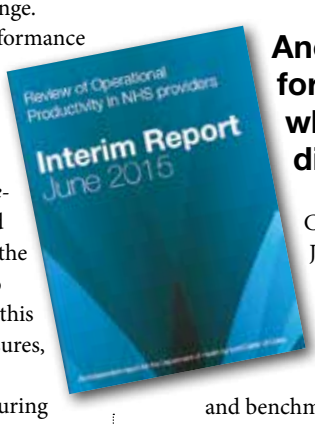
A better way forward

Another efficiency review identifies opportunities for NHS hospitals to enhance operations. But what does this review have that earlier initiatives didn't? Steve Brown takes a look

Back in December 2008, at the HFMA annual conference, the then Department of Health director general of finance David Flory called on the gathered finance directors to 'deliver efficiency and productivity like never before'. At the time, the NHS was coming to the end of significant levels of annual real-terms growth and preparing for more austere times. But the phrase might have been better saved to describe the current efficiency challenge.

The NHS's long-run efficiency performance is about 0.8% a year. This has risen to 1.5% to 2% in recent years, largely due to one-off pay restraint. But to deliver the £22bn funding gap by 2020/21, identified as part of the *Five-year forward view*, the NHS will need to repeatedly achieve 2% savings for the rest of decade – maybe even rising to 3% by the end of the period. And all this while facing some onerous cost pressures, particularly around staffing.



Finance directors do not need lecturing about efficiency. Improving efficiency is simply part of the day job, as hospitals cope with up to 4% efficiency requirements built into tariff adjustments over recent years. So reports that compare spending in several organisations, identify differences and then conjure up potential savings if the whole service delivered to the level of the best practice, tend to be regarded with suspicion. These 'savings' are often much easier to realise in theory.

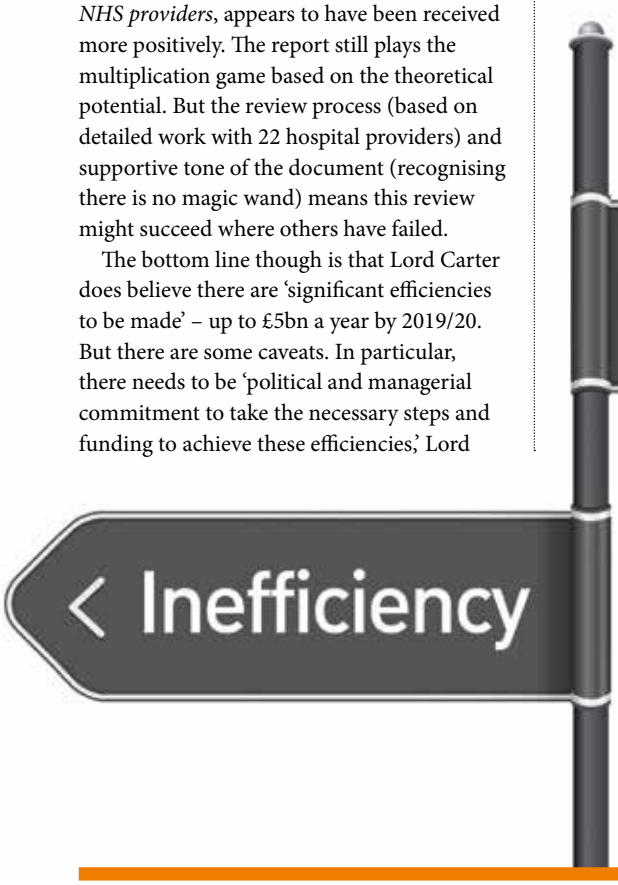
But the latest, Lord Carter's interim report as part of his *Review of operational productivity in NHS providers*, appears to have been received more positively. The report still plays the multiplication game based on the theoretical potential. But the review process (based on detailed work with 22 hospital providers) and supportive tone of the document (recognising there is no magic wand) means this review might succeed where others have failed.

The bottom line though is that Lord Carter does believe there are 'significant efficiencies to be made' – up to £5bn a year by 2019/20. But there are some caveats. In particular, there needs to be 'political and managerial commitment to take the necessary steps and funding to achieve these efficiencies,' Lord Carter told health secretary Jeremy Hunt in the report's foreword. The savings would come from four areas, informed by data analysis, new metrics and benchmarking:

- Workforce (£2bn)
- Hospital pharmacy and medicines optimisation (£1bn)
- Estates management (£1bn)
- Procurement (£1bn).

