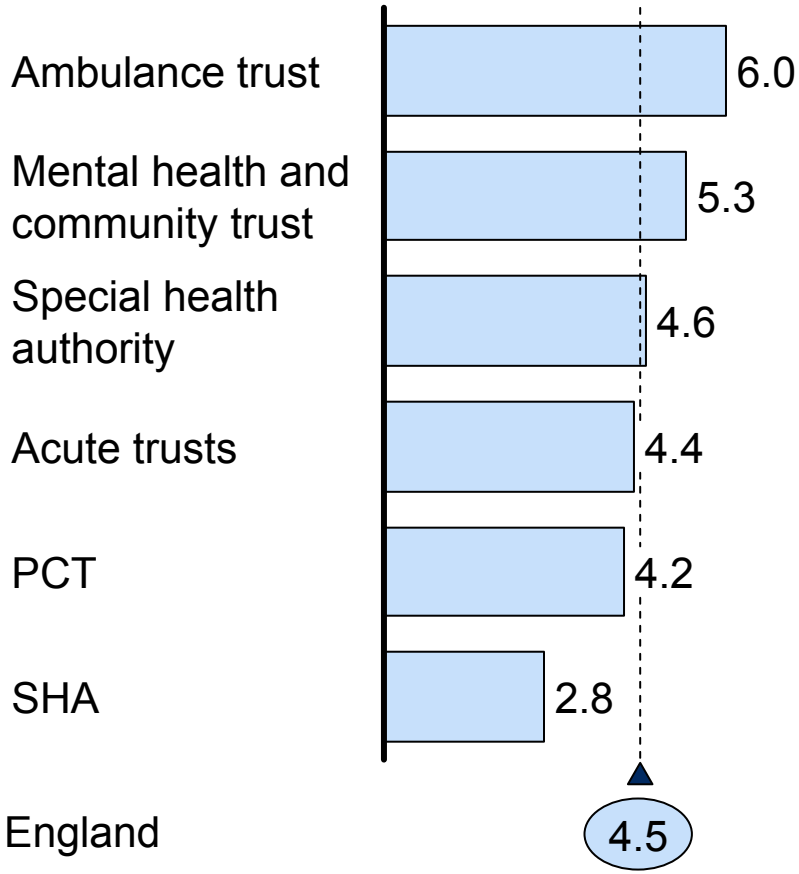
Source: HES, British Association of Day Surgery

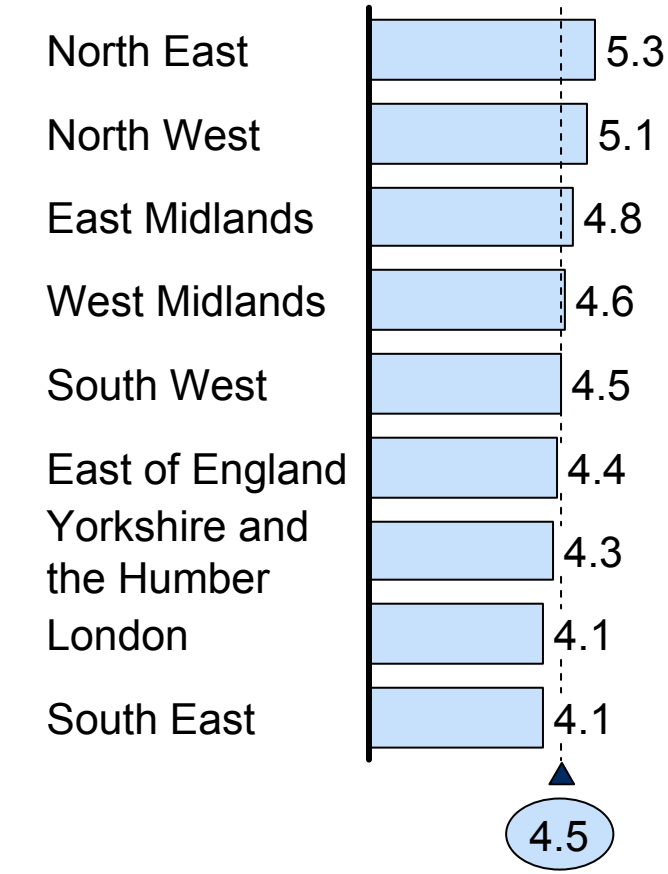
1 Acute providers – Variability of sickness rate highlights opportunities for increase staff productivity

Sickness rate[1] 2005, Percent

By organisation type



By strategic health authority



1 Time lost through absence as percent of total staff type excludes maternity leaves, carers leave and periods of absence agreed

Note: GPs and their staff not included in these figures
Source: NHS Sickness Absence Survey 2005

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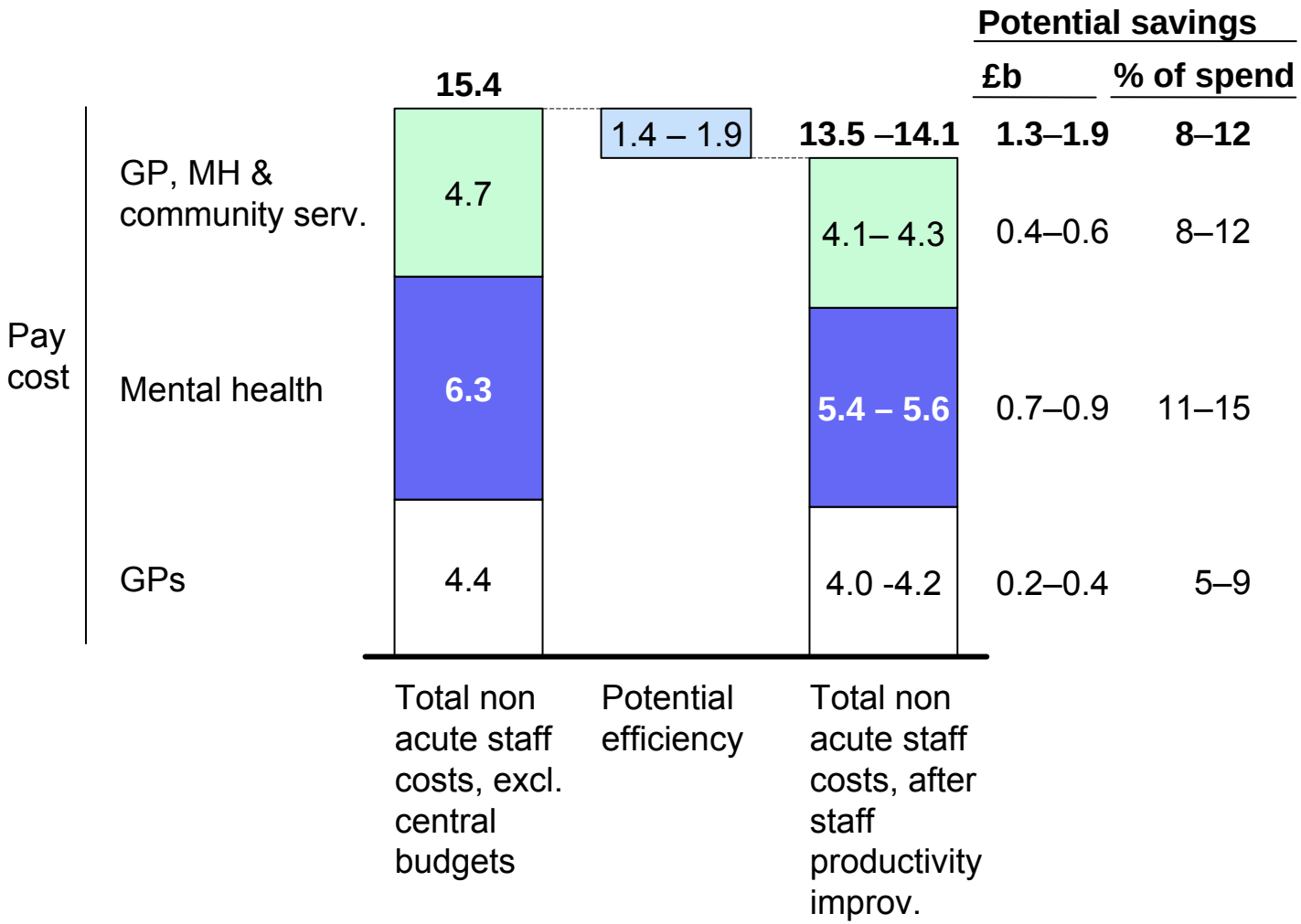
2 Non-acute providers – Potential savings of £1.3–1.9b through reducing variability in staff productivity of GPs, community services providers and mental health providers

£b, 2008/09. Non acute staff costs



Key opportunities

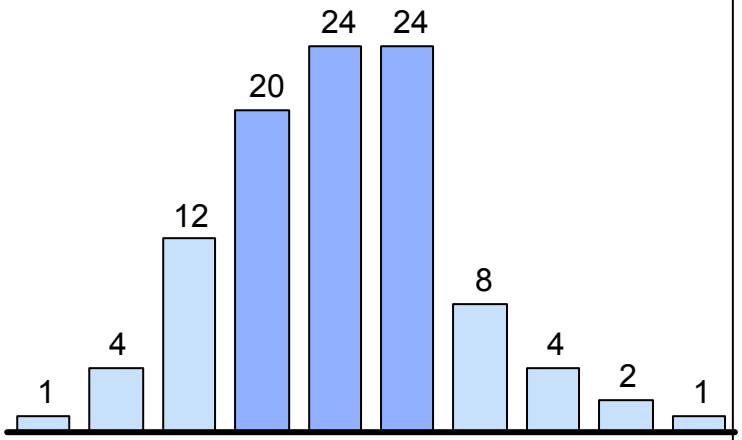
- Reduce variability in the number of daily visits of the district nurses and health visitors
- Reduce variability in the LoS of the mental healthcare providers
- Increase the number of GPs appointments available and/or hours worked by GPs

SOURCE: National Audit Office – Summarised Accounts Care purchased by PCTs, GP Systems, GPs Earnings and Express Enquiry, Workforce Census; McKinsey analysis

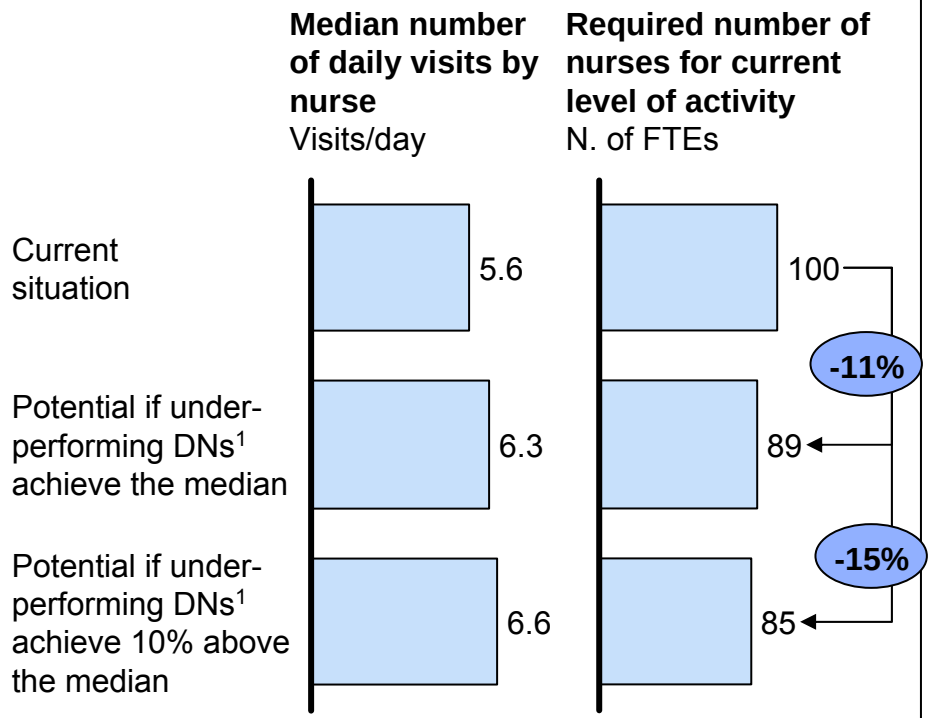
2 Community services – Potential to deliver same level of activity with 11–15% less staff, if district nurses achieved median productivity or 10% above

PCT EXAMPLE

Average number of daily visits by nurse in specified period in a PCT, 2008
%



Impact of reducing variability of district nurses productivity



1 District nurses

Source: 3-month sample of district nurses in provider arm of a PCT; McKinsey analysis

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2 Community services – One PCT has identified a set of initiatives to increase efficiencies of service line services by c. 15%

PCT EXAMPLE

Efficiency improvement initiatives	Share of savings % of budget 08
1 Adjust skill-mix of Service line staff	8.0
2 Reduce administrative time by employing more admin. staff and intro of lean processes	3.3
3 Reduce management time of lower band staffs	1.0
4 Streamline travel routes of clinical staff	1.0
5 Reduce data entry team once EMIS Web is fully functional	0.7
6 Replace night sitting agency staff with permanent staff	0.6
Total	**14.6**

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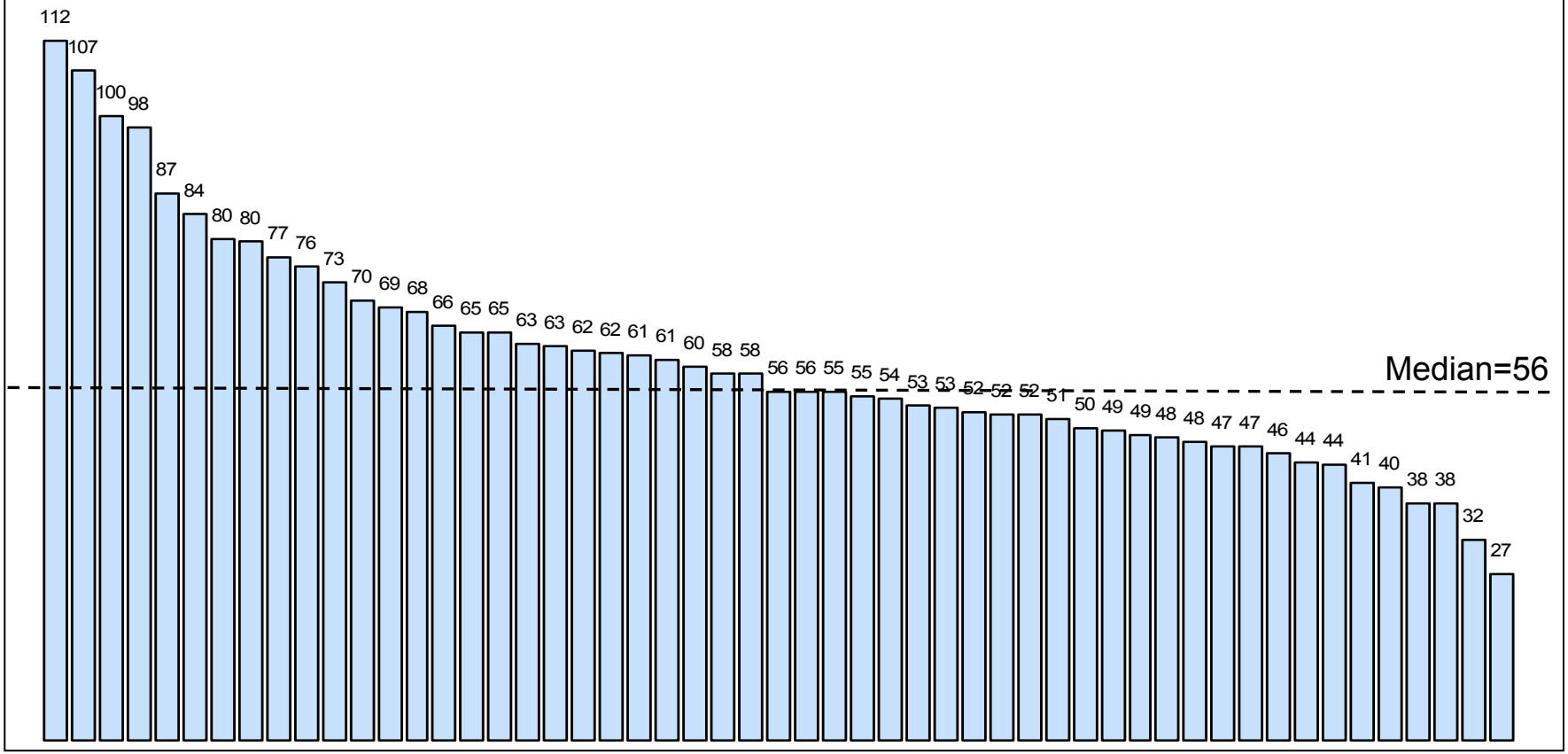
2 Mental health – Potential to reduce beddays by 8–12% if providers achieve 50-80% of the potential improvement of stepping down to median ALOS

ALOS of mental health providers
Number of days. England. 2006-07



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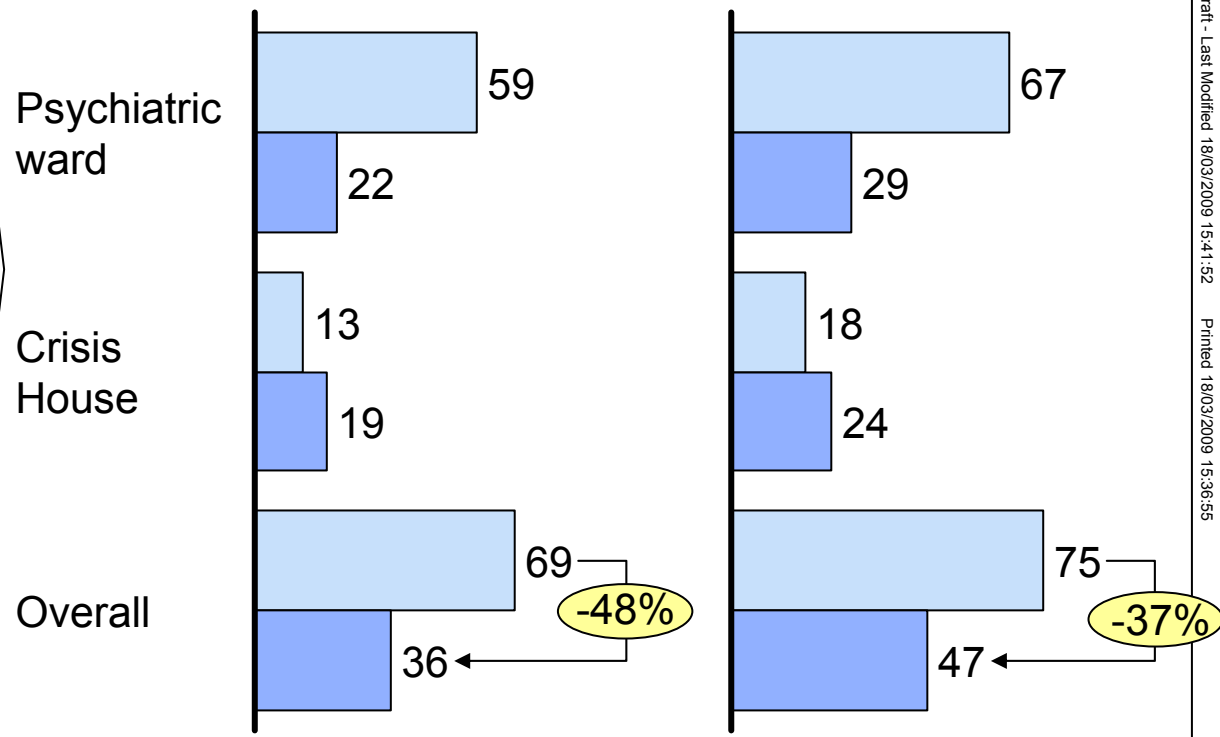
Note: Excludes data points with fewer than 25 spells
SOURCE: HES 2006/07 – Mental health HRGs codes only (T); McKinsey analysis

2 Mental health – Crisis resolution teams can reduce the need for admissions by 40–50% based on controlled trials

Description of randomised controlled trial

- 260 residents of the Inner London borough of Islington who where experiencing crisis severe enough for hospital admissions to be considered
- Compare admission rates and satisfaction of the group of 135 who received care from crisis resolution team (experimental group) vs. the group of 125 who receive the standard inpatients services and community mental health teams support (control group)

Admission rates, %



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[1] Crisis resolution team
SOURCE: BMJ August 2005

2 Mental health providers – Examples of initiatives undertaken by two PCTs to improve the value for money of MH and LD services

	Savings identified		
	Total £m	**As percentage of current spend** %	**Key initiatives**
Northamptonshire PCT	£11 - 22m	9 -18%	▪ Individual Packages of Care (IPCs): enforce a contractual framework with all MH/LD providers and develop direct payment for social care IPCs ▪ Transform block contract into an activity-driven contract and tender services ▪ Develop local MH/LD facilities when cost effective
Buckinghamshire PCT	£2 - 2.5m	3 - 4%	▪ Managing MH contract issues and tendering out services to realise savings ▪ Reducing out of area LD placements ▪ Quantifying risk in continuing care and improving procurement and review processes ▪ Exploring changes to commissioning to improve value for money of Head Injury Placements ▪ Review joint commissioning of children's services and opportunities for savings in PCT provider arm ▪ Delivery of LD performance management and S31s

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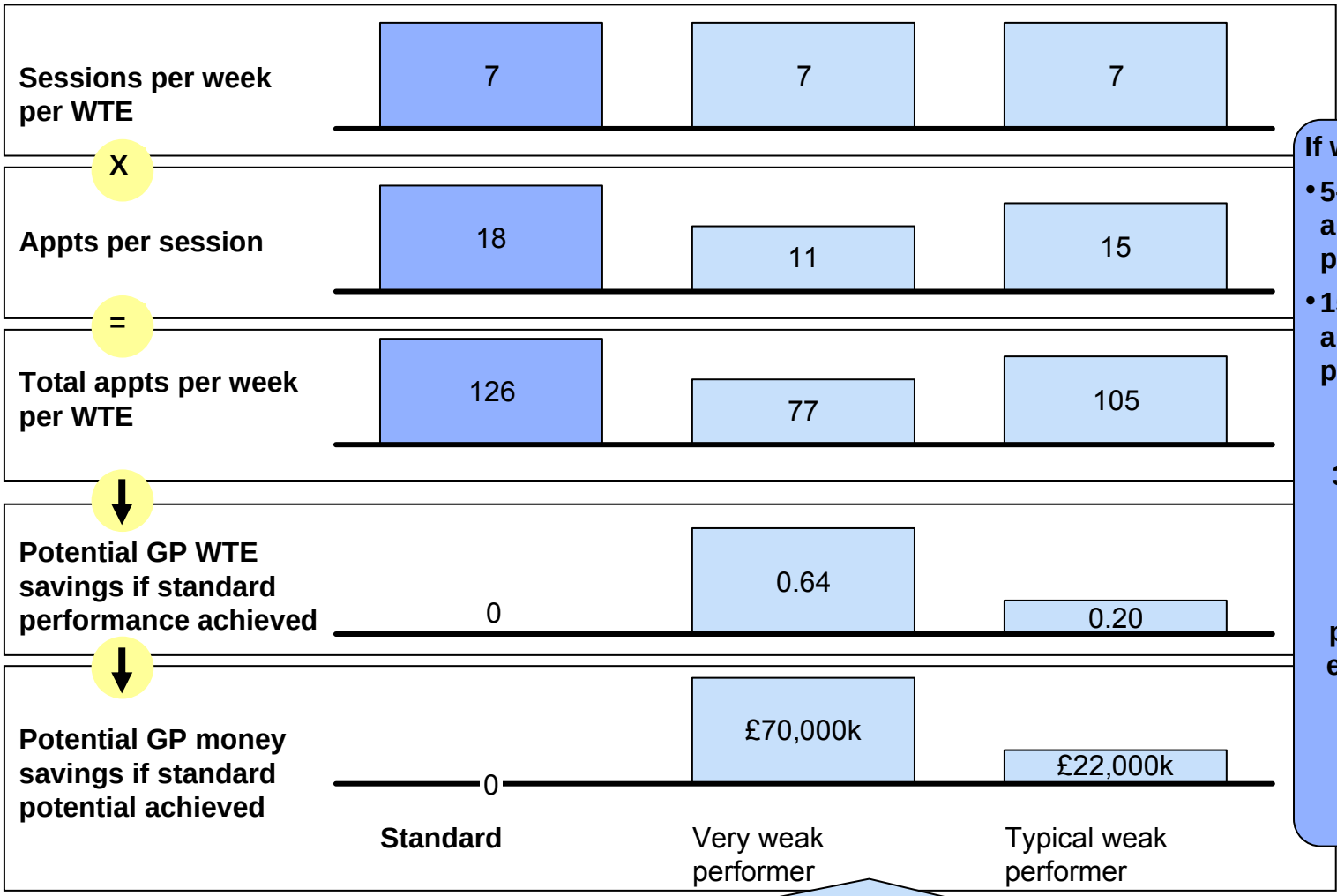
Note: LD: Learning Disabilities; MH: Mental Health

2 Primary care providers – Potential GP productivity improvement could be worth of £0.2–0.4bn, if weak performers achieve standard performance



If we assume that

- **5–10% of total GPs are very weak performers**
- **15–25% of total GPs are typical weak performers**

X

31,000 WTE GPs in England

X

£22,000–70,000 potential savings for each GP stepping up to standard performance

=

£0.2–0.4bn

Potential savings of £22,000–70,000 if a GP becomes a standard performer, depending on the starting level of performance

Note: Assumes average GP salary of £108k per year

Source: Data extracts from GP systems; McKinsey analysis

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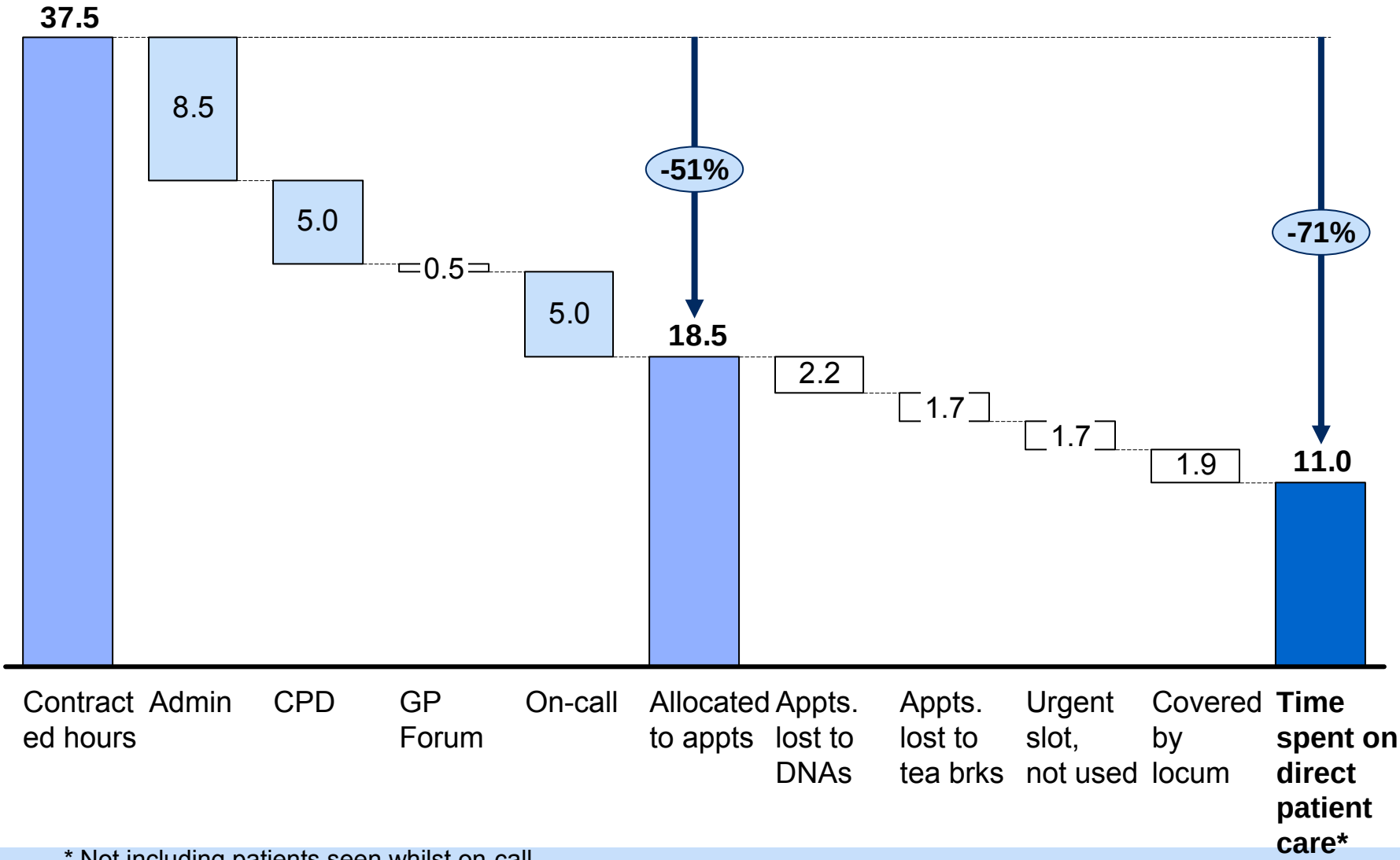
2 Primary care providers – A low-performing GP can spend less than 30% of their contracted hours actually seeing patients

Number of hours



* Not including patients seen whilst on-call

Source: Interviews with PCT and practices; McKinsey analysis

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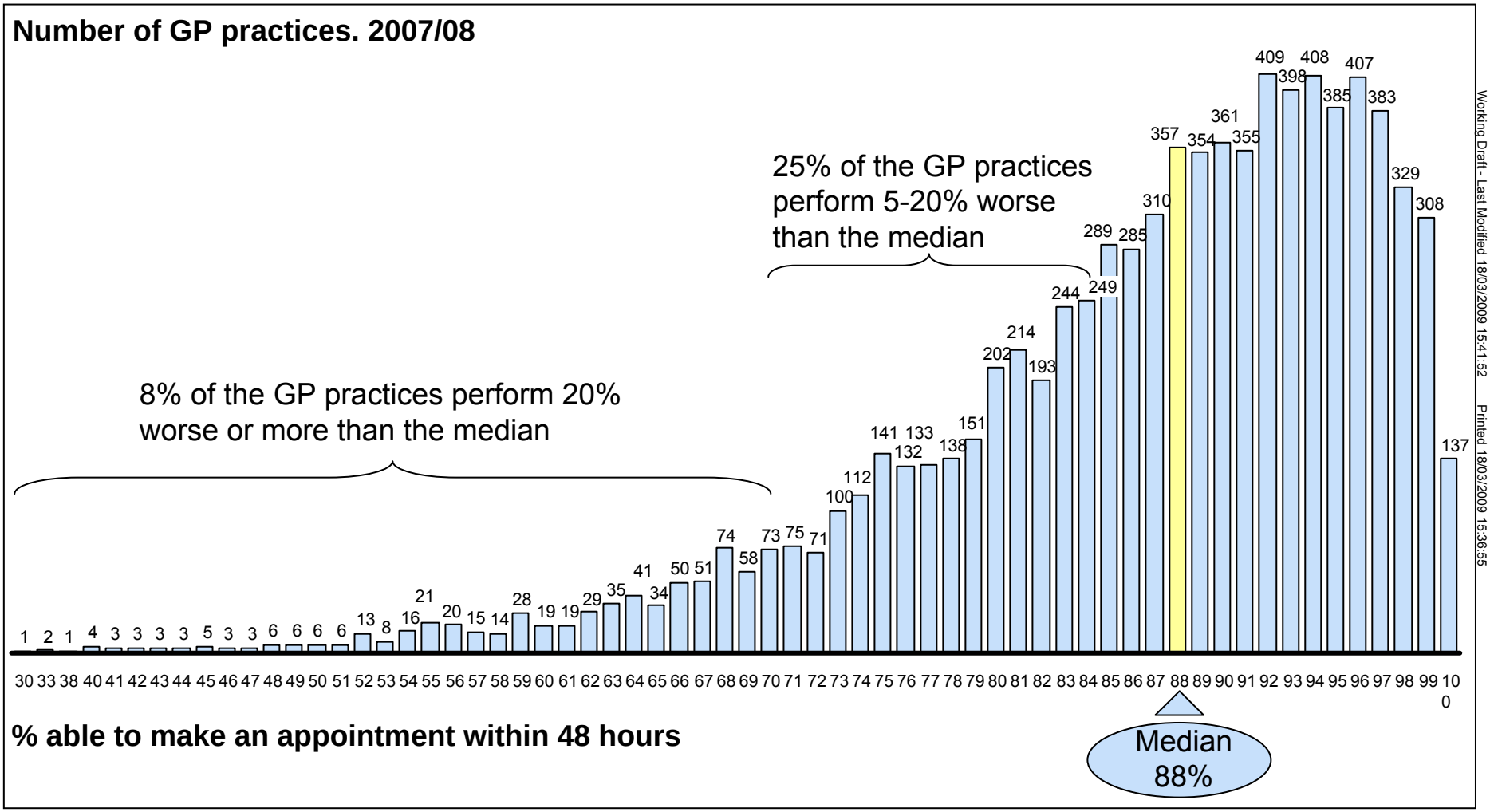
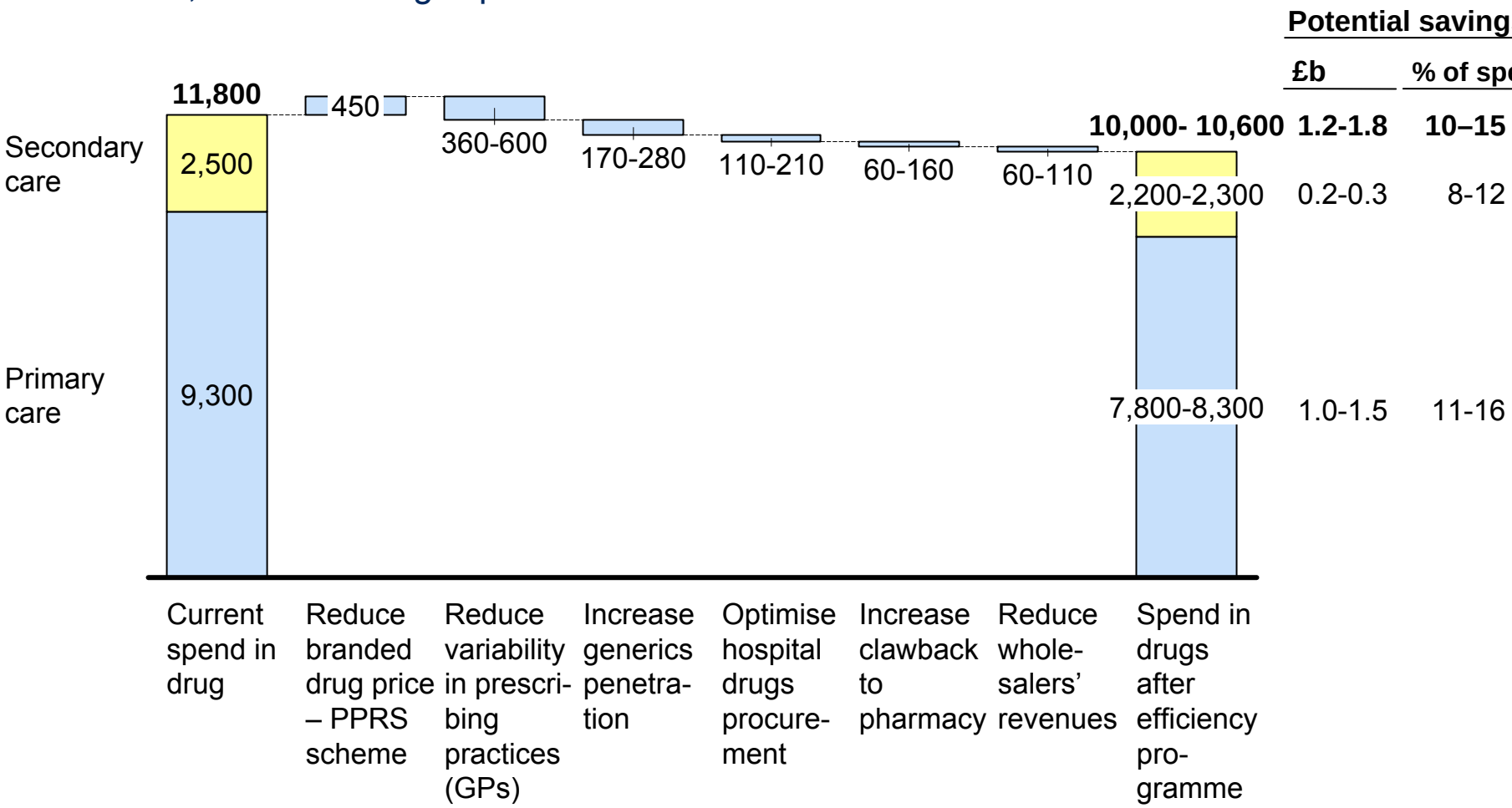
2 Primary care providers – GPs performance in access indicates that c.10% are very weak performers and c.25% are typical weak performers



