

Delivering the Healthcare for London Strategy Affordability

Back up materials - June 2009

Updated November 2009



Disclaimer

The productivity improvement and cost reduction cases described in this document are examples for each PCT, Trust or other health body to explore according to their local context and situation

In no case does this documents reflect a set of imposed directions/actions which the SHA is "telling you to take"

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Detailed pan-London assumptions

Detailed polysystem modelling assumptions and unit cost outputs

Implications for acute providers

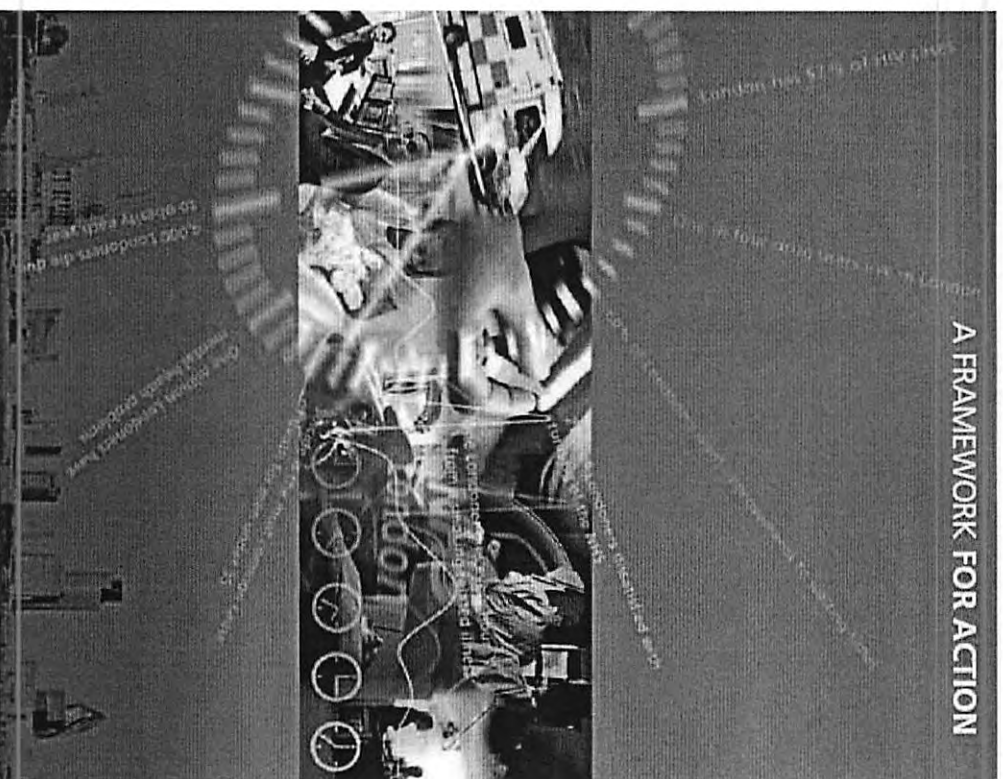
Implications for out-of-hospital settings

Miscellaneous

HfL identified a number of areas where the current healthcare system could be improved

1. Health and healthcare are not as good as they could be in London
2. As a result, the NHS is not meeting Londoners' expectations
3. Across London there are big inequalities in care
4. There are opportunities to explore different delivery models, i.e., the hospital is not always the answer
5. There is a need for concentrating specialised care
6. London should be at the cutting edge of medicine
7. The existing workforce and estate are not being used effectively
8. There is an obligation to make the best use of taxpayers' money

The final report – A Framework for Action – set out a vision for the future of health and healthcare services in London



Core proposals of HfL

- Improved access
- Increased quality of care
- Increased focus on prevention

Proposed changes in clinical care pathways

Birth	<ul style="list-style-type: none"> ① Women should be offered choice of home birth, midwife-led or obs-led care ② Obstetrics units with at least 96 hrs/week consultant cover ③ Every obstetrics unit should have a co-located midwifery unit ④ 1:1 midwife-led care should be provided in labor within existing resources ⑤ Antenatal and some postnatal care should be provided in local dedicated hubs
Staying healthy	<ul style="list-style-type: none"> ⑥ More should be invested in proven health improvement programs ⑦ The NHS should play a greater role in improving the health of its employees ⑧ All health professionals should be incented to improve health at each interaction ⑨ Need for more partnership working to help people stay healthy
LTC	<ul style="list-style-type: none"> ⑩ Integration of community and secondary care services ⑪ Pro-active primary care to reduce emergency admissions ⑫ Develop London-wide best practice Care Pathways for different LTCs ⑬ Routine diagnostics provided in a community setting
Acute	<ul style="list-style-type: none"> ⑭ Improve access through local 24/7 urgent care centers with doctors on-site ⑮ A single point of contact (by telephone) for urgent care ⑯ Centralization and networks for Major trauma, MI, and Stroke ⑰ Dispatch and retrieval protocols for LAS need to be aligned with centralization
Planned care	<ul style="list-style-type: none"> ⑱ More specialized inpatient care should be centralized into major acute hospital ⑲ Shift less complex surgery, diagnostics, and outpatients out of acute hospitals ⑳ Better use of the day case setting for many procedures ㉑ Improve community-based services (e.g., community nursing)
End of life	<ul style="list-style-type: none"> ㉒ Commission end-of-life service providers to co-ordinate end-of-life care ㉓ People have an end-of-life care plan, including preferences on place of death ㉔ All organizations should meet good practice (e.g., gold standards framework) ㉕ Greater investment to support people to die at home

6 delivery models to improve the quality of care in London

1



Home

There is increasingly potential to provide care in people's homes, including specialist care, rehab and support for long term conditions

4



Elective centres

Elective centres focus on specific types of activity and exclude emergency work to be more productive and produce better clinical outcomes

2



Polyclinic/polysystem

Polyclinics provide the infrastructure for a polysystem to shift hospital-based care into a more local setting, and improve existing GP and community care and social services

5



Major acute hospital

Major acute hospitals enable co-location and critical mass of specialist services to maximise clinical quality and efficiency, some being a hub for teaching and R&D

3



Local hospital

Local hospitals provide non-complex inpatient and day case care in the local setting, ensuring patient access and convenience without sacrificing quality of care

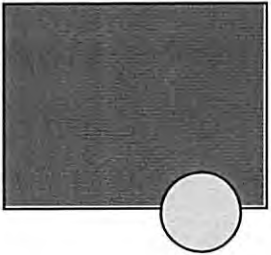

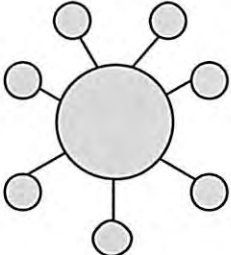


6



Specialist hospital

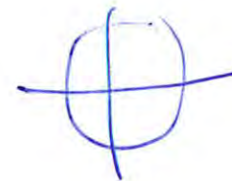
Specialist hospitals retain established infrastructure, expertise and focus to deliver leading-edge complex services in a specific area

Polysystems were seen as core to out of hospital care delivery – different options for location and organisation

2 locations for polysystem	3 options for organisation
 <ul style="list-style-type: none">▪ Collocate with every hospital▪ Front door to ATE  <ul style="list-style-type: none">▪ Free standing location community▪ Additional locations than existing	 <ul style="list-style-type: none">▪ Federated model, providing common services to existing practices  <ul style="list-style-type: none">▪ Co-located model multiple practices collocate to access services  <ul style="list-style-type: none">▪ Merger model, multiple practices combine into 1 large practice

Eight enablers were identified as critical to delivering HfL

1. Commissioners need to be better able to commission high-quality services based on their population's needs, mainly by developing strengthened **commissioning** structures, roles and arrangements, with robust performance management
2. Strong individual and organisational **incentives** need to be developed through both the provider and commissioner angles to ensure delivery of high-quality and efficient care
3. Better **communications** are needed to better engage the public and other key stakeholders
4. Clinical **leadership** needs to be improved, by identifying the best leaders and ensuring they are properly developed, supported and incentivised
5. Better **information and IT** related to service performance and patient care will improve care quality and efficiency
6. The **workforce** needs to adapt to the new delivery model by shifting to the local setting and changing their roles, skills and contractual arrangements, and promoting greater mobility
7. London needs to manage **estates** better, by understanding the skills needed and partnering with appropriate experts, and better accessing capital
8. A diverse range of potential **ownership** models (including those involving non-traditional providers such as the third sector and private sector) to improve risk, innovation, flexibility and productivity needs to be examined



The core proposals of HfL were expected to improve quality of care AND reduce the costs of care

Core proposals of HfL to improve quality

Improved access to urgent care services in the community to reduce use of A&E and admission to hospital

Improved management of long term conditions through better coordination of primary and community care services

Consolidated model for provision of primary and community care over population of ~ 50K to provide more integrated care

Integration of primary and community and secondary care and shifts of care out of hospital closer to home

Centralisation of complex services onto major acute sites

Levers to reduce costs of care

Reduced “double running costs” through single point of access to urgent care (merged MIU/WIC, GP out of hours, GP in hours)

Reduced costs of clinical staff through improved utilisation and role substitution from doctors to nurses/AHPs – underpinned by management of care across larger populations

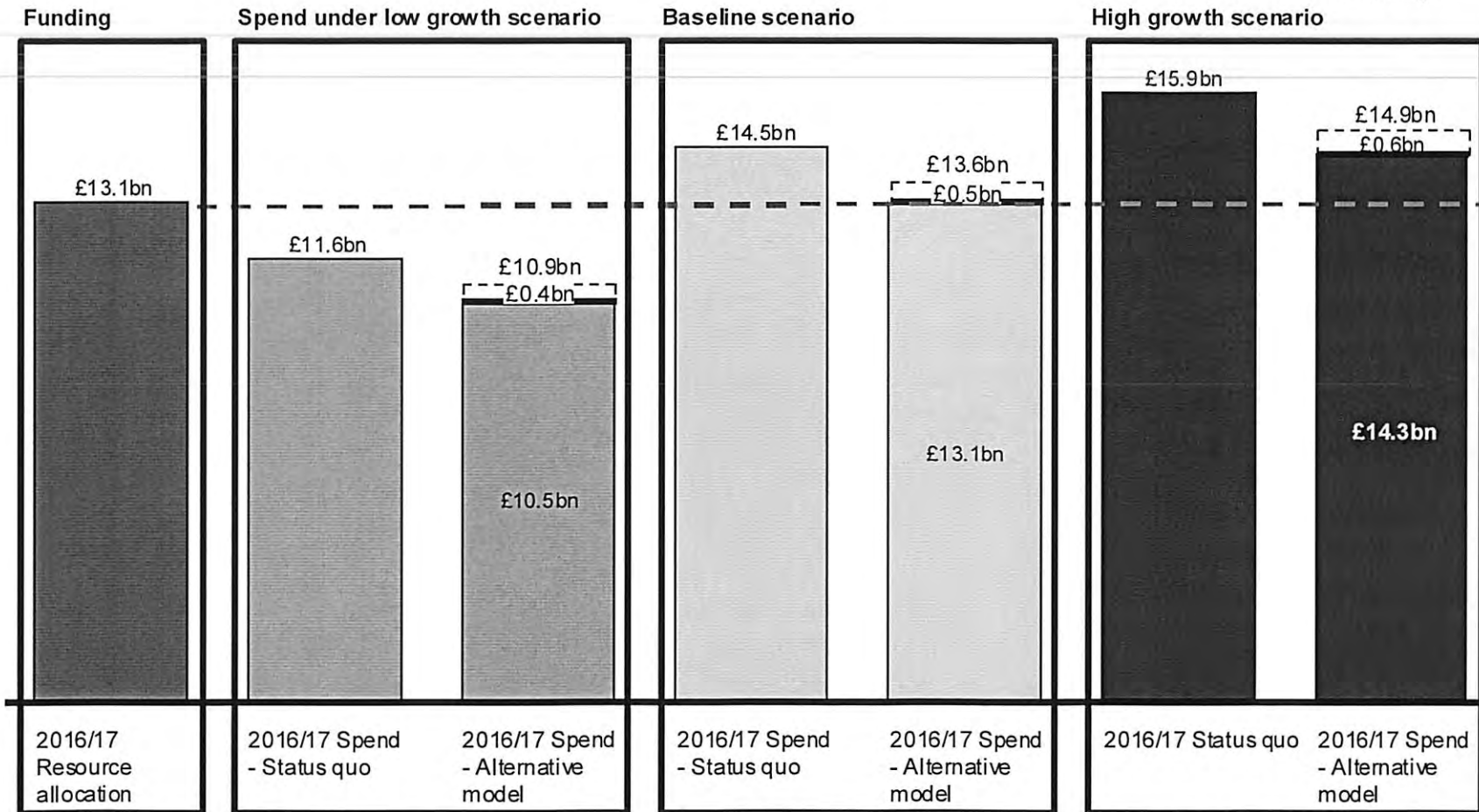
Reduced costs of overheads (receptionists, premises) through improved utilisation
Shift of care out of acute sector into non acute sector where appropriate

De-commissioning of some services

Increased scale, efficiency and quality from centralisation contributes to expected tariff reductions

The economic analysis of HfL concluded that it was more affordable than the status quo...

--- 50% Implementation of shifts in care to new setting



Projected funding
Match of target capitated allocation 2.4% real growth from 2005/06 to 2016/17

Low growth scenario
Growth in line with Demographics + impact of changing Prevalence rates for selected long-term conditions

Baseline scenario
Historical growth rates over and above demographics except for A&E

High growth scenario
Growth rates higher than historical due to improved access and pace of technological development

* All figures in real terms, 2005/06
Source: Outcomes of PCT allocation projections & activity and spend forecasts

...with the projected savings primarily driven by improved care out of hospital supported by implementation of polysystems

Area	Savings, £m	Driver of savings			
		Decomm- issioning	Improved efficiency*	Shift out of acute	Improve m'ent of LTC**
Inpatients	415	✓		✓	✓
Regular attenders	10			✓	
Outpatients	193	✓			
A&E	110	✓		✓	
Community	330		✓		
Primary	415		✓		
Total (£m)	1,473				

* Includes reduced duplication e.g. paying for core primary care, OOH and A&E/MIU services

** Includes panel management of patients with complex health and social care needs

Over the **13** months significant progress has been made on HfL implementation

Successful **consultation**, Consulting the Capital, which validated the Healthcare for London vision



Established central **support team** and high profile and highly successful **Clinical Advisory Group**



Proposals for **designation of major trauma and stroke centres** out to consultation



Detailed plans for the imminent **opening of seven new polyclinics**



Initial projects included **unscheduled care, diabetes, local hospitals**



New projects kicked off on **maternity, mental health, children's and young people, end of life**



Seven polyclinics were opened in April 2009...

Alexandra Avenue, Harrow



Heart of Hounslow,
Hounslow



Gracefield Gardens,
Lambeth



Loxford Centre,
Redbridge



Waltham Forest Centre,
Waltham Forest



Barkentine Centre,
Tower Hamlets

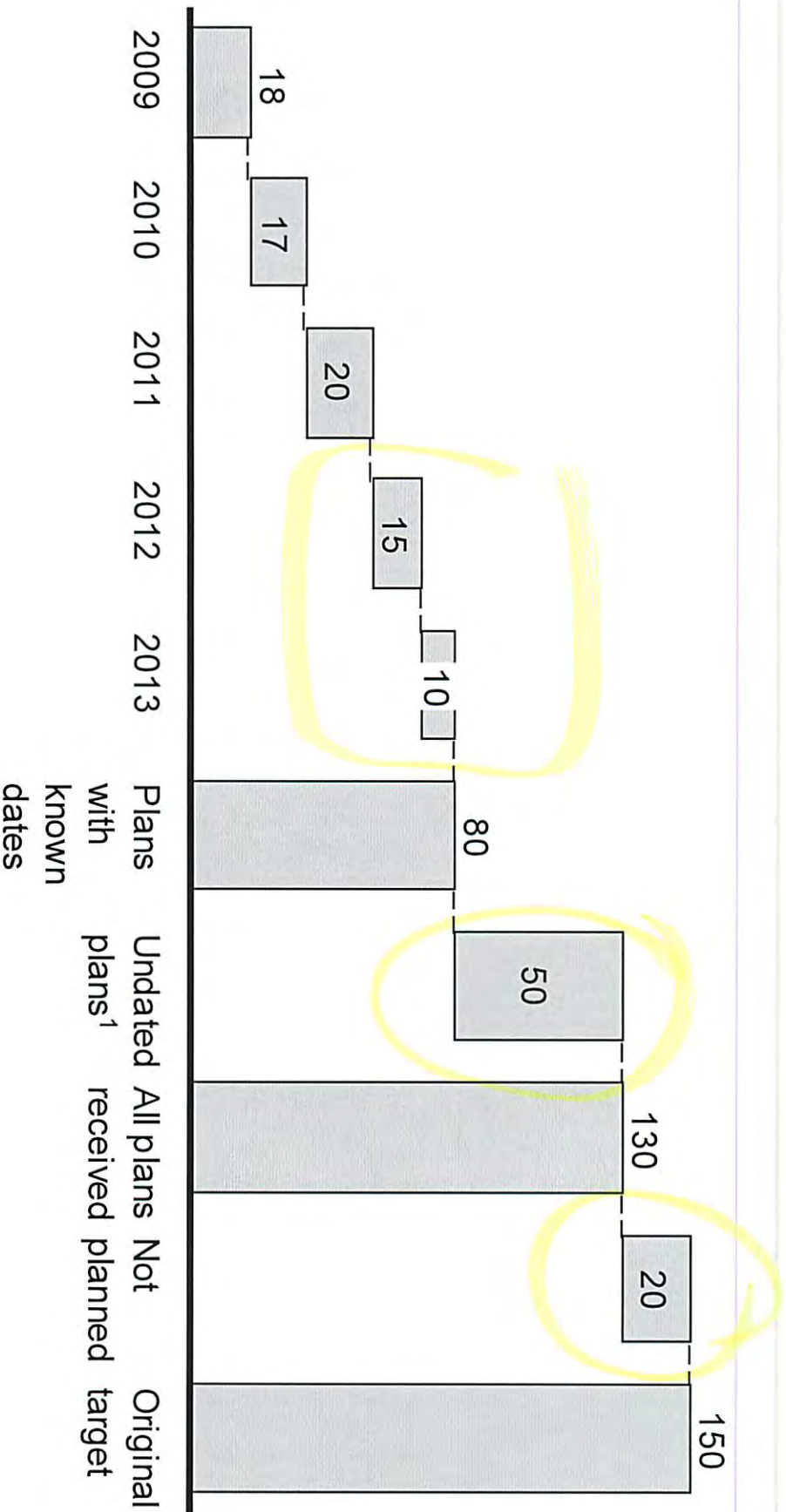


Hammersmith, at
Hammersmith hospital

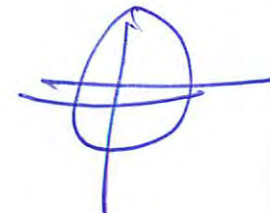


...and PCTs have identified plans to deliver 87% of the polyclinic roll-out target by 2016/17

Completion date for polyclinic plans submitted to NHS London



¹ Some plans have been submitted with date "unknown", and 2 dates are not given in the data provided



However, interviews carried out during the HfL implementation review identified a number of key challenges moving forward

The tipping point towards transformation has not yet been reached

While some polyclinics have opened, the current moderate shifts of care out of acute have not yet transformed out-of-hospital care

Current projects (e.g., stroke, trauma) have not yet been 'cash-releasing' and instead appear to be leading to 'additive' costs rather than reconfigurations

Similarly, although hospital admissions have started to stabilise they have not dropped to the extent expected under HfL implementation

Some other HfL projects – including the original projects on local hospitals, unscheduled care and diabetes – have had more limited traction and 'pull' from the system

There is some mismatch in ambitions – as evidenced by PCTs' CSPs which are incremental rather than radical in their approach

The capabilities to support large scale change are not yet fully in place

With a number of barriers having been identified

There is frustration with the overall pace of change and frustration at large number of small initiatives rather than fewer transformational initiatives

You recognise that elements of the original vision have been diluted and the change has not been as dramatic as outlined in HfL

Significantly, the core principles (and expected savings) of polysystems have proven difficult to achieve with more focus on the buildings rather than the changes to care and behaviours.