On **workforce**, the report says the size of the NHS pay bill – £45bn in 2013/14 – 'necessitates scrutiny'. It says that improved workflow and a 'stronger grip' on non-productive time, better management of rosters and improved guidance on appropriate staffing levels would help deliver these savings.

For example, tight management of annual leave, sickness and training can account for differences of up to 4% in productive time, with a 1% improvement equating to a potential £400m in savings. Again, collecting and comparing data from its 22 hospitals, the review found that non-productive time for nurses can vary from 22% to 26% and that there was considerable variation in how hospitals manage specialling (one-to-one care).



The £6.5bn spent in 2012/13 on **hospital medicines** accounted for more than a third of all NHS medicines expenditure, it says – up 11% on the previous year, driven by advancing technology and an ageing population.

Again, it emphasises that 'no single initiative will deliver major efficiency savings in the pharmacy and medicines area'. Instead, system-wide changes involving a series of decisions and smaller initiatives need to combine to make up the overall savings.

Key savings

The report gives an example of the type of small changes that need to be investigated. One trust had replaced soluble Prednisolone at more than £1.50 per tablet with the insoluble version at just £0.02 per tablet in appropriate cases, saving as much as £40,000 a year.

On **estates**, the report says the 1,200 hospitals and 3,000 other treatment facilities run by the NHS cost more than £7bn a year to run, including labour costs of more than 88,000 staff. With £1bn spent across the cohort of 22 hospitals, moving to the average efficiency level would save 14.5% of these costs.

Finally, it focuses on the estimated £9bn of **procurement** spending:

- £2bn on everyday consumables (dressings, syringes)
- £3bn on medical devices (hip joints, cardio devices)
- £4bn on common goods and services (transport, stationery).

However, the review describes the data on volumes and prices paid for products and services as 'patchy', having been able to match only 18% of accounts payable and purchase order data from its hospitals.

Accelerating the development of a single NHS electronic catalogue is seen as the 'quickest way to solve the problem of poor procurement data on prices and volumes'. And interestingly the report claims there 'are greater savings to be had by managing the demand for products through better inventory management rather than price reductions'.

In terms of everyday consumables, the

report highlights the 500,000 product lines used across the NHS with some price differences over 35%. It compares this with global best practice for everyday consumables of 6,000-9,000 product lines and a price variance of 1%-2%.

According to the report, agreeing a radically reduced range of products to be channelled through NHS Supply Chain – work already under way with nursing staff – could deliver 10%-20% savings on the consumables bill.

Savings could also be made within medical devices, both in terms of the prices paid for different orthopaedic implants, for example, and through more evidence-based selection of the most appropriate method – such as using cemented prostheses rather than uncemented implants for patients aged over 65.

Sales reps come in for specific criticism, with the review claiming that in one hospital a staggering 650 sales reps were targeting the hospital – with 65 on site at any one time. 'The proliferation of sales representatives selling in the NHS is a huge cost which neither the NHS nor its suppliers want or need if alternative models of doing business could be developed,' says the report.

Supporting all this work and encouraging boards to take a greater interest in how they are performing on efficiency is a new productivity measure – the adjusted treatment index (ATI). The index – recommended for introduction across the whole provider sector – compares a hospital's actual costs (taken from its accounts) with its cost-weighted output.

Recommendations

- Adopt adjusted treatment index (ATI) across provider sector
- Develop model NHS hospital to identify best practice across all areas of productivity
- Workforce: establish standards and best practice policies on productive time, rostering, specialling and skill range
- Pharmacy: design model approach to delivery of pharmacy servcies
- Estates: develop support to help providers target at least averaage of peers and create capital programme
- Procurement: develop product specification and single national catalogue
- Create national productivity collaboratives

The cost-weighted output is constructed using activity of different treatment types at national average costs (taken from reference costs). Similarly, metrics can be constructed at lower levels such as workforce costs and clinical supplies.

Whether NHS trust boards react to the ATI as intended – by paying 'greater and more detailed focus to their costs' – remains to be seen. But they will be pleased with the 'personal' recommendation from Lord Carter that the new indicator does not form the basis of a 'regulatory approach'.

HFMA director of policy Paul Briddock highlighted Lord Carter's recognition that the efficiency savings would come from a 'relentless focus on a multitude of efficiency opportunities'. But he added that the overall efficiency challenge of addressing the estimated £30bn gap would mean work on other fronts.

'Even if we can save the potential £5bn identified by Carter, that is a drop in the ocean compared to the overall savings organisations will be required to make,' he said. 'The report mustn't mask the fact that transforming service provision, taking a targeted look at what the NHS can and can't afford to provide and employing radically different service models must remain the key focus for the NHS.'