Source: The Information Centre for Healthcare and Social Care – GP Patient Access Surveys 2007/08; McKinsey analysis

3 Drug spend – Potential savings of £1.2–1.8b through pulling different price and volume levers

£million, 2008/09. Drugs spend



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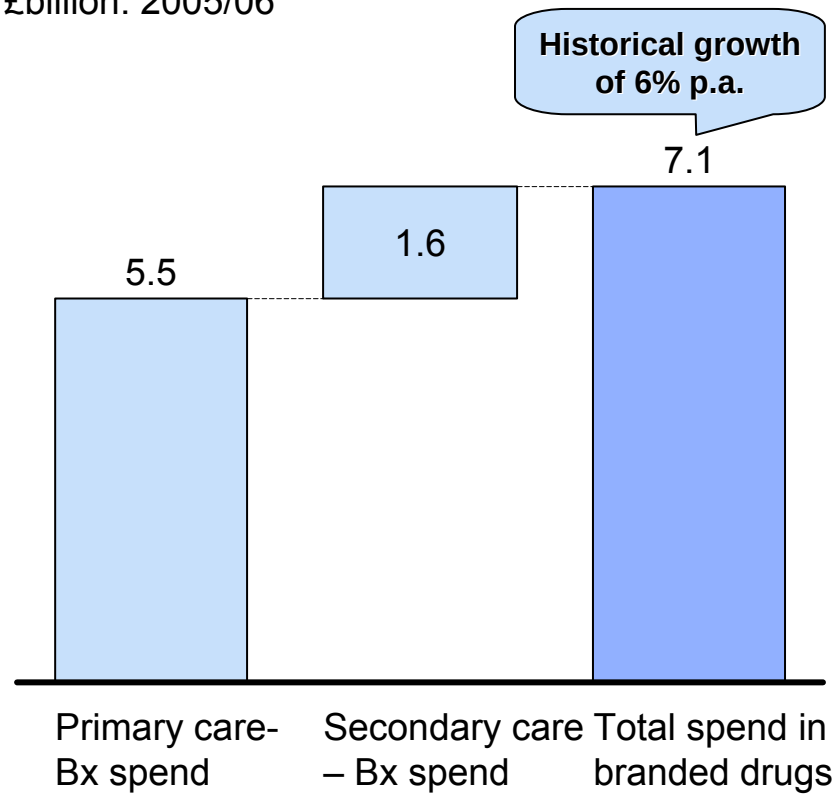
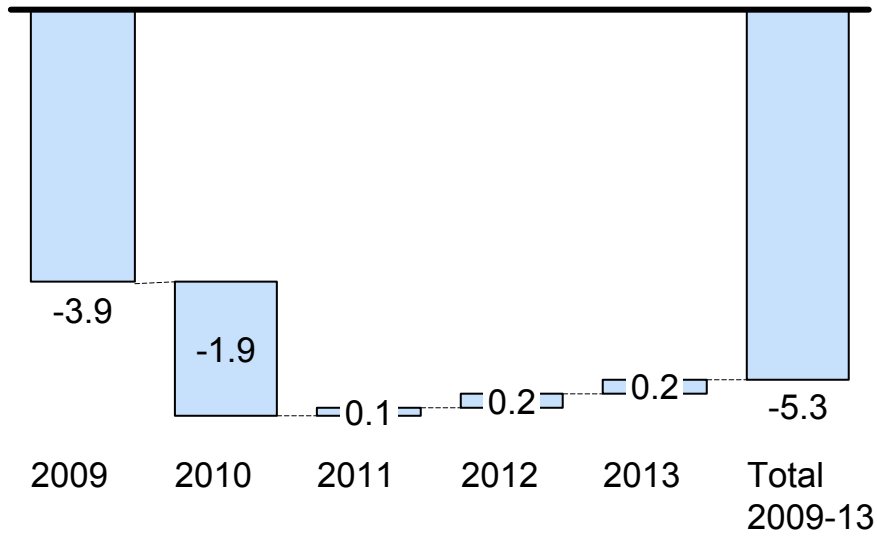
SOURCE: Office of Fair Trade – Financial Flows Relevant to Medicines; DH – PPRS 2009; Laing & Buisson NHS Financial Report, Espicom; Euro Observer 2008; DHL website; McKinsey PMP Practice

3 Drug spend – PPRS 2009 agreement expected to deliver savings of 450m p.a. from 2010-11 onwards

Total expenditure on prescription medicines in England – Branded drugs
£billion. 2005/06



Pharmaceutical Price Regulation Scheme 2009 agreed price reductions/increases
%. 2009-2013



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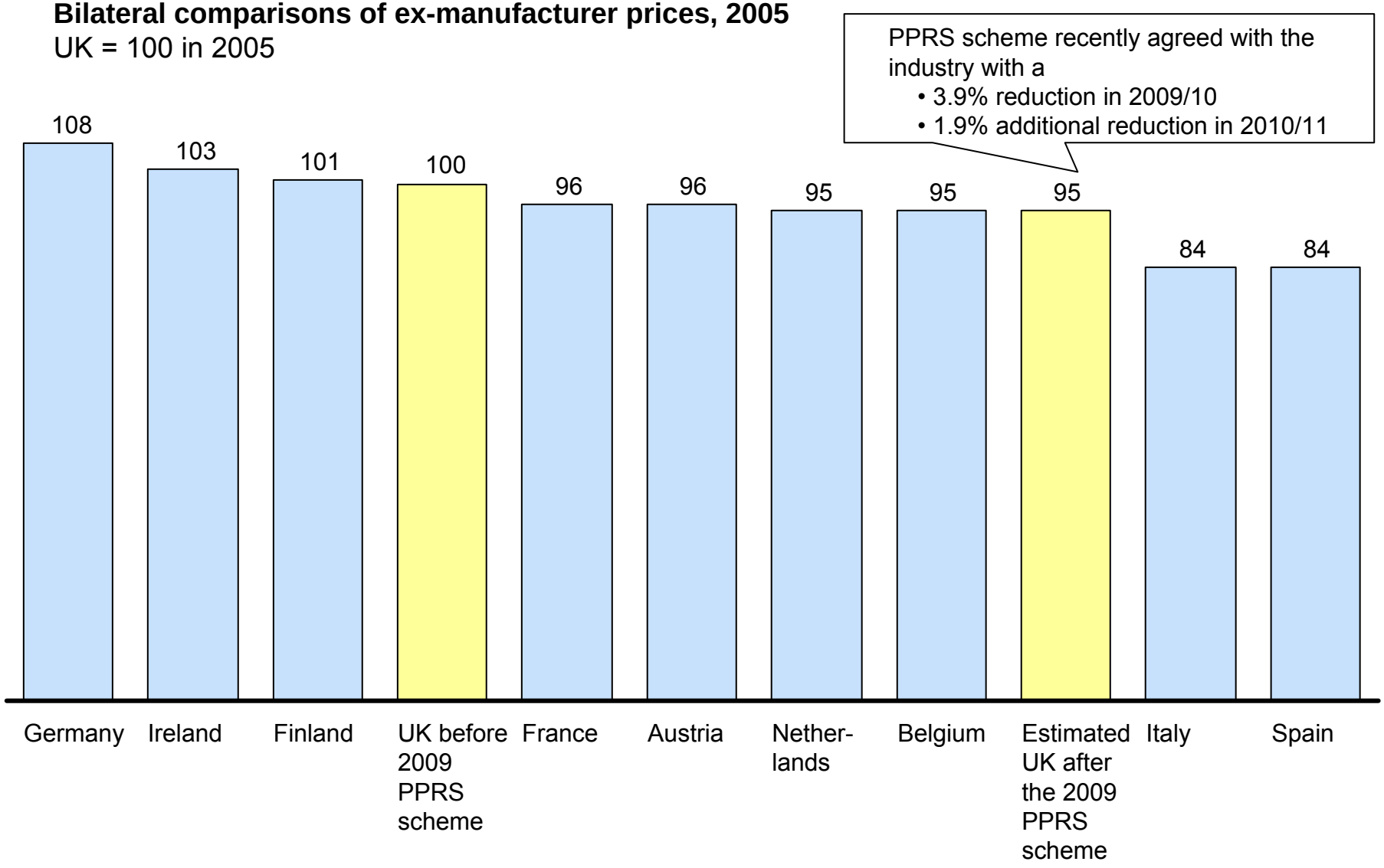
Source:Office of Fair Trading: PPRS – An OFT evaluation survey; DH PPRS 2009; McKinsey analysis

3 Drug spend – After the recently negotiated PPRS scheme, the U.K. branded drugs prices would be more aligned with the rest of Europe

Bilateral comparisons of ex-manufacturer prices, 2005
UK = 100 in 2005



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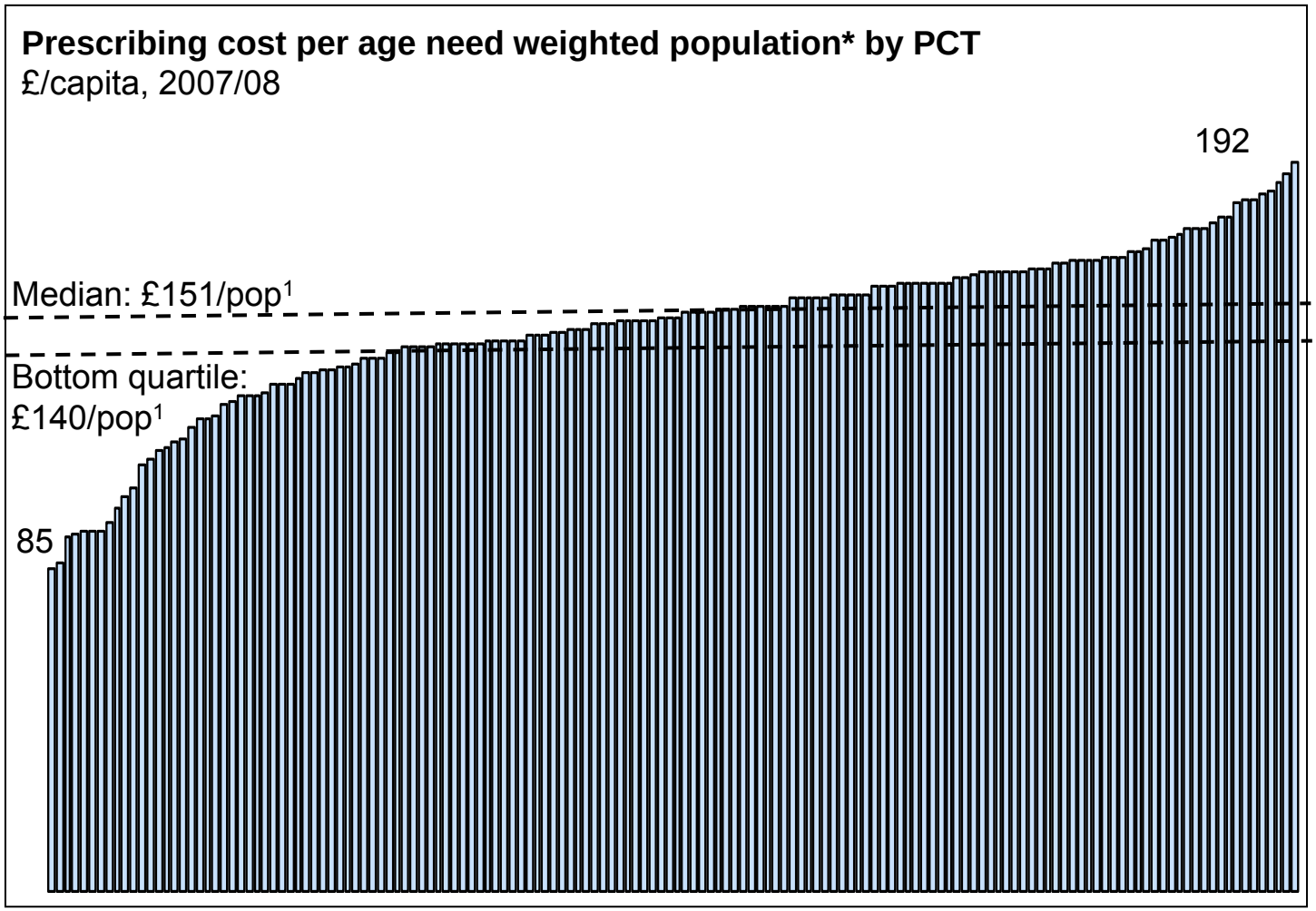
Source: OFT Report on PPRS February 2007, McKinsey analysis

3 PCTs' prescribing costs – Potential savings of £0.4-0.6bn, if PCTs achieve the median or 80% of the potential of stepping down to bottom quartile

Prescribing cost per age need weighted population* by PCT
£/capita, 2007/08



Typical sources of inefficiencies

- Unexploited switches to cheaper alternatives with identical outcomes
- Avoidable specialist and restricted drug spend
- Waste reduction
- Lack of formulary
- Supply chain inefficiencies

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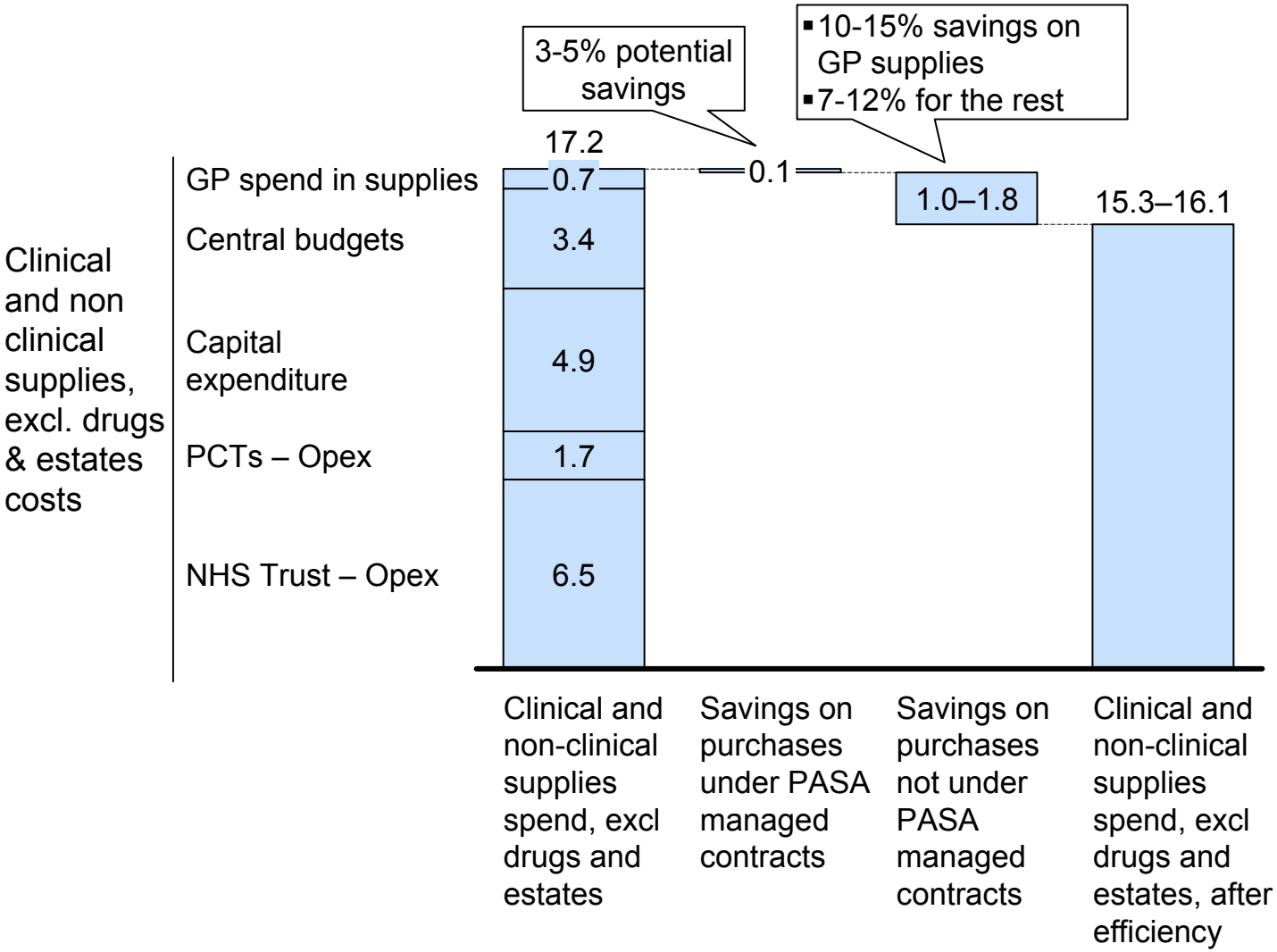
1 Age need weighted population
Source: Laing & Buisson NHS Financial Reports; DH Exposition book; McKinsey analysis

3 Supply chain/procurement: although significant savings already captured, there is still an opportunity estimated at £1.1–1.9b

£million. 2008/09. Clinical and non clinical supplies spend, excl. drugs and estates



Key opportunities

- Extend the national procurement contracts to other categories, including central budgets and capital expenditure
- Accelerate implementation of collaborative hubs
- Enforce PCTs/Trusts to buy through PASA contracts/frameworks
- Improve inventory managements

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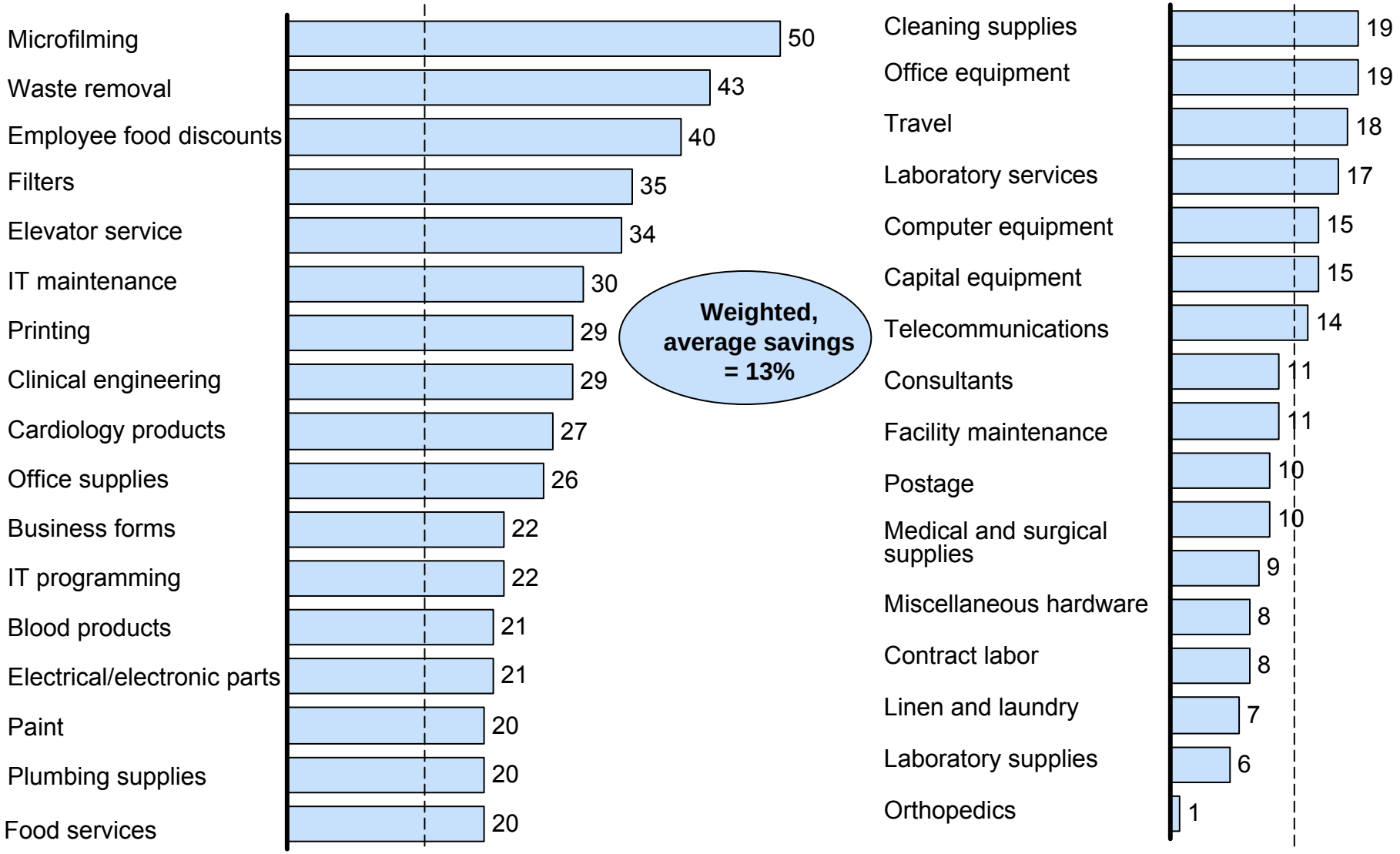
SOURCE: National Audit Office – Summarised Accounts; NHS Purchasing and Supply Annual Report 2007/08, DH – Departmental Report 2008, McKinsey analysis

3 10% to 15% savings on external spend can be typically achieved through a comprehensive procurement project

Percent savings based on 75 projects since 1997



Source: McKinsey PSM database

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3 The Supply Chain Excellence Programme aimed and captured £0.5bn savings out of £15bn spend, equivalent to 3% of the spend

	Initial savings estimate - 2004	**New targeted savings -** 2005	**Final savings achieved –** 2007/08
National Contracts Procurement[1]	240	407	240
Collaborative Procurement Hubs	270	326	270
Total	**510**	**733**	**510**

1 Includes expected savings from Wave 1 and Wave 2

Source: SCEP – Reference Pack for McKinsey- August 2005 –DH Commercial Directorate, NHS supply and procurement agency annual report 2007/08

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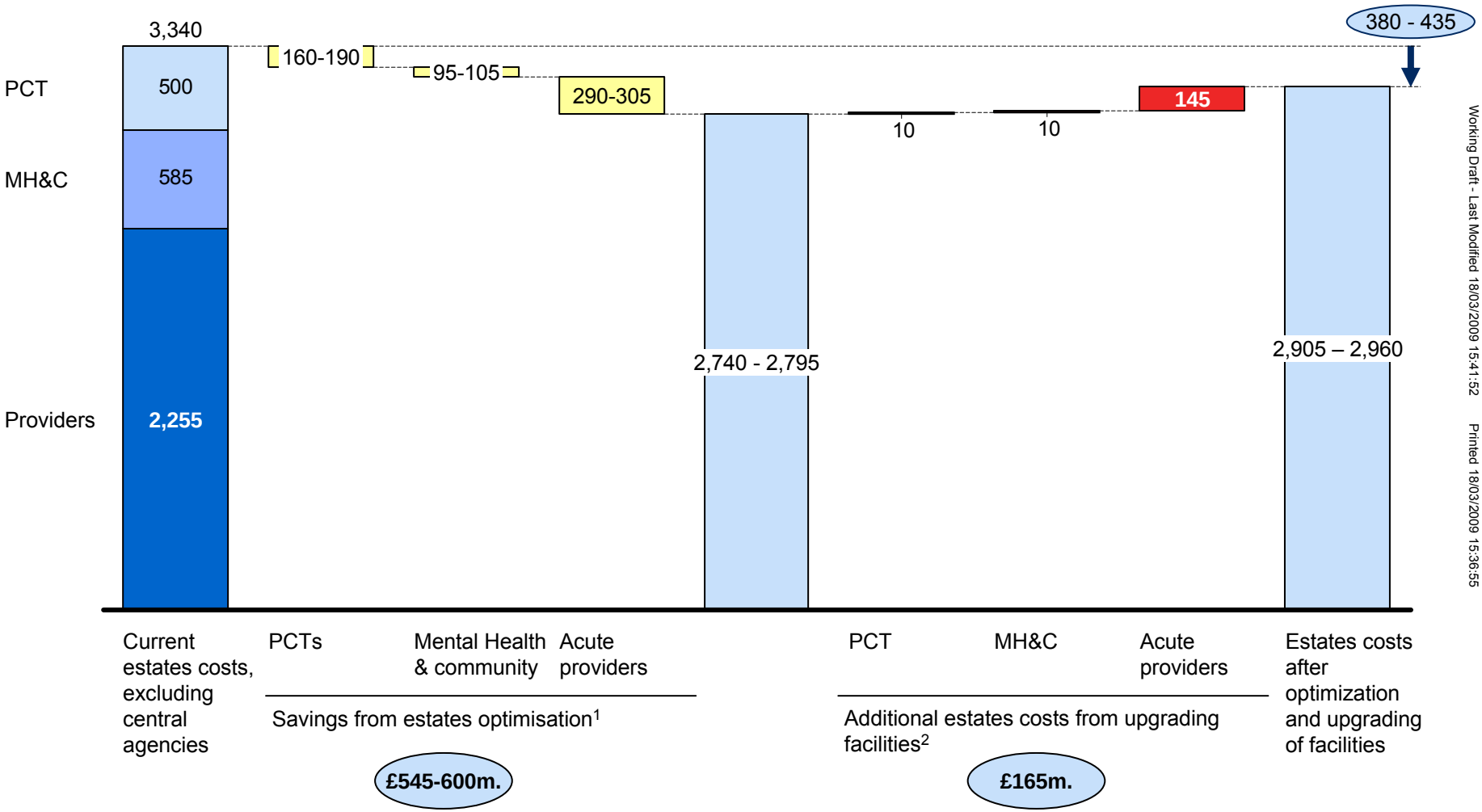
4 Estates optimisation – Potential savings of £0.4b if PCTs and trusts optimise utilisation of their estates

£million. 2007/08. Estates costs



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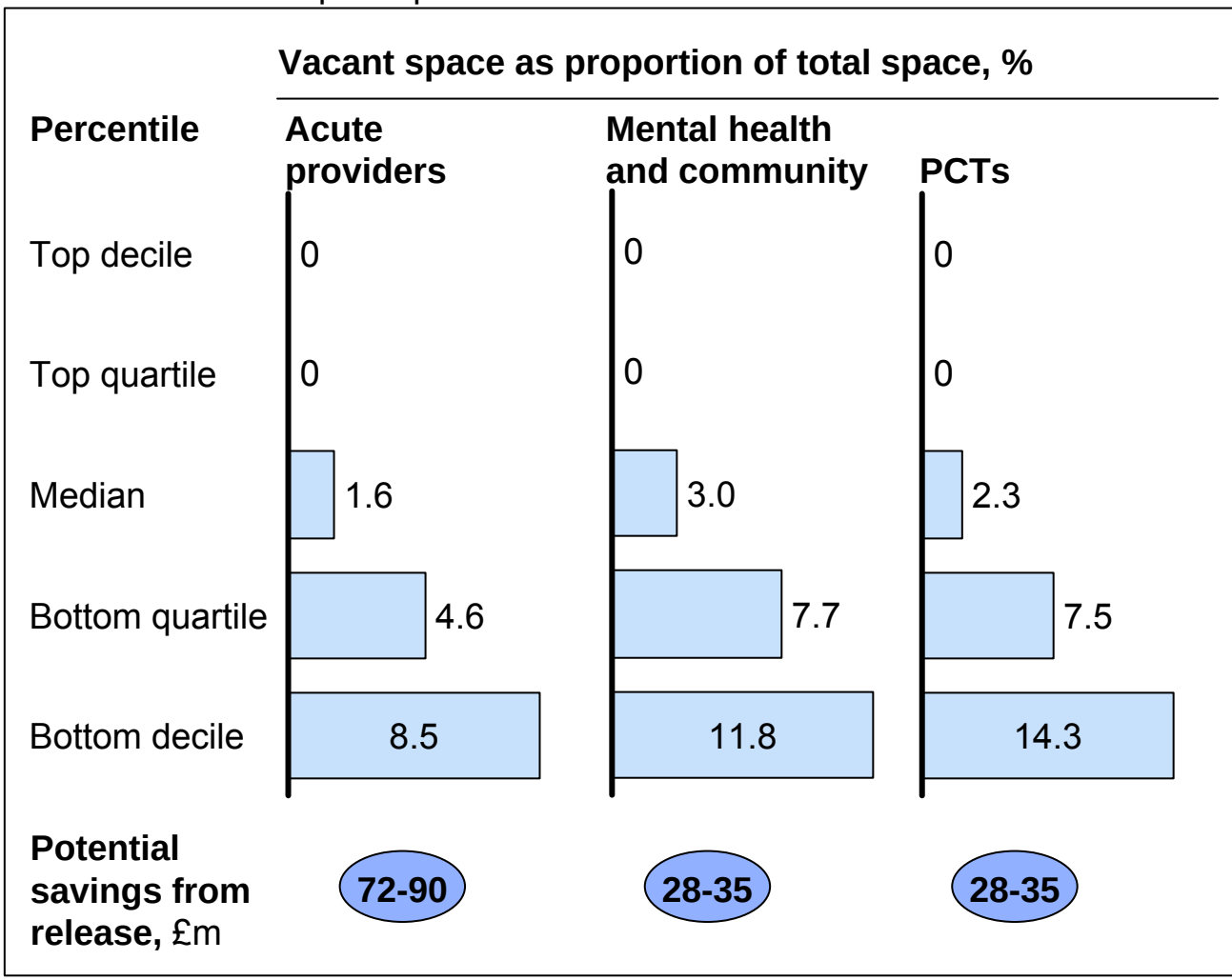
1 Calculated as trusts below median reaching median or 80% of top quartile value in sq.m. per bed or sq.m. per WTE. Same assumption applied to capture savings from vacating currently unused space

2 Calculated to reach Condition B ("the asset is sound, operationally safe and exhibits only minor deterioration") and associated annual estates costs

4 Potential savings of £130-160*m from vacating current unoccupied space at providers' and PCTs estates…

Opportunity to optimize space use if providers and PCTs vacate between 80-100% of the unoccupied space



Current vacant space
725,000 sq.m. (providers)
and
190,000 sq.m. (PCTs)

X

£172/sq.m. (providers)**
and
£183/sq.m. (PCTs)**

=

£100-125 m (providers)
and
£28-35 m (PCTs)

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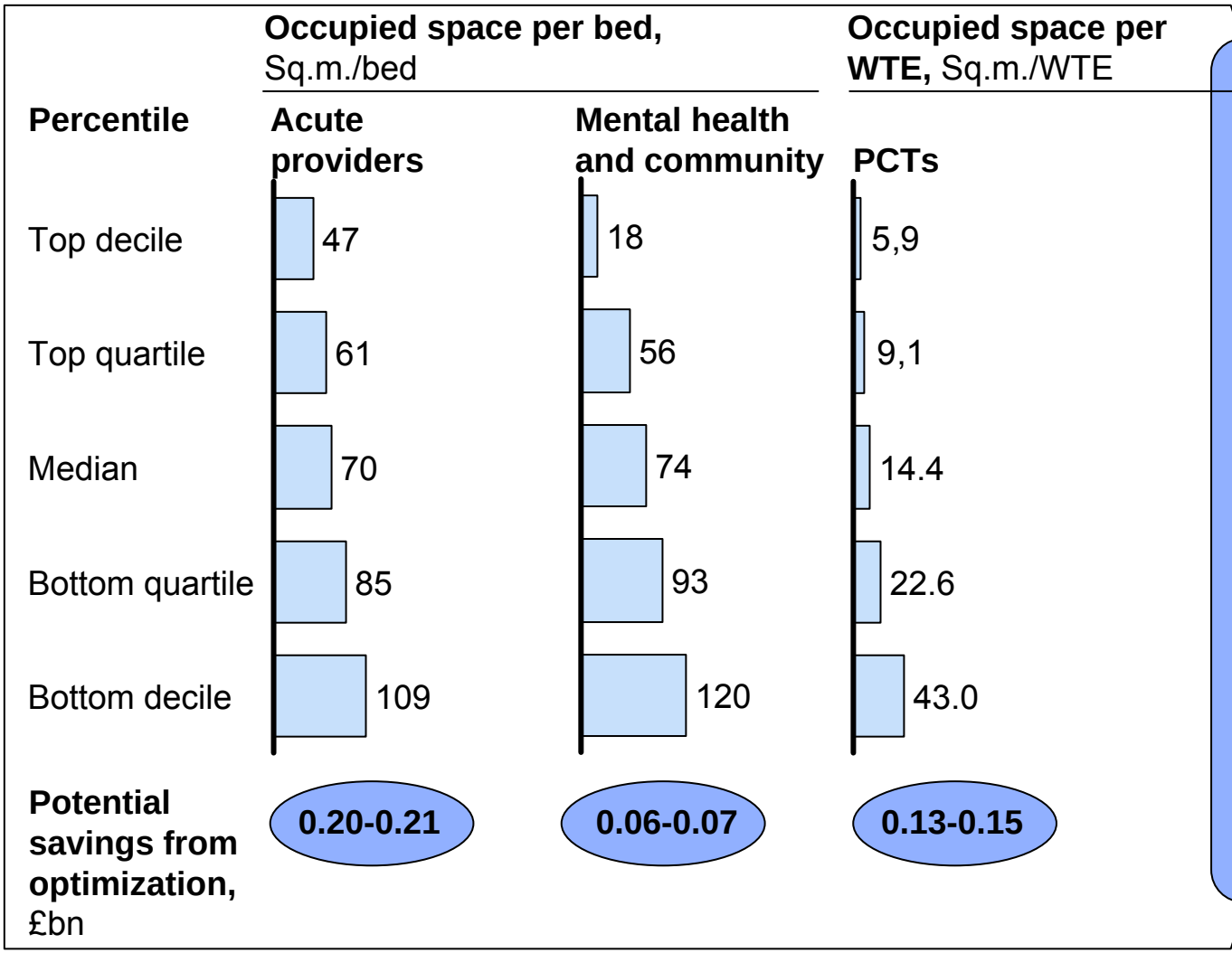
* Range assumes 80% of maximum to maximum possible vacant space is disposed of

** Extremely conservative as costs generally taken to be £300-400/sq.m.

Source: NHS Information Centre: Estates Returns Information Collection 07/08; McKinsey analysis

4 … and additional potential savings of £0.4bn from better use of providers' and PCTs' estates

Opportunity to optimize space use if all providers step down to median or 80% of top quartile in use of sq.m./bed or sq.m/ WTE



15-16% potential improvement in provider space utilization and 31-39% improvement in PCT space utilization

X

10.5m sq.m. (providers) and 2.1m sq.m. (PCTs)

X

£172/sq.m.* (providers) and £183/sq.m.* (PCTs)

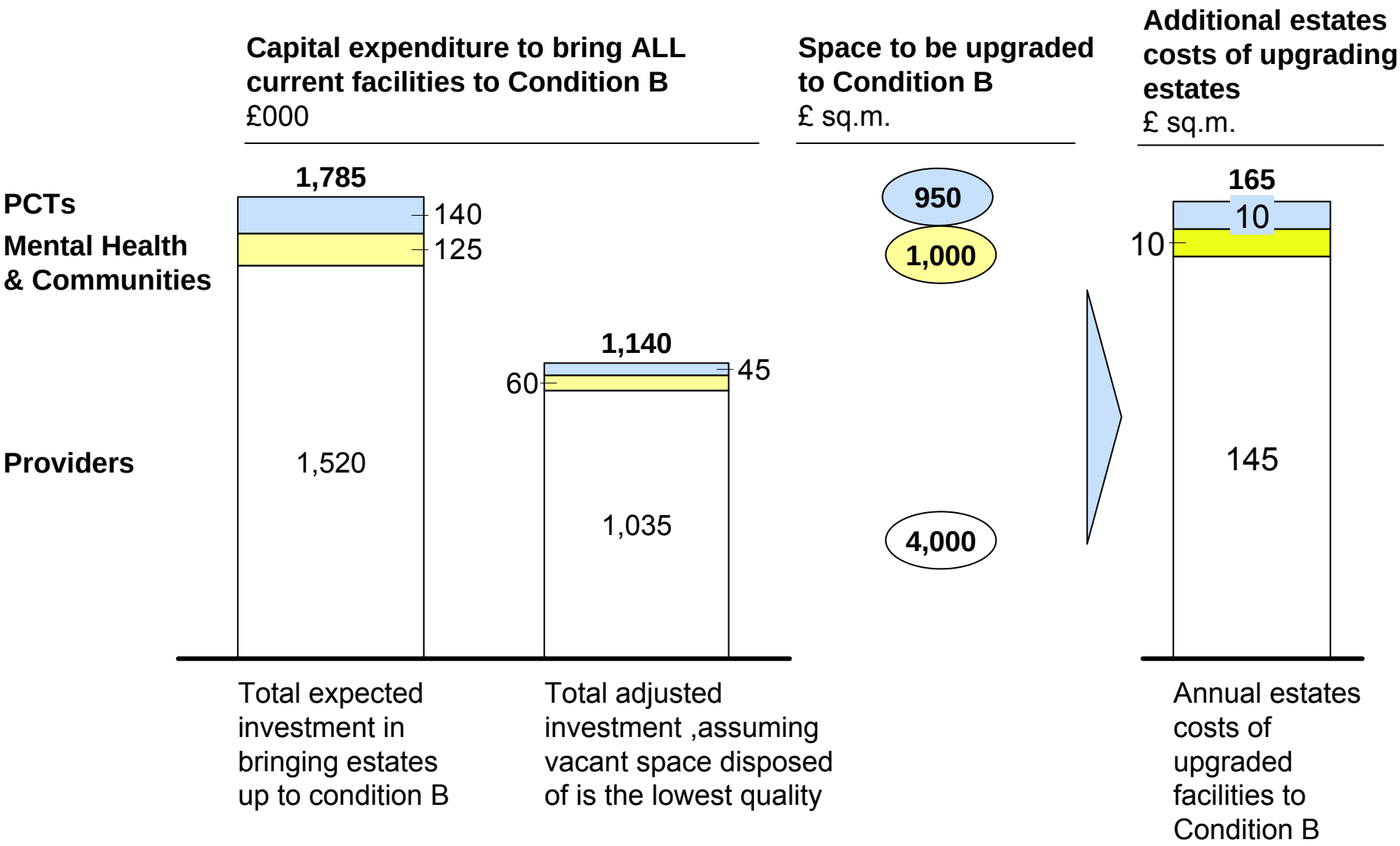
=

£0.26-0.28 bn (providers) and £0.13-0.15 bn (PCTs)

* Extremely conservative as costs generally taken to be £300-400/sq.m.