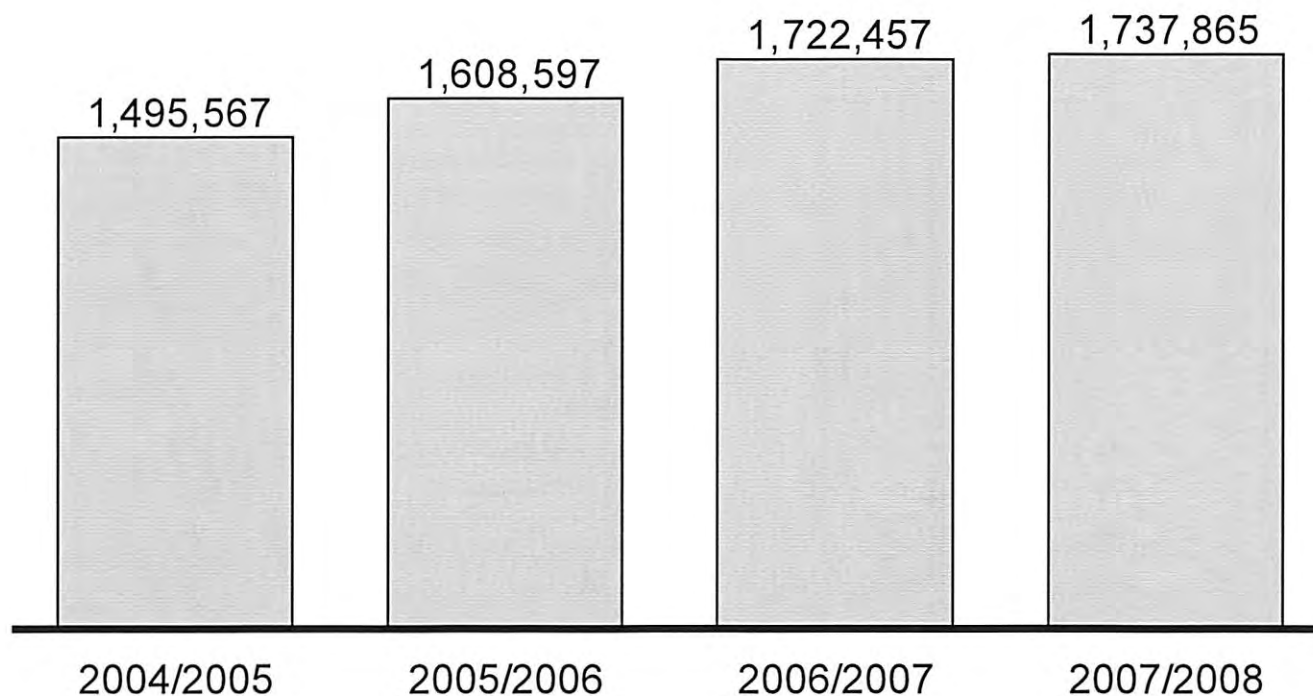
Limited progress has been made on the key enablers, which are widely-perceived as barriers to progress

Frontline lacks key capabilities and capacity for implementation when set against competing priorities and operational challenges

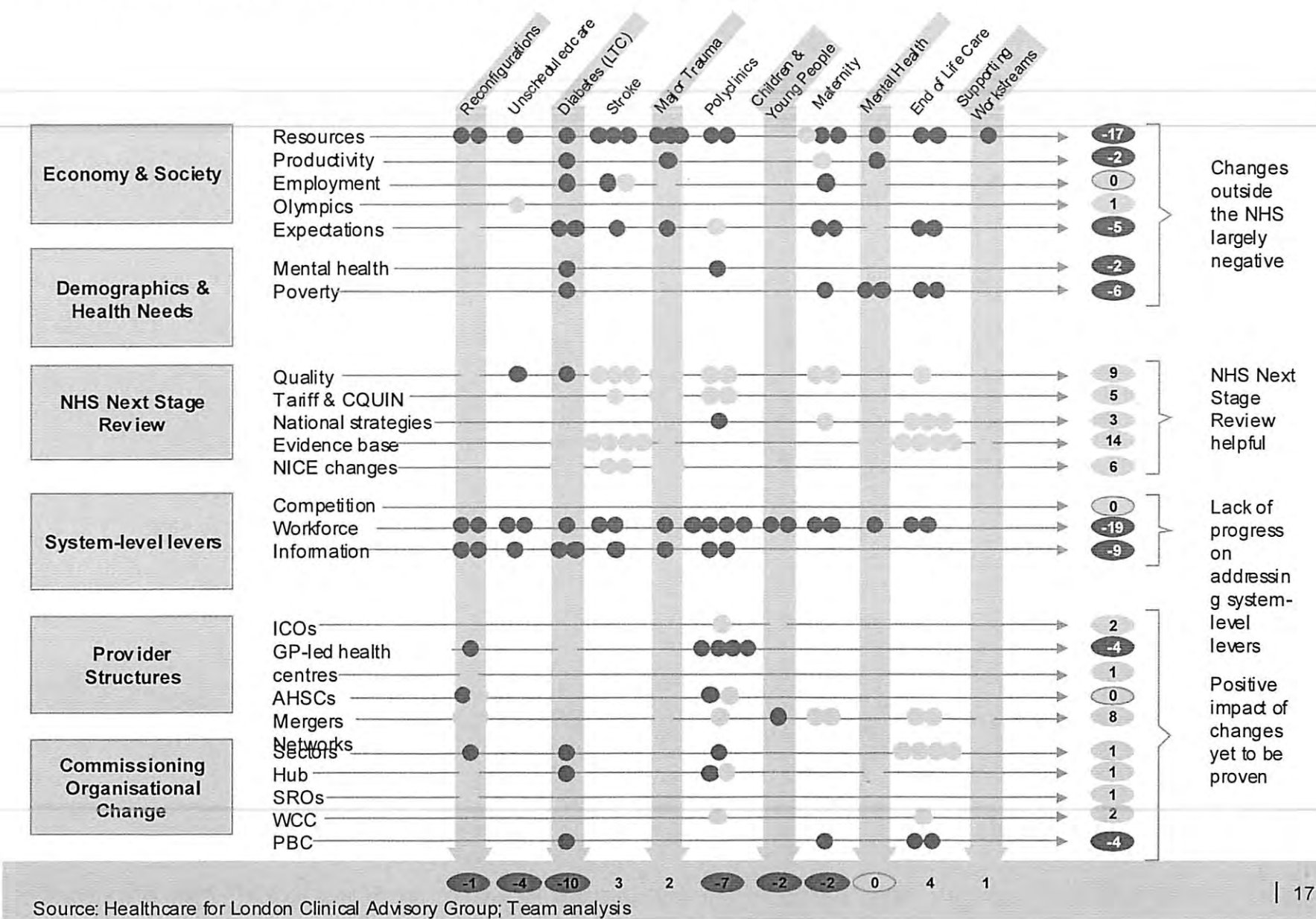


For example, the rate of hospital admissions has not fallen to the extent expected under HfL implementation

Total hospital admissions in London SHA region, 2004/5 to 2007/8



CAG identified the current barriers to progress



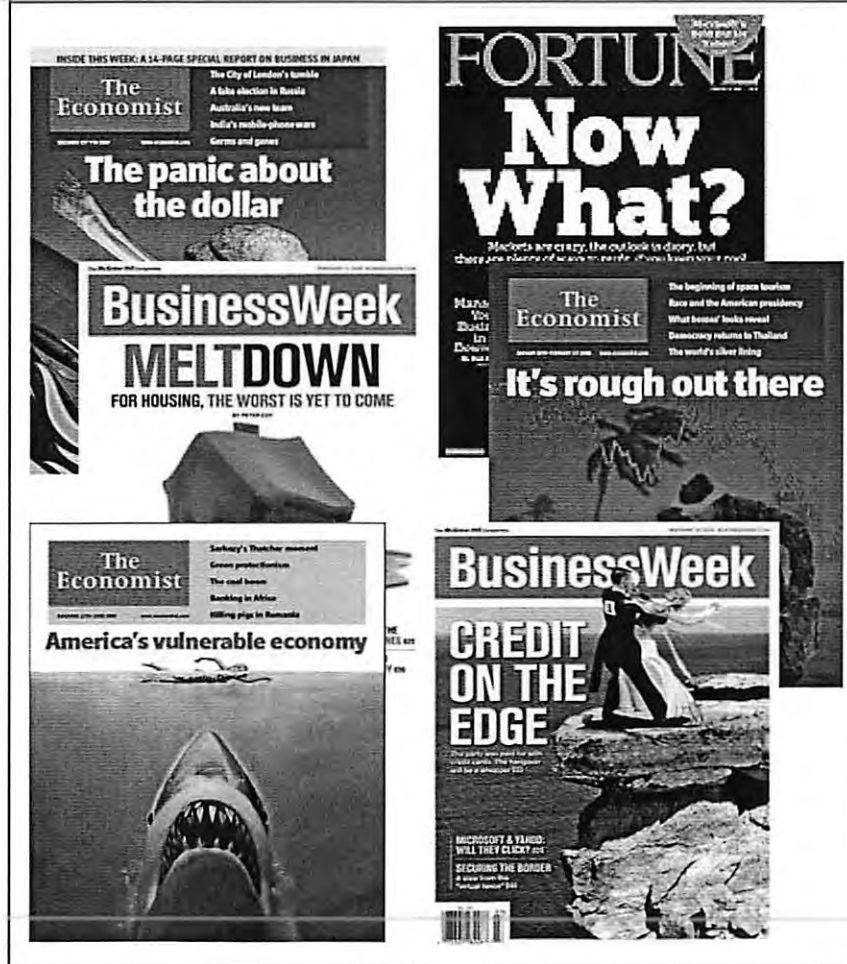
There is a recognition that the context of HfL has changed over the last 18 months

Trends and developments affecting London

- ① Economy** – The current economic situation will put greater pressure on the system, and London needs to respond
- ② NHS Next Stage Review** – Opportunity not to be missed for commissioners, providing new levers for change
- ③ Commissioning changes** – In London as an opportunity to address capability and capacity issues

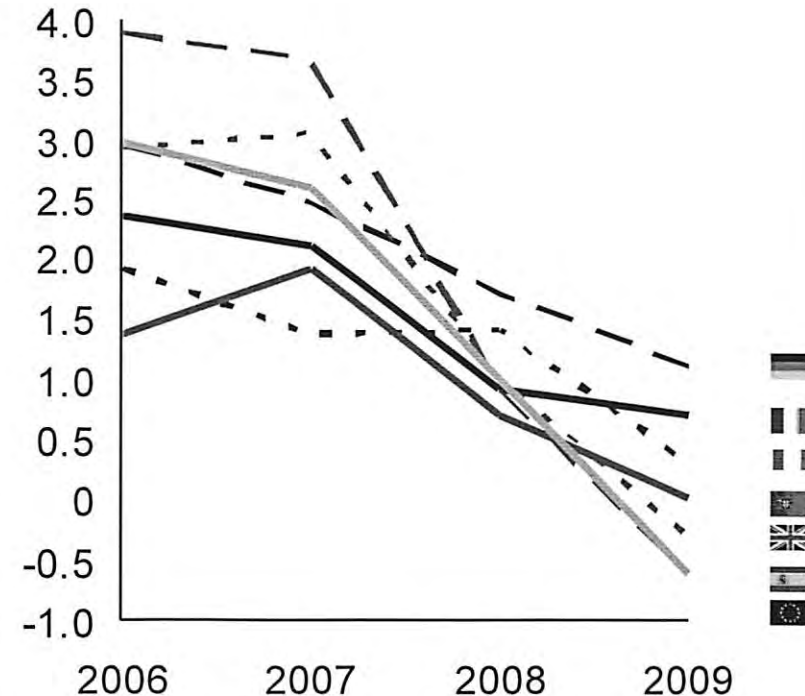
In addition, the macroeconomic context has dramatically worsened in the last 12 months

Bad news is everywhere ...



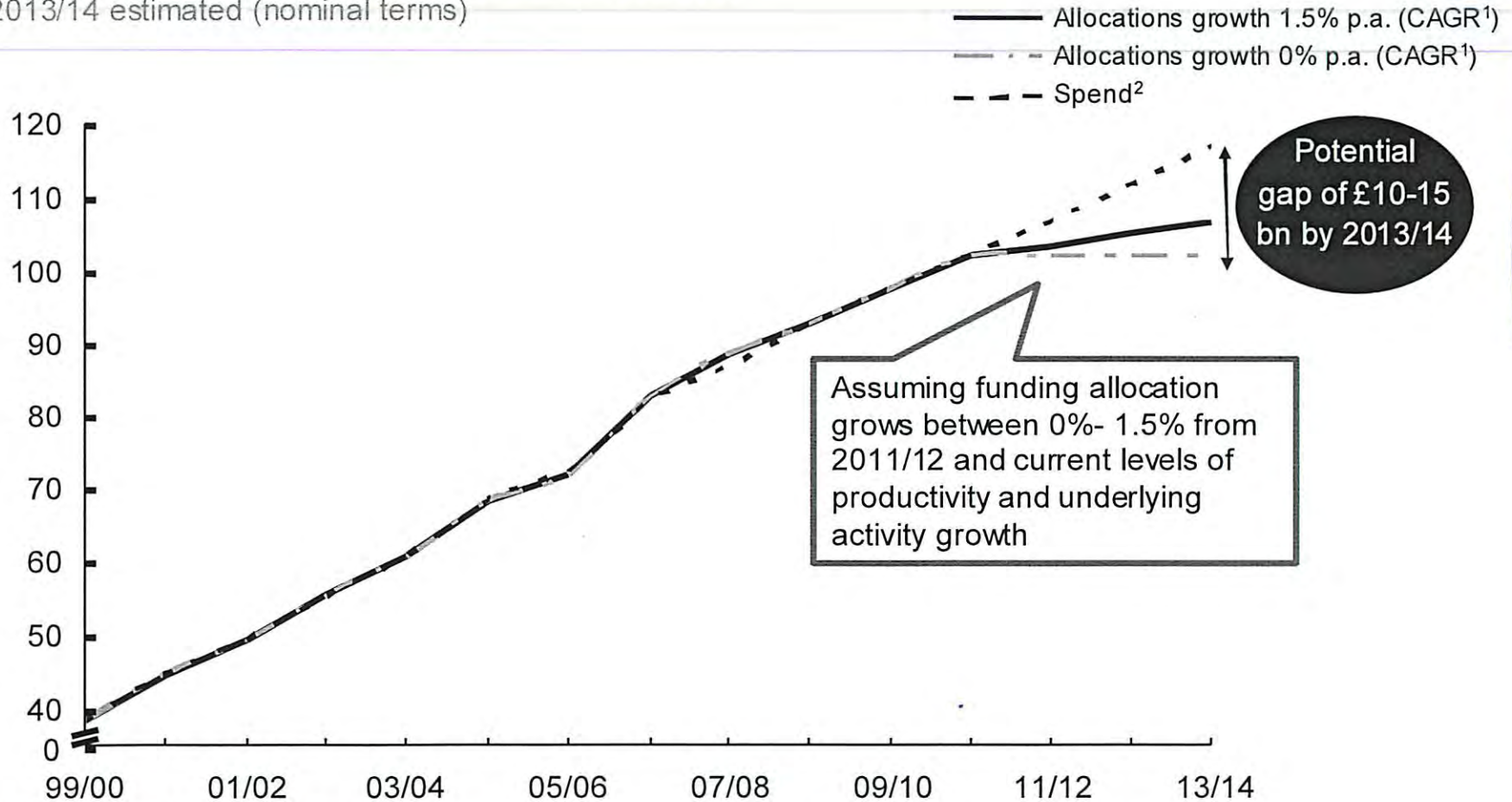
... and the numbers confirm the crisis in the real economy

Real GDP growth %



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

£b. NHS England allocations and expenditure, 1999/2000 to 2013/14 estimated (nominal terms)



1 CAGR: Compounded Annual Growth Rate

2 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)



NB

What is the gap?

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

%

□ Negative year-on-year health care growth within 2 years

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



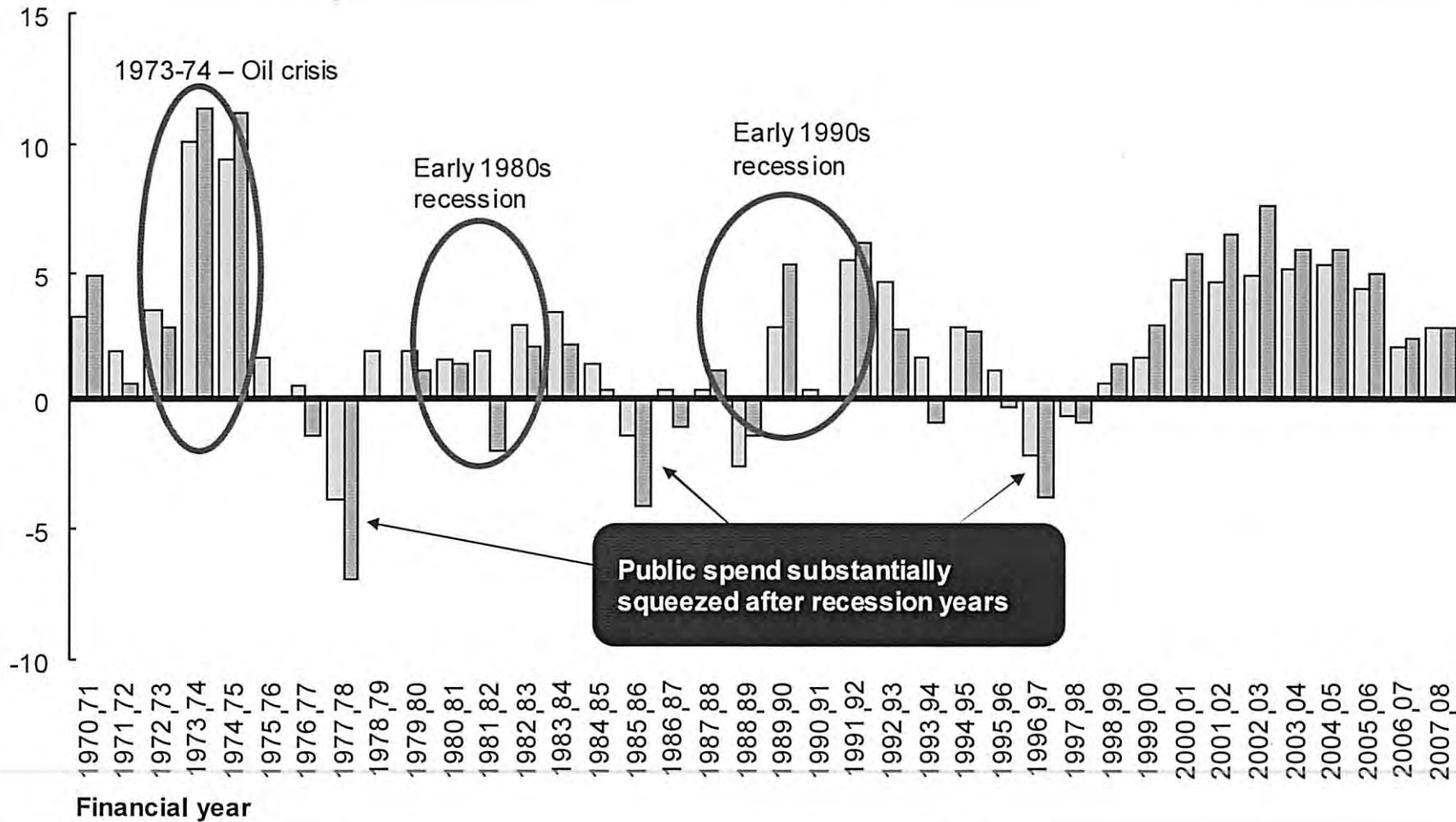
1 Austria, Belgium, Denmark, Germany, Iceland, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden, Switzerland and UK

2 Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Norway, Poland, Portugal, Spain, Sweden, Switzerland, UK

In the UK, after the private sector recession comes the public sector one growth in public spend in real terms in the UK

Percentage increase after economy-wide inflation
%

- Total government spending
- Total government spending less social security and debt interest



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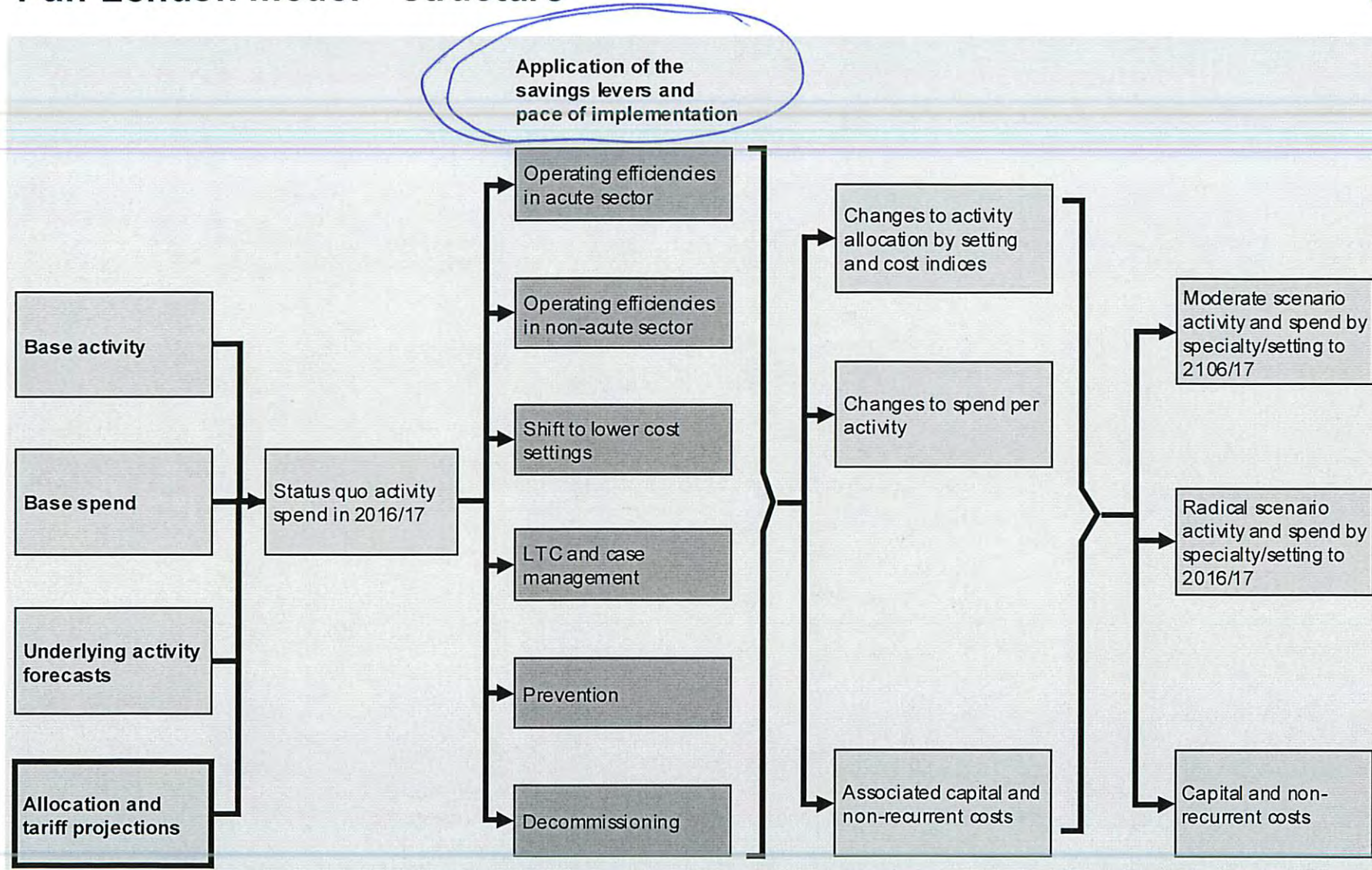
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Implications for out-of-hospital settings

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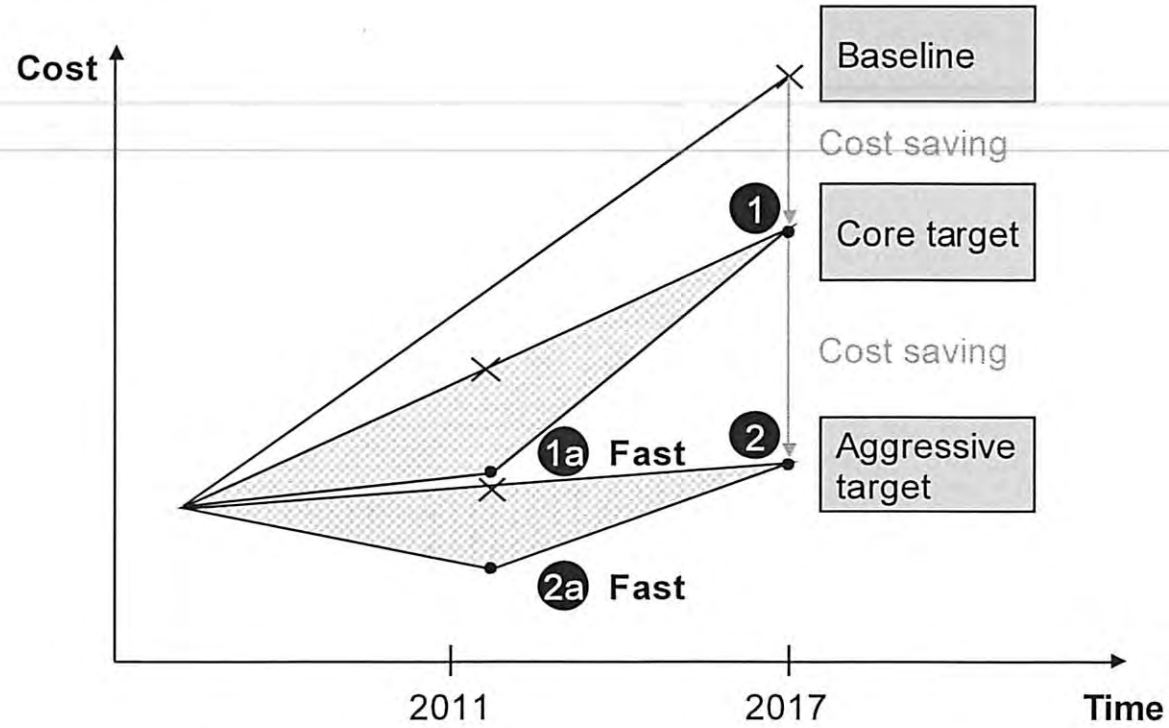


Pan-London model – structure



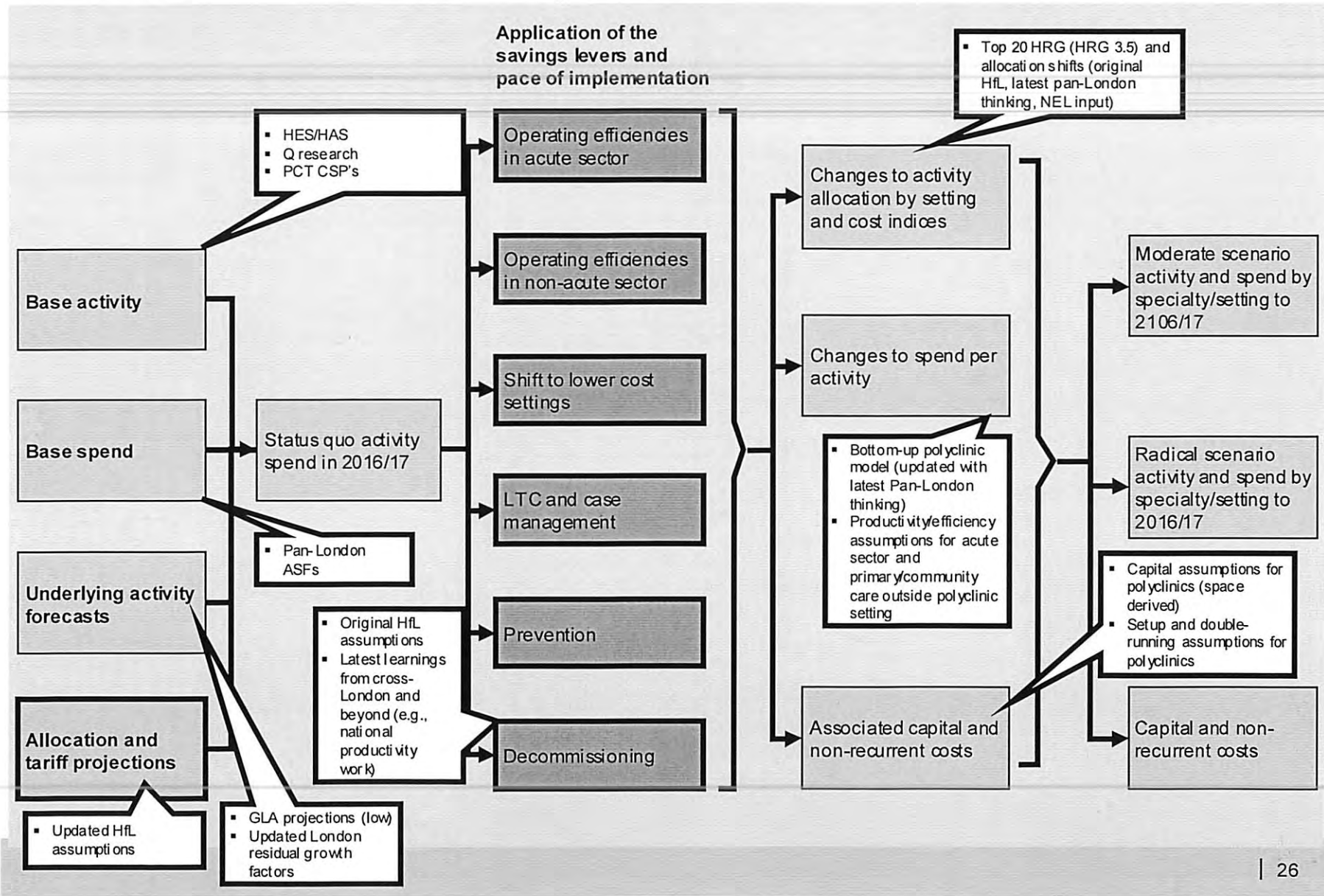
What we are building

▨ Additional saving



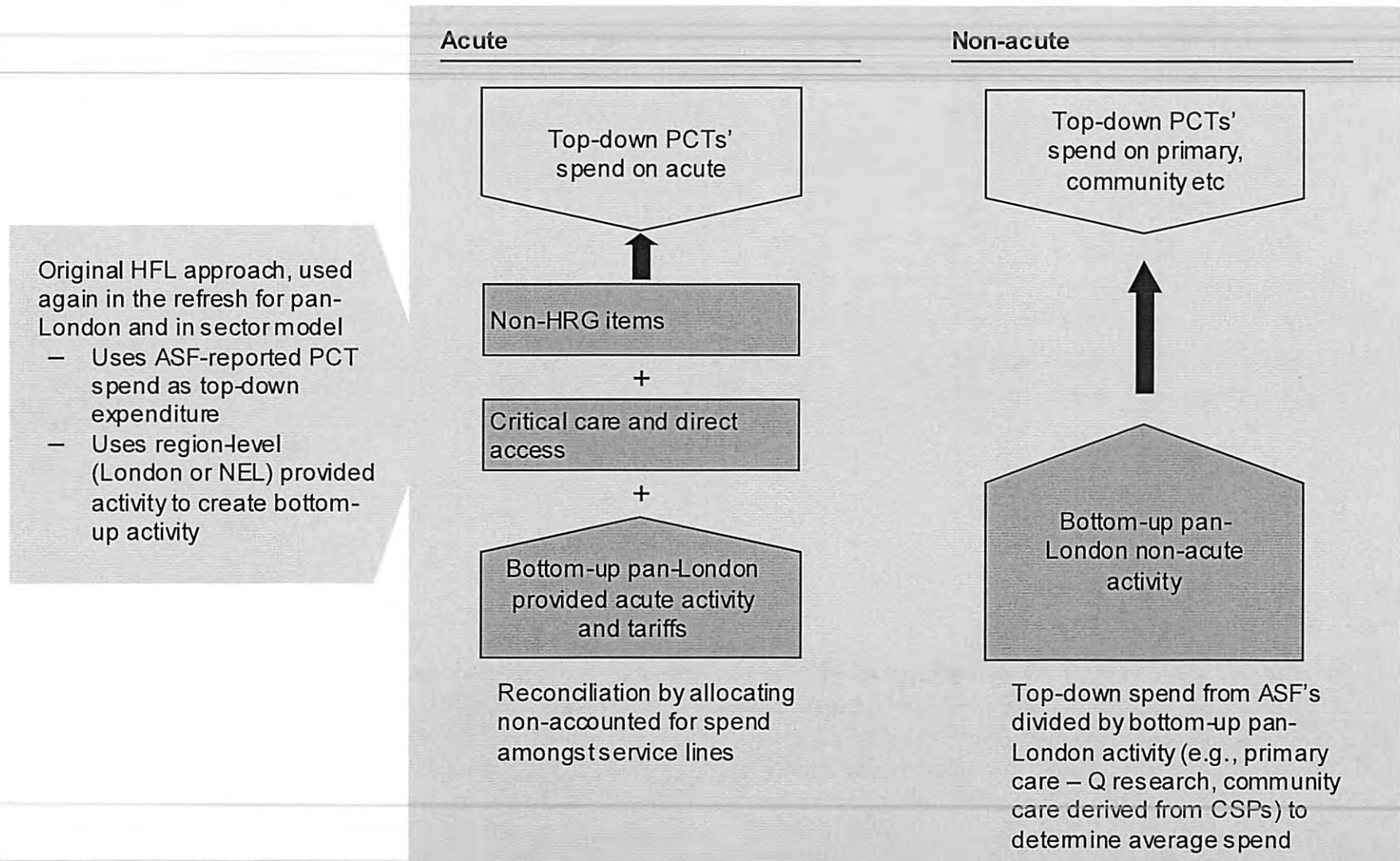
- 4 different cost scenarios to calculate with model
- ① Core target 2017 ② Aggressive target 2017
- ①a Core 'Fast' target 2011 ②a Aggressive 'Fast' 2011

Pan-London model – inputs



For acute, the pan-London HfL model reconciles top down spend with bottom up activity to derive the starting point for 2007/8