Source: NHS Information Centre: Estates Returns Information Collection 07/08; McKinsey analysis

4 On the other hand, additional estates costs of £165m would be incurred to upgrade current "poor" facilities



Source: NHS Information Centre: Estates Returns Information Collection 07/08; McKinsey analysis

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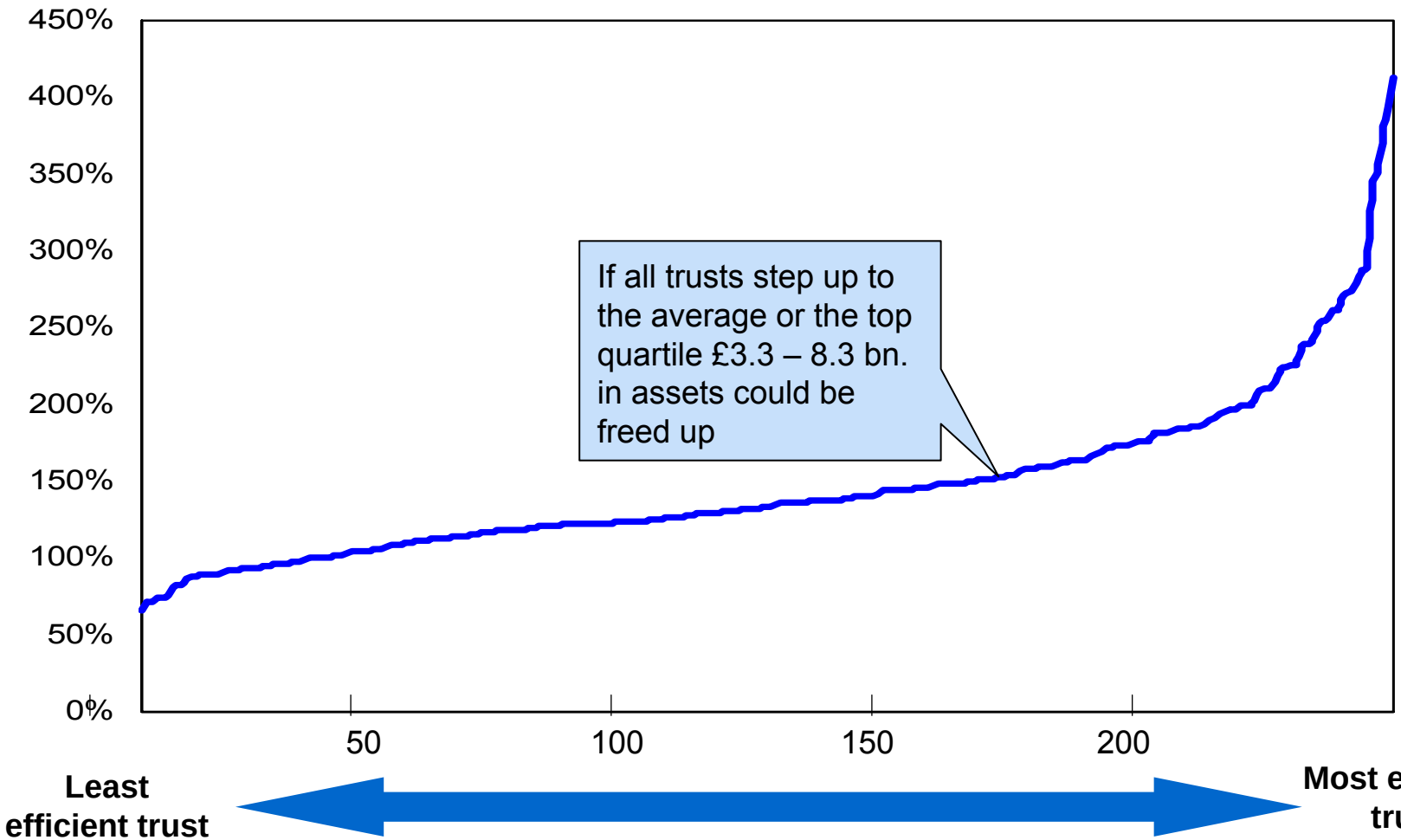
4 Estates costs – Trusts' asset utilisation varies sixfold

Revenue to fixed asset by trust*, average 2002/3 – 2004/5. Percent



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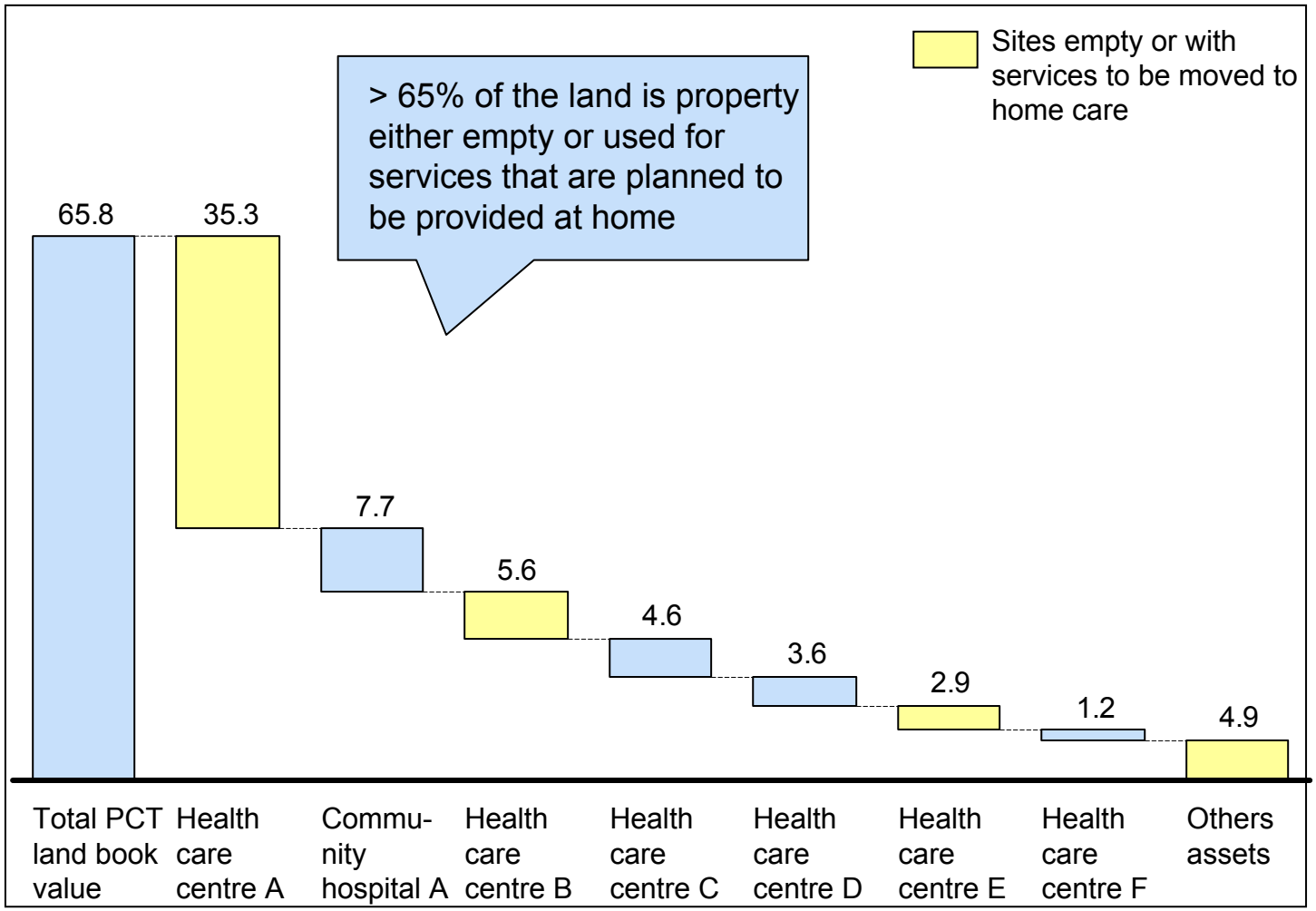
* Acute and mental health trusts

Source: Laing & Buisson financials; National Asset Register 2007; Team analysis

4 Estates costs – PCTs can also take out estates costs by renting/selling not used site

2008, Book Value in £m

PCT EXAMPLE



Examples of key efficiency initiatives

- Review PCT-owned assets and evaluate options to sell/rent vacate sites
- Consolidate sites partially occupied and dispose of surplus assets
- Drive up utilisation of estates, e.g., sharing rooms, hot-desking
- Explore renting vs. ownership options

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Source: PCT finance department

4 … and consolidating and driving up utilisation of existing space through increased sharing of space

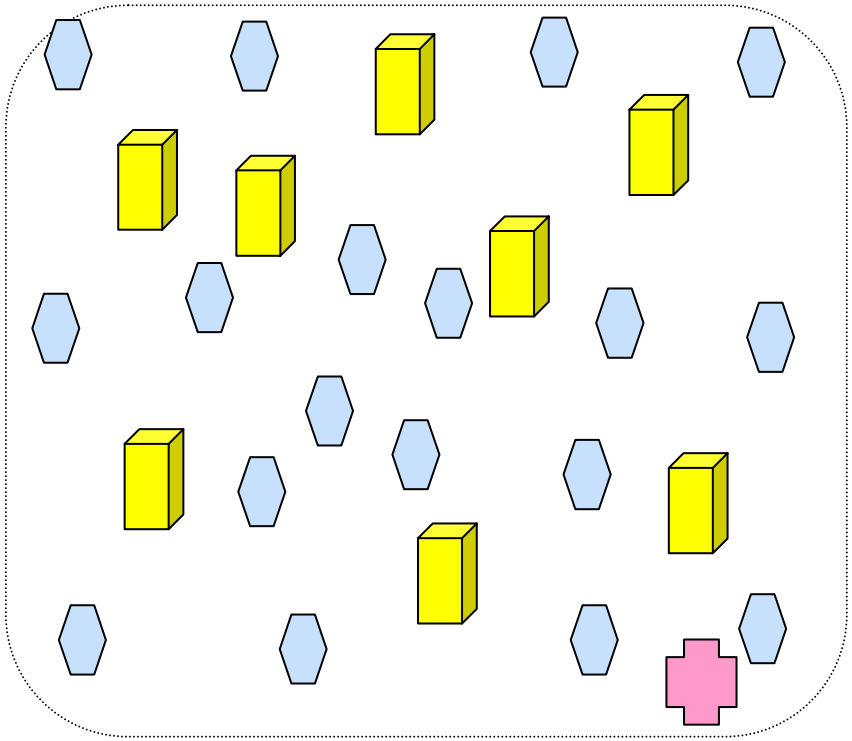
TODAY: primary and community care services provided with a very high fixed cost base and low utilisation and dedicated rooms, e.g., GPs

Typical provision for pop'n of ~ 100K

GP practice

Health centres, children's centre

Community hospital



MORE EFFICIENT MODEL: Consolidate, drive up utilisation, take out costs (and support integration and better quality care)

Efficient provision for pop'n of ~ 100K

Urgent care centre (24x7)

Therapy services

Outpatient clinics

Day case surgery unit

Base for community teams

Maternity services

Inpatient care

GP services

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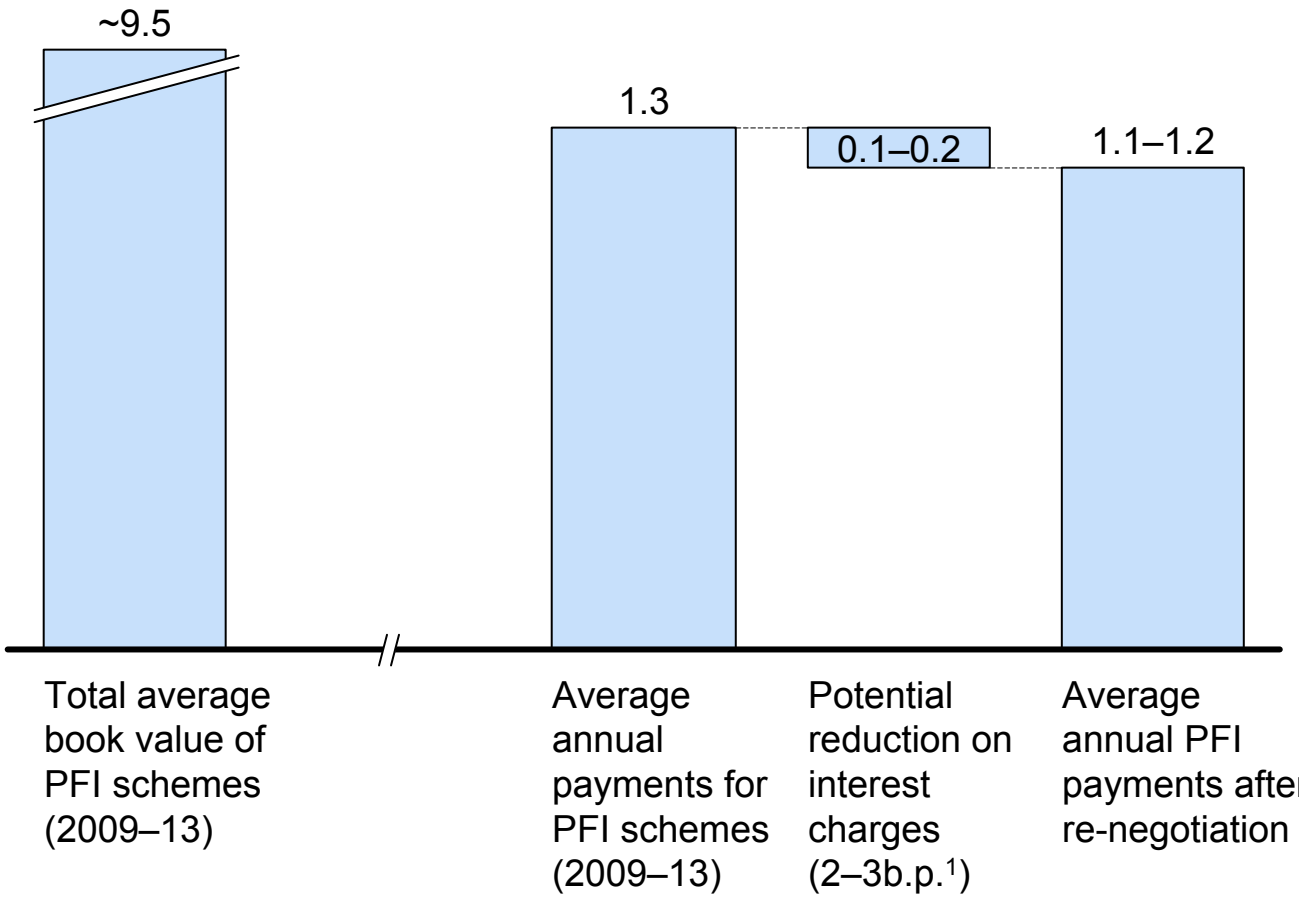
4 PFI restructuring – renegotiating the interest charges of 80% of the PFI schemes by 2–3bp[1] could reduce financing cost by £0.1–0.2b.

£ billion. 2008/09 – 2013/14



Key opportunities

- Renegotiate interest rates charges taking advantage of
  - Reduction in interest rates (from 5.5% in 2008 to 0,5% in March'09)
  - Government guarantee to borrow
  - Limited ability of the PFI holders to borrow and need of some for cash

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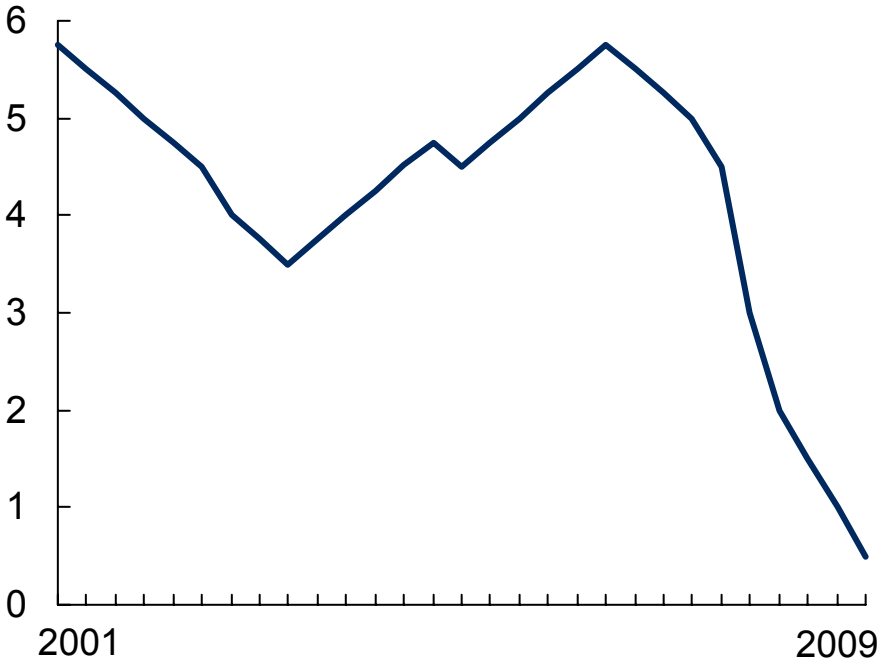
1 Basic points

SOURCE: Treasury; McKinsey analysis

4 PFI restructuring – in the new context of low interest rates, worth exploring renegotiating the PFIs to lower the £1.3bn annual payments

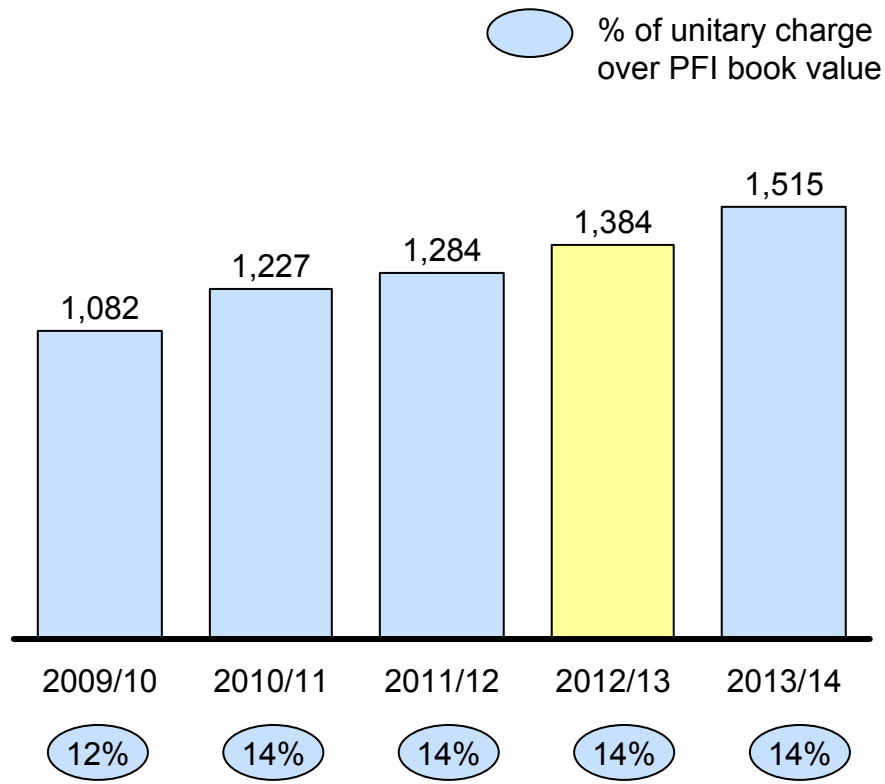
Majority of PFI schemes negotiated in times of high interest rates, typically paying 6-8% interest rate, and everybody could borrow money

Bank of England official bank rate, 2001-2009.%



Worth exploring the possibility of using the government guarantee to renegotiate the interest charges, given the large size of annual payment

PFI forecast unitary payments 2008-2013, £m



Source: Bank of England, Treasury

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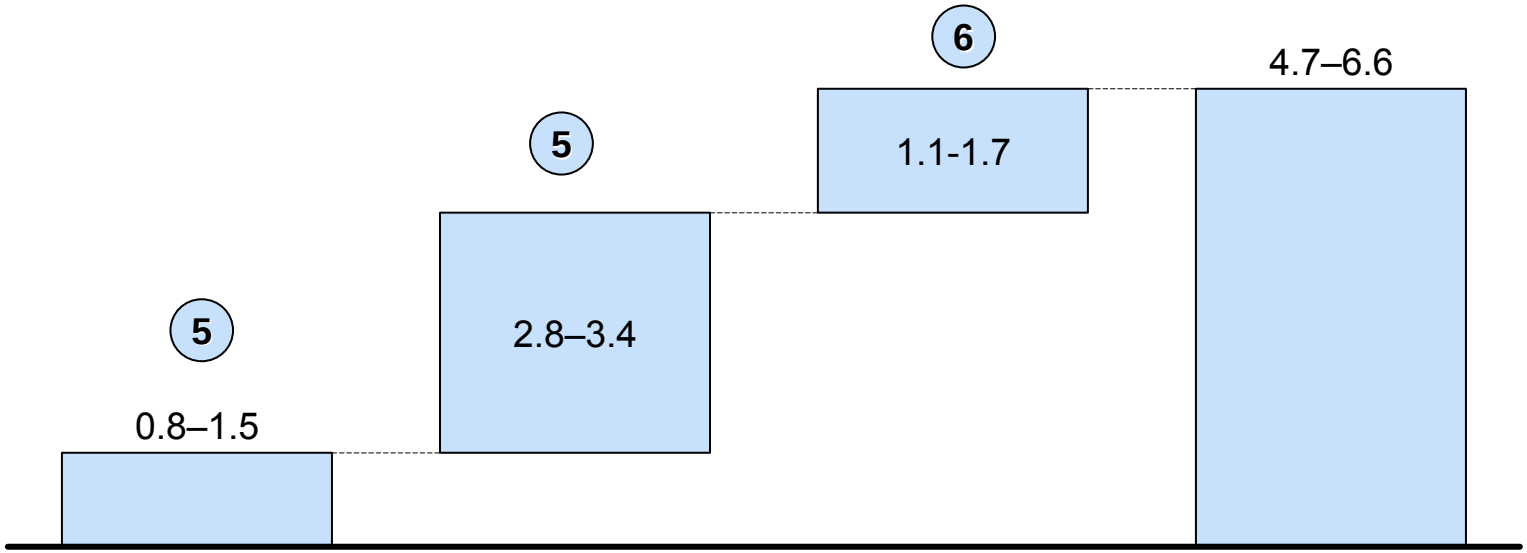
Break-down of potential opportunities to optimise spend and ensure compliance with standards

ESTIMATE

£b, 2013/14 recurrent potential savings, England

Programme number



	Stop/reduce procedures with no/limited clinical benefit	Target most costs effective interventions	Conduct utilisation reviews	Total potential of optimizing spend and ensuring compliance with standards
Current spend £b	16	47	56	92
% reduction vs. 2008/09 spend	5–9%	6–7%	2–3%	5–7%

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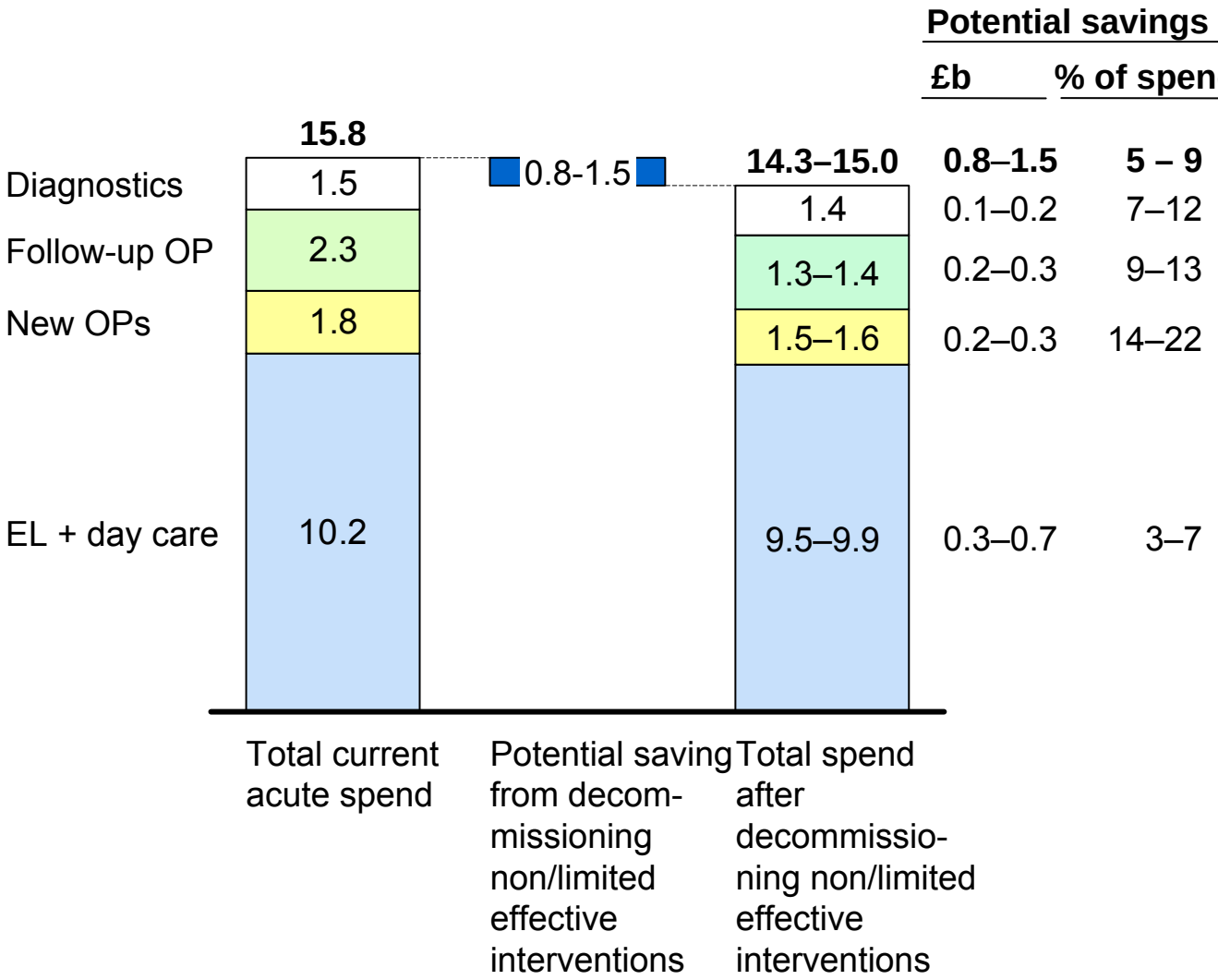
SOURCE: McKinsey analysis

5 Decommission non-effective interventions – Potential savings of £0.8–1.5b through enforcing compliance with commissioners' standards

£b, 2008/09



Key opportunities

- Decommission relatively ineffective interventions – e.g., tonsillectomy or potentially cosmetic interventions
- Provide decision aids to patients to reduce rates of discretionary surgery
- Reduce variability in GPs' new OP referrals
- Enforce target follow-up to new OP ratio by specialty
- Reduce variability in GPs referrals for diagnostics

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SOURCE: LHO - Save to invest; HES Online; DH payment by results tariff, National schedule of reference costs, tariff uplift; McKinsey analysis

5 De-commission procedures with limited clinical benefit could drive savings of £0.3–0.7bn.[1] across England (1/2)

		Potential reduction		Potential savings		
		Minimum %	Maximum %	Minimum £m	Maximum £m	
A	**Relatively ineffective interventions**					
	▪ Tonsillectomy	10	90	5	45.1	
	▪ Spinal cord stimulation	0	50	0	25.2	
	▪ Back pain – injection and fusion	20	90	5.3	23.7	
	▪ Grommets (surgery for glue ear)	10	90	2.3	20.6	
	▪ Knee washouts	20	90	4.5	20.3	
	▪ Trigger finger	10	33	1.8	5.8	
	▪ Dilation can curettage for women < 40	10	70	0.4	2.5	
	▪ Jaw replacement	5	10	0.5	0.9	
						£20–115m[1]
B	**Potentially cosmetic interventions**					
	▪ Minor skin surgery for non-cancer lesions	10	25	29.8	74.4	
	▪ Inguinal, Umbilical and Femoral Hernias	25	50	24.8	49.5	
	▪ Incisional and Ventral Hernias	10	75	3.4	25.5	
	▪ Aesthetic surgery – Breast	50	80	11.2	17.9	
	▪ Varicose Veins	20	80	4.4	17.7	
	▪ Aesthetic surgery – ENT	20	60	3.1	9.2	
	▪ Other Hernia procedures	10	30	1.9	5.8	
	▪ Aesthetic surgery – Plastics	20	95	1.1	5.2	
	▪ Aesthetic surgery – Ophthalmology	20	30	1.8	2.7	
	▪ Orthodontics	5	80	0	0.2	
						£80–165m[1]

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1 Assumes that only 80% of the maximum potential is achieved
Note: Cancelled procedures not included in analysis
Source: LHO – Save to invest: Developing criteria-based commissioning for planned health care in London; HES 2006/07; McKinsey analysis

5 De-commission procedures with limited clinical benefit could drive savings of £0.3–0.7bn.[1] across England (2/2)

		Reduction, %		Potential savings. £m		
		Minimum	Maximum	Minimum	Maximum	
C **Effective interventions with a close benefit/ risk balance in mild cases**	▪ Knee joint surgery	15	30	59.0	118.0	£160–300m[1]
	▪ Primary hip replacement	15	30	46.2	92.5	
	▪ Hip and knee joint revisions	15	30	33.2	66.4	
	▪ Cataract surgery	5	25	11.3	56.6	
	▪ Female genital prolapse/stress incontinence (surgical)	10	25	6.2	15.6	
	▪ Wisdom teeth extraction	0	24	0	11.0	
	▪ Dupuytren's contracture	10	33	2.0	6.7	
	▪ Cochlear implants (inner ear surgery)	0	25	0	4.5	
	▪ Other joint prosthetics/ replacements	15	30	1.8	3.6	
	▪ Female genital prolapse/stress incontinence (non-surgical)	5	25	0.1	0.6	
D **Effective interventions where cost effective alternatives should be tried first**	▪ Hysterectomy for non-cancerous heavy menstrual bleeding	10	70	11.5	80.6	£18–85m[1]
	▪ Carpal tunnel surgery	10	33	4.1	13.5	
	▪ Elective cardiac ablation	5	50	0.9	8.6	
	▪ Anal procedures	5	15	1.2	3.6	
	▪ Bilateral hip surgery	15	30	0.4	0.7	

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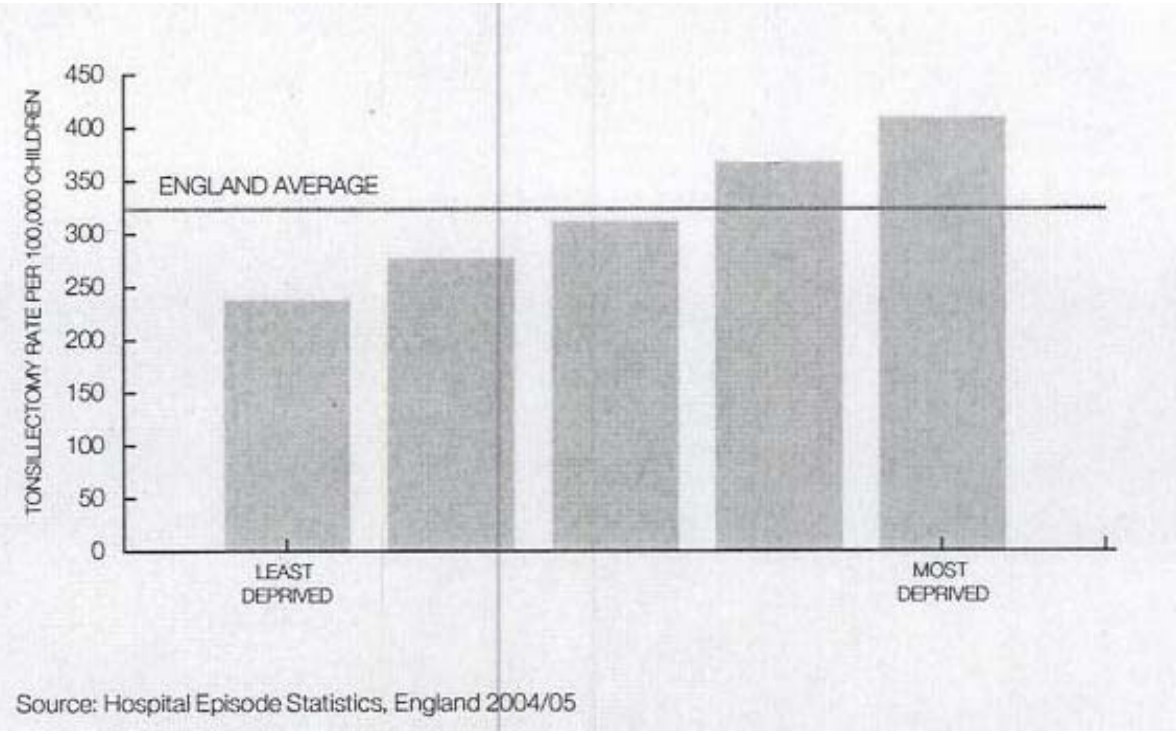
1 Assumes that only 80% of the maximum potential is achieved
Note: Cancelled procedures not included in analysis
Source: LHO – Save to invest: Developing criteria-based commissioning for planned health care in London; HES 2006/07; McKinsey analysis

5 Variation in medical practices may be appropriate but sometimes suggest waste of resources or inequity (1/2)

Example 1: Tonsillectomy

Today, children from deprived wards areas are much more likely to have their tonsils removed



Source: Hospital Episode Statistics, England 2004/05

- Over time, accepted indications for tonsillectomy have been strictly defined
- If the rate of tonsillectomy was the same as the top fifth most affluent children, c. 8,000 operations could be avoided p.a. and over £6m saved

Source: The Chief Medical Office on the state of public health – Annual Report 2005