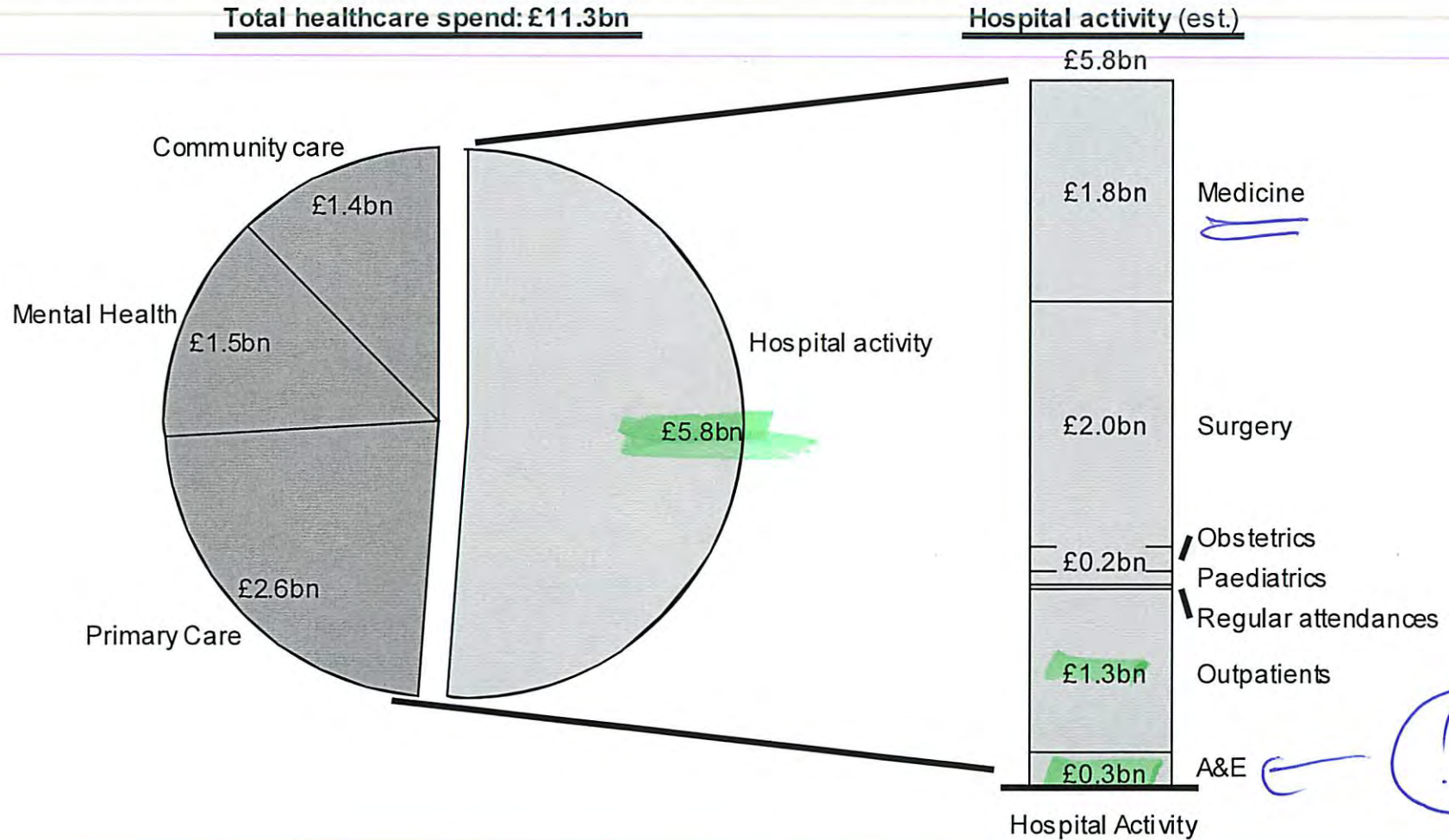
Top-down expenditure
 Bottom-up spend



£11.3bn spent on healthcare in London*, 2007/8



Total spend on purchasing healthcare across 31 Primary Care Trust in London, £bn



* Total spend by London commissioners for care provided both in and out of London. Excludes capital projects
 High level figures from PCT financial returns. Hospital spend broken down pro rata based on national tariffs applied to 2007/08 activity, plus additional costs for critical care and other non-tariff based services apportioned by activity.



Current healthcare activity by service line, 2007/8

Service lines		Activity 000's (Spells/attendances)	Examples
Elective medicine	• Complex	41	• PCI, hepato-biliary procedures
	• Non complex	342	• Neuropathies, sleep disorders, scoping, renal, haem
	• Long-term conditions	65	• Planned admission for asthma, diabetes
	• Under 17s	17	
Non elective medicine	• Complex	61	• Acute MI, stroke
	• Non complex	242	• DVT, pneumonia, pulmonary embolus
	• Long-term conditions	39	• Emergency admission for asthma, diabetes
	• Under 17s	7	
Elective surgery	• Complex	164	• Major GI procedures, transplants, neurosurgery
	• High throughput	364	• Cataracts, arthroscopy, hernia
	• Minor procedures	76	• Vasectomy, skin lesions
	• Under 17s	52	
Non elective surgery	• Complex	30	• Trauma, major GI procedures, burns
	• Non complex	142	• ENT, fractures
	• Minor procedures	3	• Minor skin procedures
	• Under 17s	13	
Obstetrics		231	• Normal delivery, assisted delivery, caesarian section, neonatal discharge
Paediatrics	• Paediatrics	72	• Cystic fibrosis, neoplasms, epilepsy
	• Neonatology	0	• Neonates with major/minor diagnoses
Outpatient		9,025	• New and follow up outpatient consultations
A&E	• Major	1,423	• Emergency admissions, trauma
	• Standard	575	• Fractures
	• Minor	1,820	• Minor illness and injury
Community care		8,889	• Health visitors, podiatrists, district nurses etc.
Primary care		34,554	• GP and Nurse consultations

+A+E?

Non Elective

547,000

Elective

1,121,000

465,000

349,000

656,000

198,000

31,998

34,554,000

= 34.5m

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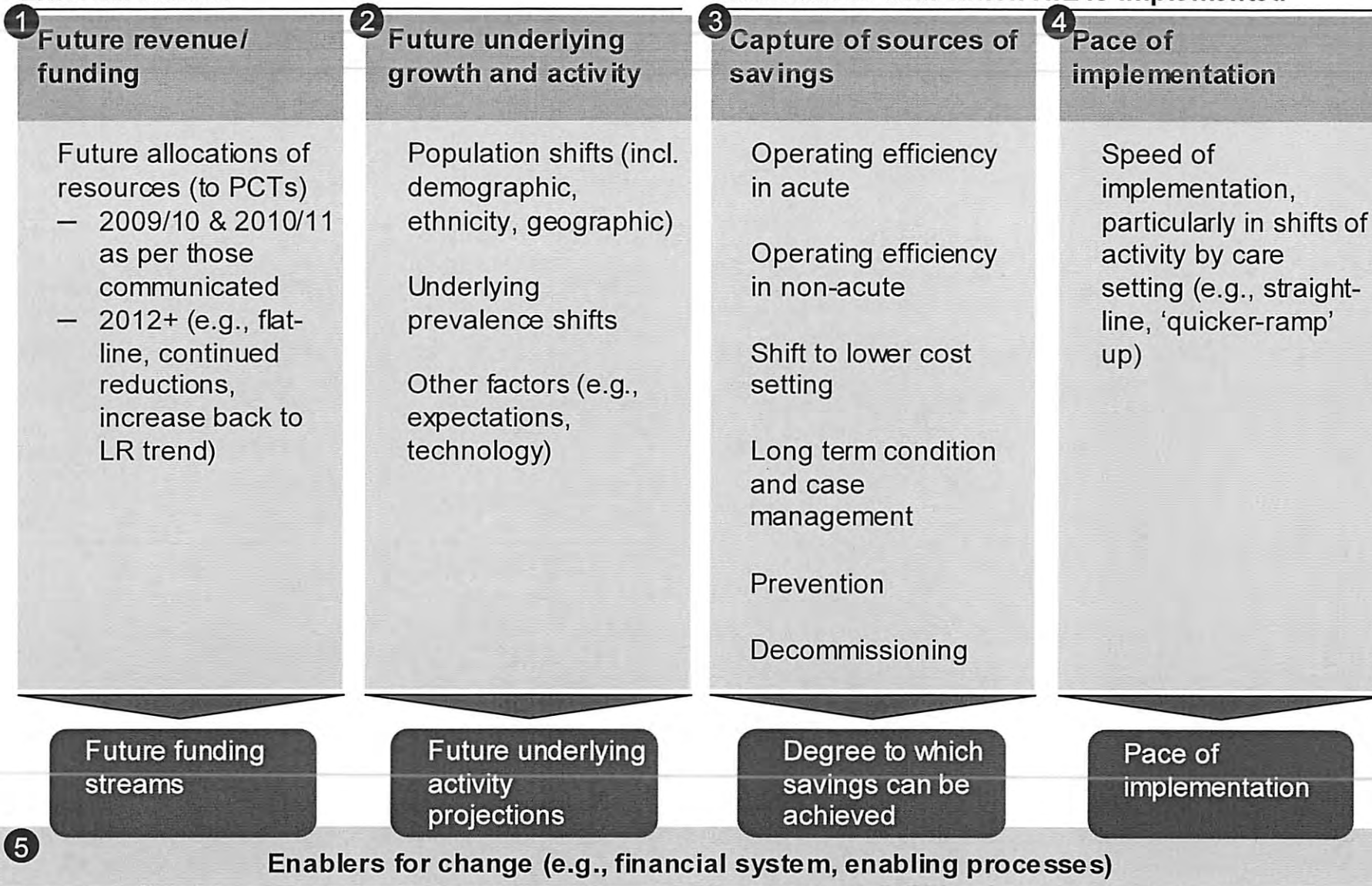
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Miscellaneous

The HfL affordability model is structured around four key areas for scenarios and sensitivities

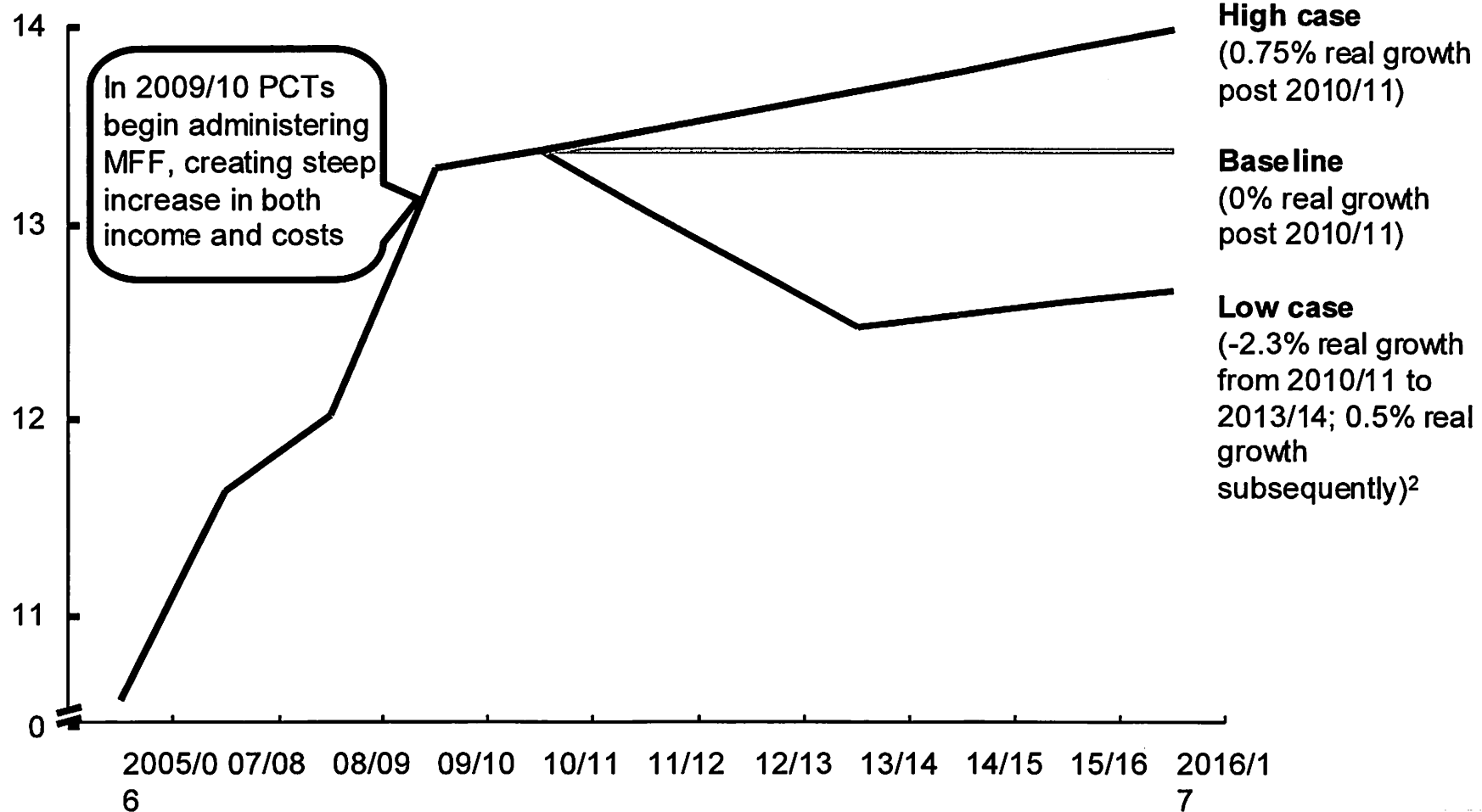
External factors

Radicalness with which HfL is implemented



1 With the tightening economic context, there is uncertainty over future funding, with the base case forecast at 0% real growth from 2010/11

Healthcare Budget, £bn¹



¹ At 2007/08 prices (inflation assumed to be 2.5% p.a.); taking latest FIMs data as base until 2010/11
² Assuming 0% nominal growth in next spending review assumed from 2011/12 to 2013/14



2 In our HfL model we have forecast activity growing overall by c. 4% CAGR in the base case

Outcomes of activity forecast and sensitivities

% CAGR from 2007/8 to 2016/17 (combined impact from demographics and residual growth)

Hospital admissions	Base case ¹	Lower end sensitivity ²	Upper end sensitivity ³
Medicine	1.8	1.3	3.7
Surgery	1.3	0.8	1.5
Obstetrics	1.9	0.4	2.2
Paediatrics	1.6	0.6	2.2
Attendances, consultations, etc.			
Regular attendances	0.7	0.7	1.2
Outpatients	0.8	0.7	3.1
A&E	0.6	0.6	4.9
Community care	3.9	0.7	5.2
Primary care	5.1	1.8	6.3
Overall	4.0	1.4	5.5

¹ Using GLA low demographic projections, and new base case residual growth projections

² Using GLA low demographic projections and new lower end residual growth projection sensitivity

³ Using GLA high demographic projections and new higher end residual growth projection sensitivity






2 Which leads to total activity increasing 42% by 2016/17 in the base case
Outcomes of activity forecasts and sensitivities, spells/attendances, (k)

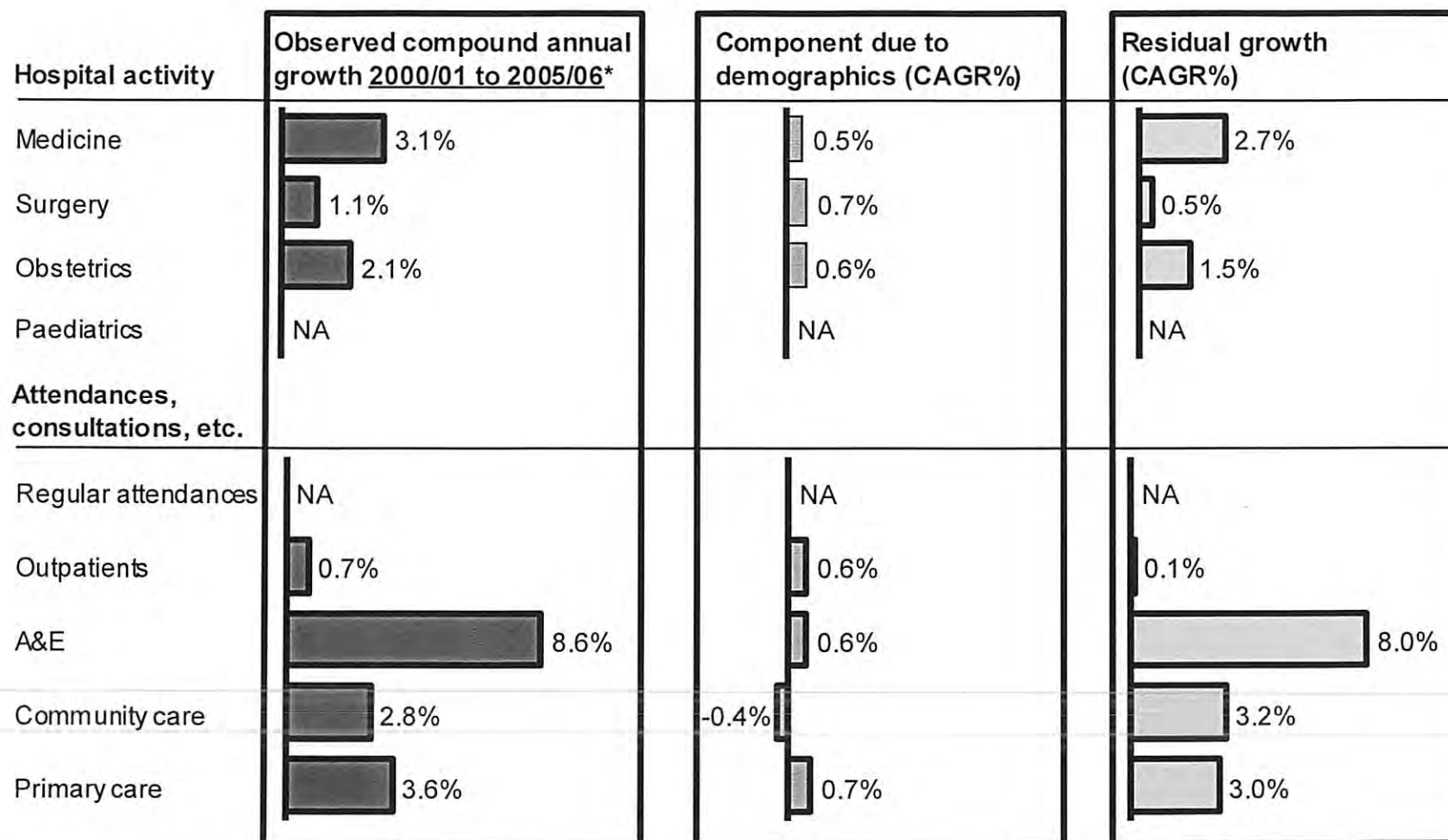
	Current 2007/08	Base case ¹ in 2016/17	Total growth 2007/08– 2016/17, %	Contribution to total growth, %
Hospital admissions				
Medicine	747	879	18	0.5
Surgery	843	945	12	0.4
Obstetrics	231	274	19	0.2
Paediatrics	72	83	15	0
Attendances, consultations, etc.				
Regular attendances	194	206	6	0
Outpatients	9,026	9,738	8	2.9
A&E	3,820	4,038	6	0.9
Community care	8,890	12,505	41	14.8
Primary care	34,555	54,177	57	80.2
Overall	58,377	82,845	42	

LESS

1 Using GLA low demographic projections, and new base case residual growth projections
 2 Using GLA low demographic projections and new lower end residual growth projections sensitivity
 3 Using GLA high demographic projections and new higher end residual growth projection sensitivity

2 We have based these on updating the original HfL modelling which showed activity growth in 2000/1 to 2005/6 was considerably higher than demographics alone

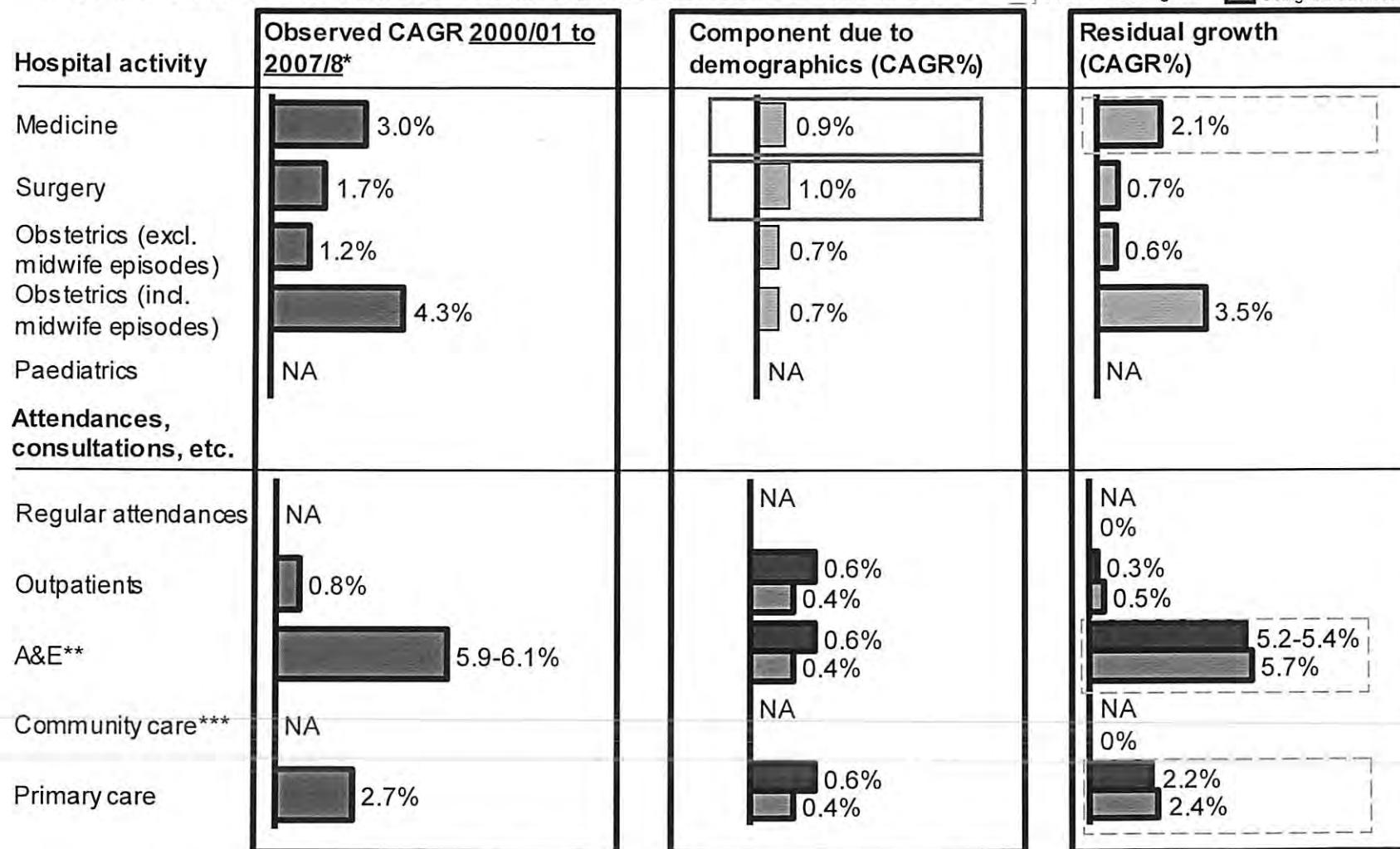
-  Historic trends
-  Demographic component
-  Residual growth



* Analysis covers the period 2000/01 to 2005/06 where data is available. Community care rates calculated on sample PCT data 2004-06. Primary care analysis provided by LHO (2001-05)
 Source: HES Online 00/01-05/06, all England; Outpatient HAS 00/01-05/06, London providers; Primary care QResearch 2006, consultation rates 2001-05, Office for National Statistics 2007; Health Statistics Quarterly 33, Population: age and sex, 1981 onwards. GLA population projections, 2006

2 Using the latest actuals from 2000/1-2007/8 shows the population component has slightly increased while the residual element has fallen in a number of areas

'Higher' than orig HfL Using GLA high for 2008
 'Lower' than orig HfL Using GLA Low for 2007




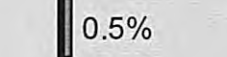
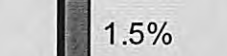
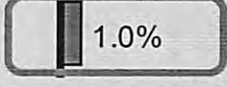
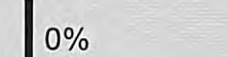
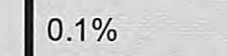
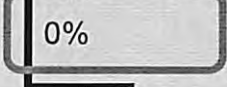


* Analysis covers the period 2000/01 to 2007/8 where data is available. Community care rates for 2000/1 calculated on sample PCT data 2004-06 and in 2007/8 from PCT CSP submissions. Primary care based on scale up of Q research data to London population levels

** 5.9% if walk-in is excluded, 6.1% if walk-in is included

*** No comparable data sets available for 2000/1 to 2007/8 (original based on extrapolation of 2004-2006 data from sample PCT data)

Source: HES Online 00/01-07/08, all England; Outpatient HAS 00/01-07/08, London providers; Primary care QResearch 2008, consultation rates 2001-08, Office for National Statistics 2009, Health Statistics Quarterly 33, Population: age and sex, 1981 onwards, GLA population projections, 2008

2 Taking these together, we have adjusted the baseline in medicine, A&E and paediatrics

Hospital activity	Orig HfL residual forecast (CAGR%)			New residual base forecast (CAGR%)	Rationale	Sensitivity range (CAGR%)	
	Low	Base	High			Low	High
Medicine	1%	2.7%	3.7%		Lower actual than originally anticipated; continues to be higher than surgery given technology shifts	0.5%	2.7%
Surgery	0%	0.5%	0.5%		Assume recent higher rates are temporary effect of 18 weeks	0%	0.5%
Obstetrics	0%	1.5%	1.5%		No significant change	0%	1.5%
Paediatrics Attendances, consultations, etc.	0%	0%	0%		Increased based on input from NEL CRGs	0%	1%
Regular attendances	0%	0%	0%		No significant change	0%	0%
Outpatients	0%	0.1%	2.1%		No significant change	0%	2.1%
A&E	1%	4%	5%		Reflecting 'flatline' growth in last two years	0%	4%
Community care	0%	3.2%	4.2%		No significant change	0%	4.2%
Primary care***	1%	4.3%	5.3%		Assume expected improved access will increase residual growth (as assumed in original HfL)	1%	5.3%

* Analysis covers the period 2005/6 to 2007/8 where data is available. Community care rates use original HfL numbers for 2004 to 2006; Primary care based on scale up of Q research data to London population levels

** Lower number if walk-in centres are excluded, higher number if they are included

*** Pan-London number available for 2005/7 from PCT CSP's - HfL used a range for 2005/6 from 2.1 million to 8.1 million

Source: HES Online 05/06-07/08, all England; Outpatient HAS 05/06-07/08, London providers; Primary care QResearch 2008, consultation rates 2001-08, Office for National Statistics 2009; Health Statistics Quarterly 33, Population: age and sex, 1981 onwards. GLA population projections, 2008

3 The HfL proposals will support lower costs of delivery and enable capture of the savings required to affordably improve health outcomes

Core proposals of HfL

Improved access to urgent care services in the community to reduce use of A&E

Consolidated model for provision of primary and community care over population of ~ 50K

Centralisation of complex services onto major acute sites

Increased rate of day case surgery

Integration of primary and community and secondary care

Shift of planned care services out of hospitals

Improved management of long term conditions through enhanced primary and community care services

Savings sources and role in supporting HfL affordably

- A. **Operating efficiency in the acute sector:** Drive productivity improvements in acute through more efficient deployment of staff, increased utilisation of asset base, improved purchasing, rationalisation of estate and operating services at scale
- B. **Operating efficiency in the non-acute sector:** Drive productivity improvements through more efficient deployment of staff, increased utilisation of asset base, improved purchasing, rationalisation of estate and operating services at scale; eliminate unnecessary and costly service overlaps (e.g., out-of-hours, extended hours, urgent care, A&E)
- C. **Shift to lower cost settings:** Shift services that can be safely and more cost effectively provided out of the hospital closer to home
- D. **LTC / case management:** Provide care for people outside of hospital to prevent emergency admissions
- E. **Prevention:** Increase communications on present and future risks to promote health & well-being
- F. **Decommissioning:** Stop paying for low value added interventions (e.g., grommets, some joint replacements, some OP follow-ups)

0 Original HfL activity settings and decommissioning

	Major acute/ specialist hospital %	Elective centre %	Local hospital %	Polyclinic %	Home %	Not done (decommissioned) %
Elective medicine						
Complex	93		7			
Non-complex	29	4	43	23		
LTC ¹	50		50			
Under 17s	66	9	15	10		
Non-elective medicine						
Complex	88		12			
Non-complex	16		73	11		
LTC ¹	17		63	20		
Under 17s	83		13	4		
Elective surgery						
Complex	52	40				7
High-throughput	10	85				5
Minor procedures		32		59		8
Under 17s	57	35				8
Non-elective surgery						
Complex	100					
Non-complex	55		45			
Minor procedures				100		
Under 17s	84		12	4		
Paediatrics						
Paediatrics	72		22	7		
Neonatology	88		12			
Obstetrics						
	60		34		6	
Regular attenders						
	17		51	32		
Outpatients						
	13	13	13	40		20
A&E						
	20		20	50		10
Community care						
Primary care						
				50	50	
				70		

1 Long-term condition, e.g., diabetes

2 Assumes other 30% takes place in GP practices outside of, but linked into, polyclinics


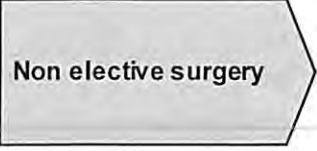
SOURCE: HfL feasibility; Polyclinic plans, Redbridge PCT, Kingston PCT, Tower Hamlets PCT, Sutton & Merton PCT

is no evidence

0 Rationale for activity distribution (1/3)

Service lines	Rationale	
<div style="border: 1px solid black; padding: 5px; text-align: center;"> Elective medicine </div>	<ul style="list-style-type: none"> • Complex • Non complex • Long-term conditions • Under 17s 	<ul style="list-style-type: none"> • Majority of care delivered in major acute/specialist centres of excellence; where some HRGs allocated to the service line contain a mixture of complex and non-complex work (e.g., "Other non-viral infections), ICD10 codes were used to agree proportion of activity in local setting • Starting assumption is that majority of care should be delivered in local hospital setting but with some cases (e.g., comorbidities, patients receiving novel therapeutic agents, other complicating factors) requiring major acute hospital; final distribution reflects fact that a large proportion of the service line is chemotherapy and red blood cell disorders for which a proportion is assumed to be able to be delivered in polysystem • Hospital-based planned interventions for long-term conditions assumed to require local hospital setting except for patients with rarer chronic conditions or with comorbidities which require major acute setting • Majority of care assumed to require major acute or specialist hospital; some opportunity to provide diagnostic procedures or minor interventions in local setting
<div style="border: 1px solid black; padding: 5px; text-align: center;"> Non elective medicine </div>	<ul style="list-style-type: none"> • Complex • Non complex • Long-term conditions 	<ul style="list-style-type: none"> • Vast majority of emergency complex medicine will require major acute infrastructure; some cases will be appropriate for local setting (e.g., stroke > 3 hrs since onset of symptoms, non-complex portion of some HRGs allocated to the service line which contain a mixture of complex and non-complex work) • Majority of care expected to be delivered at local hospital with escalation of a few more complex cases to major acute setting; some patients currently requiring hospital admission could be dealt with in polysystems with good diagnostic and community infrastructure • Majority of care assumed to require local hospital setting; shift to polyclinic driven by clinical evidence where available, or expert opinions; some conditions or patients with comorbidities assumed to require major acute hospital setting
	<ul style="list-style-type: none"> • Under 17s 	<ul style="list-style-type: none"> • Similar rationale to elective medicine

0 Rationale for activity distribution (2/3)

Service lines	Rationale	
 <p>Elective surgery</p>	<ul style="list-style-type: none"> • Complex • High throughput • Minor procedures • Under 17s 	<ul style="list-style-type: none"> • Majority of care delivered in major acute/specialist centres of excellence; where HRGs allocated to the service line contain a mixture of complex and non-complex work (e.g., Intermediate breast surgery), procedure codes were used to agree proportion of activity in elective centre; where published evidence exists that some procedures are not clinically indicated, this was used to determine level of demand management • Majority of procedures allocated to elective centre; where published evidence exists that some procedures are not clinically indicated, this was used to determine level of demand management; 10% of cases assumed to be more complex patients and require infrastructure of major acute hospital • Activity allocated to polysystem where appropriate based on review of procedures within each HRG (e.g. minor skin procedures); where cases are not appropriate for polysystem they are allocated to elective centre; where published evidence exists that some procedures are not clinically indicated, this was used to determine level of demand management • Less complex procedures can take place in dedicated paediatric wards at elective centre; more complex assumed to go to major acute or specialist; where published evidence exists that some procedures are not clinically indicated, this was used to determine level of demand management; majority of cases are intermediate mouth or throat procedures
 <p>Non elective surgery</p>	<ul style="list-style-type: none"> • Complex • Non complex • Minor procedures • Under 17s 	<ul style="list-style-type: none"> • All patients will be channelled to major acute setting • Local hospitals will serve their local catchment population for minor trauma (major trauma goes to major acute hospitals); majority of other emergency surgery cases go to major acute hospitals if surgical intervention is indicated • All emergency minor procedures would be dealt with in local hospitals • Majority of patients would be treated at major acute or specialist hospital; a few less complex cases would be managed in paediatric assessment units at local hospitals or in dedicated paediatric urgent care facilities

0 Rationale for activity distribution (3/3)

Service lines		Rationale
Obstetrics	<ul style="list-style-type: none"> Deliveries Antenatal admissions 	<ul style="list-style-type: none"> Roughly half of obstetric units would be collocated with major acute hospitals; in addition, high risk cases or cases with major complications would be treated at major acute hospital; 10% of normal deliveries would take place at home Antenatal admission would be distributed among hospitals with a greater number going to major acutes to represent that fact that they would be higher risk patients; some antenatal admissions could be avoided by use of the polyclinic and improved community infrastructure
Paediatrics	<ul style="list-style-type: none"> Paediatrics Neonatology 	<ul style="list-style-type: none"> There is a clinical evidence base for consolidating the majority of paediatric "P-code" HRGs; however a proportion of less complex cases could be treated at local hospitals (e.g., mild asthma) or even in polysystems where admissions could be prevented through use of improved diagnostic and community infrastructure Major acute hospitals will provide a level 2 or level 3 NICU; local hospitals would have a level 1 NICU when there is a collocated obstetric unit
Outpatients	? evidence? sources	<ul style="list-style-type: none"> A number of follow-up outpatient appointments are not necessary; of the remainder, it is assumed that half could be devolved to a local setting and half would remain in the hospital setting for efficiency reasons and need for access to infrastructure
Regular attendances		<ul style="list-style-type: none"> The vast majority of these are renal dialysis of which the bulk could be delivered in a polysystem or local hospital; there is also a high volume of chemotherapy which could also be delivered in the polysystem or local hospital but some will require the major acute infrastructure (e.g., novel therapeutic agents, patients not tolerating treatment well)
A&E	NO EVIDENCE	<ul style="list-style-type: none"> 60% of A&E activity is typically minor illness or minor injury and can be dealt with either by telephone advice or within the polysystem; half of the remainder is likely to require step up to local hospital infrastructure (e.g., pneumonia) with the other half requiring major acute hospital infrastructure (e.g., acute stroke, major trauma)
Community care	assumed	<ul style="list-style-type: none"> 50% of community care assumed to be delivered within polysystems and 50% at home; the polysystem would however form a base for all of these services
Primary care		<ul style="list-style-type: none"> It is assumed that 70% of GPs work out of polyclinic facilities with the remainder working in large practices networked to polyclinics

A Operational efficiencies in the acute sector are modelled via the net tariff

Real tariff change (against RPI¹)

	<u>2008/9 – 2010/11</u>	<u>2011/12 – 13/14</u>	<u>2014/15 – 17/18</u>	<u>Driver of assumptions</u>
Healthcare cost inflation above RPI	2.4%	1.0%	1.0%	Original Monitor guidance used until 2010/11 Cost inflation then assumed to fall from 2011/12 given economic environment and increasing workforce supply
	–	–	–	
NHS efficiency requirement	3.0% ²	4.0%	4.0%	
	=	=	=	As per original Monitor guidance to 2013/14 and assumed at 4% subsequently
Real tariff change	-0.4%	-3.0%	-3.0%	As per original Monitor guidance to 2013/14 and assumed at 4% subsequently

¹ Assumed to be 2.7% p.a.