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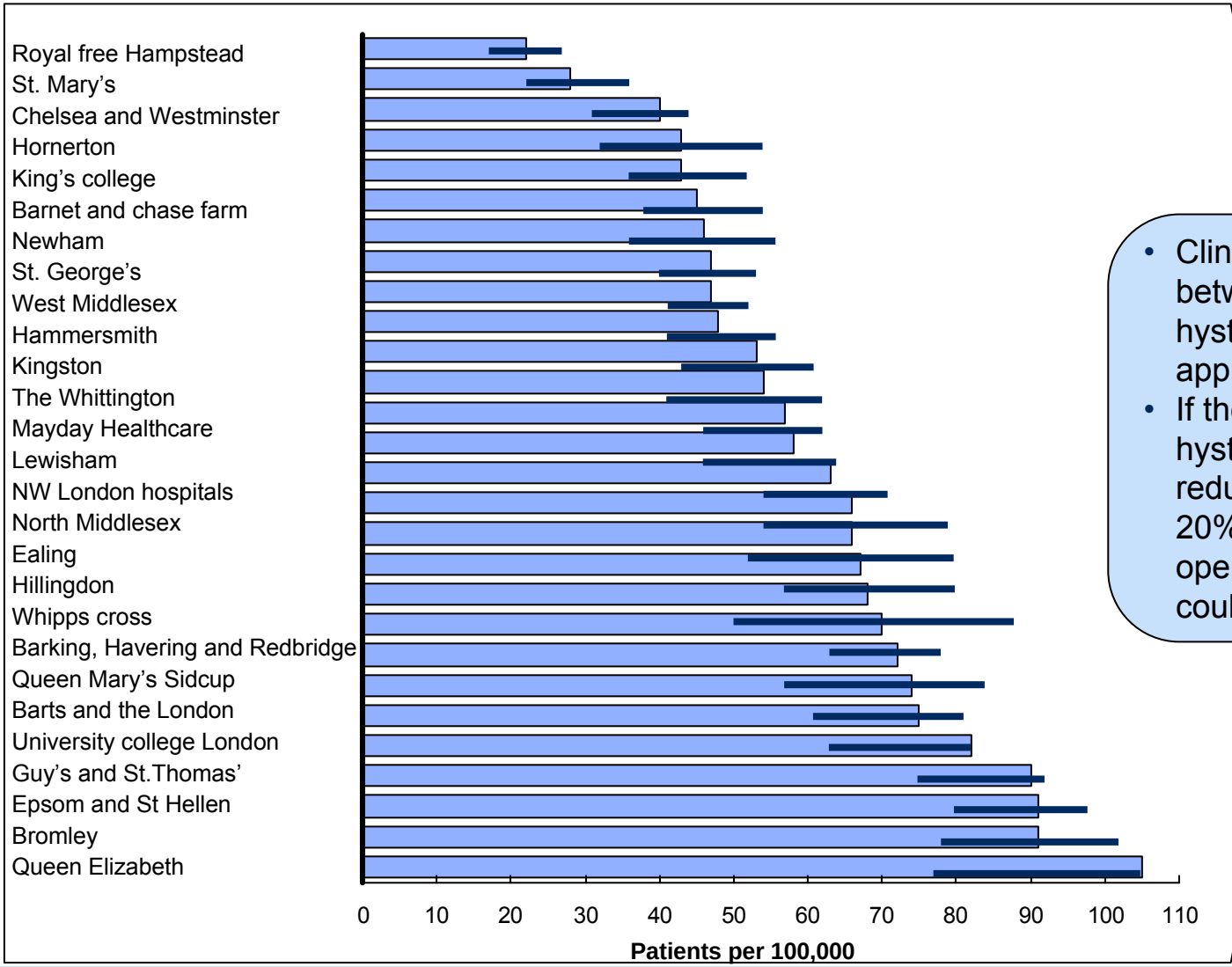
5 Variation in medical practices may be appropriate but sometimes suggest waste of resources or inequity (2/2)

Example 2: London hospitals - hysterectomy



- Clinical studies show that between 5-84% of the hysterectomies were not appropriate
- If the average rate of hysterectomy could be reduced to the rate of the 20% lowest, then 5,900 operations costing £15m could be avoided

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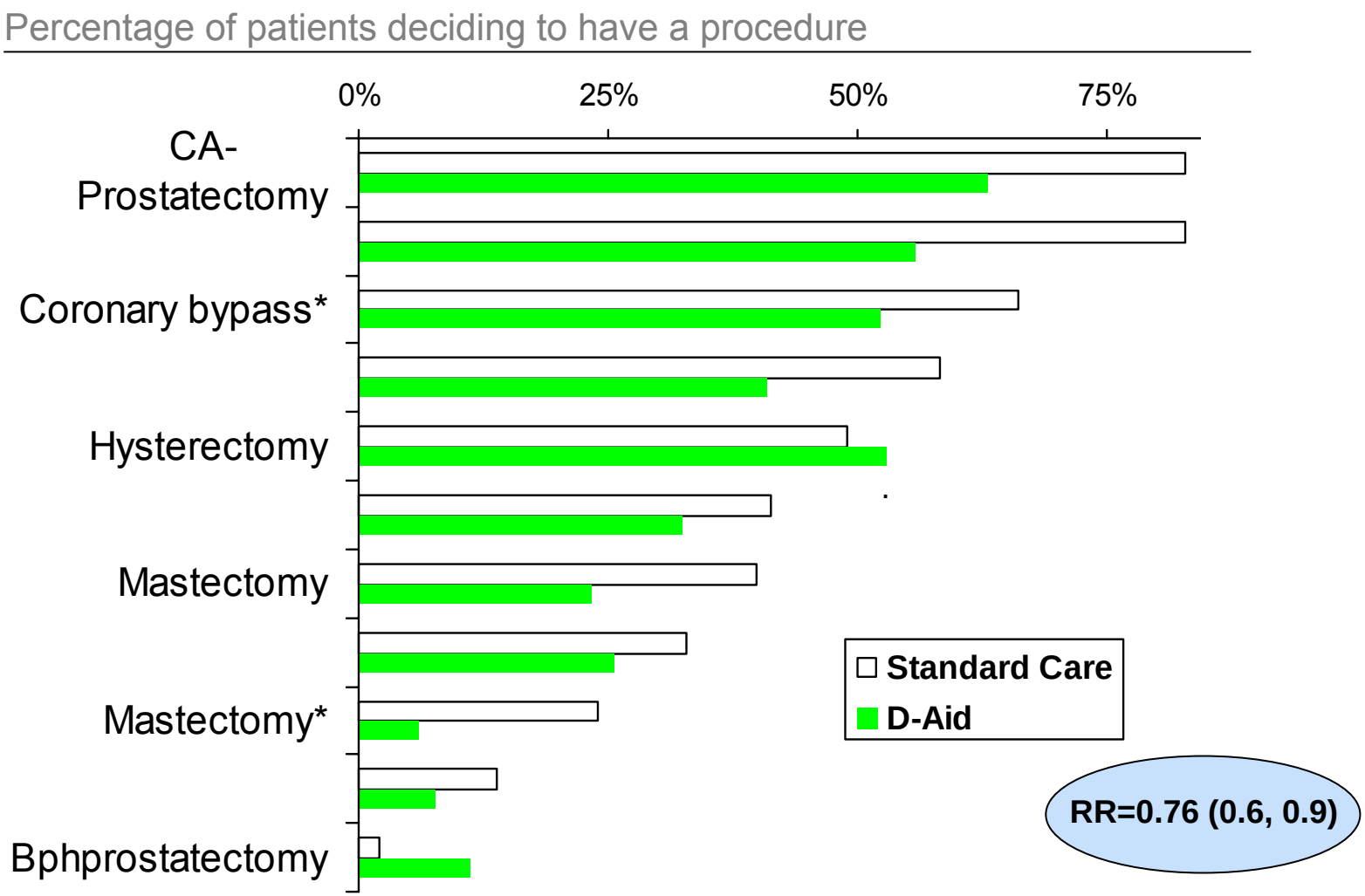
Source: HES 2005–06, ONS mid-year female population estimates. Hospital-specific rates are crude rates based on hospital episodes; Trusts with fewer than 10 observations not included; LHO, HSJ

5 Providing decision aids to patient will be one of the mechanisms to reduce rates of discretionary surgery



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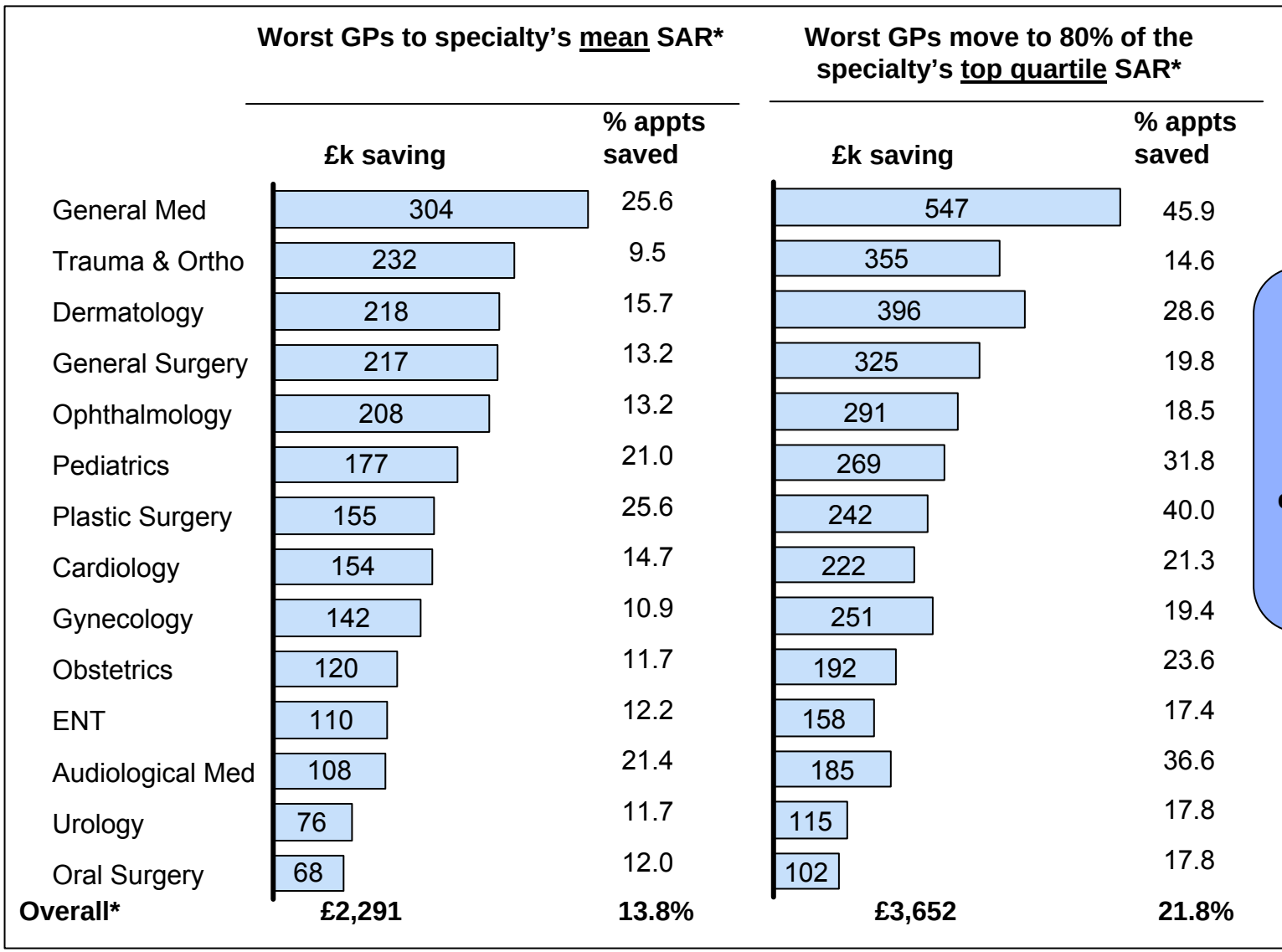
Source: O'Connor et al., *Cochrane Library*, 2007

5 Reducing variance of GP referrals for new outpatient appointments could lead to savings of £0.2-0.4bn. across England

PCT EXAMPLE



If this PCT potential savings from reducing variance in GP referrals for new outpatients is extrapolated to all PCTs in England, potential savings of £240-380m

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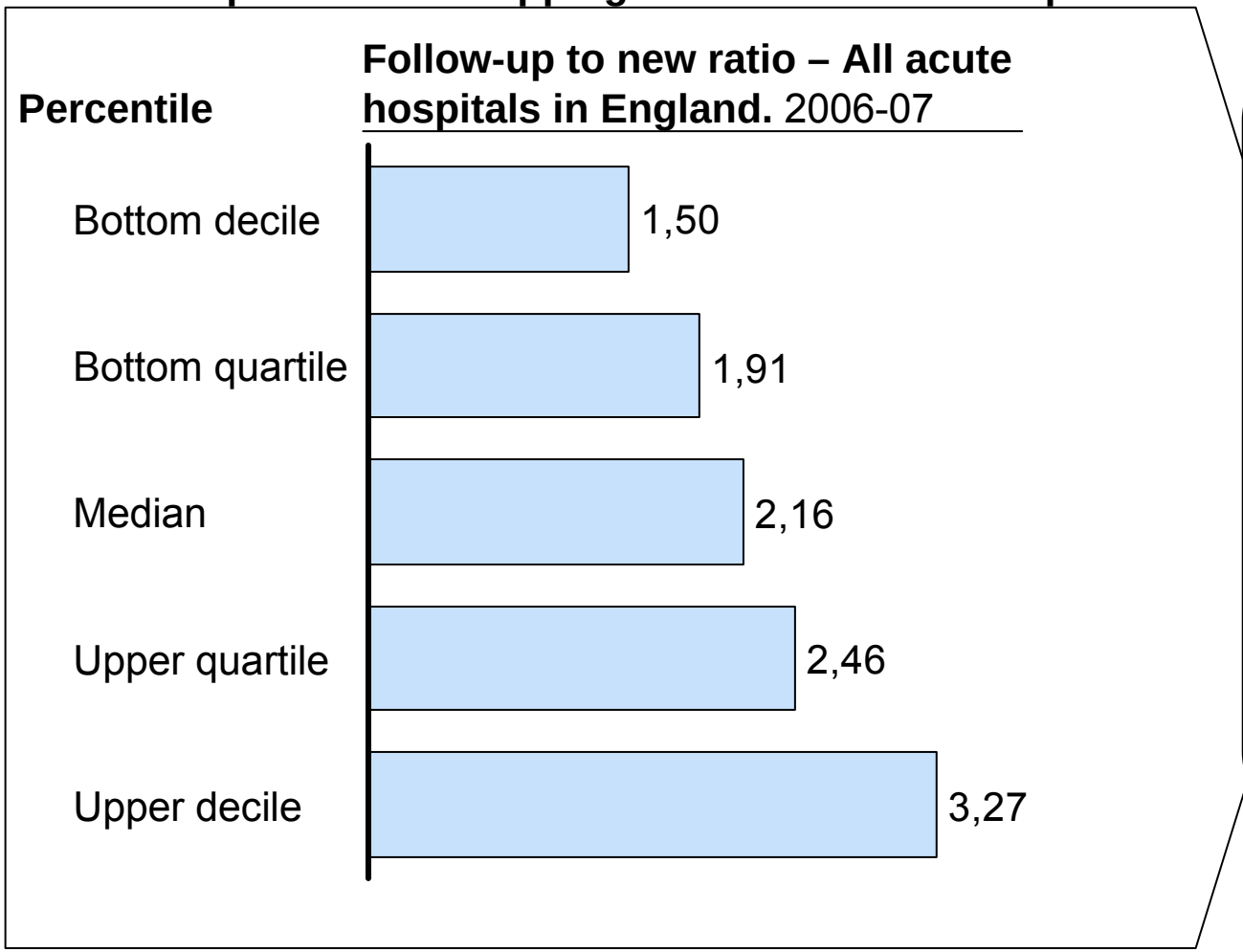
* Adjusted Standardized Activity Ratio (SAR) represents the difference between the expected and the actual admissions per population adjusted for deprivation. An SAR value of 100 means the actual number of admissions was the same as the expected number.
Source: Doctor Foster 2006-07 data

5 Potential savings of £0.2-0.3b, if PCTs achieve the median follow-ups to new OP ratio or 80% of the potential of stepping down to bottom quartile

Impact of reducing ratio of OP follow-ups to new to the median or 80% of the potential of stepping down to the bottom quartile



9–13%[1] reduction in OP follow-up attendances

X

29m. OP follow-up attendances

X

£79 average price per OP follow-up

=

£200- 300m

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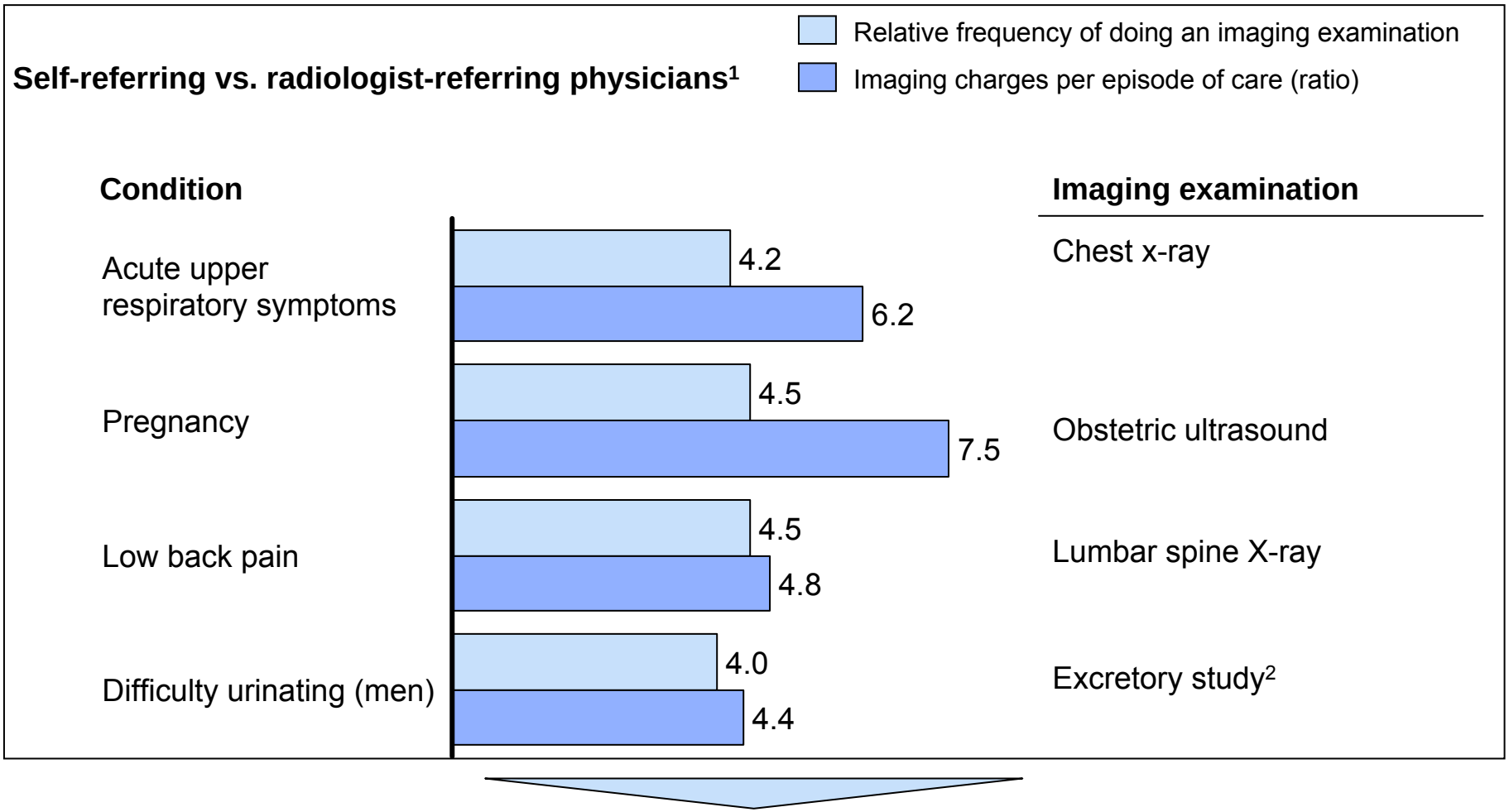
1 Top of range: underperformers achieve 80% of the potential improvement of stepping down to bottom quartile. Bottom of the range: underperformers step down to the median

Source: HES data 2006/07, Mckinsey analysis

5 In the US, there is strong evidence that physician self-referral leads to inappropriate utilization of diagnostics

Self-referring vs. radiologist-referring physicians[1]



In general, self-referrals led to four times more use of imaging examination and a total cost of diagnostics per episode of care that would be between 4.4 and 7.5 times more

[1] Based on analysis of 60,000 episodes of outpatient care by 6,400 physicians [2] Urography, cystography, or ultrasonography

Source: BJ Hillman et al., "Frequency and costs of diagnostic imaging in office practice – a comparison of self-referring and radiologist-referring physicians," 323 NEJM (Dec. 6, 1990); JM Mitchell & E Scott, "Physician ownership of physical therapy services. Effect on charges, utilization, profits, and service characteristics," 268 JAMA (October 1992)

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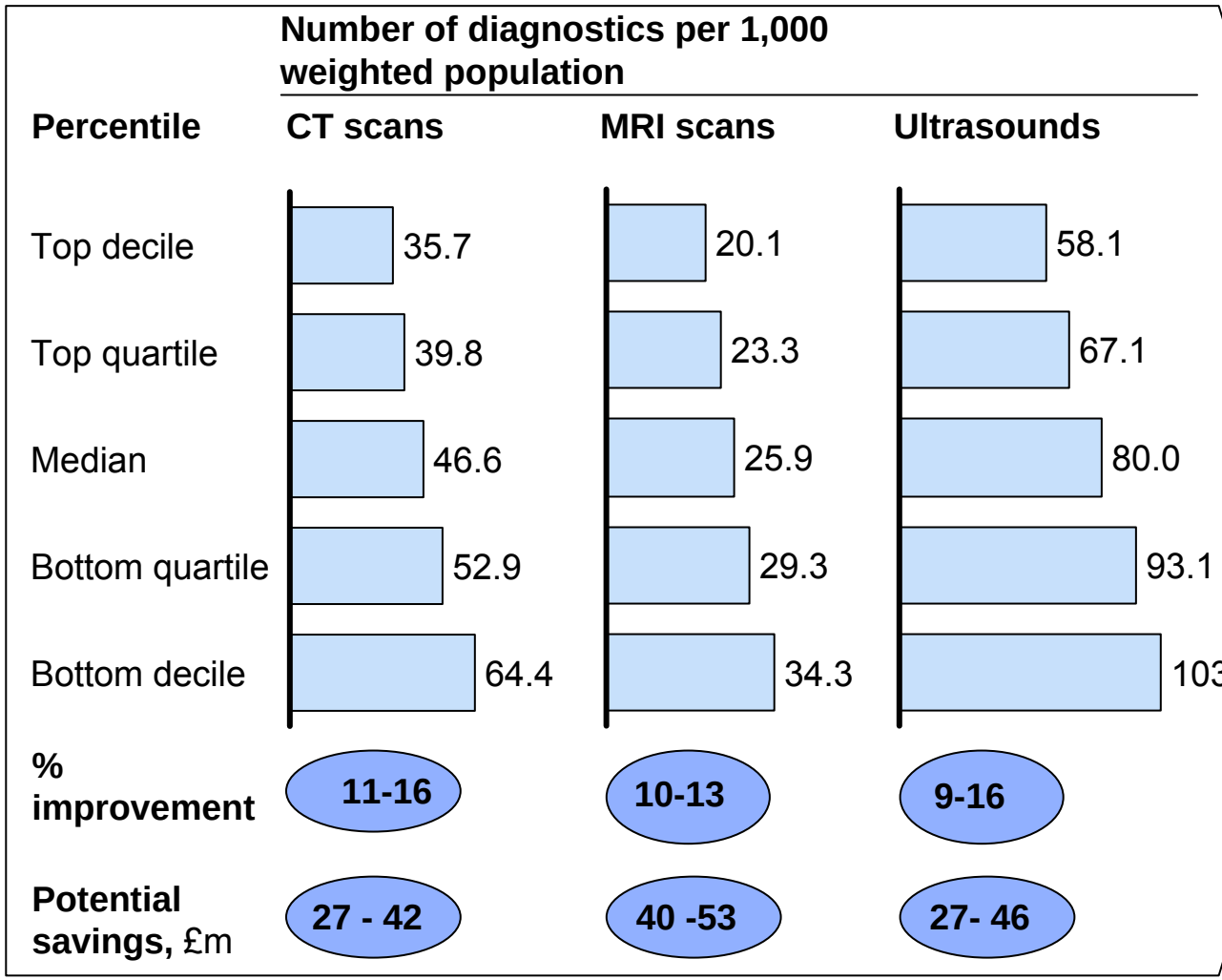
5 Potential savings of £95-140m by reducing variation in three types of diagnostic referrals

Potential improvement if PCTs step down to median or 80% of the top quartile in the number of diagnostics per 1,000 weighted population



9 – 16% potential improvement in these three investigations

X

8m. diagnostics

X

£70 – 295 per diagnostics

=

£95 – 140m savings

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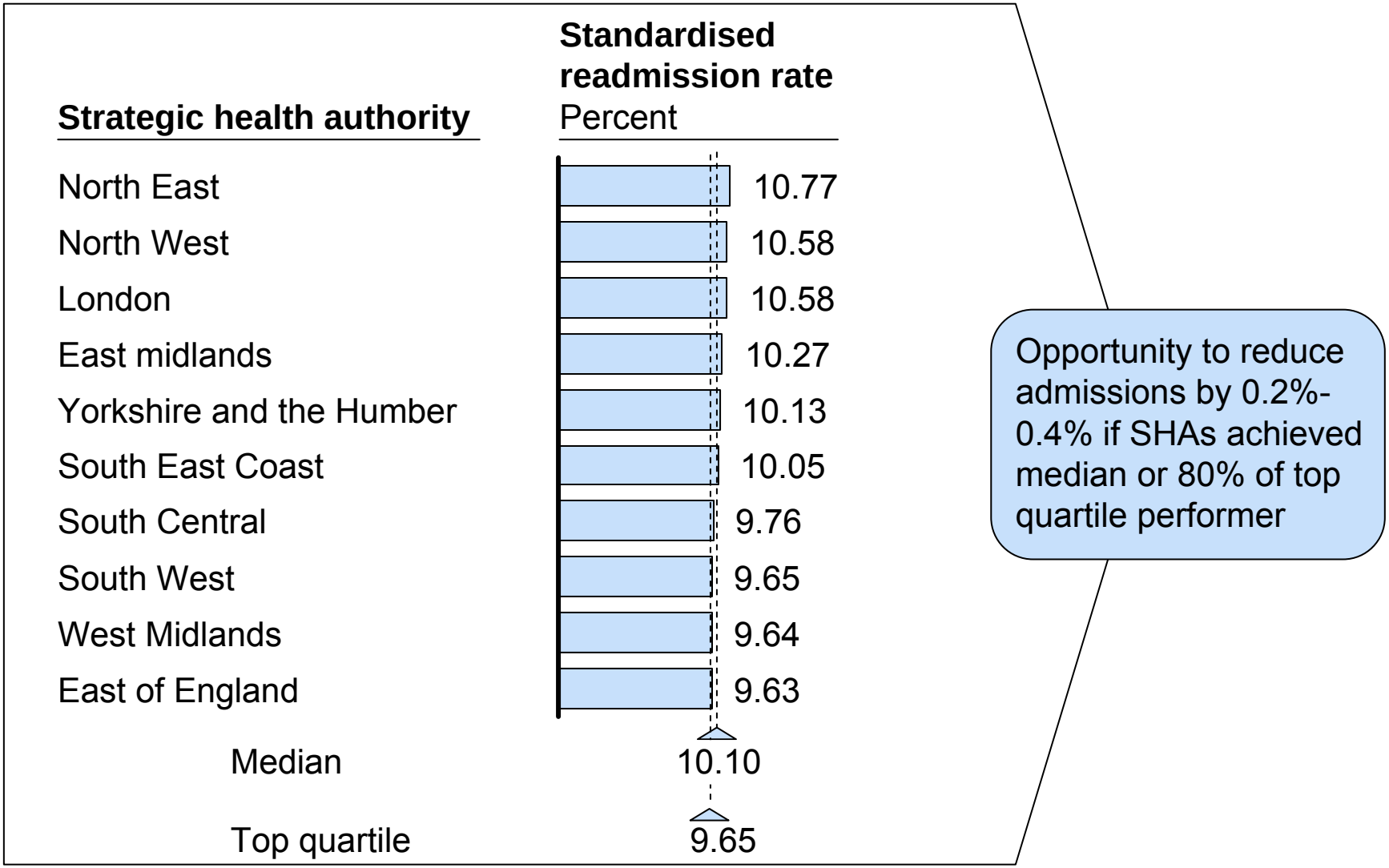
Source: Department of Health Diagnostic Waiting List Returns; DH Exposition book 07/08

5 Readmission rates: Variability in performance between SHA indicates opportunity of £60-100m[1] if median or 80% of top quartile achieved

Emergency admissions within 28 days of discharge from hospital. Adults of ages +16. 2006/07



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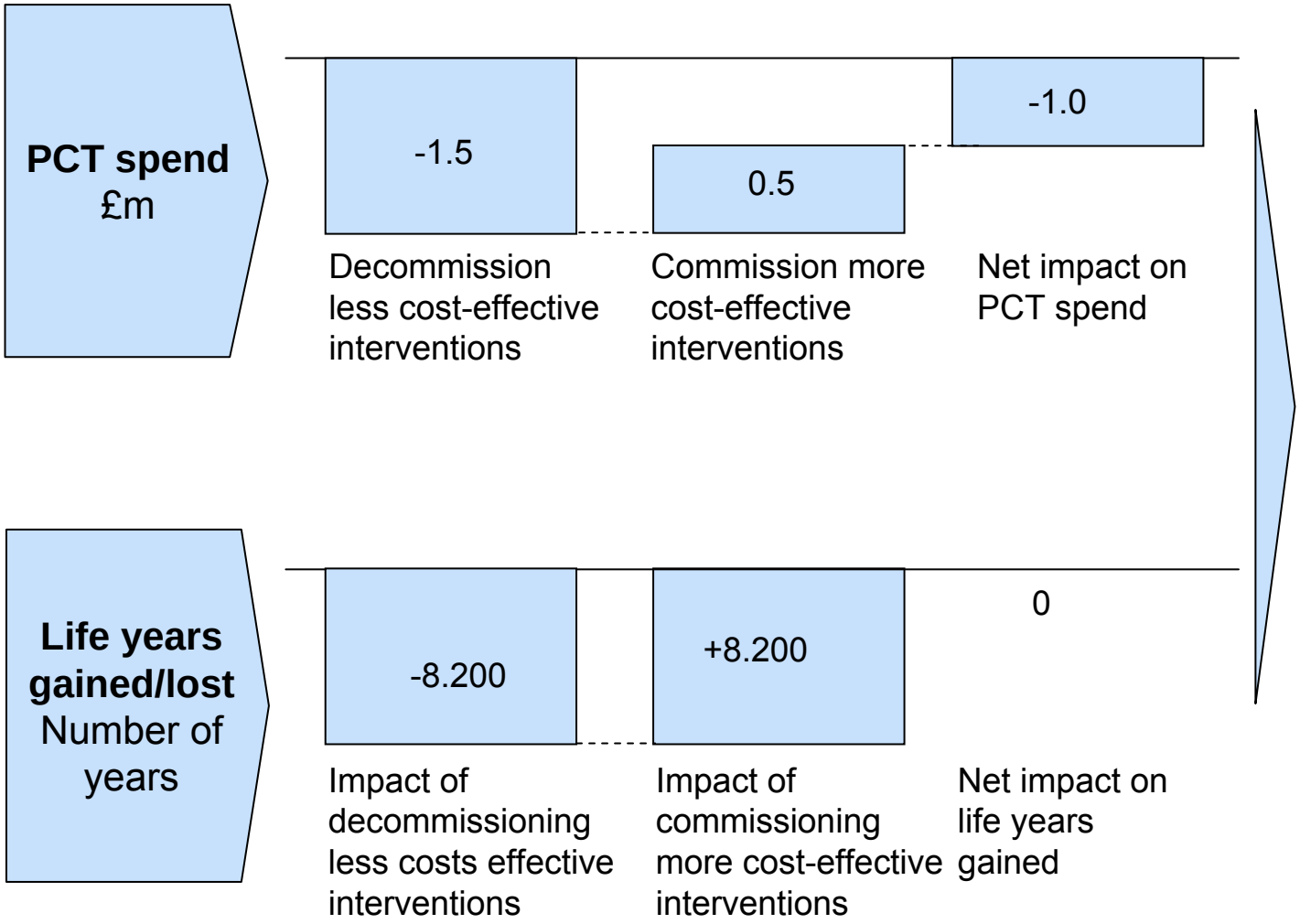
1 Not included as part of the total potential efficiency

SOURCE: HES NCHOP FY 2006/07 and National Statistics, team analysis

5 Targeting most cost-effective interventions could lead to savings of £2.8-3.4bn

Example: congestive heart failure (CHF) pathway in a PCT of ~1 million population



If we assume that PCTs can optimize 10-15% of their spend targeting the most cost-effective interventions[1], potential reduction in spend without any change in the life years of the population is estimated at £2.8-3.4bn. (6-7% of current PCTs spend[2])

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1 Based on CHF example, assumption is that PCTs can target interventions 3 times more cost-effectively
2 Includes total PCT commissioning spend excluding drugs, estates costs and clinical and non clinical supplies spend

5 It is feasible to prioritise interventions…

Example: congestive heart failure

	Most effective Interventions	Eligible population	Current perf., %	Target perf., %	LYG*	Cost to PCT £k	Calculated cost/ LYG*, £	Rank
Initial treatment	8 Diuretic	3,390	90	95	1,148	66	58	2
	9 ACE inhibitor	3,390	78	90	808	152	188	4
	10 B blocker	3,390	55	75	1,501	327	218	5
Severe/ refractory	13 Spironolactone	407	85	95	111	-60	0	
	14 Digoxin	407	83	95	0	-53	0	
Secondary prevention	25 Smoking cessation	1,468	10	50	2,166	390	180	3
	26 Vaccination	6,118	75	95	4,296-5,949	227	38-53	1
	28 Community monitoring	6,118	50	75	0	n.a.	0	
	29 Exercise	6,118	50	90	5,065	4,725	933	6