² Increases over period from 2.4% to 3.5%

B Removing duplication will be modelled through changes in primary care payments

		24 hour period													
Paid activities		8 am	10 am	12 pm	2 pm	4 pm	6 pm	8 pm	10 pm	12 am	2 am	4 am	6 am	Payment type	
A&E		[Shaded]												Fee for service	
GP tariffs		GMS/ PMS					Ext. hours							Capitation	
							Out of hours						Capitation		
Enhanced service/ Walk-in centre		[Shaded]												Pay per use	
Urgent care centre		[Shaded]												Fee for service	

'Radicalness' of lever pull

Core scenario	Stop paying duplication of extended hours and out of hour fees between 6-8pm, with total savings of ~£20m across London ¹
Aggressive scenario	GPs paid a fee for service at £50/ consultation ² , with total savings of ~£25-40m across London



Pace of implementation

Straight line	All levers implemented gradually up to 2016-17 for core scenario
Front-end	All levers reach 50% implementation by 2011/12 and 100% by 2016-17

1 Based on £2.95/registered patient extended hours annual fees across c. 7 million registered population (87% of 8 million population)

2 Based on £6-8/ registered patient out of hour annual fees across c. 7 million registered population with 5% registered population attending out of hours



■ Detailed facts/
assumptions
provided

B Many operational efficiency parameters will be adapted according to latest learnings

'Radicalness' of lever pull				Pace of implementation
Service line	Efficiency parameter	Core	Aggressive	
PC	More efficient GP utilisation	Gains implied by zero real terms tariff increase (original HfL assumption) ¹	6-11% increase in efficiency (patient-facing time) + 15% reduction prescribing costs	Straight-line Implementation follows the pace of shift to lower care setting Front-end: Same as straight-line
Home base community care	More efficient nurse utilisation	Gains implied by zero real terms tariff increase (original HfL assumption) ²	10-15% increase in efficiency (patient-facing time)	

??

1 Reflecting learnings from interviews with polyclinics manager (TH), detailed clinical specification outcomes workshops (SMPCT) and learnings from other PCTs (Redbridge, NEL)

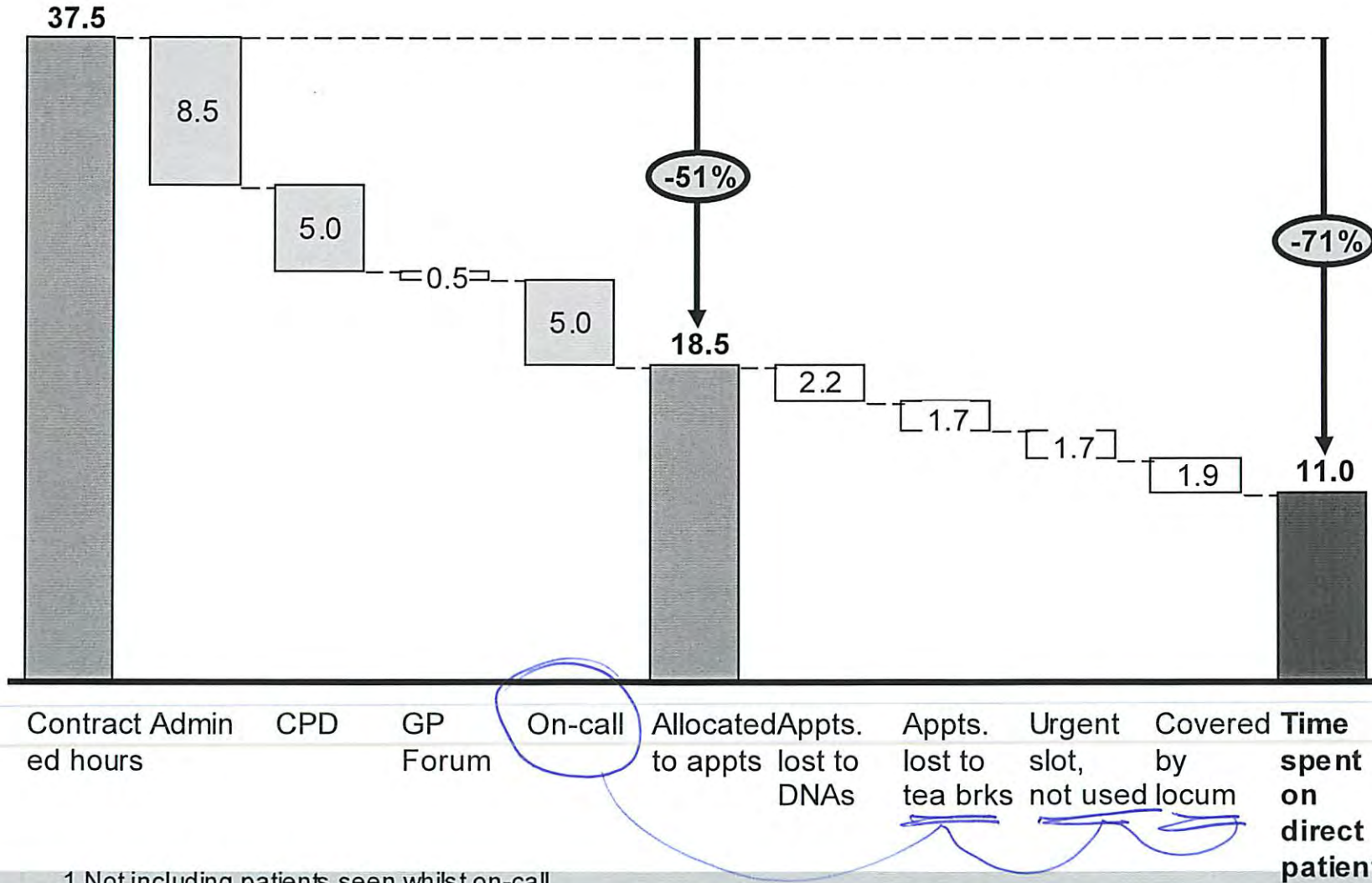
2 Based on current spend or best knowledge

B Primary care – Low-performing GPs can spend less than 30% of their contracted hours actually seeing patients

NB



Number of hours



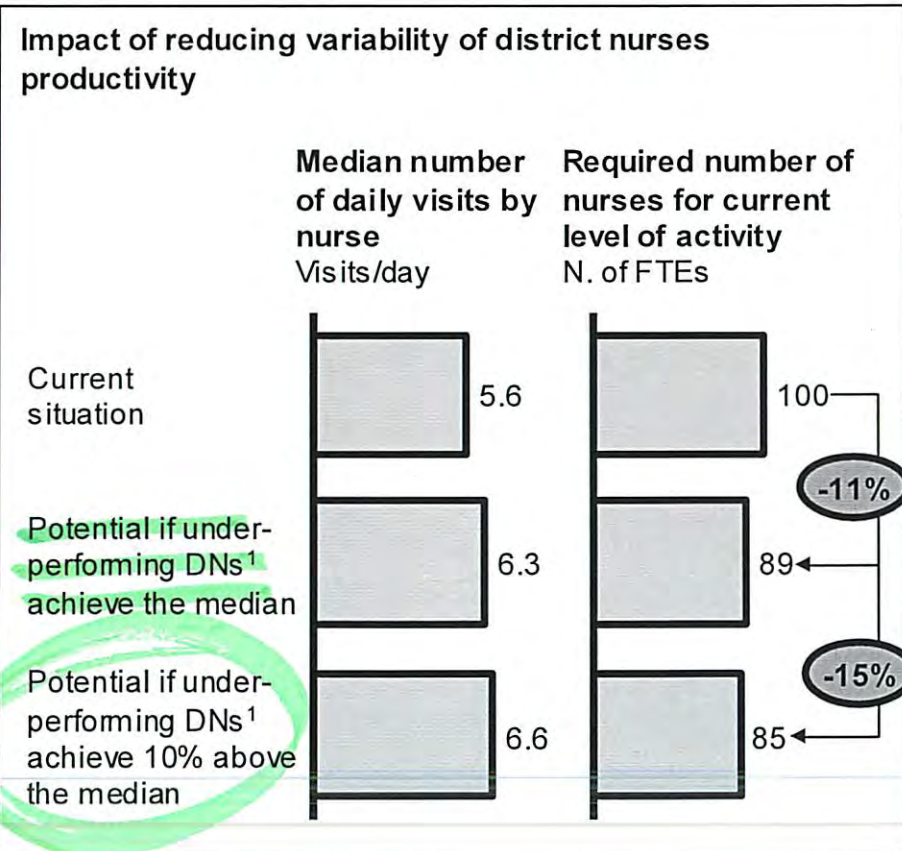
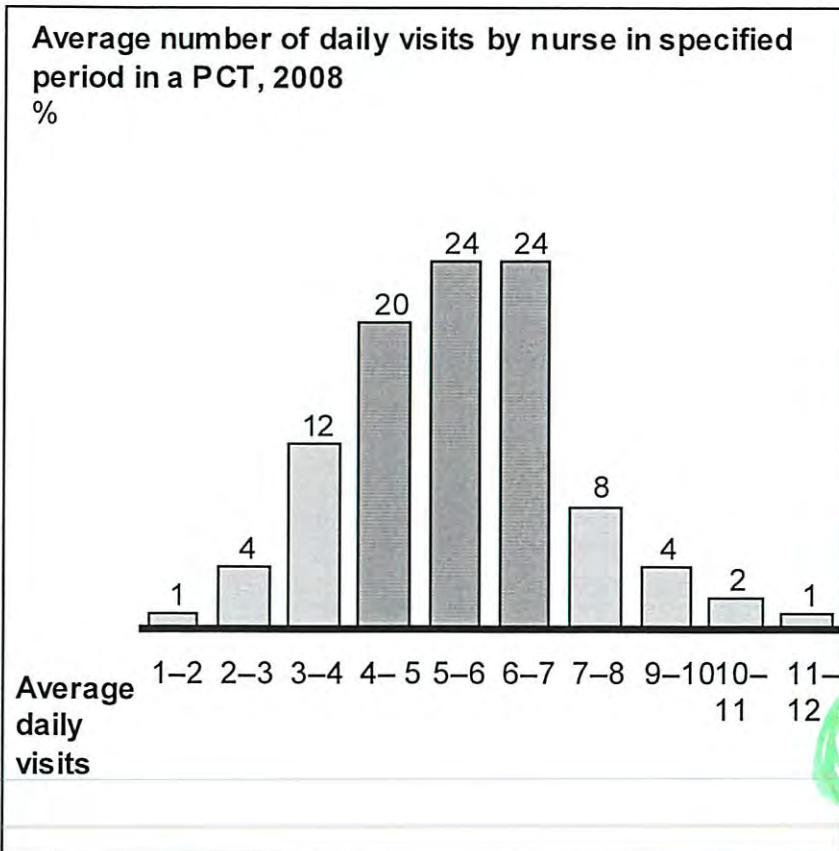
RMA View?

1 Not including patients seen whilst on-call
 Source: Interviews with PCT and practices; team analysis

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

How to expect them to do this?

PCT EXAMPLE



1 District nurses

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

B Community care – 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



C Many operational efficiency parameters will be adapted according to latest learnings

Detailed facts/
assumptions
provided

'Radicalness' of lever pull			Pace of implementation
Efficiency parameter	Core	Aggressive	
Medical workforce			Straight-line Implementation follows the pace of shift to lower care setting Front-end: Same as straight-line
– Staff utilisation	54% for PC and 64% for other medical staff	64% for all medical staff	
– Level of role substitution	Original HfL assumptions amended for increased consultant/GP ratio in OP ¹	More role substitution from consultant/GP to nurses ¹	
– Time required per case	Original HfL assumptions across all activities ¹	Reduction of consultation time by 33% in primary care	

Supplies/diagnostics			
– Prescribing costs	Original HfL assumptions ²	10% reduction for secondary care, 15% for primary care	
– Supplies	Original HfL assumptions ²	Original HfL assumptions ²	
– Diagnostics	Updated HfL assumptions	Updated HfL assumptions	

Admin overheads (receptionists,...)	1 A&C + 2 receptionists in consolidated; 5 A&C + 6 receptionists in hub & spoke	1 A&C + 2 receptionists in consolidated; 5 A&C + 6 receptionists in hub & spoke	

¹ Reflecting learnings from interviews with polyclinics manager (TH), detailed clinical specification outcomes workshops (SMPCT) and learnings from other PCTs (Redbridge, NEL)

² Based on current spent or best of knowledge

SOURCE: HfL feasibility, Polyclinic plans, Redbridge PCT, Kingston PCT, Tower Hamlets PCT, Sutton & Merton PCT

C Polysystem - Estimated time per consultation and proportion of consultations managed by type of staff

Changes from original HfL

	Time required per care			GP			Consultant			Nurse practitioner/AHP ¹			Staff nurse
	Hours			%			%			%			%
	HfL	Core	Aggr.	HfL	Core	Aggr.	HfL	Core	Aggr.	HfL	Core	Aggr.	All scenarios ²
Elective medicine													
Complex	0.50	Same	0.50	10	Same	5	85	Same	Same	5	Same	10	60
Non-complex	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	60
LTC ¹	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	60
Under 17s	0.50	Same	0.50	80	Same	75	15	Same	Same	5	Same	10	60
Non-elective medicine													
Complex	0.50	Same	0.50	10	Same	5	85	Same	Same	5	Same	10	60
Non-complex	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	60
LTC ¹	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	60
Under 17s	0.50	Same	0.50	80	Same	75	15	Same	Same	5	Same	10	60
Elective surgery													
Complex	0.50	Same	0.50	10	Same	5	85	Same	Same	5	Same	10	60
High-throughput	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	90
Minor procedures	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	75
Under 17s	0.50	Same	0.50	80	Same	75	15	Same	Same	5	Same	10	60
Non-elective surgery													
Complex	0.50	Same	0.50	10	Same	5	85	Same	Same	5	Same	10	60
Non-complex	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	60
Minor procedures	0.50	Same	0.50	70	Same	60	10	Same	Same	20	Same	30	75
Under 17s	0.50	Same	0.50	80	Same	75	15	Same	Same	5	Same	10	60
Paediatrics													
Paediatrics	0.50	Same	0.50	80	Same	70	15	Same	Same	5	Same	10	60
Neonatology	0.50	Same	0.50	-	-	-	-	-	-	-	-	-	-
Obstetrics	0.50	Same	0.50	-	-	-	-	-	-	-	-	-	-
Regular attendances	0.50	Same	0.50	10	Same	Same	10	Same	Same	10	Same	Same	70
Outpatients	0.50	Same	0.50	32	10	10	33	55	40	37	Same	50	60
A&E	0.25	Same	0.25	60	Same	50	-	-	-	40	Same	50	60
Community care	0.50	Same	0.33	-	-	-	-	-	-	67	Same	Same	33
Primary care	0.25	Same	0.17	60	Same	50	-	-	-	40	Same	50	-

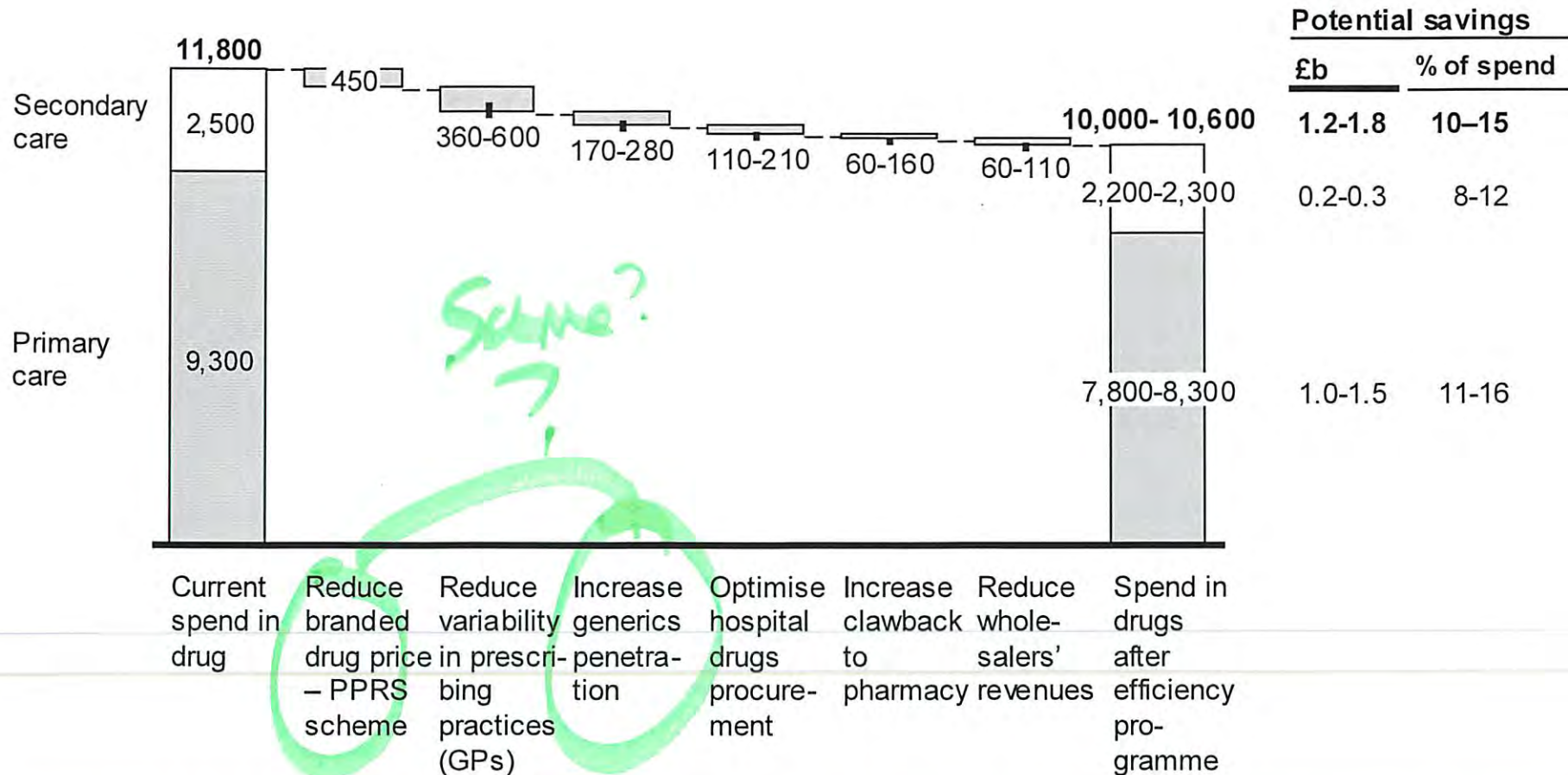
1 Allied health professional e.g., physiotherapist

2 HfL core and aggressive

SOURCE: HfL feasibility; Polyclinic plans, Redbridge PCT, Kingston PCT, Tower Hamlets PCT, Sutton & Merton PCT

B Drug spend – Potential reduction of 11-16% spend for primary care
C and 8-12% for activities shifted from hospital through pulling different price and volume levers

£million, 2008/09. Drugs spend across England



C Recent polysystem and PCT studies have confirmed the possibility to shift to lower cost settings, with variations by service lines

Detailed facts/assumptions provided

'Radicalness' of lever pull (% shift to polysystems)			Pace of implementation
Service line	Core	Aggressive	
Elective medicine	23% of non-complex, 10% of under 17 and 0% of long term conditions	As per original HfL	Straight-line 19 polyclinics per year up to 2015/16 to allow full savings implementation by 2016/17 - 38 polyclinics by 2011/12 - 130 by 2016/17
Non-elective medicine	11% of non-complex, 20% of LTC's and 4% of under 17's	As per original HfL (not including LTC management)	
Outpatients	40%	55% (Redbridge, SMPCT)	Front-end: 50% of remaining polyclinics implemented by 2011/12 - 65 polyclinics by 2011/12 - 130 by 2016/17
A&E	50%	60%	
Primary care	100%	100%	
Elective surgery, non-elective surgery, regular attendances, obstetrics, community care (due to no new evidence post HfL) and paediatrics (confirmation of HfL assumptions) will be modelled as per original HfL in both core and aggressive scenarios			

Quoting themselves again as a source!

C Outpatients - Much outpatient activity could be conducted in the local care setting

% outpatient activity that could be shifted out of acute setting

	DH guidelines	Clinicians workshop
Medicine	70	100
Surgery	80	100
Trauma & orthopaedics	40	90
Ophthalmology	50	80 (non-surgical)
Gynaecology	60	90 (except oncological gynae)
Dermatology	75	100 (including Moh's surgery)
ENT	50	80
GUM	60	90
Paediatrics	50	100

60-80% of total London outpatients could be removed or devolved from hospital outpatients, leaving only 20-40% in the traditional outpatients setting

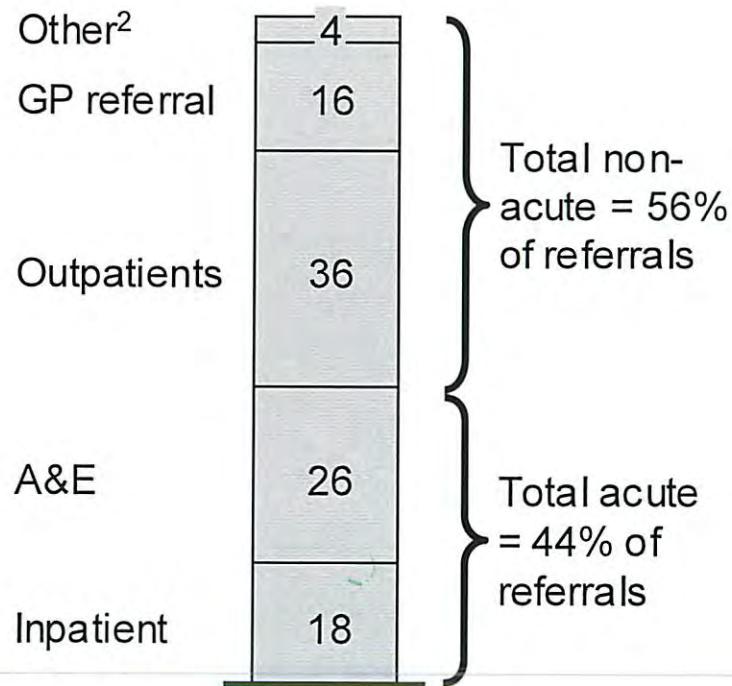
Source: DH 2002, HAS 2005, SMPCT clinical specification outcomes workshops, clinicians interviews, team analysis

| 53

ie - No real evidence here. Sutton + Meltzer PCT's guesswork.

C Outpatients - Sources of radiology imaging requests suggest much could be delivered in the community as well

Breakdown by source of referral, all modalities¹, %



*Referrals?
Radiographers?*

There is a large potential to deliver radiology services in the community

56% of referrals are non-acute, all of which can be delivered in out-of-hospital settings

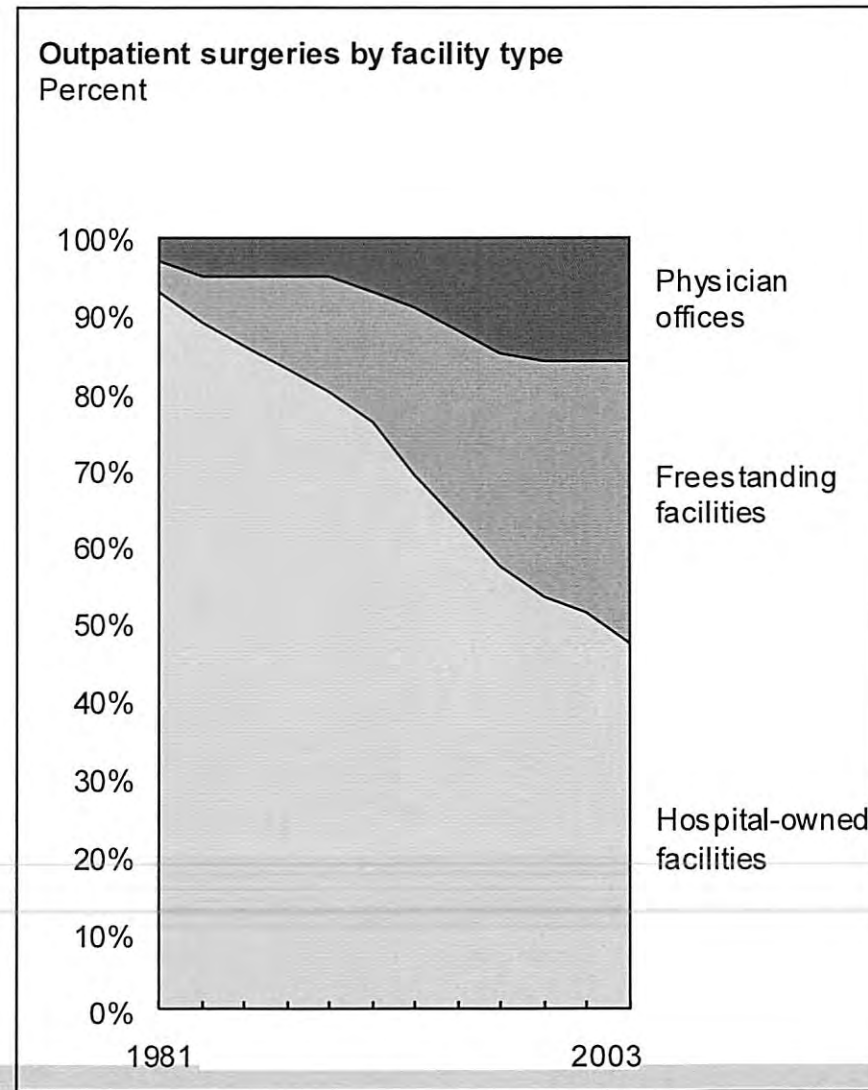
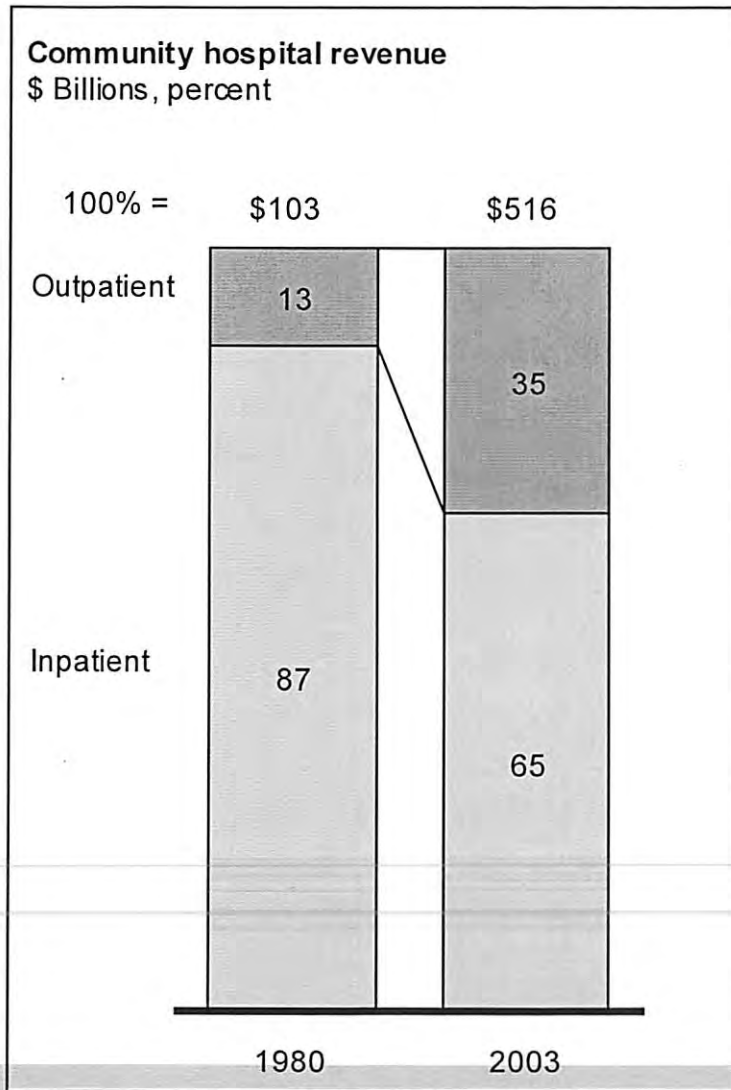
Of the 26% referred from A&E, the majority are for plain films, which can also be delivered via community-based urgent care centres

This above leaves only a minority of volume tied to acute hospitals

¹ Data from Bedfordshire and Hertfordshire SHA

² Other includes 3000 MRIs purchased from Lodestone, dental sources for X-rays

© Outpatients - A significant shift has occurred already in the US from inpatient to outpatient, and from hospital to community



C A&E - Analysis of A&E attendances in London shows a large proportion could be dealt with in primary care



- LAS estimates that in 2013, 200,000 fewer patients will be taken to A&E through an improved operational model that is better able to deliver appropriate definitive care first time to more patients
- This will require a greater range of care options such as telephone advice, treatment at home, emergency care from a single responder or direct referral to alternative providers such as walk-in centres, minor injuries units, community psychiatric services or inter mediate care teams

1 Based on HRG coding

D Investing for the future in LTC and case management contributes to shifting more care to lower cost settings

■ Detailed facts/assumptions provided

'Radicalness' of lever pull		Pace of implementation
<p>Core (original HfL assumptions)</p> <p>20% of total emergency hospital cases for long-term conditions could be prevented through better care in a polyclinic (each initial hospital admission was replaced by 4 consultations in the polyclinic)</p>	<p>Aggressive (new considerations)</p> <p>Analyses from Redbridge PCT, Tower Hamlet PCT, SMPCT as well as the 'Achieving World Class Productivity' study suggest 30- 40% of total (all) emergency admission costs could be saved through improved management of people with long term condition/complex health needs</p> <p>This is modelled by increasing non-elective medicine shift to polyclinics as follows: 10% complex, 30% non-complex and 40% LTC</p>	<p>Straight-line All levers implemented gradually up to 2016-17</p> <p>Front-end: All levers reach 50% implementation by 2011/12 100% implementation by 2016/17</p>

Resources? Staff? Evidence?

D With good disease management at primary care level, hospital activity for long term conditions can be significantly reduced

Condition	Intervention	Reduction in acute unscheduled activity		Increase in PC consultations required to deliver LTC in London	Core references
		Adm ¹	LOS		
Congestive heart failure	Multi-disciplinary managed care ²	23-85% ³		x 2.5	Heart,2005,91,899-906 (74 trials); JGenInternMed,1999,14 (2), 130-4 (7 trials); Chest, 2005,127;2042-8 (4yr study) BMJ,2001;323;715-8 (1 RCT) JAMA,2004,291,11 (18 RCTs) CHD NSF Chapter 6 Euro Heart Journal, Guidelines for the diagnosis and treatment of CHF, 2005
	Specialist nurse interventions	58%	54%		
	Discharge planning and post discharge support	25%			
Asthma	Active case management ⁴	36%		x 1.7	Cochrane,2003(1) (36 trials); BTS Asthma Guideline, 2004 (25 trials) DH Compendium of CDM citing BMJ,2004,328,144;Thorax,2001,56,687-90;Pub Health Med,2002;25;258-60
	Specialist asthma nurses	10-38%			
COPD	Early discharge planning and hospital-at-home	10-30%	50%	x 1.8	Thorax(NICE),2004,59,39-130 (2 RCTs; 1 for each intervention) NHS Institute Directory of Ambulatory Emergency Care for Adults (citing NICE guidance)
	Multi-disciplinary pulmonary rehab for 6-12 weeks	10-30%	50%		
Diabetes	Active disease management Specialist primary care (GPwSIs)	25%	40%	x 2.4	DH CDM Compendium citing Cochrane (41 RCTs) & 3 RCTs Diabetes Med, 2003(1),32-8 (1 study)

Evidence that if could work - but needs right systems + staff in place

*NP
here is some evidence here*

1 Hospital readmission (inpatient); 2 Best evidence for programmes of 3m including education, lifestyle advice, exercise, home visits, nurse case managers and regular monitoring; 3 Weighted average = 27%; 4 Including written care plan, supported self-monitoring and regular practitioner reviews

E Investing for the future in prevention has potential to bring some savings, limited given time frame

'Radicalness' of lever pull'		Pace of implementation
Core (original HfL assumptions)	Aggressive (new considerations)	
None given timeframe	<p>An overarching theme of vascular prevention was identified for London, which could deliver significant improvements in obesity, smoking and vascular diseases prevalence</p> <p>Although many studies exist to prove the clinical impact of such prevention programs, exact costs, financial benefits and implementation timelines remain unclear – but early work suggests that detection, monitoring and social marketing for prevention could save ~£2.4b p.a. nationwide once all healthy behaviour initiatives are implemented</p> <p>In our scenarios, we assume (conservatively) that an additional 10% complex, 10% non-complex and 10% LTC non-elective medicine can be prevented through early detection and counselling¹, as suggested by early studies on identifiable morbidity and hospital activities</p>	<p>Straight-line All levers implemented gradually up to 2016-17</p> <p>Front-end: All levers reach 50% implementation by 2011/12 100% implementation by 2016/17</p>

Refined?

1 Each initial hospital admission (at £3,164 current unit cost) is replaced by 4 consultations in the polysystem (at £85-105 unit cost)

E An approach to quantifying impact of prevention

	London prevalence	Morbidity	Mortality absolute	Mortality avoidable	Wider impact
Smoking	1,325,000 ¹	CHD prevalence ⁵ – 193,000 Cancer prevalence ⁵ – 58,000 (with hospital activity due to respiratory chemotherapies > 4,500)	None - all avoidable	Early deaths from smoking - 29,680 ⁸	Passive smoking
Diet (5 a day)	3,610,000 ⁴ (less than 5-a-day)	Obesity adults ⁷ - 1,105,000 Obesity children ⁷ - 291,000 Co-morbidities: diabetes, hypertension, dyslipidaemia, breathlessness, sleep apnoea, gall bladder disease...	None - all avoidable	More fruits & vegetables - 5,000 ¹¹ Reduction of salt - 2,800 ¹¹	Cost of obesity at ~ £6bn for NHS ¹¹
Physical activity	2,170,000 ⁴ (less than 30 min activity/ week)				
CHD	193,000 ²	Hospital activity ³ due to hypertension ^{6,9} - 13,250 Hospital activity ³ due to CHD ^{9,10} - 91,100	17,300 ¹²	Early deaths due to heart disease and stroke – 5,150 ¹³ (deaths before age 75)	Absolute number of early deaths

Current identified hospital activity related to smoking and CHD represents at least 10% of non-elective medicine, which could be prevented by applying new care pathways and taking charge of patients through poly-setting. Although the impact of obesity is substantial in terms of co-morbidity and costs (potentially £6bn annually nationwide), more studies are required to identify exact costs, impact and mechanism of preventive measures, which need alignment of a broader set of public networks (health, transportation, city planning, ...)