* Life years gained

Source: Mckinsey analysis

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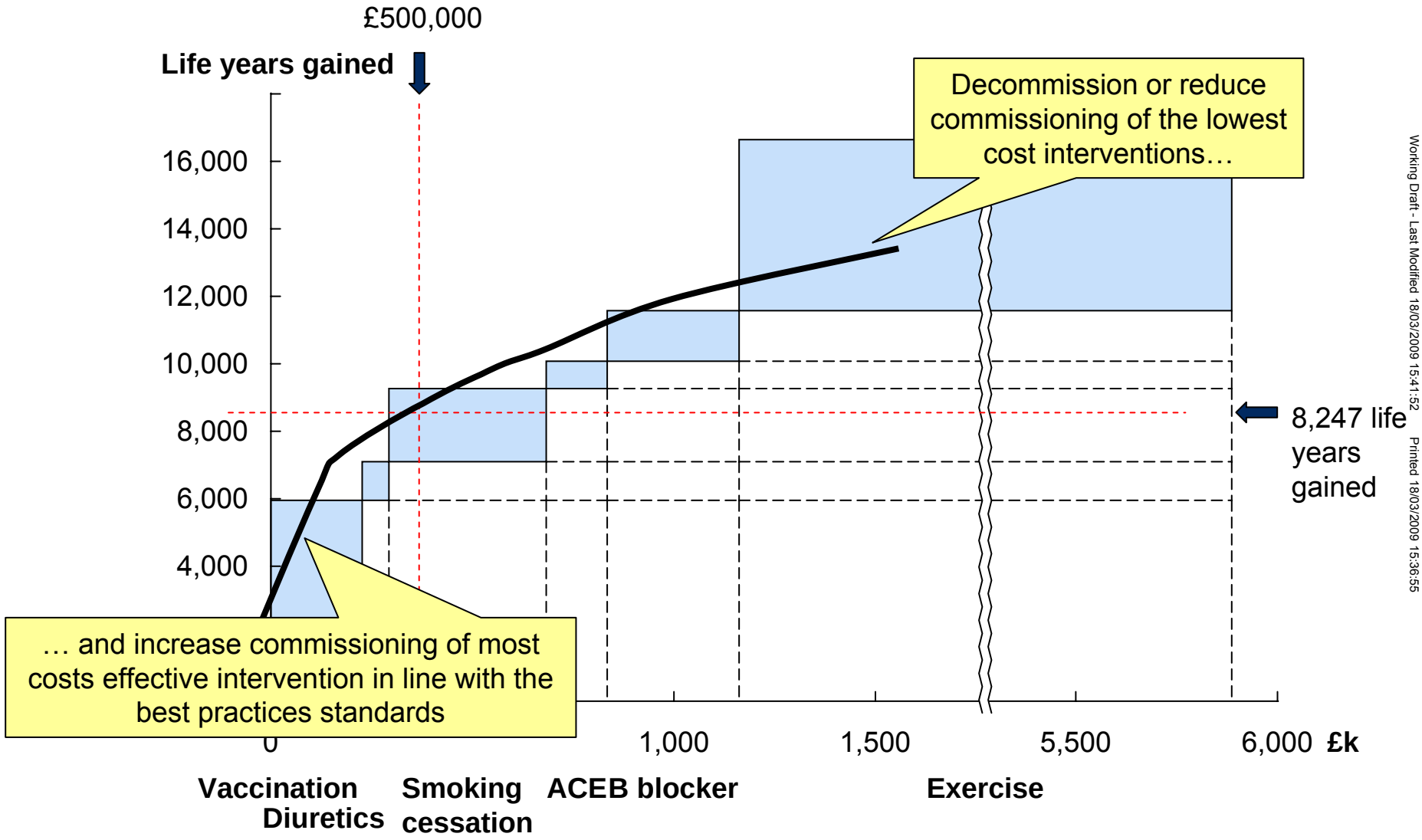
5 It is feasible to identify which interventions will deliver maximum return in order to de-commission less cost effective interventions

Example: congestive heart failure



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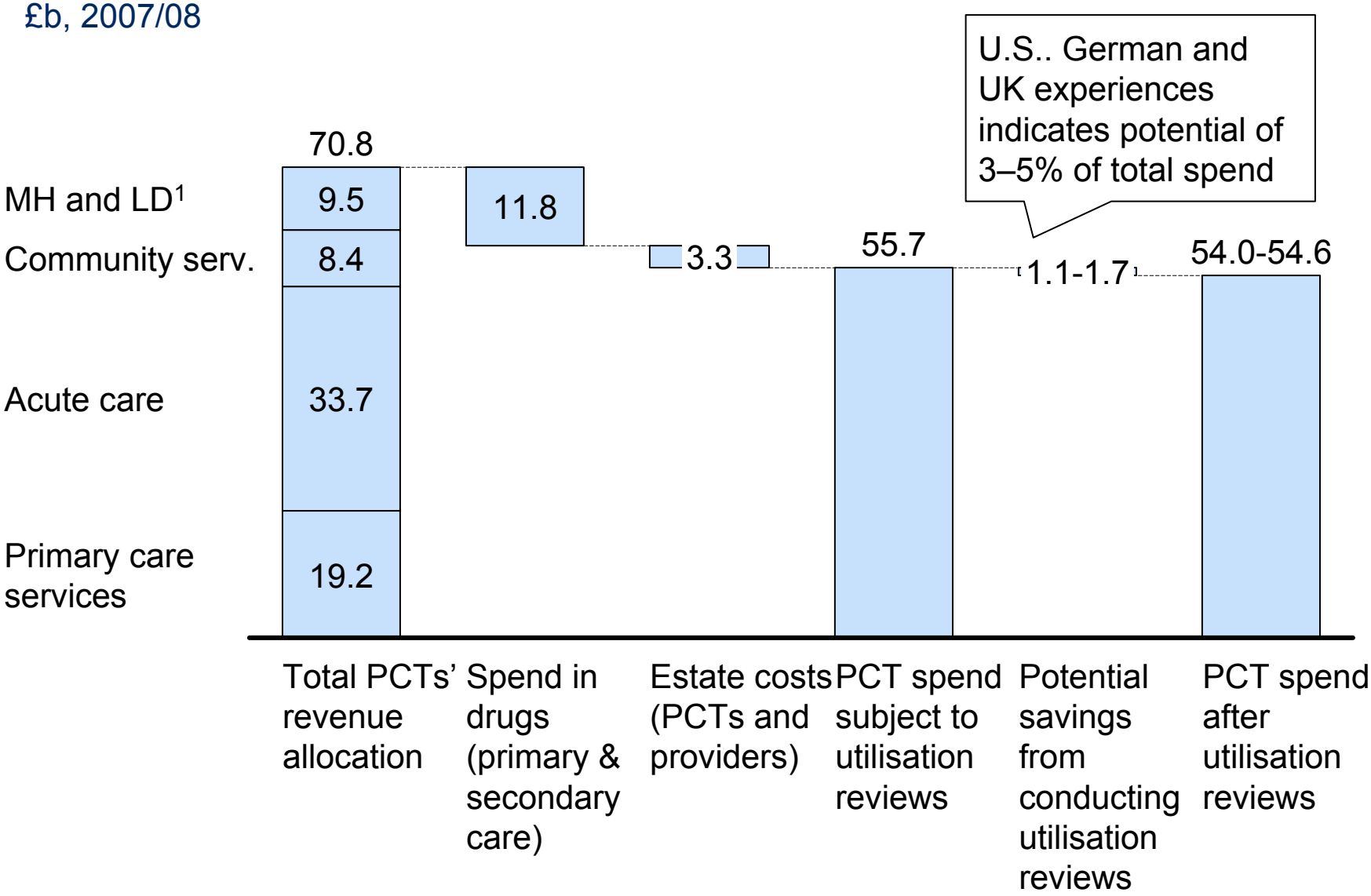
6 Conduct utilisation reviews – potential savings of £1.1–1.7b, equivalent to 2–3% of current commissioning spend

£b, 2007/08



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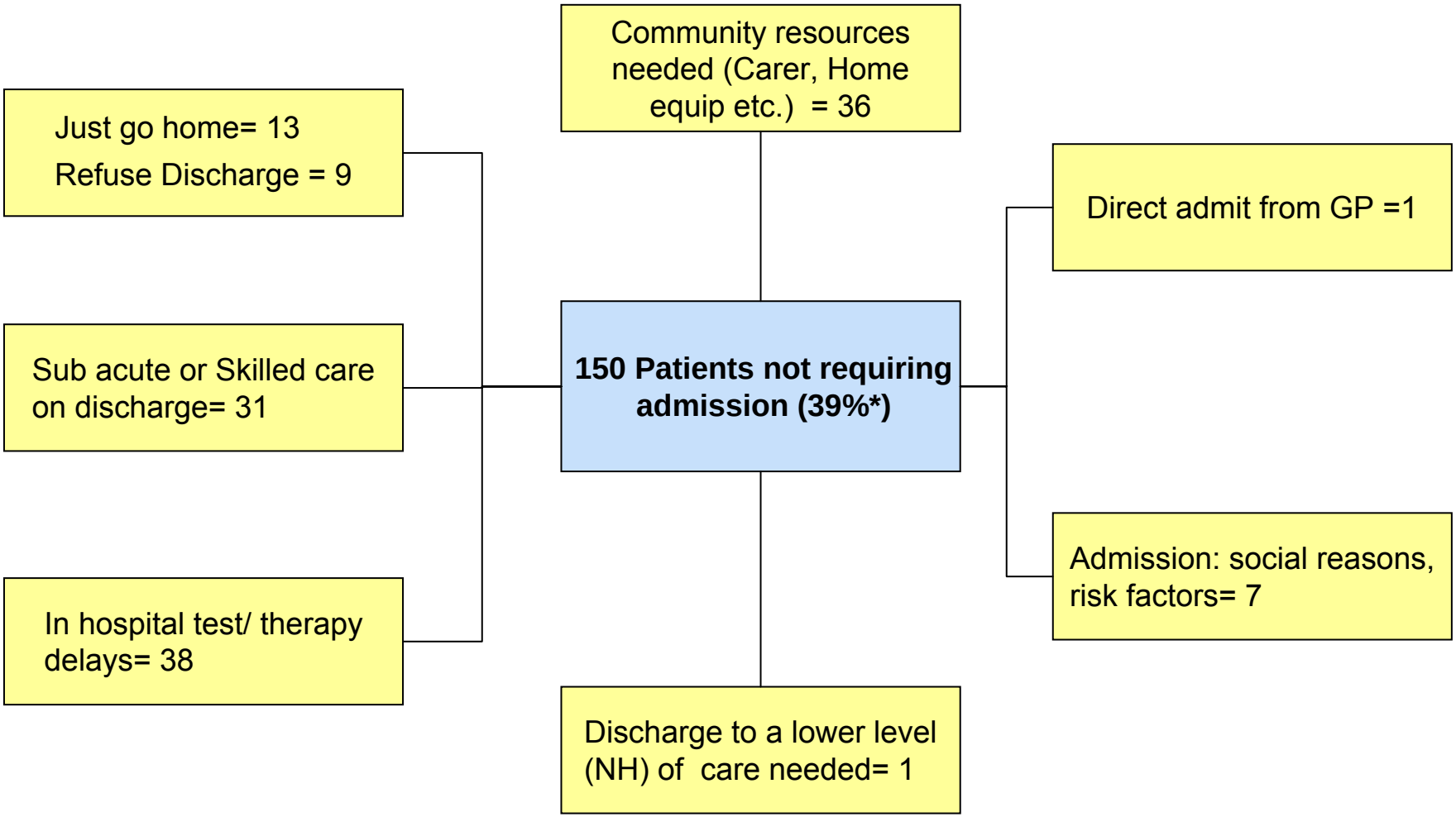
1 Mental health and learning disabilities

SOURCE: McKinsey experience in U.S., Germany and U.K. National Audit Office – PCT Care purchased by PCTs; Office Fair Trade – Financial Flows relevant to medicines, ERIC, McKinsey analysis

6 Conduct utilisation reviews: Application of protocols in a trust resulted in identification of c40%* patients who did not require admission



* Total sample of 383
Source: Interqual (McKesson)

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6 Reduce upcoding: Typical areas of upcoding challenge and/or requiring utilisation review

Elective/ other challenges

- Excess Bed Days
- Daycare instead of regular day attender (excluding Respiratory)
- Same day readmissions EL
- Outpatient procedures instead of DC tariffs
- Excess charges for high-cost drugs (IPPD drugs spend in excess of plan)

Non-elective challenges

- Excess Bed Days
- Increase in NEL Short Stay after CDU capacity increase
- NEL Readmissions within 14 days
- Inappropriate CDU/PEAU/AMU stays
- Short Stay Tariff not applied
- Same day Readmissions NEL
- Patients admitted more than once on same T-code
- Unbundled tariff

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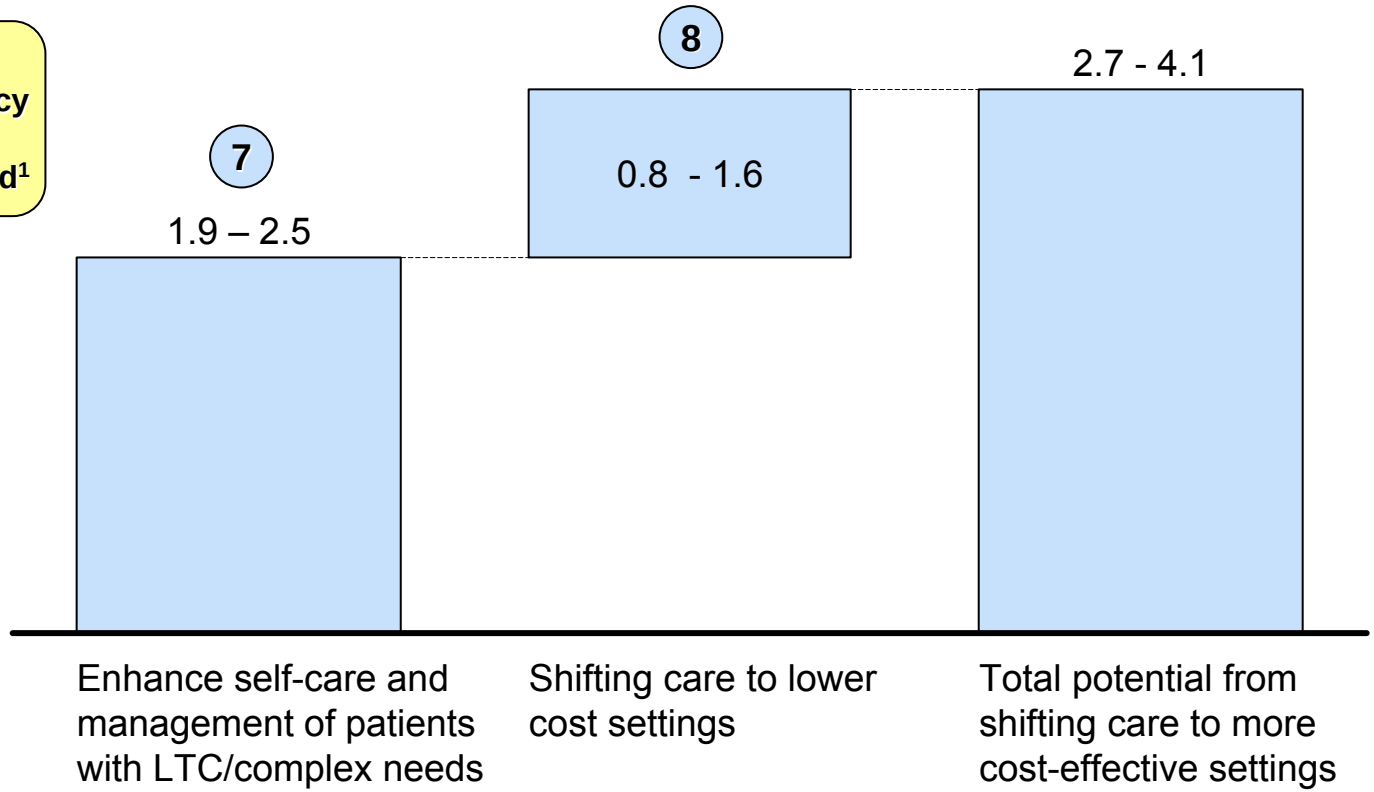
Break-down of potential opportunities to shift care into more cost-effective settings

ESTIMATE

£bn. 2013/14 recurrent potential savings. England

Programme number

Assumes previous opportunities for efficiency and effectiveness improvement are achieved[1]



	Enhance self-care and management of patients with LTC/complex needs	Shifting care to lower cost settings	Total potential from shifting care to more cost-effective settings
Spend after efficiency opportunities achieved[1] £bn	19	24	43
% reduction vs. 2008/09 spend	10-13%	4-7%	6-9%

1 Average of the minimum and maximum potential improvement used (15% of current spend)

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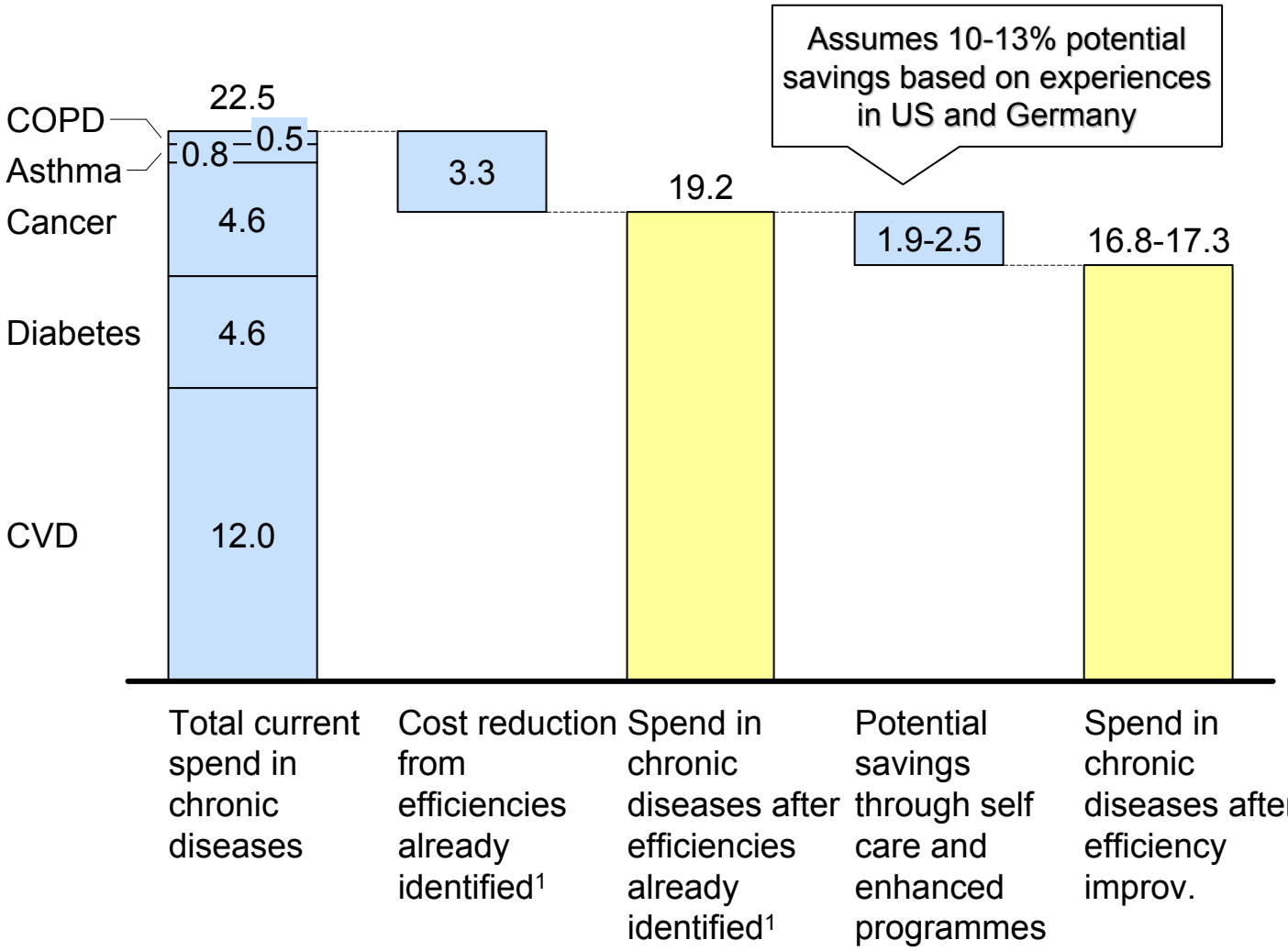
7 Chronic disease management: £1.9 – 2.5bn savings could be achieved through enhanced programmes

£b, 2007/08



Key opportunities

- Increase self care e.g. patient information, blood pressure test at home, …
- Enhanced chronic disease management
  - Patient database
  - Incentives for enrolment and commitment
  - Targeted contacts

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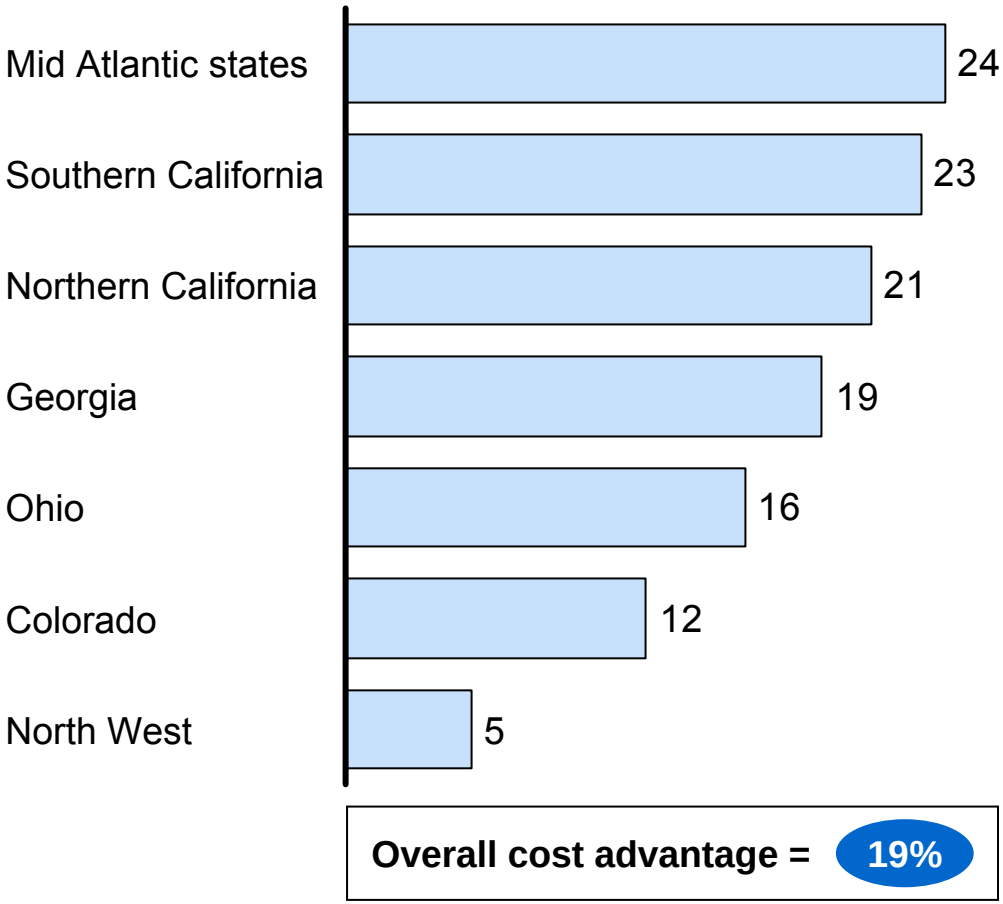
1 Driving through productivity improvements in all providers and optimizing spend (average savings assumed)

SOURCE: British Heart Association; Cancer Reform Strategy DH; DH Publications Diabetes; British Lung Association, Healthcare Commission Facts about COPD

7 Integrated systems like Kaiser Permanente are 20% more cost effective than other competing systems

Kaiser Permanente cost advantage vs. all plans (including HMOs PPO and POS plans)
% of cost advantage



- By creating a continuum of care, integrated systems are more cost effective because
  - Providers do not have an incentive to overtreat patients but rather to keep them healthy
  - Providers focus on preventive measures and therapies that are most cost effective
  - Tests/procedures are not needlessly duplicated or competing treatments prescribed

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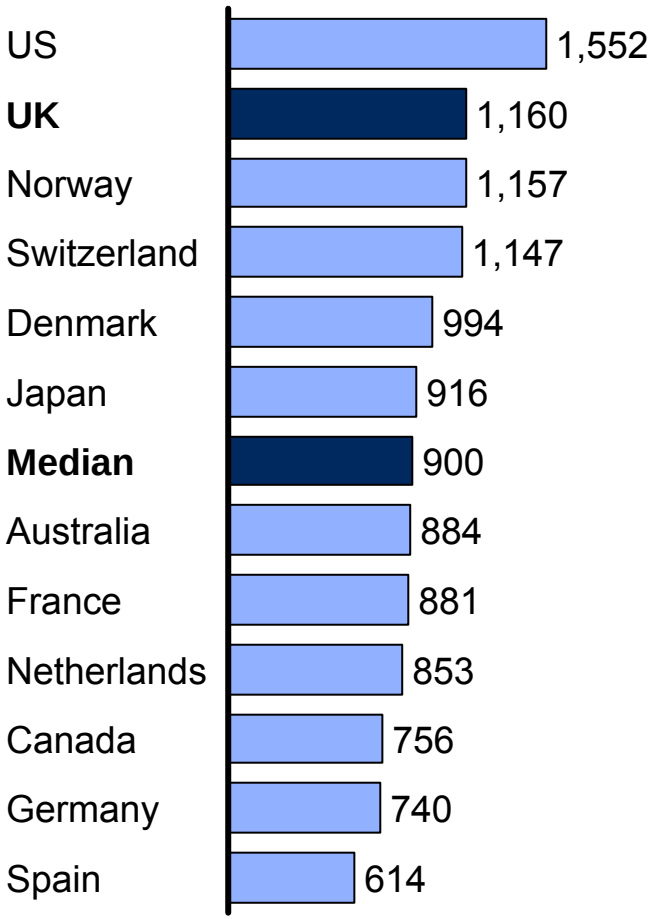
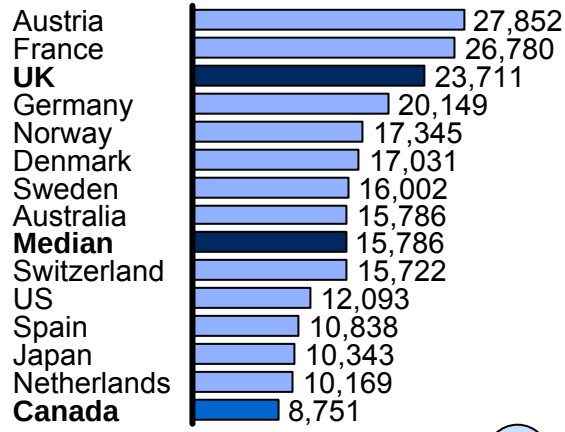
SOURCE: Hewitt's Health Value Initiative (HHiV) – evaluating financial efficiency and plan performance

8 Uk has relatively high hospital spending which is driven by high use of hospital care

Hospital expenditure/ capita, 2004-7
EUR, adjusted to PPP



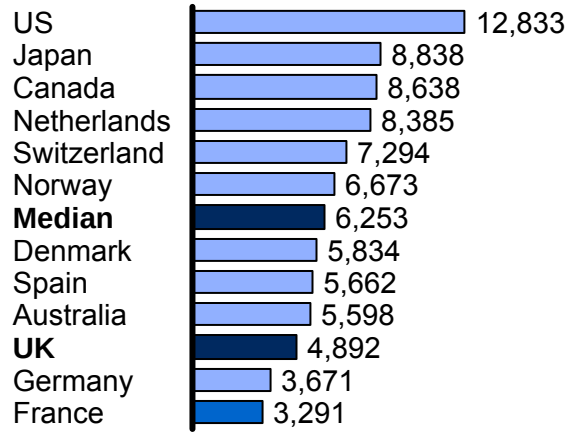
No. of discharges 2004-7
Per 100,000 residents



UK hospital spending has been driven by high utilisation

X

Average cost per case
EUR, adjusted to PPP; 2004-7



Despite relatively lower cost per case

* Or most recent available year

Source: OECD Health Data 2007, McKinsey calculations

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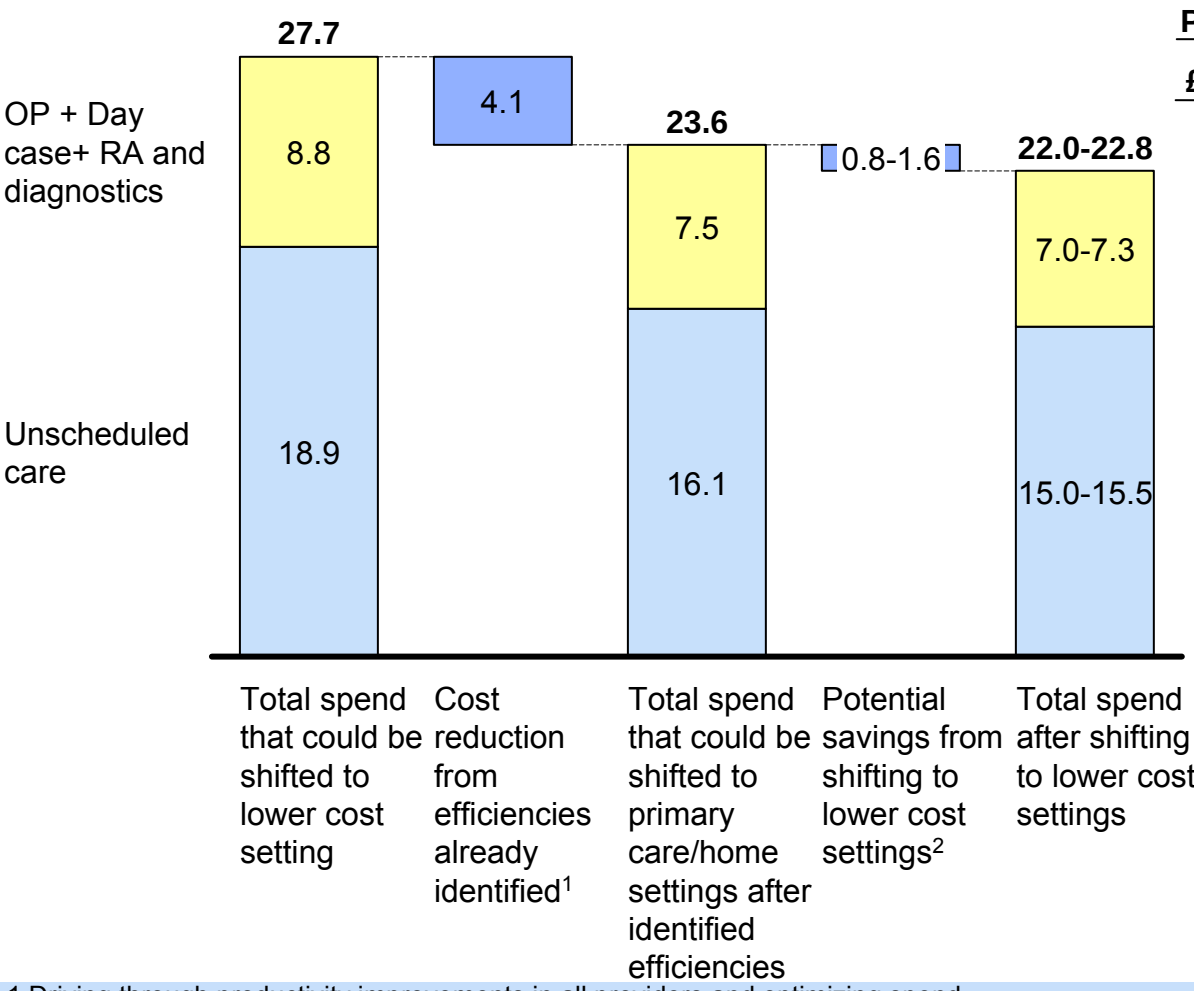
8 Shifting to lower cost settings – Potential savings of £0.8-1.6b through transforming unscheduled care and shifting care to primary care

£b, 2008/09



Potential savings	£b	% spend
	0.8–1.6	**4–7**
OP + Day case+ RA and diagnostics	0.2–0.5	2–7
Unscheduled care	0.6–1.1	4–7

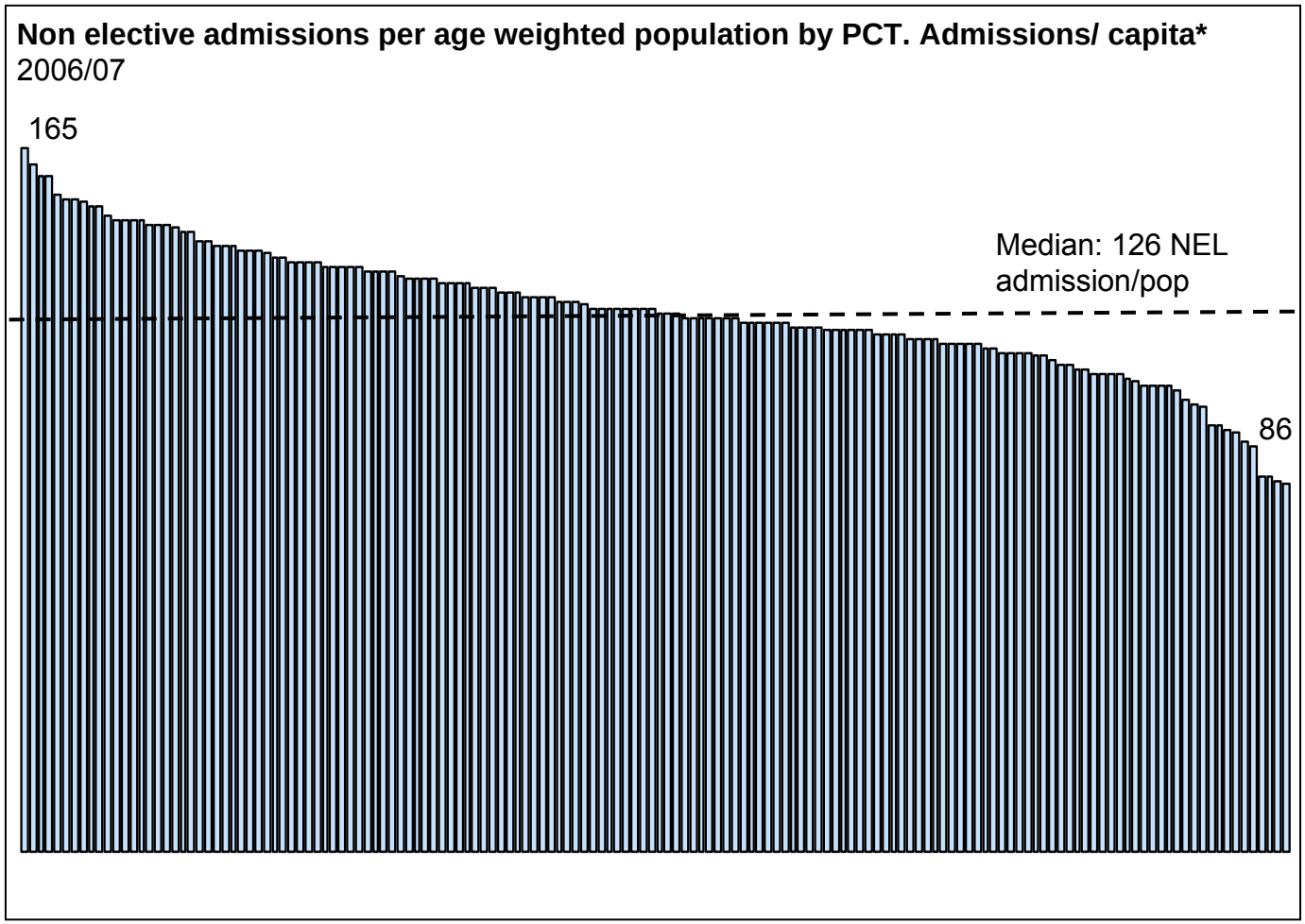
Key opportunities

- 45% of A&E attendances are minors
- Admissions for ACS conditions (those that should not require an admission) account for 10-15% of non-elective spend
- Significant number of OP attendances, day-cases and diagnostics could be delivered in GP surgeries or polyclinic

1 Driving through productivity improvements in all providers and optimizing spend
2 Net savings after the cost of providing the care in the new settings
SOURCE: HES online, National Audit Office – Summarized Accounts Care Purchased by PCTs, McKinsey analysis

8 Shift care to lower cost setting: Twofold variation in non elective admissions per population* by PCTs

Large variation of non elective admissions per population* by PCT



Potential initiatives to target unscheduled care spend

- **Urgent care centres**
  - Triage centre
  - Primary care services at front end of A&E
- Upgraded role of **single point of access**
- **Clinical assessment unit**
- Proactive **care for people with complex needs** and **long-term conditions**
- **Discharge facilitation** (with the Provider Arm)
- Increased range of **out-of-hospital services**
  - Out-of-hour services
  - Develop better access to diagnostics

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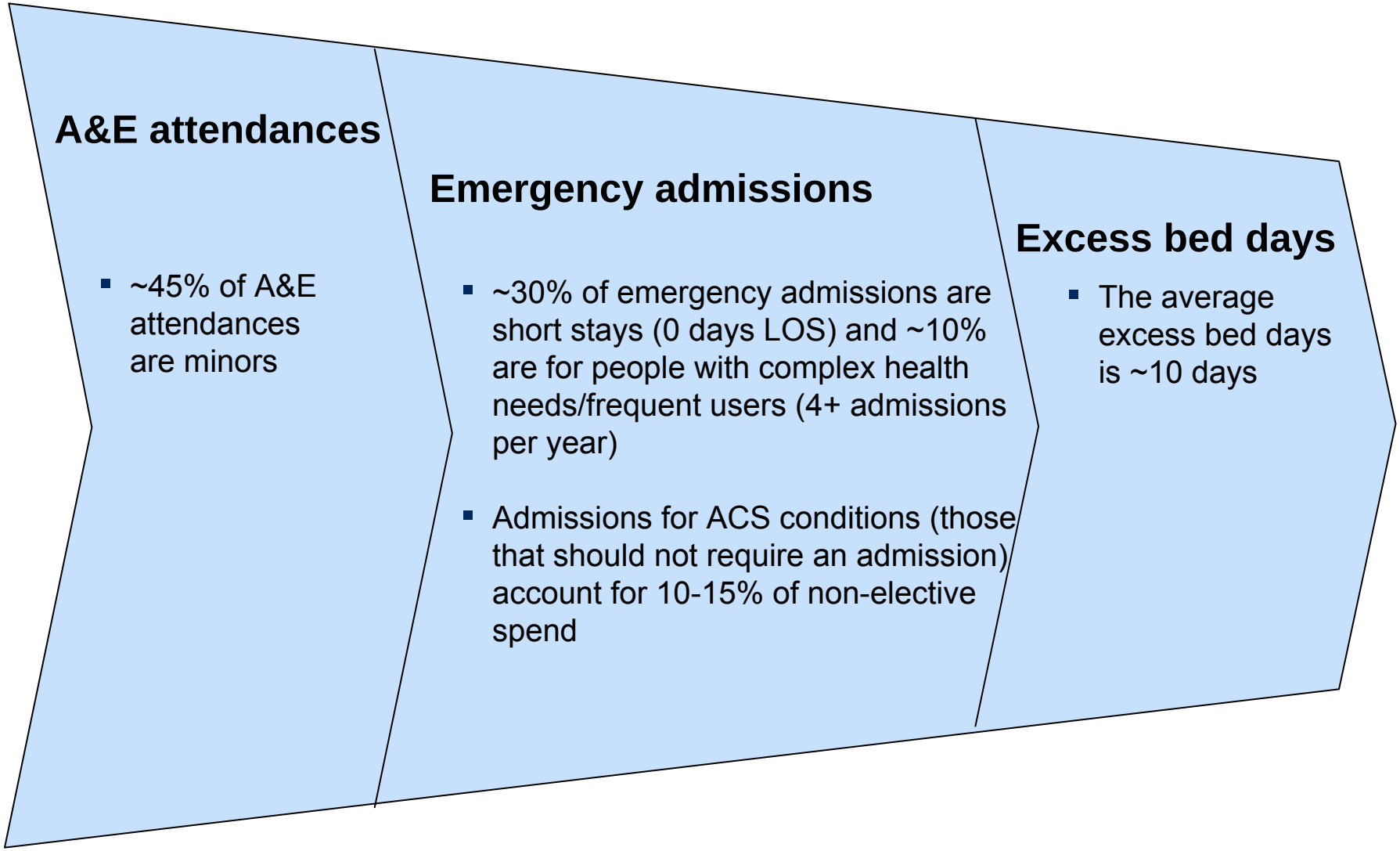
* Age weighted population

Source: PCTs spend, Mckinsey analysis

8 Shift care to lower cost setting: Reducing unscheduled care spend…



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SOURCE: PCT analysis, 2006/7

8 … through a combined portfolio of 7 initiatives targeting the 3 main areas of spend in unscheduled care

Initiatives	Impact: Reduce A&E attendances	Impact: Emergency admissions avoidance	Impact: Excess bed days
1 **Urgent care centers** – Triage center – Primary care services at front end of A&E – Multidisciplinary primary care services at A&E to take care of ambulatory patients	✓	(✓)*	
2 Upgraded role of **single point of access**	✓	✓	
3 Rapid response services	✓	✓	
4 Proactive **care for people with complex needs** and **long-term conditions (LTCs)** (includes frequent fliers)	✓	✓	
5 **Clinical assessment unit** (CAU)	✓	✓	
6 **Discharge facilitation** (in conjunction with Provider Arm), e.g., through unique care model pilot	(✓)*	(✓)*	✓
7 Increased range of **out-of-hospital services** – Out-of-hour services – Expand range of services in practices – Develop better access to diagnostics	✓	✓	✓

• These initiatives must be implemented simultaneously to maximize their impact

• Failure to implement one or more initiatives has a direct impact on the savings to be captured by the implemented initiatives

* (✓) indirect effect

Source: Team analysis

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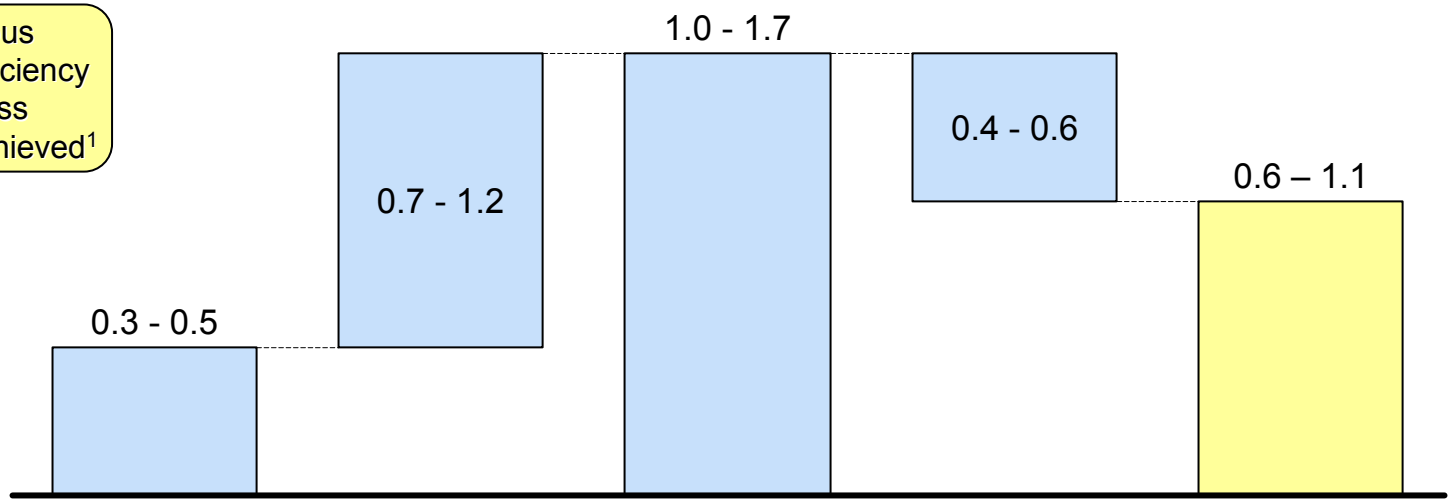
8 Estimated savings from transforming provisioning of unscheduled care estimated at £0.6-1.1bn

£b.

Assumes previous opportunities for efficiency and effectiveness improvement are achieved[1]



Comissioning costs after productivity improve-ments achieved £bn	1.5	15		
% of potential cost savings	20-32%	5-8%	35% of savings	

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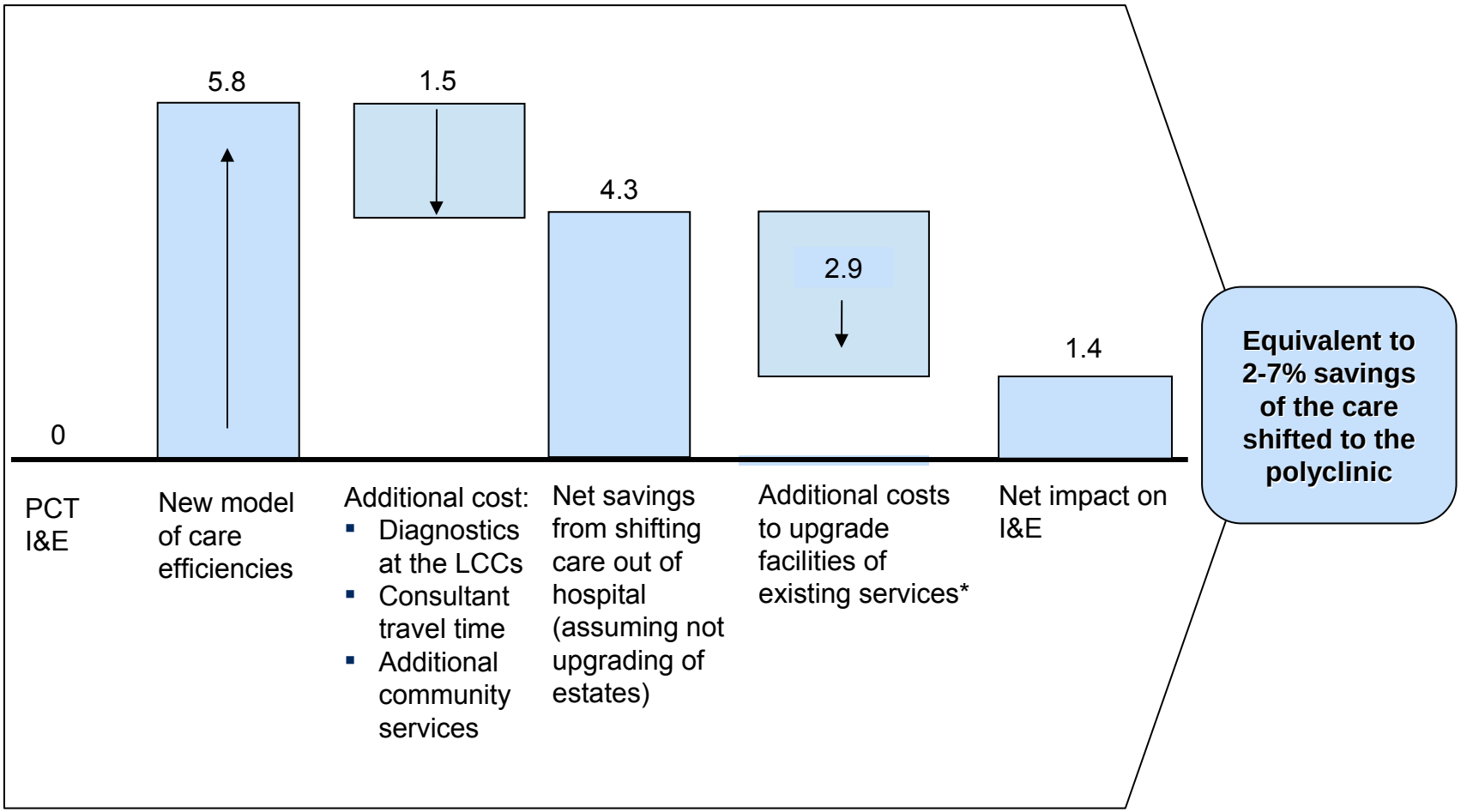
Source: National Audit Office Summarized Accounts; HES online, team analysis

8 Shifting day and OP care from acute to primary/community care is more cost effective even factoring costs of building new facilities

Annual impact of shifting OP and day care. £m at today's prices.



* Includes upgrading of facilities for GPs, community services, team bases, mental health trust moving to new polyclin

Source:OBC models, team analysis

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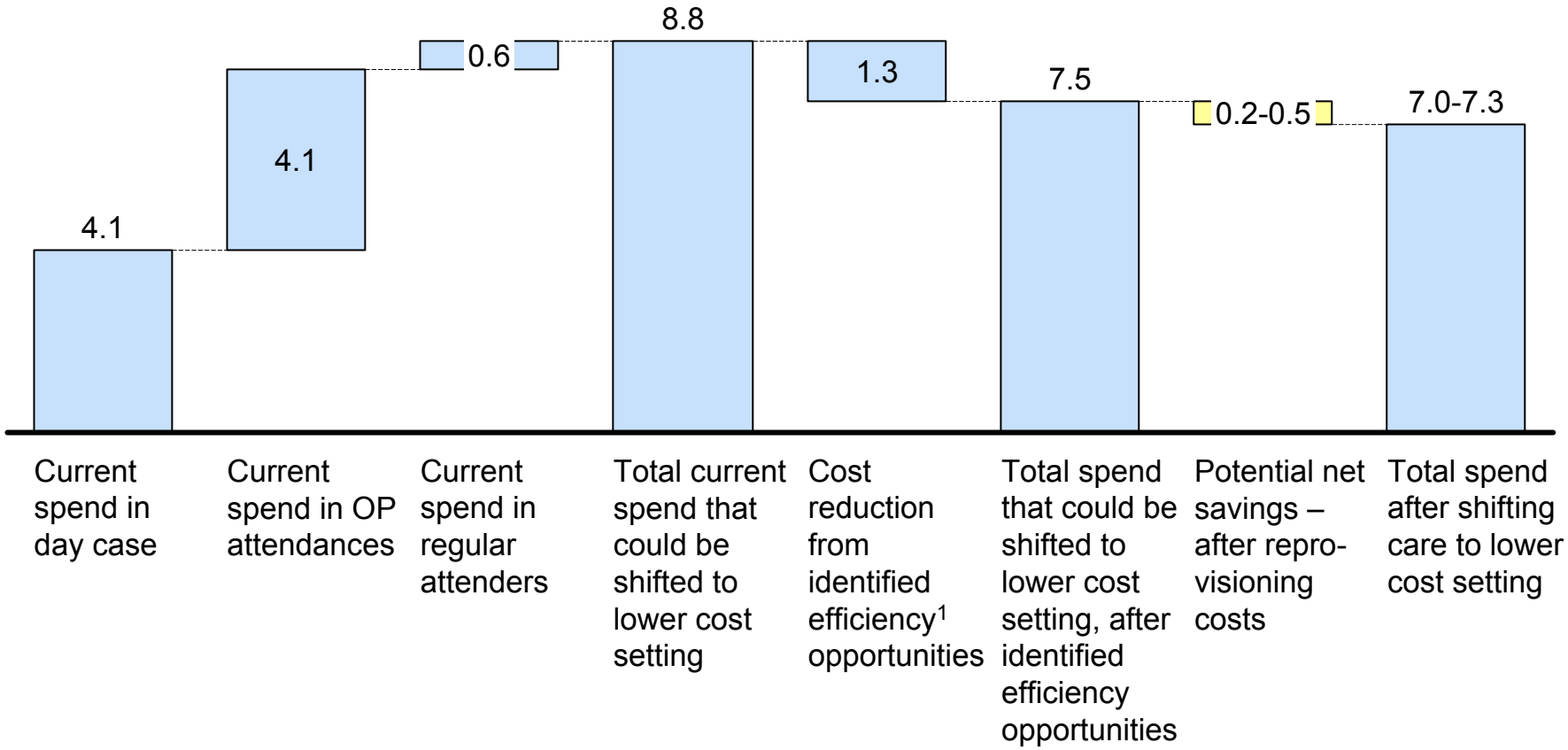
8 Assuming similar potential savings for all other PCTS, potential savings from shifting acute care to primary care of £0.2-0.5bn

£bn

Assumes previous opportunities for efficiency and effectiveness improvement are achieved[1]



1 Driving through productivity improvements in all providers and optimizing spend

Source:OBC models, team analysis

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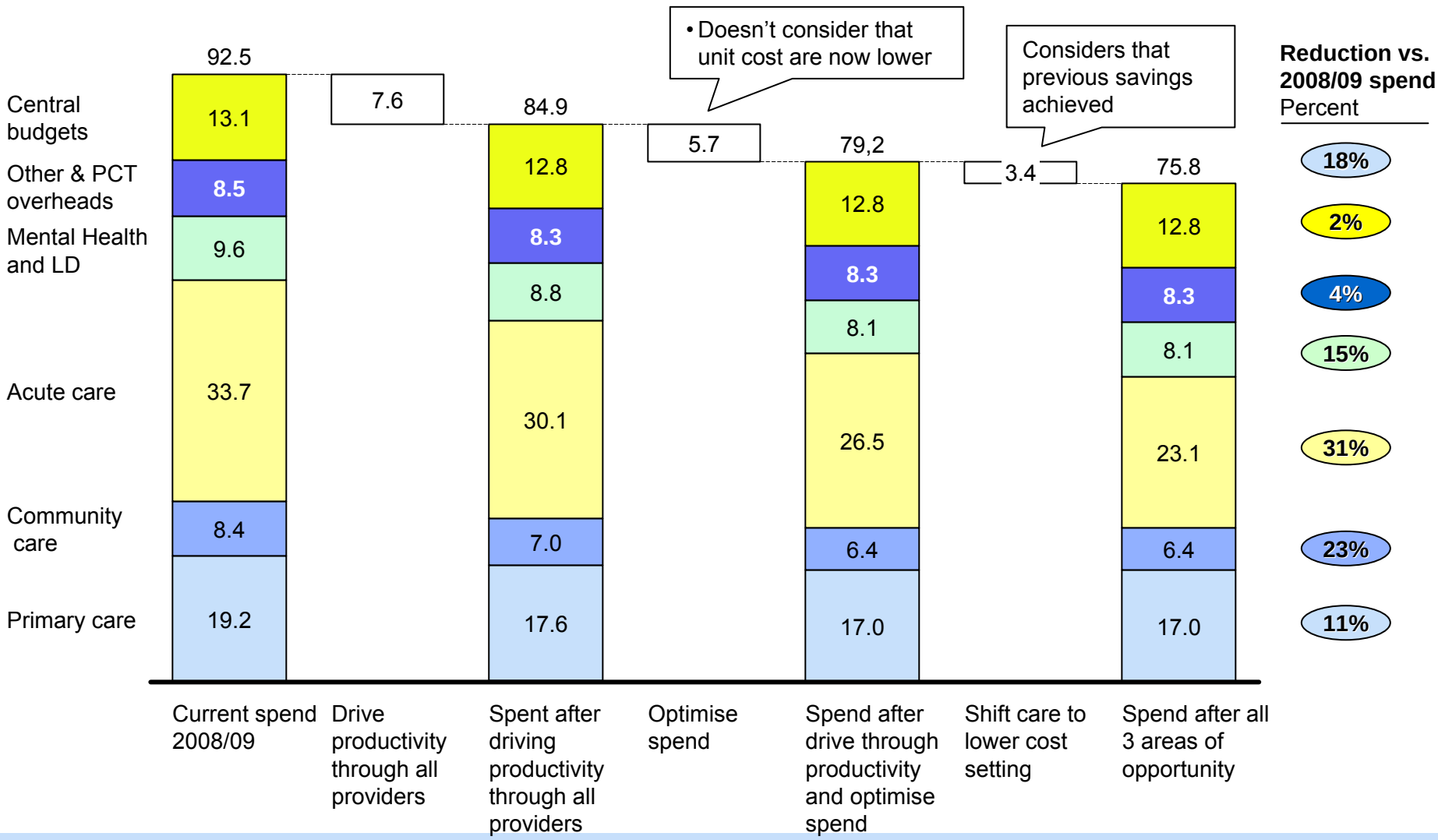
Implementation of all programmes will have the largest impact in acute and community services spend (1/2)

£bn. 2008/09. Mid point of maximum and minimum size of the opportunity.



1 Optimisation of spend allocate proportionally to current spend between primary, community, mental and acute care

SOURCE: McKinsey analysis

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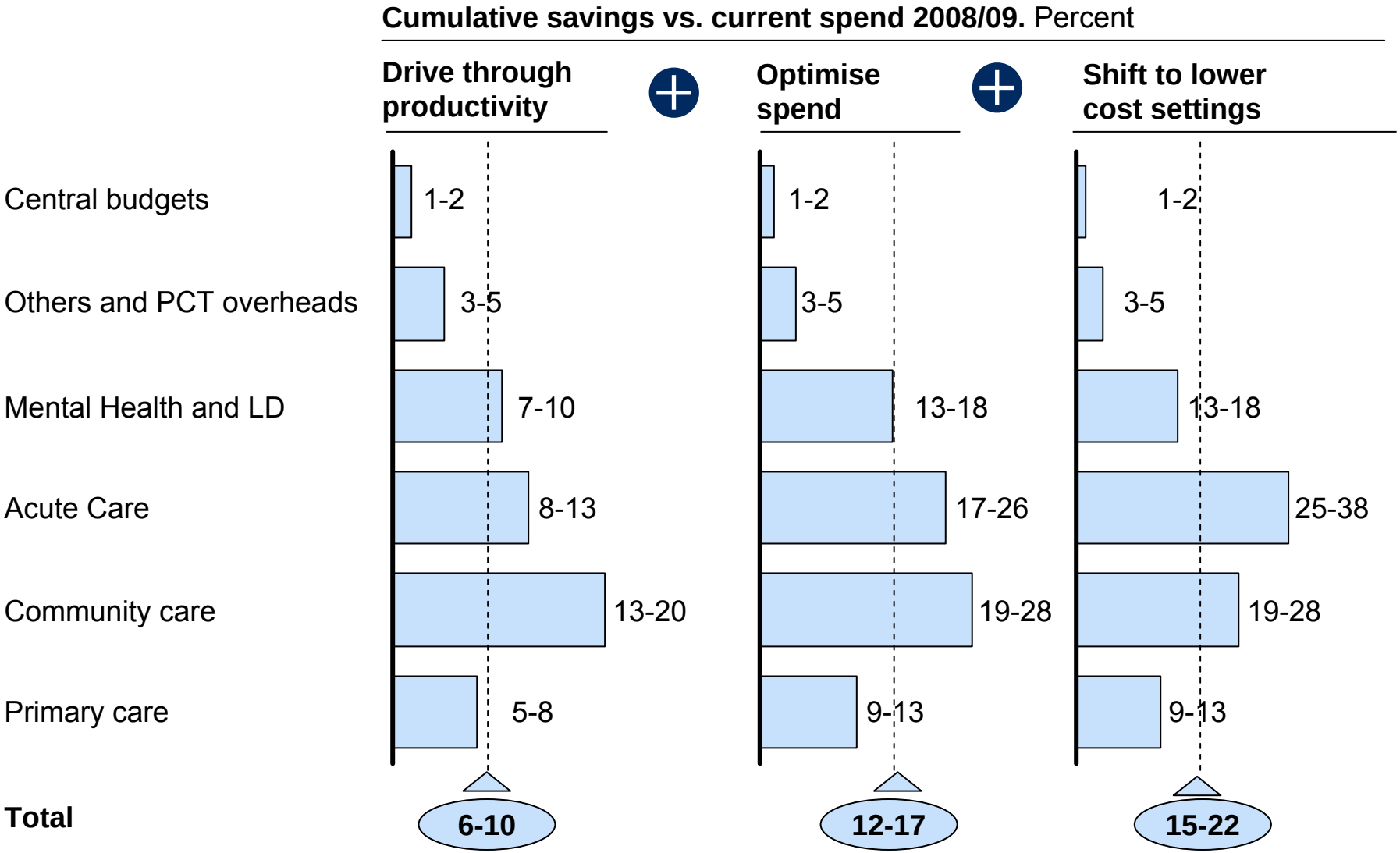
Implementation of all programmes will have the largest impact in acute and community services spend (2/2)

Percentage reduction vs. 2008/09 commissioning spend. Cumulative[1]



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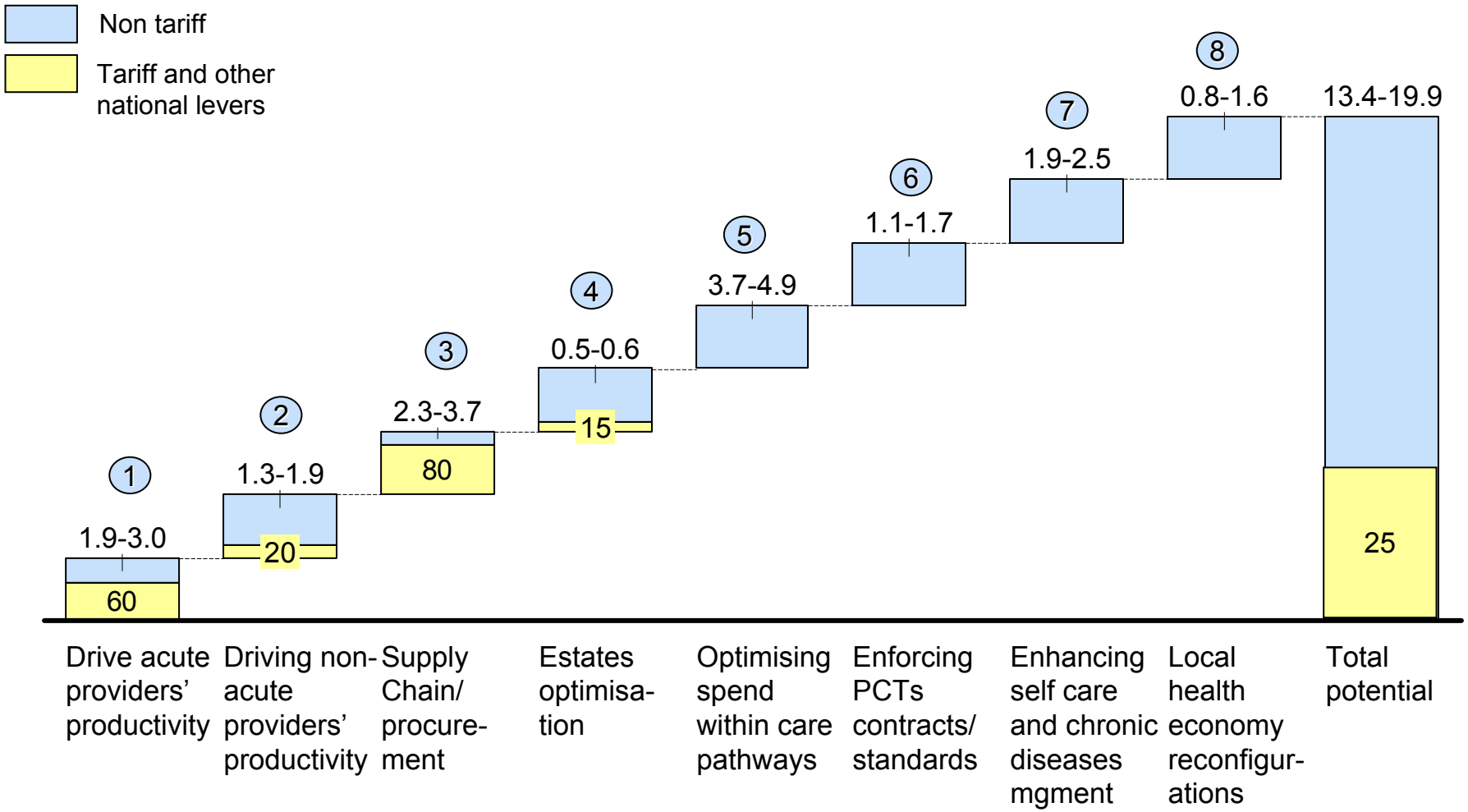
! Range indicates the low and maximum potential identified
SOURCE: McKinsey analysis

25% of the potential savings are driven by tariff or other national levers

ESTIMATE

£bn. 2013/14 recurrent potential savings. England



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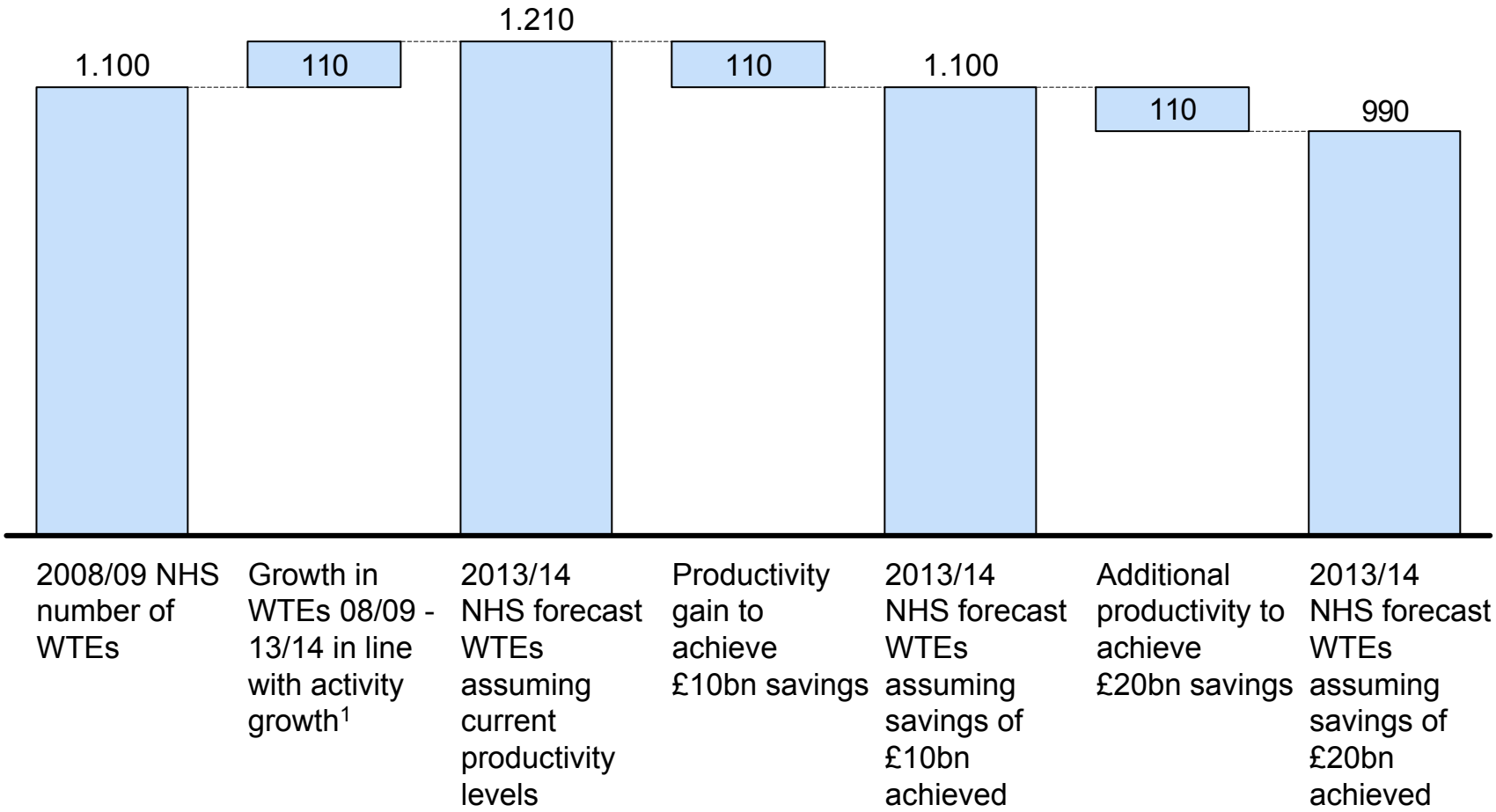
In the best case, headcount will have to be maintained flat; if savings of £20bn are required, headcount will need to be 10% lower

ESTIMATE

Number of WTE '000. NHS England.



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SOURCE: The information centre for social and community care, NHS staff 1997–2007; McKinsey analysis

Need to decide early on the mechanisms to minimize the "pain" to the workforce

	Description of current situation	Potential actions in next 6 months
Align training positions with reviewed funding	▪ Medical school places grew ~8% per year between 2000 and 2005, above the expected growth in activity of 5.5%	▪ Consider a reduction of the training positions, starting next academic year, to avoid further oversupply in 5 years from now, given new scenario
Introduce an early retirement programme	▪ 30-40% of the GPs and 50% of community nurses are above 50 years old[1] ▪ Multiple companies and industries have used early retirement programmes to cope with recessions while ensuring "new blood/talent" keeps coming into the system	▪ Design an attractive and cost efficient early retirement programme to be implemented in the next 2 years
Limit introduction of mandatory staffing ratios	▪ Some Royal Colleges are recommending introduction of mandatory staffing ratios on safety grounds that will lead to increases in staff required above the activity growth e.g ratio of 1/28 per midwife ▪ Certain service reviews are also recommending more staff is required e.g. stroke, children	▪ Review current plans to introduce mandatory staffing costs or investments in quality of care requiring an increase of the staffing levels
Introduce a staff hiring freeze	▪ Current average NHS leaving rate is 10.5% for medical staff and 10.1% for not medical staff although it varies widely by skill e.g. nurses and HCA 14% and 22% respectively, consultants 7.2%	▪ Evaluate options and timing of introducing a staff hiring freeze in the next 2 years, even if funding available

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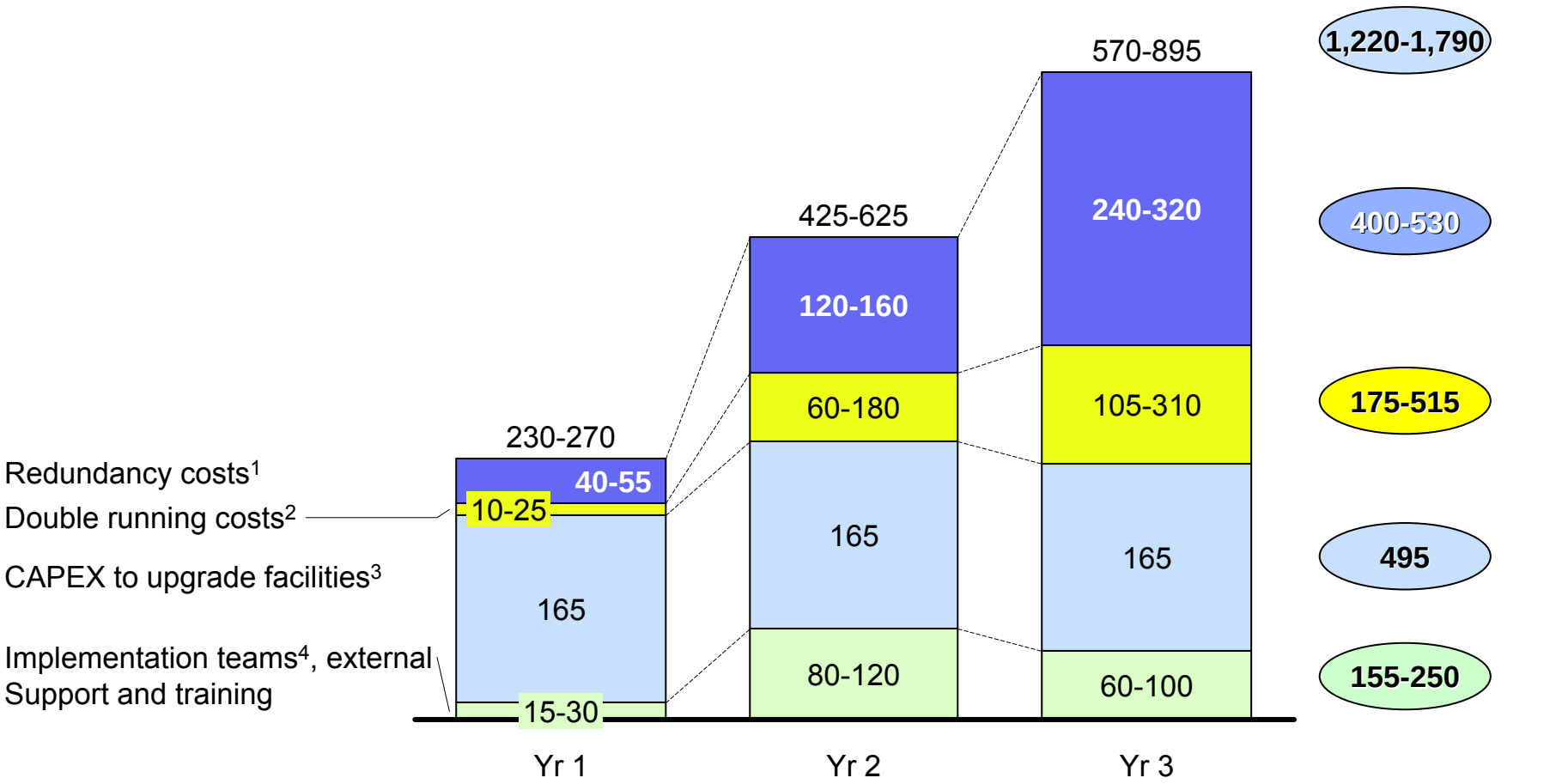
1 – King's Fund – NHS workforce – 2005
SOURCE: Kings Fund – NHS Workforce 2005; Information Centre for Social and Community Care

Implementation costs are estimated at £1.2-1.8bn over 3 years, equivalent to ~9% of potential annual savings

ESTIMATED

£m



1 Assumes 6-8 months wages as redundacy pay, 11% normal turnover, and 80% of turnover used to capture necessary redundancies
2 Assumes 10-20% costs doubled for 4-6 months, with 5% care shifted in 1st year, 40% shifted in second year and 100% in thrid year
3 See page 39
4 Includes the Central Productivity Unit (see page 96) and the PCTs and SHAs central teams as per
Note: Does not include IT spend

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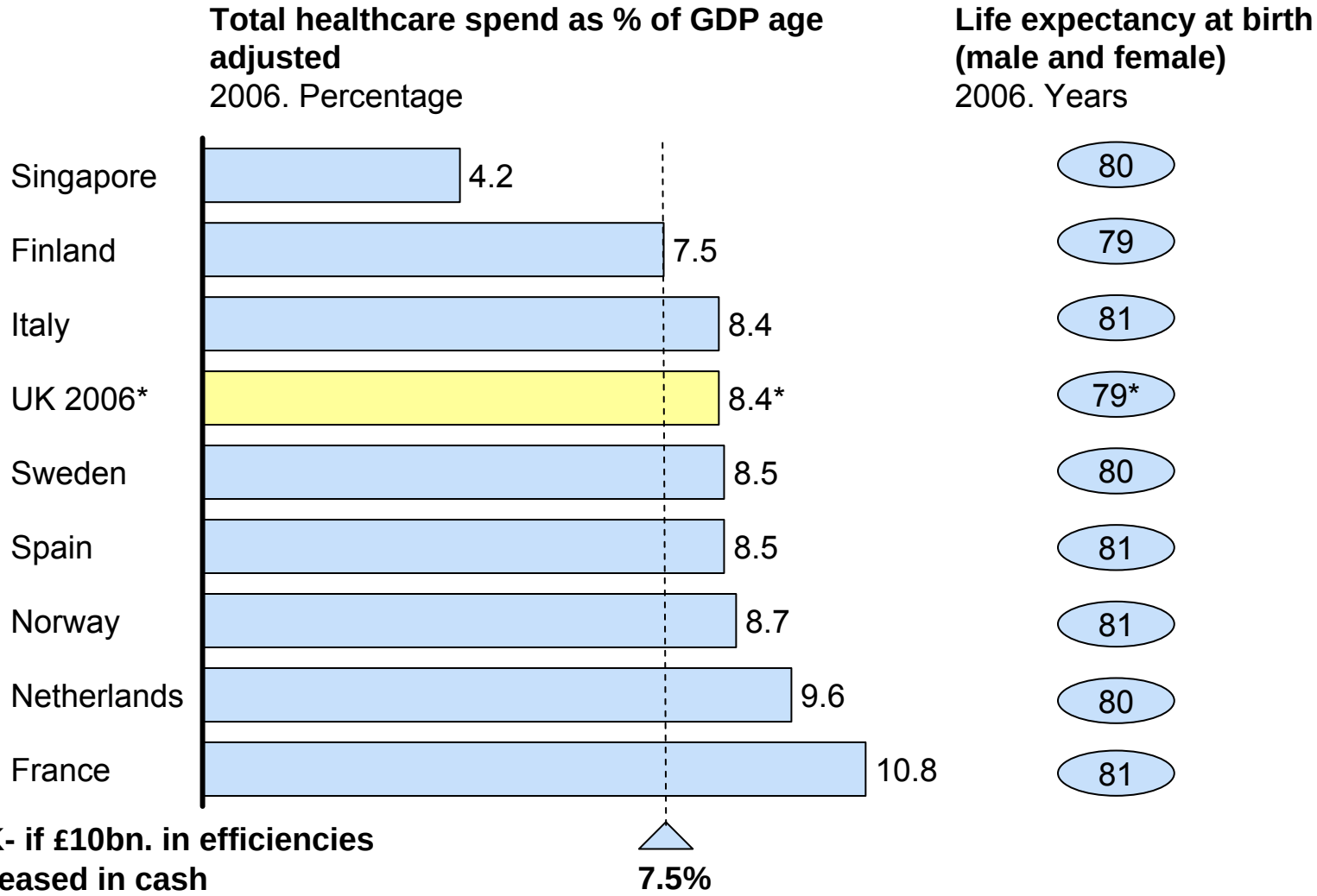
If £10bn were released in cash to close the potential funding gap, England would be one of the most cost effective countries, starting from a low base

2006



* Healthcare spend as % of GDP age adjusted is for UK, Life expectancy is for England

Note: Calculations based on 2006 to ensure comparability with other countries.

Source: WHO Statistical Information System, United Nations Statistics Division

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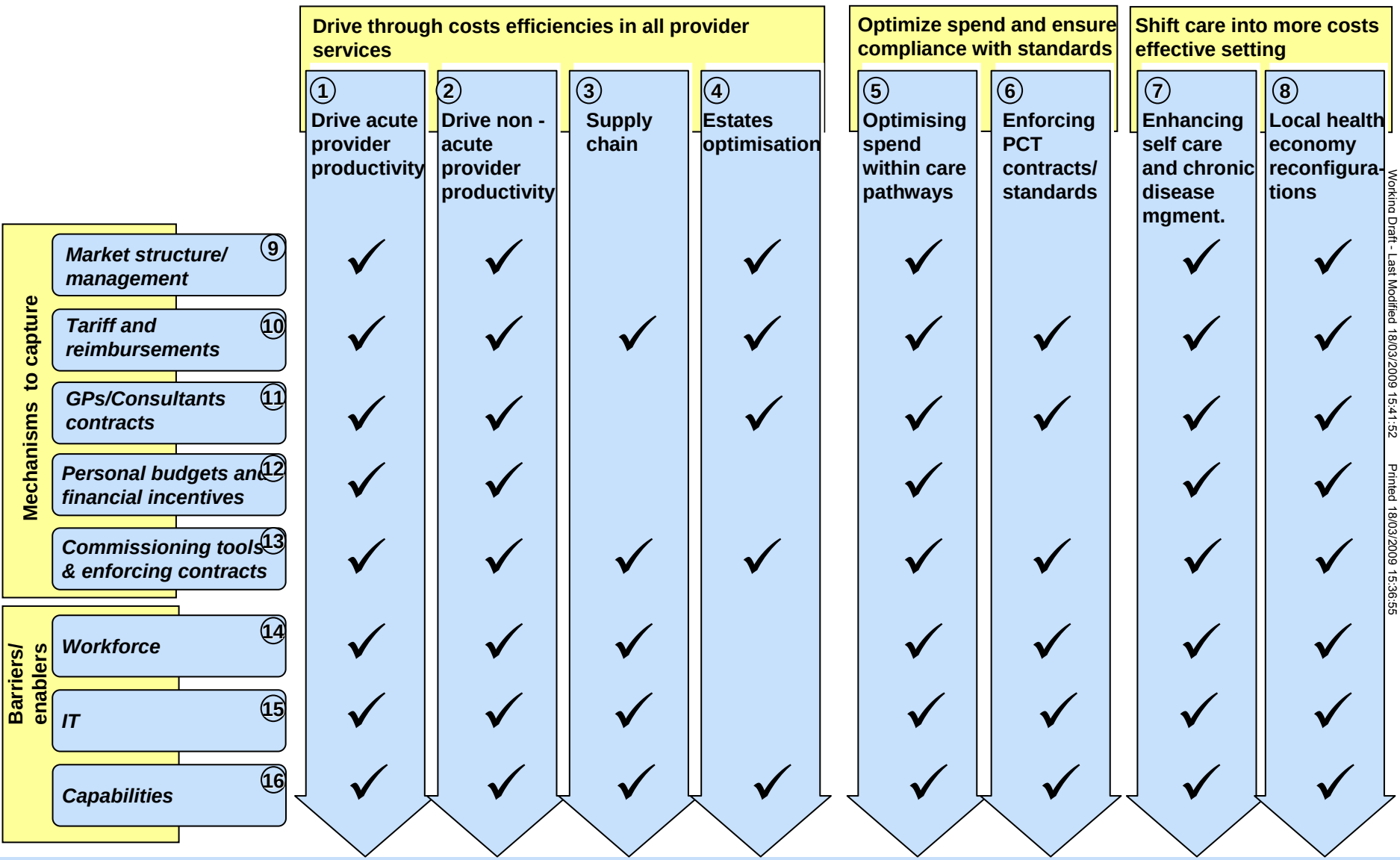
8 of the 16 programmes would focus on mechanisms and enablers necessary to capture the identified opportunities

✓ Applicable to capture the value



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Key questions when designing the overall programme

Case for change

- Which will be the **key messages** of the **case for change**?
  - Why do we need this programme?
  - How much is needed and by when? Impact on quality?
  - What will happen if we don't deliver?
- **How and when** this case for change **will be communicated?**

Plan delivery

- Which **process** will be used to **develop implementation plans** at SHAs, PCT and provider level?
- **How** will **targets be cascaded down** to the system?
- **How existing programmes** e.g. WCC, PCT performance regime will be **used to support the delivery** of the programme?

Facilitate change

- Which **barriers to change need to be removed** e.g., workforce mobility, incentives for M&A
- Which **success examples** of improved efficiency without compromising quality could be shared?

Support development of skills/capabilities

- Which tools/methodologies can **the Productivity Unit and/or the SHAs** develop to support **development of capabilities and skills** e.g. productive ward, utilisation reviewing, market management?
- What would be the **resources required** to **provide this support?**
- **Which pilots** could be used to **test tools/methodologies** and **show early success to build momentum?**

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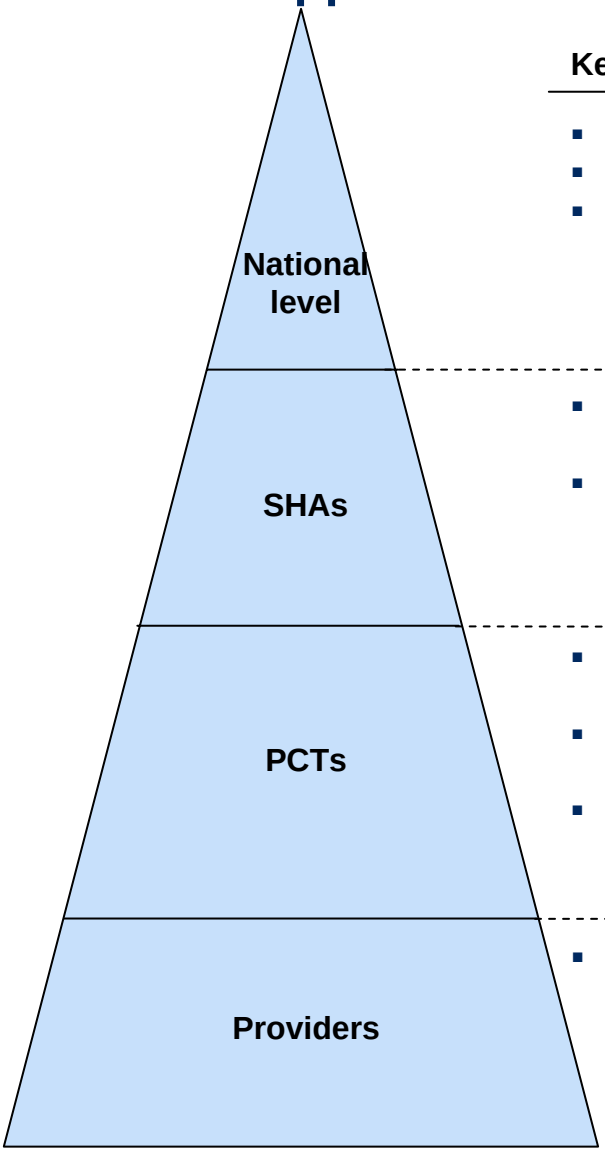
Actions and enabler to put in place at each level to capture the identified opportunities

NOT EXHAUSTIVE



	Key actions to capture opportunities	Key enablers to put in place
National level	▪ Set tariffs ▪ Negotiate/define central contracts ▪ Set overall funding levels	▪ Design programme structure/ governance and track progress ▪ Develop a compelling story for change and level of ambition ▪ Remove key barriers to change ▪ Embed within existing mechanisms e.g., WCC
SHAs	▪ Support and lead creation of potential "hubs" ▪ Implement reconfiguration processes	▪ Support efforts that required specialized skills/ capabilities e.g. market management ▪ Support reviews to assess potential for improvement ▪ Remove key barriers to change e.g. resistance to reconfigurations
PCTs	▪ Drive providers' performance through contracts ▪ Reallocate spend to most cost effective interventions ▪ Realize potential savings through reduction of staff or non pay spend (e.g. estates)	▪ Build world class commissioning capabilities ▪ Set up appropriate incentives for providers ▪ Build skills and capabilities e.g., contracting/ utilisation reviews
Providers	▪ Realize savings through: – Providing more care with same level of staff/resources – Reducing staff and other spending (particularly estates)	▪ Build skills and capabilities e.g., lean operations

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We envision a central programme for which delivery will be driven through the SHAs

Key roles
- Develop a compelling case for change and set targets
- Design the programme structure/ governance and track performance
- Remove barriers to change and share best practices/success stories
- Develop policies/methodologies for allocative efficiency

Central Productivity Unit

Steering Committee World Class Productivity (DH, SHAs and Productivity Unit

Strategic Health Authorities (SHA)

NHS London | NHS East Midlands | NHS South East Coast | . . . | NHS Yorkshire and the Humber

Local implementation teams for each programme

Team Acute productivity programme

Team Acute productivity programme

Key roles
- Deliver identified productivity improvement opportunities
- Take out costs maintaining or increasing quality of care

Key roles
- Drive through local delivery of the programme
- Set targets at PCT/provider level
- Design local programme structure/ governance and allocate resources
- Lead delivery of SHA-wide opportunities e.g., service reconfigurations, "hubs"

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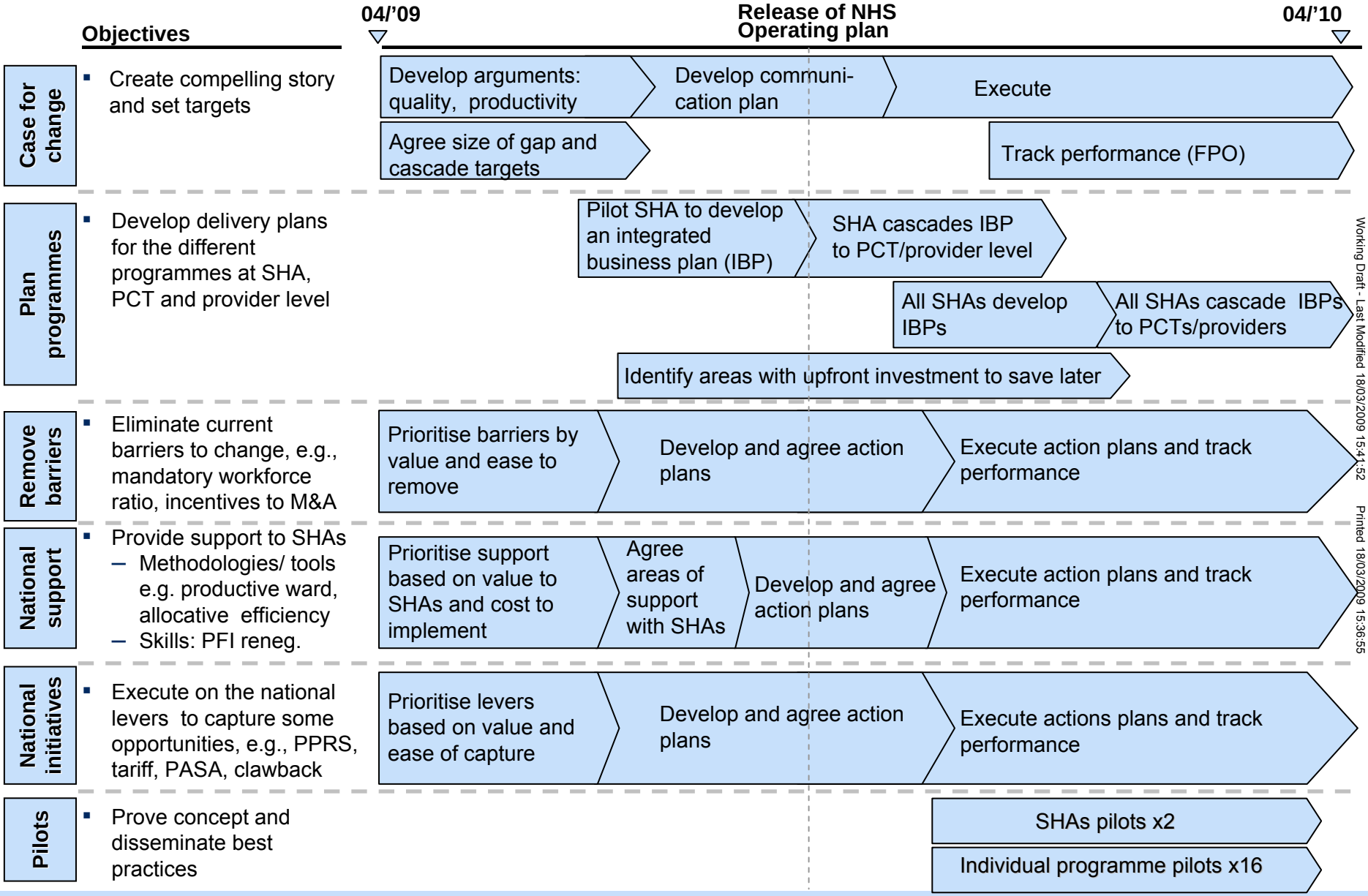
Potential key activities of the programme in the first 12 months



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Examples of barriers to change to be removed

Workforce	• Facilitate workforce mobility (e.g. geographic, setting) • Align workforce plans/forecasts with new context • Relax national central negotiation and planning
Reconfiguration processes	• Focus consultation on services not on buildings • Simplify consultation process • Support SHAs/ PCTs to manage resistance to reconfiguration
Performance management	• Need for a clear “failure regime” for providers who are consistently failing clinically and/or financially • Relax “excessive” focus on some targets e.g. waiting times
Mandatory initiatives	• Limit or remove mandatory staffing ratios e.g. 1:28 midwife staffing ratio, when some centres achieve 1:40 and high quality • Mandatory GP led centres without ensuring full utilisation • Mandatory single tariffs across settings
M&A/ consolidation	• Clarify how the competition framework regime would work • Set up the “right” incentives for M&A/consolidations e.g. FTs

Productivity Unit should prioritise the barriers to tackle first and develop action plans

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Examples of tools/methodologies that could be developed nationally or at SHA to support the delivery

Acute setting dashboard: Version 1 - Can do now with nationally available data

Top quartile
51-75th percentile
26-50th percentile
Bottom quartile

NHS London

		A&E	Ward	Theatre	Outpatient	Diagnostics	Overhead
Productivity	Overall productivity			▪ FCEs/surgeon (TBD ?)	▪ Outpatient appointments/Clinical WTE (TBD ?)		▪ Medical secretaries / consultant ▪ Clinical coordinators/ 1,000 Ops ▪ Finance staff/ total staff ▪ HR staff/total staff ▪ IT staff/total staff
	External systems		▪ DOSA, %				
	Patient Flow	▪ % seen within 4 hours	▪ Weighted LOS ▪ % bed days >14 ▪ % HRG beyond trim point ▪ Bed utilisation (%) ▪ DNA and cancellation	▪ DNA and cancellations	▪ DNA, cancellations ▪ New to follow-up ratio		
	Staff						
		▪ Staff satisfaction Turnover ▪ Trainee WTEs/Consultant WTEs		Agency + Bank costs(%)	Nurse grade mix		
Other KPIs	Quality	▪ 28 day re admissions rate ▪ MRSA Infection rate		Safety and error rate Patient satisfaction/complaints	Mortality (index v 100) SMR C. Diff Infection rate		
	Access	▪ 18 weeks ▪ 2 weeks cancer target					
	Finance	▪ Income or EBITDA/WTE ▪ ROCE		R&D income/total income MPET income/total income			

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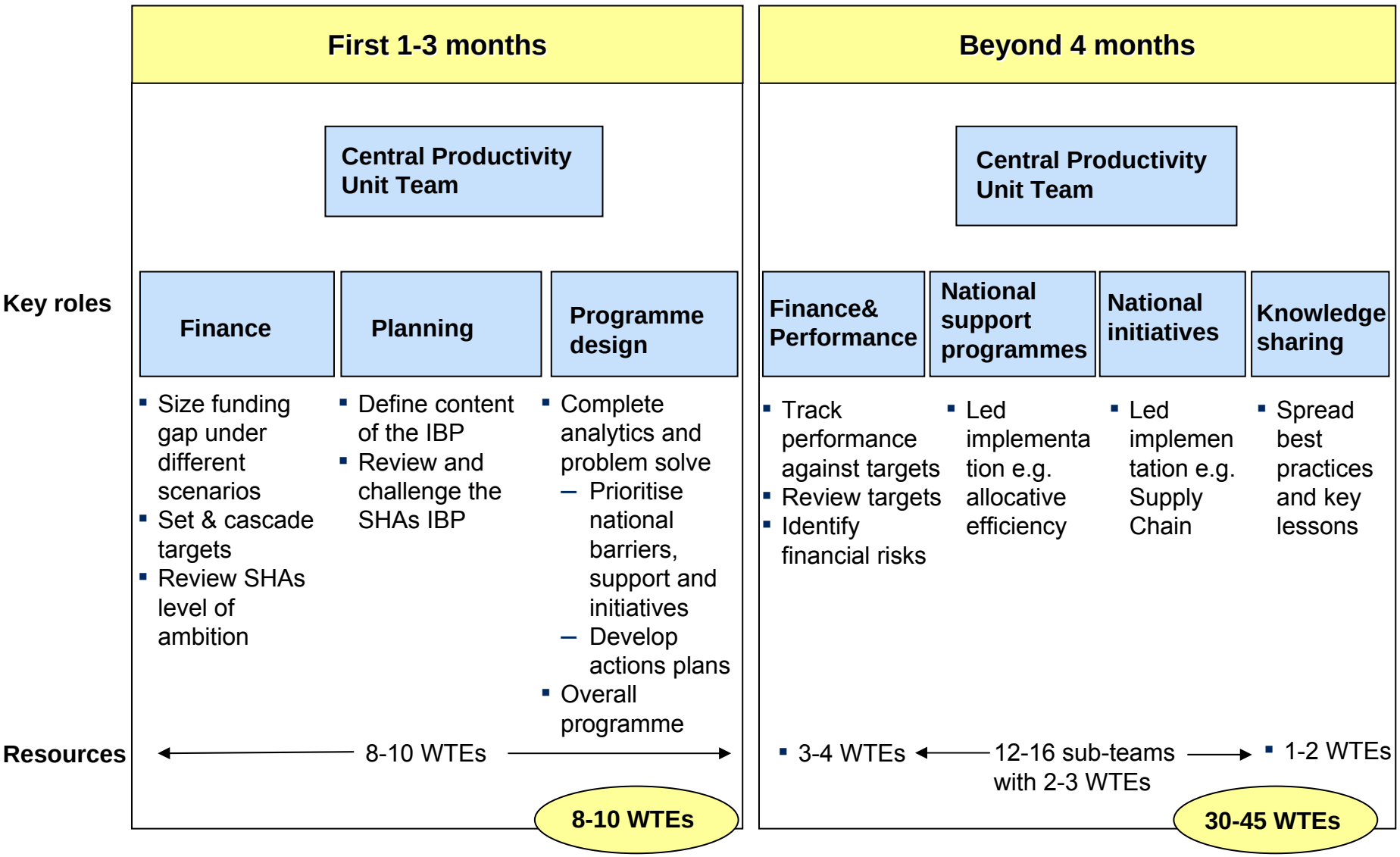
SOURCE: Team analysis

Productivity Unit potential team and how it could evolve over time



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Each SHA will design its programme delivery structure/governance considering the local opportunities and skills/resources available

NON EXHAUSTIVE

Potential spectrum of options for SHA programme delivery structure

Potential options / When most appropriate?	SHA-level dedicated team with or without external support	Individual PCT or provider dedicated team with or without external support	Embedded in current targets/responsibilities
Type of opportunity	▪ Economies of scale – not economical to replicate for individual PCTs ▪ Implementation requires cross-PCTs or cross-providers collaboration	▪ Opportunity is PCT and provider specific i.e. design or implementation is local ▪ Somehow new or not typically part of the business as usual	▪ Opportunity is part of the business as usual of the PCT/provider
Skills/ experience	▪ Opportunity requires building new or specialised skills ▪ Economies of scale	▪ Capturing opportunity requires skills that should be core to PCTs/providers competencies but – Have not been built before/ are new – Not successful before	▪ Capturing opportunities requires skills that are within current job description skills/experience
Examples	▪ Collaborative 'hubs' ▪ Service reconfigurations ▪ PFI renegotiation	▪ Reducing variability in referrals or prescribing practice ▪ Estates optimisation	▪ Conduct utilisation reviews ▪ Optimising theatre utilisation

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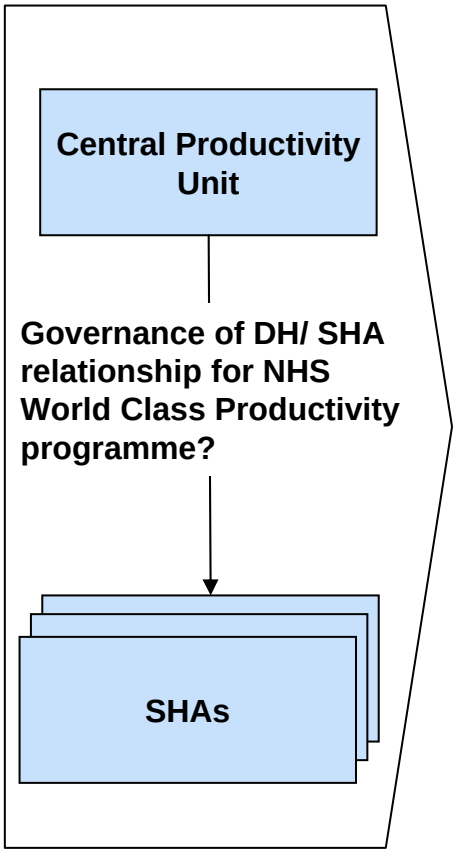
How the governance of the programme between the Central Productivity Unit and the SHA could work



Productivity unit key roles	Potential governance
Set targets	▪ Productivity unit sets overall level of ambition by SHA and set financial envelop ▪ Each SHA develops a business plan detailing opportunities, expected size of the opportunity and required resources ▪ Productivity unit and SHAs discuss and agree final targets and resources
Monitor/track performance	▪ Quarterly Steering Committee to discuss performance/progress – 2-3 representatives of DH Board – 2-3 representatives of the SHA board – 1-2 representatives of the Central and SHA Productivity Units ▪ Identify jointly root causes of under- delivery and jointly agree corrective actions plans and support from Productivity Unitl
Develop policies/ methodologies	▪ Led by Productivity Unit team who will engage SHAs ad hoc to: – Prioritise areas to develop/address first – Input on drafts of policies/methodologies
Remove barriers/ enable change	▪ Led by the Productivity Unit who will engage SHAs ad hoc to – Prioritise barriers to remove first/ enablers to put in place – Discuss most appropriate actions to remove barriers

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Pilots in SHAs could be targeted to demonstrate early successes

LONDON SHA EXAMPLE

Potential pilots for London SHA

SHA level

- Accelerating implementation of HfL
- London collaborative hub – targeted service lines
  - Claims management and coding review
  - Provider intelligence, contracting negotiation and commercial advice
- Estates optimisation
- Local health economy reconfiguration in the North East

Provider level

- Acute providers: Imperial College productivity programme
  - Theatre utilisation
  - Bed management
  - Pathology (use and delivery model)
  - Service reconfiguration
- GPs productivity: Tower Hamlets PCT
  - Increasing GP patient facing time
  - Increase slots/appointments

PCT level

- Polyclinic development in Redbridge
- Reduce variability in prescribing practices (target PCTs to be identified)

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What does this mean for an average PCT?

Activities

- Review of PCT strategy to identify and incorporate opportunities for productivity improvements whilst still maintaining strategic direction
- Renegotiation of GP and provider arm contracts to drive down unit costs of non-tariff providers
- Support providers in restructuring in response to tariff reduction
- Active performance and contract management to ensure productivity and quality targets are being met
- Evaluation of all clinical pathways to identify non-effective interventions, and replace in favour of high-impact interventions
- Comprehensive redesign of care pathways to shift activity to out-of-hospital settings

People

- New team created within existing staff with sole focus on implementing productivity improvements

Skills

- Specific training to improve commissioning and negotiating skills
- Information and data analysis augmented by upgraded management information systems

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What does this mean for an average Provider?

Activities

- Review of patient contact time and processes involved in ward rounds and clinics
- Recalculation of staffing rotas

People

- Focussed communication and training to underline need for and goals of productivity improvement and implied impact on status quo
- Reduction in headcount equivalent to 35 FTEs from a clinical staff of 300[1]:
  - 2 Consultants
  - 1 Registrar
  - 10 Nurses
  - 10 Healthcare Assistants
  - 3 Allied Health Professionals
  - 8 Non-clinical staff

Skills

- Specific training on change management skills
- Review of costs and rationalisation of all services to meet new tariffs
- Information and data analysis augmented by upgraded management information systems

1 Based on reduction in headcount proportional to estimated potential for productivity improvement (see methodology) against current staffing ratios from NHS Information Centre Staff Numbers Mar 2008

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For each of the 16 identified programmes and geographies, need and type of external support would have to be defined

ILLUSTRATIVE

External support
- Required
- Not required

SHA 10
SHA 2
SHA 1

		Make goals plausible/ identify specific opportunities	Identify approaches/ develop tools	Draw up actions/ measures	Put re-sources/ enablers in place	Implement action plan	Capture potential
Areas of oppor-tunity	1 Improve acute providers' productivity		■				
	2 Improve non-acute providers' productivity		■				
	3 Supply chain	■	■	■			
	4 Estates optimisation	■	■	■	■	■	
	5 Optimising spend within the care pathways	■	■	■	■	■	■
	6 Enforcing PCTs contracts/ standards	■	■	■			
	7 Enhancing self-care and chronic disease management			■	■		
	8 LHE* reconfigurations	■	■	■	■	■	■
Mech-anisms/ enablers	9 Market structure/ management	■	■	■			
	10 Tariffs and reimbursements	■					
	11 GP/ Consultant contracts	■	■	■			
	12 Personal budgets and financial incentives	■					
	13 Commissioning tools and enforcing standards	■	■	■	■		
	14 Workforce						
	15 IT	■	■	■	■		
	16 Skills/capabilities building	■	■	■	■		

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There are different options for the procurement strategy of this external support

Tender support for all programmes

	SHA 1	SHA 2	. . .	SHA 10
Programme 1	A single provider/consortium			
Programme 2				
. . .				
Programme 15				

Tender support by SHA

	SHA 'A'	SHA 'B'	. . .	SHA 10
Programme 1	Provider /consor-tium 1	Provider /consor-tium 2		Provider /consor-tium 10
Programme 2				
. . .				
Programme 15				

Tender support by programme /group of programmes

	SHA 1	SHA 2	. . .	SHA 10
Programme 1	Provider/consortium 1			
Programme 2	Provider/consortium 2			
. . .				
Programme 15	Provider/consortium 'n'			

Tender support by programme and SHA or a combination

	SHA 'A'	SHA 'B'	. . .	SHA 'N'
Programme 1	Provider 1	Provider 2		Provider 3
Programme 2	Provider 4	Provider 5		Provider 6
. . .				
Programme 15	Provider 7	Provider 8		Provider 10

- Potential to tender support to design overall programme
- Decide the type of skills required (e.g., management consultants to review strategy and identify opportunities, implementa-tion specialists to drive shop-floor change, IT consultants to deliver enabling IT architectures, health insurers with payment and contracting expertise)

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1 Methodology and assumptions – Drive-through cost efficiencies in all providers' services (1/2)

ESTIMATE

	Methodology/assumption	Potential size of opportunity, £b	Implied productivity/ savings, %
1a Acute staff productivity	▪ **Clinical staff** – All acute trusts below the median of FCEs by doctor, nurse and other clinical staff achieve 50%-80% of the potential productivity improvement of stepping up to the median – Clinical costs account for 50% of acute costs	1.5 – 2.4	9 – 14
	▪ **Non-clinical staff** – All acute Trusts above the median of non-clinical staff to clinical staff ratio achieve 50%-80% of the potential productivity improvement of stepping down to the median – Average total earnings of non-clinical staff of 20,000/year	0.4 – 0.6	7 – 11
1b Non-acute staff productivity	▪ **Community services** – Estimate potential productivity improvement by reducing variability in distinct nurses daily visits. Assumes underperformers achieve the median or 10% above the median (based on one PCT) – Typical potential savings identified in the provisioning of community services in different PCTs	0.7 – 0.9	11 – 15
	▪ **Mental health providers** – All trusts above the median ALOS achieve 50%-80% of the potential improvement of stepping down to the median ALOS – Reduction of beddays if crisis resolution teams' effectiveness increase by 10% (TBC)	0.5 – 0.6	10 – 12
	▪ **Primary care providers** – 5–10% pf the GPs are very weak performers and 15–25% are weak performers in the number of appointments offered per week – Weak and very weak GP performers achieve the standard performance – GPs staff costs account for 60% of the total GP practice costs	0.2 – 0.4	5 – 9
1c Reduce drug expenditure	▪ **Reduce brand drugs price** – Agreed Pharmaceutical Price Regulatory Scheme 2009 (PPRS) includes an overall price reduction of 5.3% for the next 5 years – No additional price reduction beyond the 2009 PPRS agreement as UK BX prices would be in line with EU countries with the exception of Spain and Italy (10% higher after PPP[1])	0.45	5
	▪ **Reduce variation in prescribing practices** – PCTs can reduce variability in current prescribing costs per age need weighted population – Specifically, assume that PCTs can achieve the median spend or 80% of the bottom quartile	0.36 – 0.60	5 – 8

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1 Purchase Power Parity

1 Methodology and assumptions – Drive-through cost efficiencies in all providers' services (2/2)

ESTIMATE

	Methodology/assumption	Potential size of opportunity, £b	Implied productivity/ savings, %
1c Reduce drug expenditure (continued)	▪ **Increase generics penetration** – Generics penetration in value grows from 29% in 2007 to 32-33% in 2013 based on the assumption that penetration continues growing at a pace that is 50-80% that of the last 3 years – Gx prices are on average 80% lower than the originators' 3 years after their introduction	0.17 – 0.29	1.5 – 2.5
	▪ **Increase clawback to pharmacies** – Clawback is increased from current 9.3% (c £900m) to 10-11% (typical discounts received currently by pharmacies are c. 10.5% for branded and higher for generics)	0.06 – 0.16	7 – 18
	▪ **Build scale in procurement of hospital drugs** – Top 50 Bx drugs: current discounts of 12.3% could be increased by 50–80% – Rest of Bx: current discounts of 9.3% could be increased by 30–40% – Generics: limited scope for increase in discounts as already part of PASA managed contracts	0.08 – 0.11	3 – 4.5
	▪ **Outsource hospital drug supply chain** – 3 – 5% savings based on the DHL 10-years outsourcing contract which targets 4.5% savings – 50 - 80% of the hospital drug spend is outsourced	0.04 – 0.10	1.5 – 4
	▪ **Reduced wholesalers' revenues** – Current wholesalers' revenues average 8.5% of Bx ex-manufacture price and 10.5% for Gx – UK wholesalers' revenues are reduced to become closer to Spain (7.6%) and Italy (7.1%) wholesalers' revenues	0.06 – 0.11	8 – 14
1d Supply chain optimisation	▪ **Clinical and non clinical supplies, capital expenditure and central budgets** – 7-12% cost savings for purchases not under PASA managed contracts – 3-5% costs savings for purchases under PASA managed contracts – 10-15% cost savings of GP supplies purchases; GPs supplies costs account for 10% of the total GP practice costs	1.1 – 1.9	6 – 11
1e Estates optimisation	▪ 10–15% potential reduction on estates costs ▪ Estates costs include amortisation, depreciation, capital charges and premises costs but exclude impairments and loss/gain from sale of assets	0.5 – 0.8	10 – 15
1f Restructuring PFI	▪ On 80% of the PFI schemes, government can renegotiate interest rates down by 2–3 b.p. ▪ PFIs holders need the cash and cannot renegotiate in same conditions as government	0.1 – 0.2	11 – 17

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1 Purchase Power Parity

1 Sources– Drive-through cost efficiencies in all providers' services (1/4)

	Metric used in calculations	Data used	Source	Year
1a Acute staff productivity	▪ N. of doctors by acute provider (FTEs)	▪ 78k	▪ The Information Center for Health and Social Care 2007 – Workforce census	▪ Sept 2007
	▪ N. of nurses by acute provider (FTEs)	▪ ~15k		
	▪ N. of other clinical staff by acute provider FTEs)	▪ 80k		
	▪ N. of other non-clinical staff by acute prov. (FTEs)	▪ 280k		
	▪ Total staff by acute provider (FTEs)	▪ 375k		
	▪ Total number of FCEs by acute provider	▪ 14 million	▪ HES online	▪ 2007/08
	▪ % of clinical staff costs over total acute costs	▪ 50%	▪ Stephen Dorgan memo	▪ N.a.
	▪ Average total earnings of non-clinical staff	▪ 20,000 p.a.	▪ Information Center for Health and Social Care 2008 – NHS staff median total earnings/FTE	▪ 2008
	▪ Total acute commissioning costs	▪ £ 33 billion	▪ National Audit Office Summarized Accounts – Care purchased by PCTs	▪ 2007/08
1b Non-acute staff productivity	**Community care services**			
	▪ Community services and others costs	▪ £ 8.4 billion	▪ National Audit Office Summarized Accounts – Care purchased by PCTs	▪ 2007/08
	▪ % of staff costs over total costs	▪ 75%	▪ Assumption based on one PCT Provider Arm	▪ 2007/08
	▪ % of potential staff productivity improvement	▪ 11–15%	▪ Assumption – reduction of variability in DN productivity; experience in community services	▪ N.a.
	Primary care services			
	▪ GMS, PMS, AMPS and PCTMS contract costs	▪ £ 7.2 billion	▪ National Audit Office Summarized Accounts – Care purchased by PCTs	▪ 2007/08
	▪ % of GPs staff costs over total costs	▪ 60%	▪ Polyclinic model; the Information Center for Health and Social Care 2008; workforce census	▪ 2007
	▪ Sessions per week per GP WTE	▪ 7	▪ Typical practice	▪ N.a.
	▪ GP appointments per sessions per GP	▪ 11–18	▪ Data extracts from GP systems – one PCT	▪ 2008
	▪ Average GP salary	▪ £ 108,000	▪ The Information Center for Health and Social Care 2007– GPs earnings and expenses enquiry ▪ Tariff inflation 2.5% (07/08) and 2.3% (08/09)	▪ 2006/07
	▪ Number of GPs in England	▪ 31,000	▪ The Information Center for Health and Social Care 2007 - Workforce census	▪ Sept 2007

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1 Weighted average of the growth in spend of branded drugs (6% p.a.) and generics (12% p.a.)

1 Sources– Drive-through cost efficiencies in all providers' services (2/4)

1c Reduce drug expenditure

Metric used in calculations	Data used	Source	Year
Reduce brand drug price			
▪ Total expenditure in branded medicines	▪ £7.1bn.	▪ Office of Fair Trade – Annexe D: Financial Flows relevant to medicines Dec. 2007	▪ 2005
▪ % annual growth in Bx spend 2005-07	▪ 6% p.a.	▪ Office of Fair Trade: PPRS – An OFT study	▪ 2005-07
▪ Bx price reduction in PPRS for next 5 years	▪ 5.3%	▪ DH - PPRS 2009	▪ Dec.'08
Reduce variation in prescribing practices			
▪ Total prescribing costs by PCT	▪ £7.5bn.	▪ Laing & Buisson NHS Financial Report	▪ 2007/08
▪ Age need weighted population by PCT	▪ 50.5m.	▪ DH Exposition book	▪ 2006/07
Increase generics penetration			
▪ Total spend in generics	▪ £2.4bn	▪ Office of Fair Trade – Annexe D: Financial Flows relevant to medicines Dec. 2007	▪ 2005
▪ % annual growth in Gx spend 2005-07	▪ 12% p.a.	▪ Office of Fair Trade: PPRS – An OFT study	▪ 2005-07
▪ Historical growth in generics penetration in value	▪ 3.4% p.a.	▪ Espicom	▪ 2004-07
▪ Price gap between originator and Gx product	▪ 80%	▪ Euro Observer 2008 based on 12 molecules	▪ 2008
Increase clawback to pharmacies			
▪ Current clawback to pharmacies	▪ 9.3%	▪ Office of Fair Trade – Annexe D: Financial Flows relevant to medicines Dec. 2007	▪ 2005
▪ Total spend on medicines in primary care	▪ £7.5bn.		
▪ Growth on spend on medicines in primary care	▪ 8% p.a.[1]	▪ Office of Fair Trade: PPRS – An OFT study	▪ 2005-07
Build scale in procurement of hospital drugs			
▪ Current hospital discounts on top 50 Bx drugs	▪ 12.3%	▪ Office of Fair Trade: PPRS – An OFT study	▪ 2008
▪ Current hospital discounts on rest of Bx drugs	▪ 9.3%		
▪ Total spend in Bx medicines in secondary care	▪ 2.5bn		
Outsource hospital drug supply chain			
▪ DHL outsourcing contract expected savings	▪ 4.5% p.a.	▪ DHL website – Presss release 2006	▪ 2006
Reduce wholesalers' revenues			
▪ Current wholesalers' revenues as % of price: Bx	▪ 8.5%	▪ Mckinsey pharmaceutical practice	
▪ Current wholesalers' revenues as % of price: Gx	▪ 10.5%		
▪ Wholesalers' revenues as % of price in Spain	▪ 7.6%	▪ Regulated margins from manufacturers	▪ 2008
▪ Wholesalers' revenues as % of price in Italy	▪ 7.1%	▪ Regulated margins from manufacturers	▪ 2008

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1 Sources – Drive-through cost efficiencies in all providers' services (3/4)

	Metric used in calculations	Data used	Source	Year
1d Supply chain optimisation	**PCTs – NHS Trusts - OPEX**			
	Clinical and non clinical supplies[1] – FTs	£2.1bn	National Audit Office Summarized Accounts	2007/08
	Clinical and non clinical supplies[1] – NHS Trusts	£4.4bn		
	Clinical and non clinical supplies[1] – PCTs	£1.7bn		
	PASA total value of contracts managed	£4.6bn	NHS Purchasing and Supply Agency – Annual report and Accounts 2006/07	2007/08
	% of PASA managed contracts related to drugs	40%	Assumption	N.a.
	% of potential costs savings for PASA managed contracts	3-5%	Assumption - 10% savings already captured	N.a.
	% potential costs savings for non PASA managed contracts	7-12%	Assumption	N.a.
	Primary care - OPEX			
	GMS, PMS, AMPS and PCTMS contract costs	£ 7.2bn	National Audit Office Summarized Accounts – Care purchased by PCTs	2007/08
	% of supplies costs as % of total GPs contract costs	10%	Assumptions – based on typical GP practice	N.a.
	CAPEX			
	Capital investment	£4.9bn	DH – Departmental report 2008	2008/09
	Central budgets – non pay[2]	£3.4bn	DH – Departmental report 2008, assumptions	2008/09
	% of potential costs savings on CAPEX procurement	10-15%	Assumption based on previous experiences	N.a.
1e Estates optimisation	Estates costs – PCTs	£0.5bn	NHS Information Centre – Estates Returns Information Collection 2007/08	2007/08
	Estates costs – Trusts	£0.6bn		
	Estates costs – Mental health and community services[3]	£2.3bn		
	Space utilisation – PCT sq.m./WTE	17.1	National Audit Office – Improving the efficiency of central government's office property	2007
	Space utilisation – Providers sq.m./bed	61.4	NHS Information Centre – Estates Returns Information Collection 2007/08 – top quartile	2007/08
	Total risk-adjusted backlog	Var.	NHS Information Centre – Estates Returns Information Collection 2007/08	2007/08

1 Includes supplies and services (general and clinical), consultancy services, auditors fees and other
2 Includes training, R&D, ALB, Contingency, Ophthalmology, DH admi., Welfare Foods and others. Excludes NHS Litigations, CfH, EEA Medical Costs, Pharmacy, Vaccines and Pandemic Flu

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1 Sources – Drive-through cost efficiencies in all providers' services (4/4)

	Metric used in calculations	Data used	Source	Year
1f Restructuring PFI	▪ Average 2009-2013 annual unitary payments for PFIs	▪ £1.2bn	▪ Treasury – Signed PFI schemes	▪ Nov'08
	▪ Potential reduction in interest rates	▪ 2-3 b.p.	▪ Assumption – based on interest rates trend	▪ N.a.
	▪ % of PFI schemes renegotiated	▪ 80%	▪ Assumption	▪ N.a.

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1 Includes supplies and services (general and clinical), consultancy services, auditors fees and other
2 Includes training, R&D, ALB, Contingency, Ophthalmology, DH admi., Welfare Foods and others. Excludes NHS Litigations, CfH, EEA Medical Costs, Pharmacy, Vaccines and Pandemic Flu

2 Methodology and assumptions – Optimise spend and ensure compliance with commissioners' standards

ESTIMATE

	Methodology/assumption	Potential size of opportunity, £b	Implied productivity/ savings, %
2a Stop/reduce procedures with no/limited clinical benefit	▪ **EL procedures** – Use London Healthcare Observatory (LHO) and the Chief Medical Officer report 2007 to identify the HRGs&OPCS with no/limited clinical benefit – Apply the LHO percentages of potential minimum and maximum reduction for those HRGs/OPCS to England overall activity and costs, assuming that only 80% of the maximum potential could be achieved	0.3–0.7	3–7
	▪ **New OP attendances** – PCT estimated savings of 14–22% of new OP attendances through reducing the variability in GP referrals for new OP (SAR[1]) – assumed underperformers GPs achieve the median or 80% of the potential improvement of stepping down to bottom quartile – Apply the 14–22% identified opportunity to England total spend in new OP attendances	0.2–0.4	14–22
	▪ **OP follow-up attendances** – Underperforming acute hospitals achieve the median FU/new OP ratio or 80% of the potential improvement of stepping down to the bottom quartile ratio	0.2–0.3	9–13
	▪ **Diagnostics** – 10–16% potential reduction in direct access diagnostics (DAD) – £~10m spend in DAD per PCT (???)	0.1–0.2	10–16
2b Target most costs effective interventions	▪ 10–12% of PCTs commissioning spend can be optimised by reallocating to interventions that are 3 times more cost-effective ▪ PCT spend impacted £c38m. – includes spend in GPs, community services, acute care (except NEL and A&E) and mental health care	2.8–3.3	7–9
2c Conduct utilisation reviews	▪ 2–3% potential savings on current PCT commissioning spend (c70b) based on experience in Germany and US where savings of 3–5% have been achieved at the end of a 2-year programme	1.5–2.0	2–3

1 Adjusted standardized activity ratio

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2 Sources – Optimise spend and ensure compliance with commissioners' standards

	Metric used in calculations	Data used	Source	Year
2a Stop/reduce procedures with no/limited clinical benefit	**EL procedures**			
	▪ Activity for each of the 34 HRG and OPCS identified by LHO	▪ 1.1m spells	▪ HES online	▪ 2006/07
	▪ Commissioning costs for each of the 34 HRG and OPCS identified by LHO	▪ £2.1bn.	▪ HES online	▪ 2006/07
	▪ % of potential minimum and maximum reduction through decommissioning of limited/no clinical benefit activity	▪ Varies by HRG and OPCS	▪ LHO – Save to invest: Developing criteria-based commissioning for planned healthcare in London	▪ 2007
	New OP attendances			
	▪ Total commissioning spend in new OP attendances	▪ £1.7bn	▪ HES online ▪ DH payment by results tariff ▪ Tariff uplift – DH	▪ 2006/07 ▪ 2006/07 ▪ 2007/08
	Follow- up OP attendances			
	▪ Total follow-up OP attendances by specialty and by acute trust	▪ 29m attendances	▪ HES online	▪ 2006/07
	▪ Total new OP attendances by specially and by acute trust	▪ 13m attendances	▪ HES online	▪ 2006/07
	▪ Follow-up OP average price	▪ £79/attendance	▪ National schedule of reference costs ▪ Tariff uplift	▪ 2006/07 ▪ 2007/08
	Diagnostics			
	▪ Diagnostics per weighted population	▪ Varies by diagnostic test	▪ Department of Health Diagnostic Waiting List Returns; DH Exposition book	▪ 07/08
2b Target most cost-effective interventions	▪ Total commissioning spend for which allocation could be optimised[1]	▪ £38bn.	▪ National Audit Office NHS Summarised Accounts	▪ 2007/08
	▪ % of PCT spend that can be optimised	▪ 10–12%	▪ Assumption	▪ n/a
	▪ Difference between procedures most cost effective and less cost effective	▪ 3 times	▪ Assumption based on CHD pathway analysis	▪ 2008
2c Conduct utilisation reviews	▪ Total PCT commissioning spend, excluding prescribing costs	▪ £63b	▪ National Audit Office NHS Summarised Accounts	▪ 2007/08
	▪ % potential reduction in spend	▪ 2–3%	▪ Assumption based on U.S. and Germany experiences (3–5%)	▪ n/a

1 Includes spend on GPs, community services, acute care (except NEL and A&E) and mental health

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2 Methodology and assumptions – Optimise spend and ensure compliance with commissioners' standards

ESTIMATE

	Methodology/assumption	Potential size of opportunity £bn	Implied productivity/ savings, %
3a Enhance self care and management of people with LTCs and complex needs	▪ Calculate current direct costs to the NHS of CVD, diabetes, cancer, asthma and COPD ▪ Assume current costs of LTCs are reduced by the achievement of the productivity improvement opportunities identified in 1 and 2 ▪ Use U.S. and German experience in savings achieved in LTCs using more self care and disease management programmes (20%) as a reference of potential in England	1.9 – 2..5	10 – 13%
3b Shift care to lower care settings	▪ **Unscheduled care** – Calculate current spend in A&E and Non Elective assuming that productivity improvement identified in 1 and 2 have been achieved – ***A&E attendances*** – clinical evidence on % of minor, standard and major attendances that can be provided in alternative settings indicates potential savings of 20 – 40%. – ***Avoided NEL*** admission avoided based on clinical evidence and experience of some PCTs reconfiguring unscheduled care – ***Cost of reprovision***: – costs of reprovision typically equivalent to 35% of the potential savings based on bottom-up costing of the required alternative services e.g. UCC, CAU – Only 80% of the maximum potential is achieved	0.3 – 0.5 0.7 – 1.2 (0.4 – 0.6)	20 – 32% 5 – 8% n/a
	▪ **OP, day care and diagnostics to polyclinics/ GP surgeries** – Calculate current spend assuming that productivity improvements identified in 1 and 2 have been achieved – Clinical evidence on % of potential OP, day cases and simple diagnostics that can be shifted to primary/community/home care settings – Use-bottom-up costing of providing the care in primary/community/home setting of a specific business case – conservative modelling – Assume 80% of the maximum potential is achieved	0.2 – 0.6	2 – 7%

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4 Methodology and assumptions – Prevent people from becoming ill through increased prevention

	Assumptions	Source
Smoking	• Based on 11m current smokers with an average cost to the NHS of £150 per smoker per year and a one-time off cost per quitter of £173 • Assumes 30% reduction in number of smokers and reduction of health burden by 50% per quitter • Benefit will accrue over many years but the calculation of net benefit cost of intervention is assumed to be spread over 5 years.	▪ www.ic.nhs.uk
Obesity	▪ Based on 2015 additional costs of obesity in case of no additional intervention is taken ▪ Assumes DH undertakes announced pledge to return to 2000 levels of obesity by 2020 with an initial an investment of c.£370m over 3 years.	▪ 2007 Foresight Tackling Obesities: Future Choices Report
Alcohol	▪ Currently the total cost to NHS of alcohol misuse is £2.7bn ▪ £1 invested in tackling alcohol misuse saves £1.30-£1.70 in health service cost ▪ Assumes £0.5bn investment in tackling alcohol misuse of	▪ DH website ▪ U.K. alcohol treatment Trial (BMJ)
Flu vaccination	▪ Increasing vaccination rates within at-risk groups in the UK from current level of 45-75% (DH website) assumed to be close to cost neutral	▪ Mullolly et al study (Kaiser Permanente Center for Health Research) which showed that for the elderly population overall the net saving per person were $1.10
Breastfeeding	▪ Impact extrapolated from the US to UK assuming – Both countries have similar starting positions – Proportional to population sizes ▪ Assumes cost of implementation campaign to be 20%	▪ US Dept of Agriculture Food Assistance and Nutrition Report no 13 founds that $3.6bn could be saved by increasing US breastfeeding

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Assumptions used to estimate the percentage of savings by national/central levers

	Tariff/ centrally set
1) Reduce brand drugs price (PPRS scheme)	100,0%
2) Reduce variability of prescribing practices	0%
3) Increase penetration of generics	50,0%
4) Increase clawback to pharmacy	100,0%
5) Optimisation of supply chain of hospital drugs	100,0%
6) Reduce wholesalers payments	100,0%
7) NHS outsource drug spenditure (alas DHL contract)	100,0%
Total costs savings from drugs	**60,5%**

Part compliance part central policies, e.g., allowing pharmacist to substitute

Assumes centrally providers force to use PASA vs. today optional policy

1) Drug spend	60,5%	
2) Acute providers productivity	60,0%	% of acute trust income based on tariff
3) Community services productivity	0,0%	
4) Mental health productivity	0,0%	
7) Supply chain optimisation	100,0%	Assumes centrally providers force to use PASA vs. today optional policy
8) Estates costs	22%	
9) Restructuring PFI costs	0,0%	
11) IT spend optimisation	0,0%	
12) Improve primary care productivity	100,0%	Assumes productivity can be driven by GP contracts
Total	**56%**	

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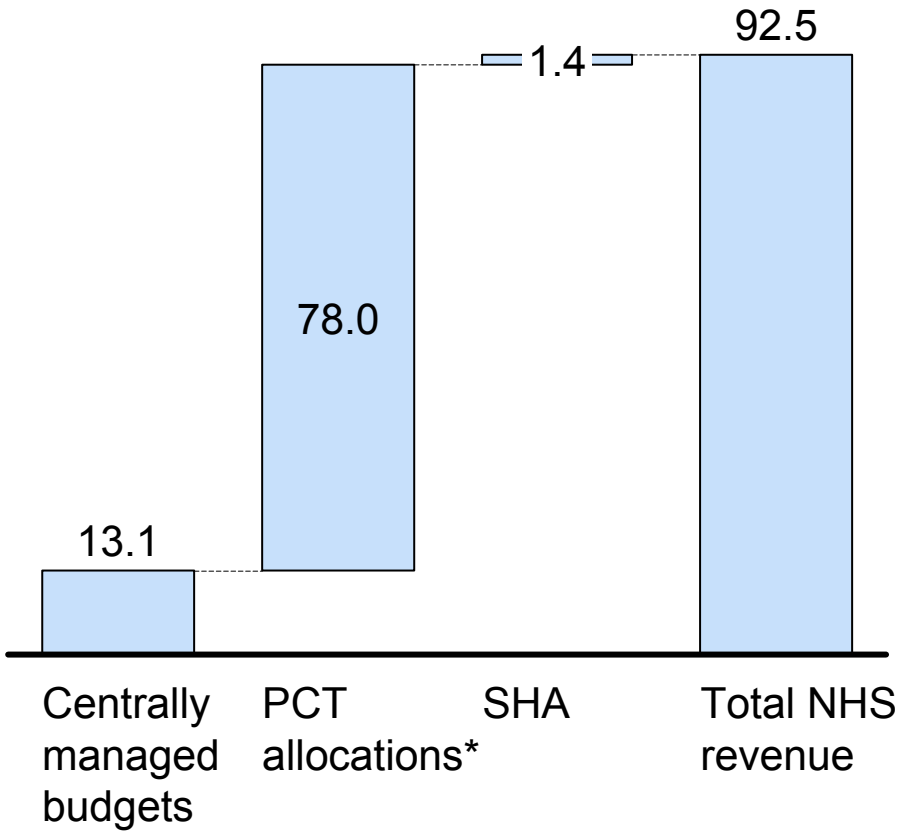
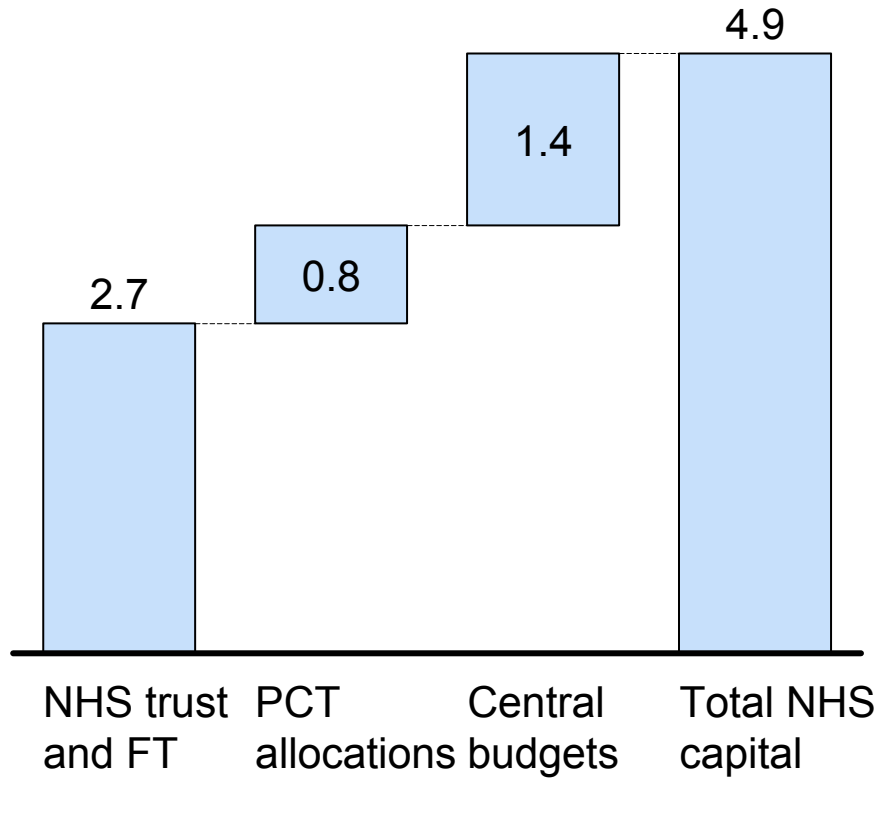
NHS resources 2008–09

£bn

NHS revenue settlement



Total NHS capital



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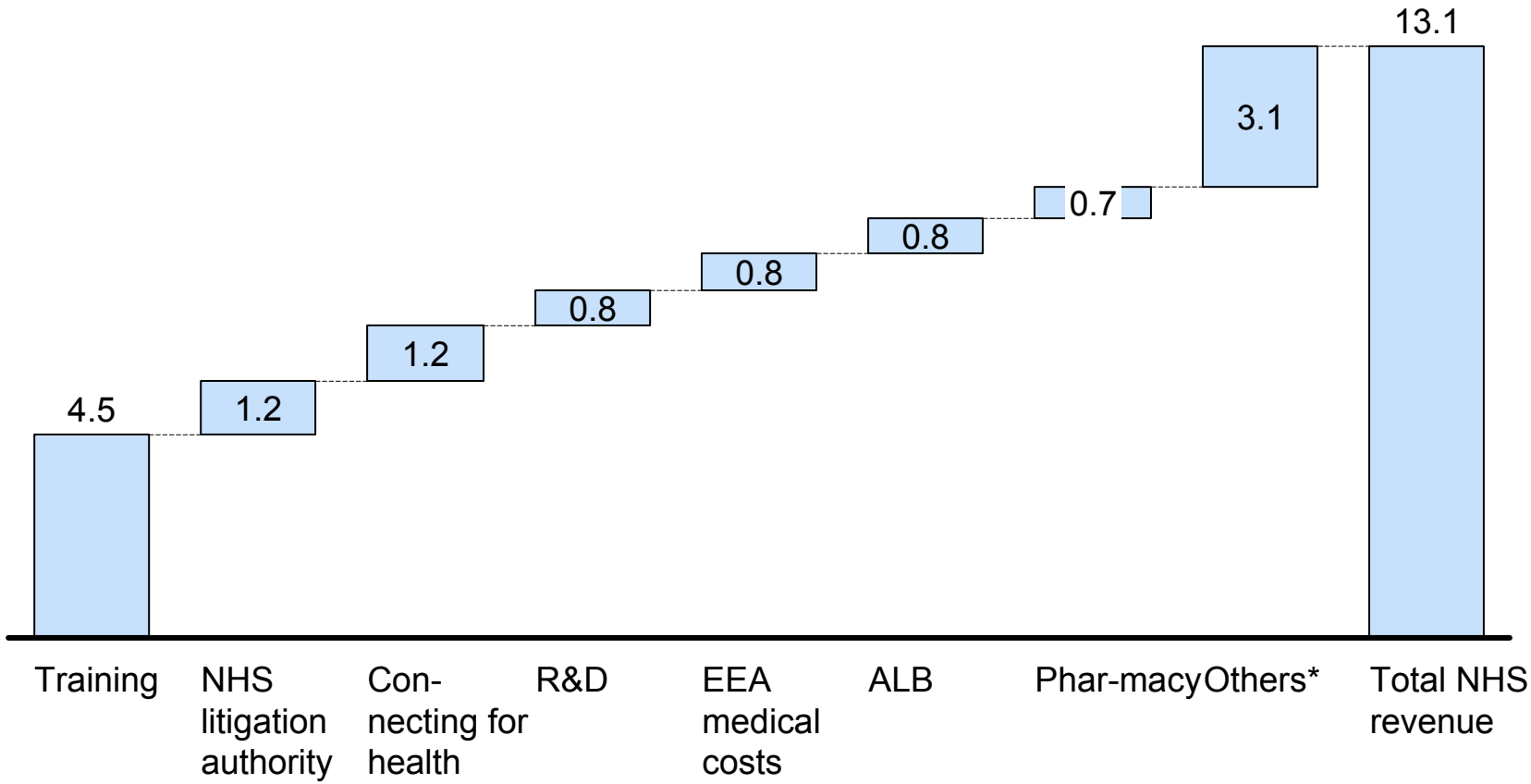
* Includes initial loans limits (£74.2b), direct allocations (£1.7b) and density (£2.1b)

Source: Department of Health – Departmental report 2008

Breakdown of the centrally managed budgets – Revenues 2008/09

£bn



* Includes contingency (£0.4b), ophthalmology (£0.4b), substance misuse (£0.4b), Vaccines (£0.3b), DH administration (£0.3b), welfare foods (£0.2b), pandemic flu (£0.1b) and others (£1.1b)

Source: Department of Health – Departmental report 2008

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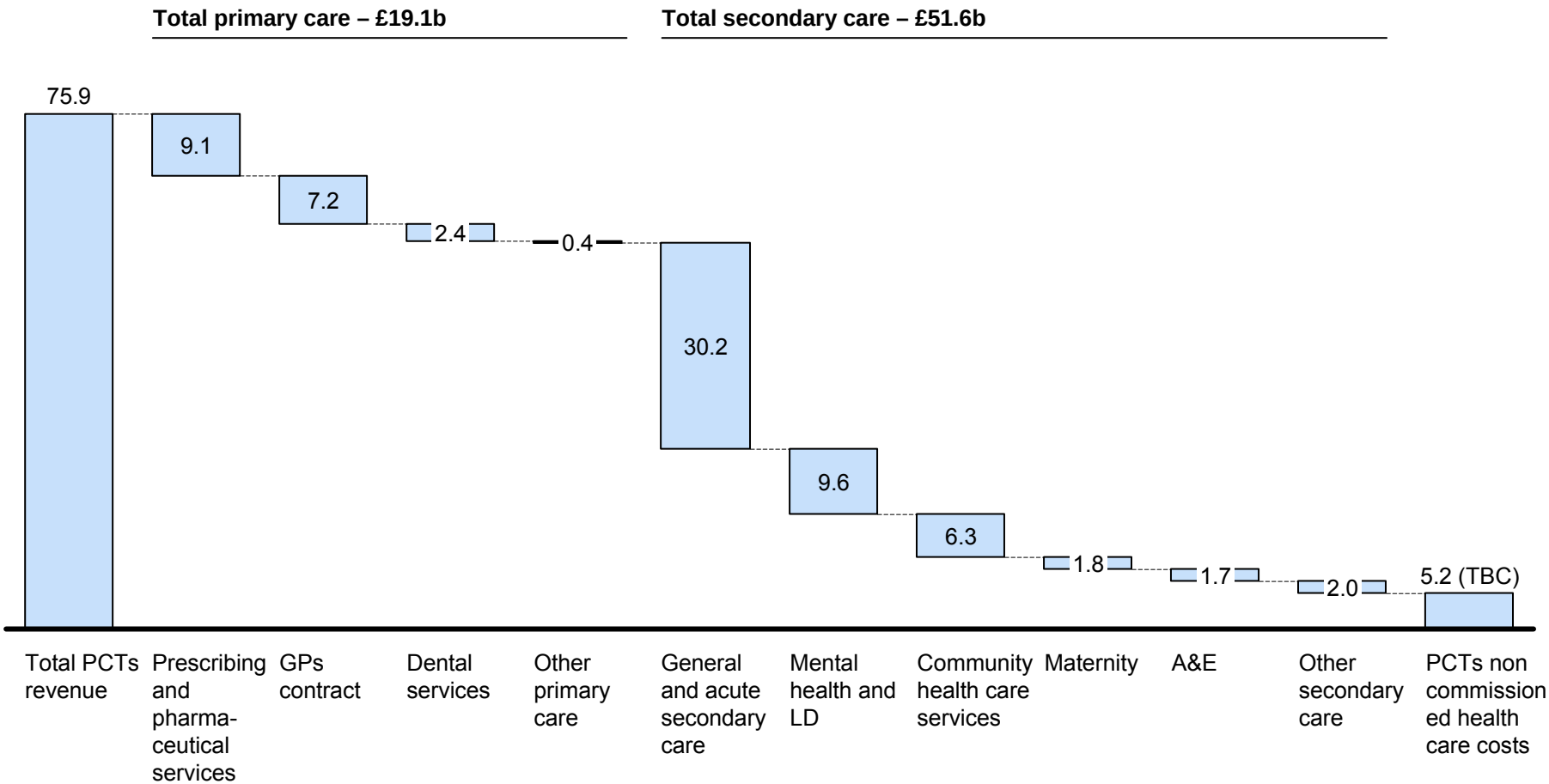
Breakdown of PCTs revenues allocations 2007/08

£bn



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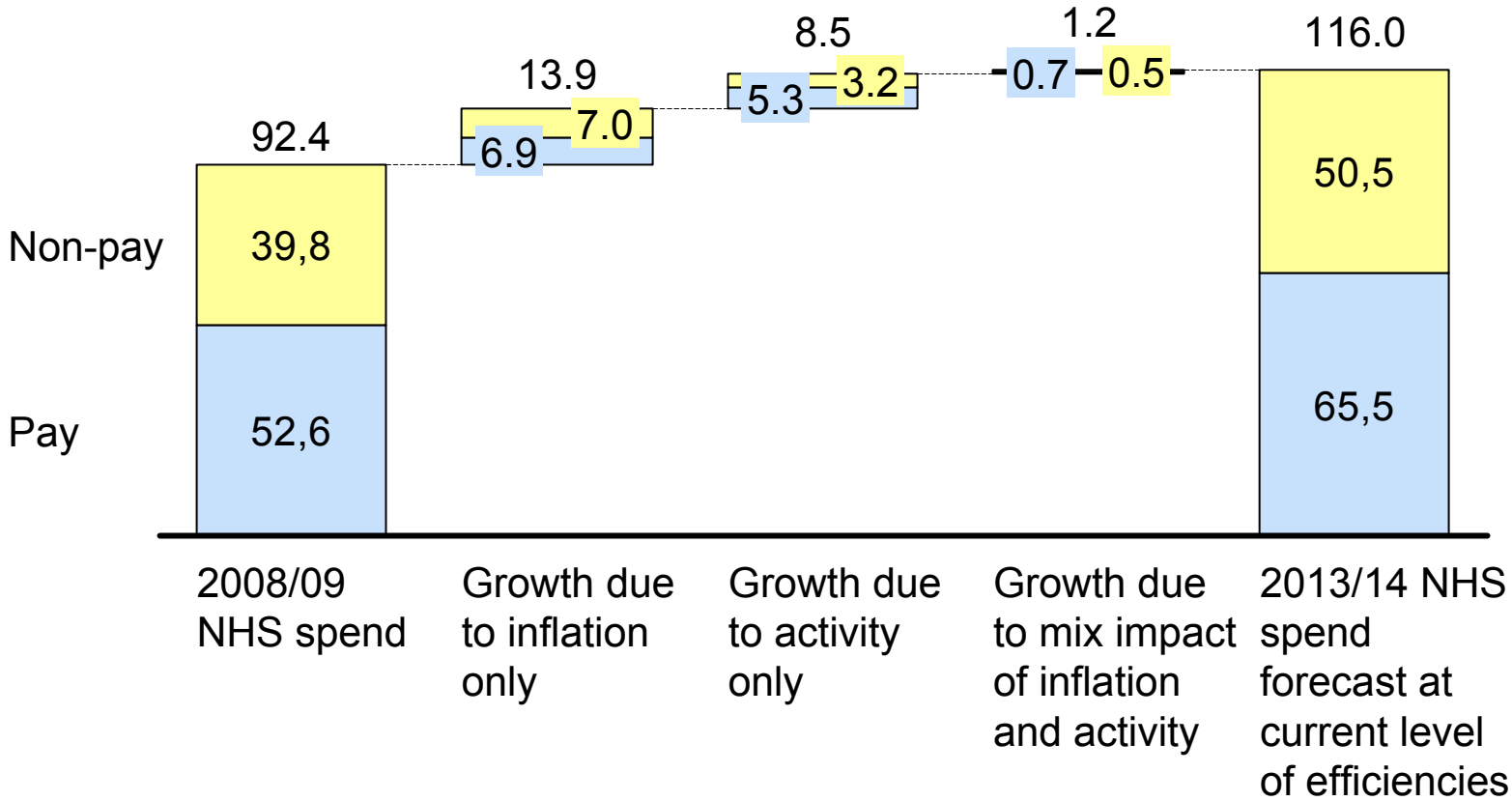
Source: National audit office, NHS summarized account 2007/08

Breakdown of the forecast increase in NHS spend

ESTIMATE

£bn



CAGR 2009/10–2013/14 %	Growth due to inflation only	Growth due to activity only	Growth due to mix impact of inflation and activity	2013/14 NHS spend forecast at current level of efficiencies
Pay	2.5%	2.0%	–	9.5%
Non-Pay	3.3%	1.5%	–	4.8%
Total	2.8%	1.8%	–	4.6%

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Key assumptions on activity, inflation and mix of pay and non-pay to develop NHS spend forecast

Commissioning spend, PCTs budget

	Current spend 2007/08, £b	% pay vs. total costs	2008/09–(2013–14) forecast % Inflation rate p.a.	2008/09–(2013–14) forecast % activity growth p.a.
▪ Acute services	33.7	65	2.5	1.9
▪ GMS, PMS, APMS, and PCTMS	7.1	65	2.5	3.0
▪ Prescribing costs	7.6	0	5.5	0.5
▪ Mental illness	7.2	65	2.5	2.1
▪ Community services	6.3	65	2.5	3.0
▪ Contractor led GDS and PDS	2.3	65	2.5	3.0
▪ Learning disabilities	2.4	60	2.5	2.1
▪ Pharmaceutical services	1.2	0	5.5	0.5
▪ A&E	1.7	65	2.5	1.9
▪ General Ophthalmology services	0.4	65	2.5	0.5
▪ New pharmacy contract	0.3	65	2.5	0.5
▪ Other	11.0	65	2.5	1.9
Total	**79.4**	**58**	**2.9**	**2.0**

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SOURCE: National Audit Office of Annual Accounts; HES historical data 2003–07; McKinsey analysis

Key assumptions on activity, inflation and mix of pay and non-pay to develop NHS spend forecast (CONTINUED)

Central budgets

	Current spend £b	% pay vs. total costs	2008/09–(2013–14) forecast % Inflation rate p.a.	2008/09–(2013–14) forecast % activity growth p.a.
Training	4.5	65	2.5	0.5
NHS litigations	1.2	25	2.5	0.5
CfH	1.2	50	2.5	0.5
R&D	0.8	65	2.5	0.5
EEA medical costs	0.8	65	2.5	0.5
ALB	0.8	80	2.5	0.5
Pharmacy	0.7	0	5.5	0.5
Contingency	0.4	0	2.5	0.5
Ophthalmology	0.4	65	2.5	0.5
Substances misuse	0.4	50	2.5	0.5
Vaccines	0.3	0	2.5	0.5
DH Administration	0.3	75	2.5	0
Welfare foods	0.2	0	2.5	0.5
Pandemic flu	0.1	0	5.5	0.5
Others	1.0	65	2.5	0.5
Total	**13.1**	**52**	**2.8**	**0.5**

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