¹ General Household survey 2005, population data 2007; ² QOF 2006–2007; ³ Inpatient, day case, regular attendances at NHS trust; ⁴ Health Survey for England 2006, The Information Centre, population 2007; ⁵ QOF 2006–07; ⁶ NHS London; ⁷ Health Survey for England 2006, population 2007; ⁸ ERPHO, 2003–05; ⁹ NHS London, HRG E04, 11-15, 22-23, 2005–2006; ¹⁰ NHS London, HRG D39-40, 2005–2006; ¹¹ "Food – An analysis of the issues", Government Strategy Unit (2008); ¹² ONS, 2006; ¹³ Deaths < 75 years, deaths due to diseases of the circulatory system, ONS 2006;

C Activity estimated to be provided in polysystem – original HfL model
D and new learnings

	Original HfL (core)	Other models			C	D	E
		S&M	Redbridge	NEL ²	Aggressive (without LTC)	Aggressive (with LTC)	Agg. (with prevention)
Elective medicine							
Complex	0	0	0	1	0	0	0
Non-complex	23	11	27	14	23	23	23
LTC ¹	0	0	36	3	0	0	0
Under 17s	10	17	X	X	10	10	10
Non-elective medicine							
Complex	0	0	0	3	0	10	20
Non-complex	11	0	0	2	11	30	40
LTC ¹	20	0	0	6	20	40	50
Under 17s	4	0	X	X	4	4	4
Elective surgery							
Complex	0	0	0	9	0	0	0
High-throughput	0	0	0	7	0	0	0
Minor procedures	59	60	42	43	59	59	59
Under 17s	0	0	X	X	0	0	0
Non-elective surgery							
Complex	0	0	0	2	0	0	0
Non-complex	0	0	0	3	0	10	10
Minor procedures	100	0	80	27	100	100	100
Under 17s	4	0	X	X	4	4	4
Paediatrics							
Paediatrics	7	7	17	X	7	7	7
Neonatology	0	0	X	X	0	0	0
Obstetrics							
	0	0	37	0	0	0	0
Regular attendances							
	32	5	0	20	32	32	32
Outpatients							
	40	67	55	38	55-70 ³	55-70 ³	55-70 ³
A&E							
	50	0	0	57	60-70 ³	60-70 ³	60-70 ³
Community care							
	100 ⁴	X	41	X	100	100	100
Primary care							
	100 ⁴	X	X	X	100	100	100

1 Long term condition – e.g., diabetes; 2 Preliminary; 3 High range if less activity is decommissioned; 4 Was only 50% in original HfL assumptions but increased to 100% to reflect hub and spoke model

F The amount of unnecessary elective procedures and duplication in A&E will be modelled in different scenarios

■ Detailed facts/assumptions provided

'Radicalness' of lever pull					Pace of implementation
Service line	Core		Aggressive		
	% activity de-commissioning	Rationale	% activity de-commissioning	Rationale	
Elective surgery	7% 'complex', 5% 'high throughput', 8% 'minor procedures' and 8% 'under 17' (original HfL assumption)	Published evidence that some procedures are not clinically indicated	7% of overall procedures with no or limited clinical benefit	More ambitious assumptions likely to be reviewed nationally based on need to improve productivity	Straight-line All levers implemented gradually up to 2016-17 Front-end: All levers reach 50% implementation by 2011/12 100% implementation by 2016/17 Additionally, prioritizing the most cost-effective intervention (without any change in the life years of the population) could bring additional savings of 2.5-3.5% of total budget
Outpatients	20% of total activity ¹ (original HfL assumption)	Est. proportion of unnecessary first and follow-up patient visits	30% of total activity ²	More ambitious reduction in number of follow-up appointments	
A&E	5% (reduced from 10% in H/L)	Est. proportion of minor illness/injury that can be dealt with by self care	10% (original HfL assumptions)	Same	
Diagnostics	0%	-	10-15%	Reduction of GP referrals' variability in diagnostics (to national median)	
Services for which the original HfL assumptions will be used in both core and aggressive scenarios: elective medicine, non-elective medicine, non-elective surgery, paediatrics, obstetrics, regular attendances, community care and primary care					

1 Roughly equivalent to decommissioning 15% of first appointments with a follow-up to first ratio of 2.2 (between national median and top quartile)

2 Equivalent to decommissioning 15% of first appointments with a follow-up to first ratio of 1.90 (national top quartile)

F Elective surgery - Procedures with limited clinical benefit represent 3-10% of activity and could save £25-65 millions¹ across London (1/2)

	Reduction, %		Potential savings. £m			
	Minimum	Maximum	Minimum	Maximum		
A Relatively ineffective interventions	Tonsillectomy	10	90	0.7	6.6	£2-11m ¹
	Spinal cord stimulation	0	50	0	<0.1	
	Back pain – injection and fusion	20	90	0.5	2.4	
	Grommets (surgery for glue ear)	10	90	0.3	2.3	
	Knee washouts	20	90	0.5	2.2	
	Trigger finger	10	33	0.2	0.6	
	Dilation and curettage for women < 40	10	70	<0.1	<0.1	
	Jaw replacement	5	10	<0.1	0.1	
B Potentially cosmetic interventions	Minor skin surgery for non-cancer lesions	10	25	3.7	9.3	£10-22m ¹
	Inguinal, Umbilical and Femoral Hernias	25	50	3.1	6.2	
	Incisional and Ventral Hernias	10	75	0.3	2.4	
	Aesthetic surgery – Breast	50	80	1.2	1.9	
	Varicose Veins	20	80	1.1	4.5	
	Aesthetic surgery – ENT	20	60	0.4	1.2	
	Other Hernia procedures	10	30	0.2	0.6	
	Aesthetic surgery – Plastics	20	95	0.1	0.5	
	Aesthetic surgery – Ophthalmology	20	30	0.2	0.3	
	Orthodontics	5	80	<0.1	<0.1	

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 2007/08; team analysis

F Elective surgery - Procedures with limited clinical benefit represent 3-10% of activity and could save £25-65 millions¹ across London (2/2)

C Effective interventions with a close benefit/ risk balance in mild cases

	Reduction, %		Potential savings. £m	
	Minimum	Maximum	Minimum	Maximum
Knee joint surgery	15	30	4.7	9.4
Primary hip replacement	15	30	2.8	5.6
Hip and knee joint revisions	15	30	2.7	5.4
Cataract surgery	5	25	1.3	6.5
Female genital prolapse/stress incontinence (surgical)	10	25	0.5	1.3
Wisdom teeth extraction	0	24	0	1.0
Dupuytren's contracture	10	33	0.1	0.4
Cochlear implants (inner ear surgery)	0	25	0	0.4
Other joint prosthetics/ replacements	15	30	0.2	0.5
Female genital prolapse/stress incontinence (non-surgical)	5	25	<0.1	<0.1

£12-24m¹

D Effective interventions where cost effective alternatives should be tried first

Hysterectomy for non-cancerous heavy menstrual bleeding	10	70	1.1	7.6
Carpal tunnel surgery	10	33	0.4	1.2
Elective cardiac ablation	5	50	0.1	1.1
Anal procedures	5	15	0.1	0.4
Bilateral hip surgery	15	30	<0.1	<0.1

£2-8m¹

Total of elective procedures

2-3% 9-10%

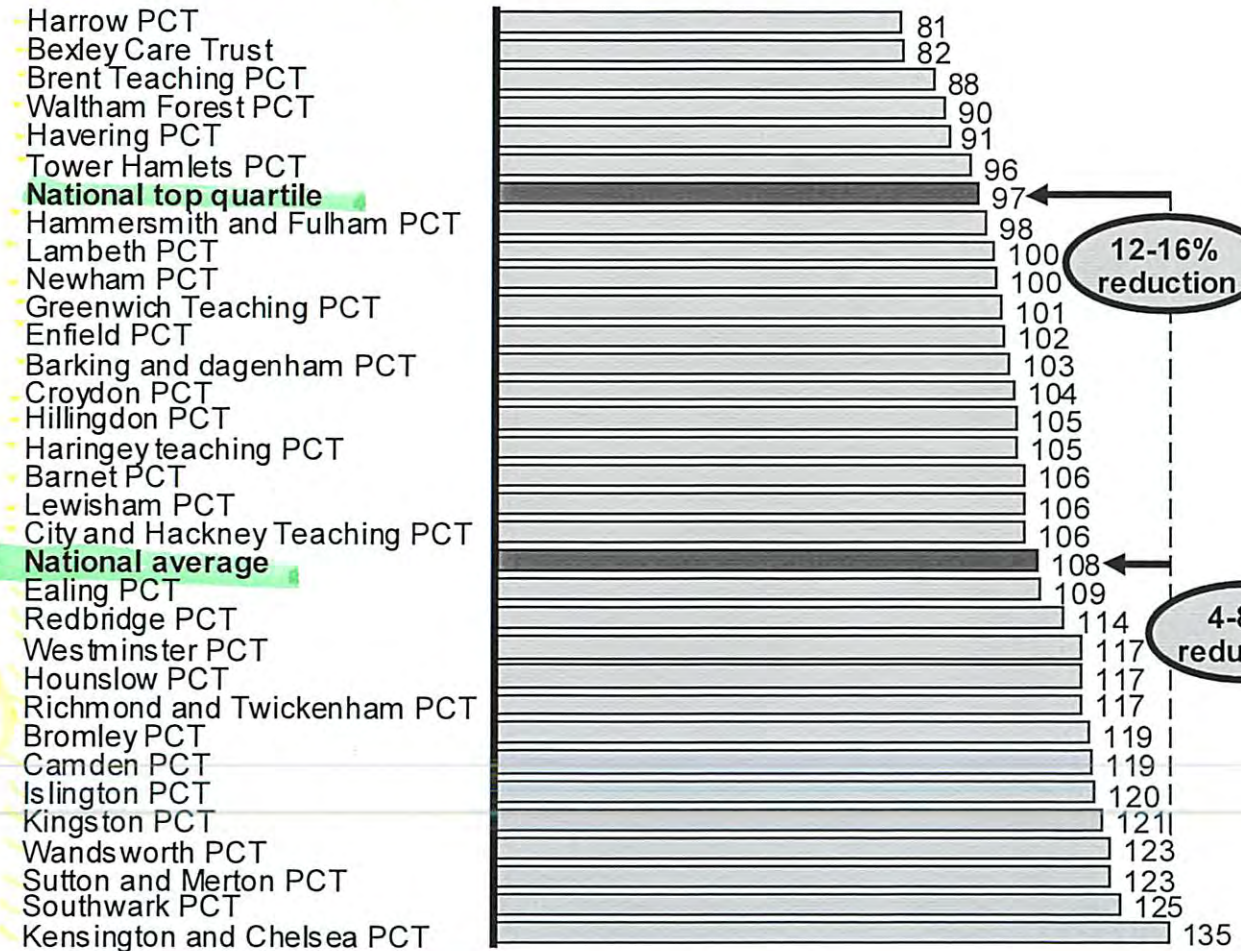
¹ Assumes that only 80% of the maximum potential is achieved

Note: Cancelled procedures not included in analysis

Source: LHO – Save to invest: Developing criteria-based commissioning for planned health care in London; HES 2007/08; team analysis

F Outpatients - PCTs could decommission 6-14% of first outpatient appointments by bringing London referrals to high national standards

Relative level of first outpatient appointments referrals



Bringing the bottom 40% London PCTs to national average could reduce outpatient referrals by 4-8%
 Bringing 80% of London PCTs to the national top quartile could reduce outpatient referrals by 12-16%

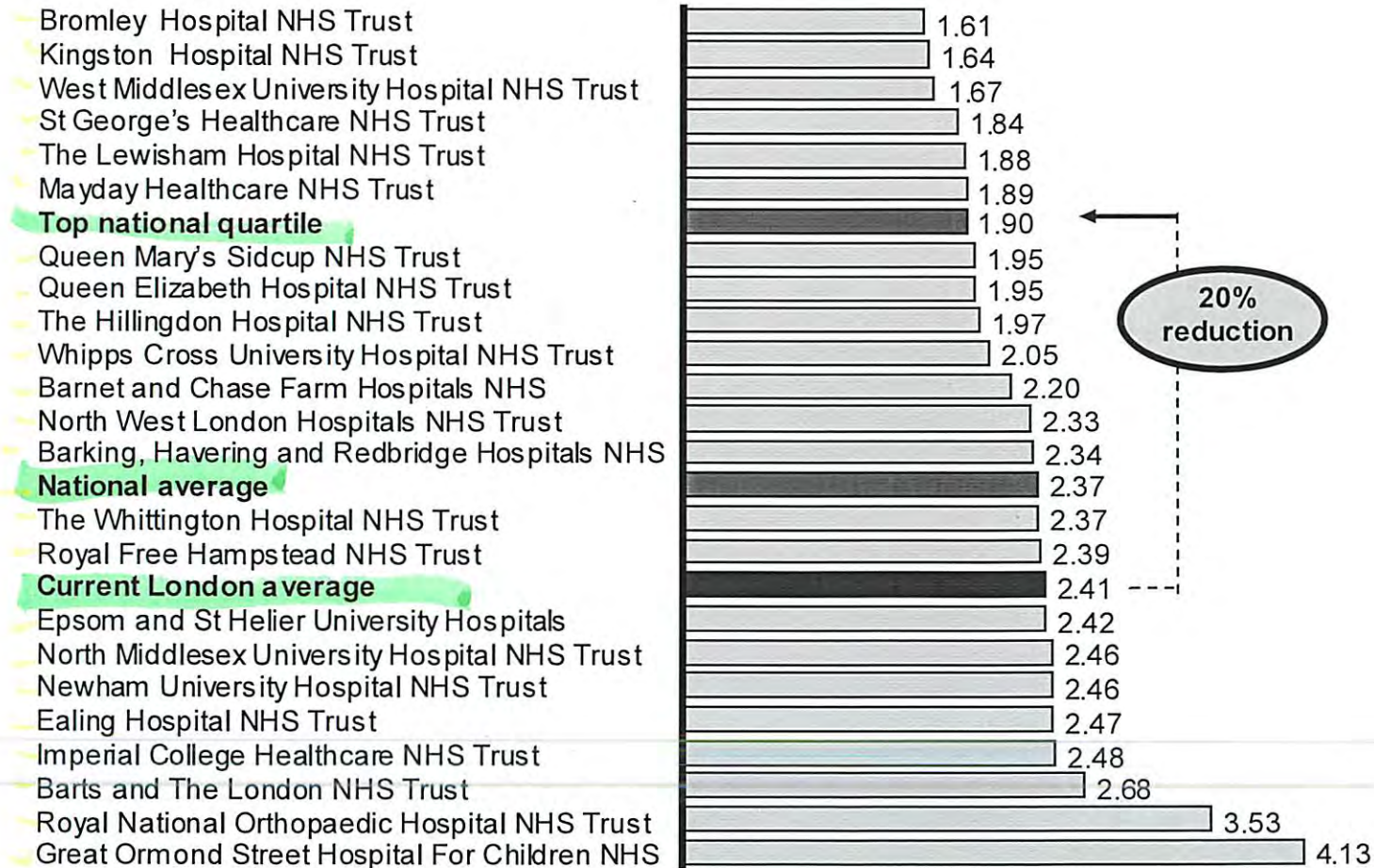
*Less access to health care
 ? Medical consequences?*

19

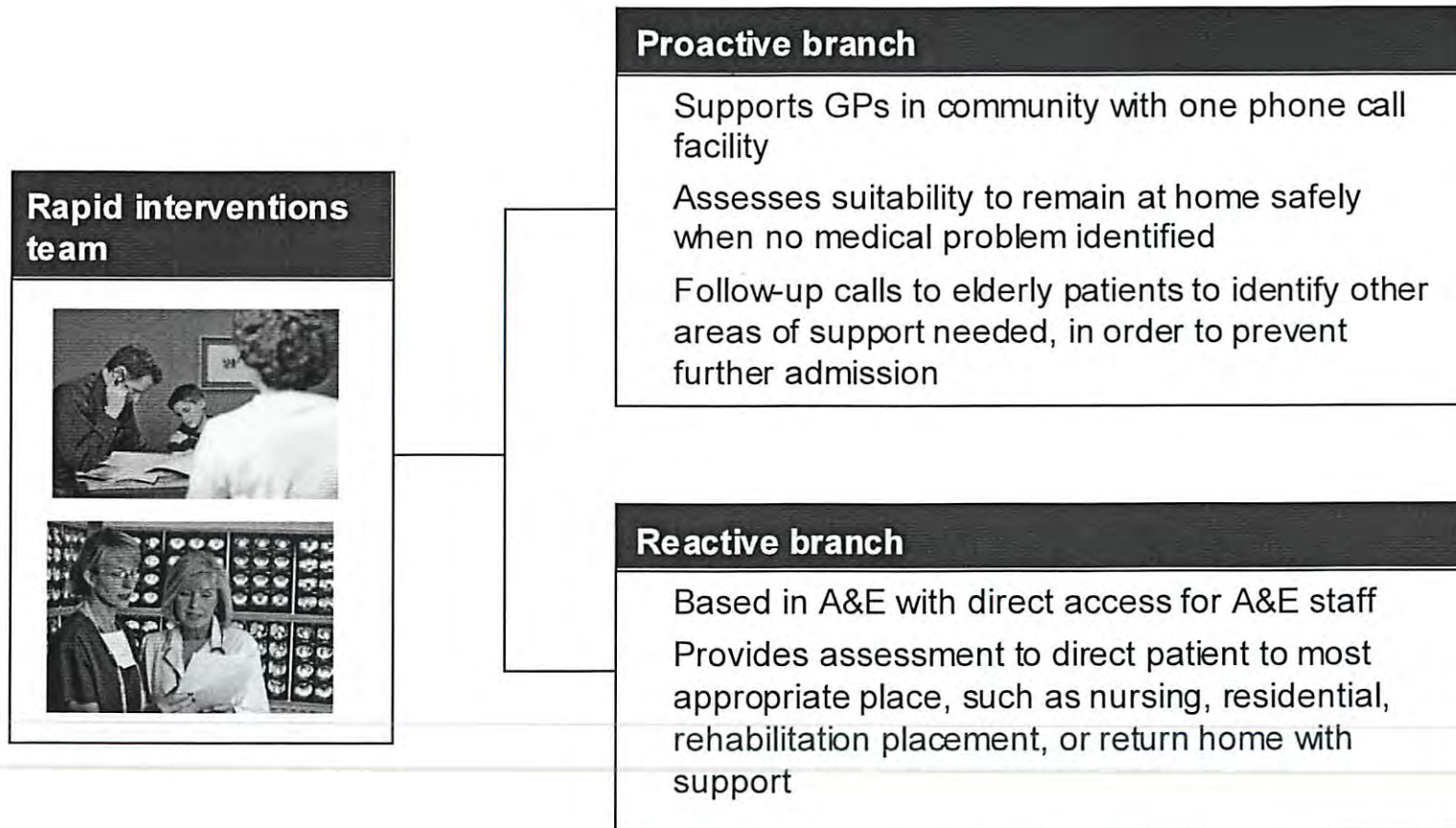
13

F Outpatients - Follow-up appointments could be reduced 20% by stepping down to national top quartile benchmark

Outpatient follow-up to new appointment ratio for London acute trusts, 2008-09



F A&E – Rapid interventions team assessment service **reduces** acute admission by 8%
Case study

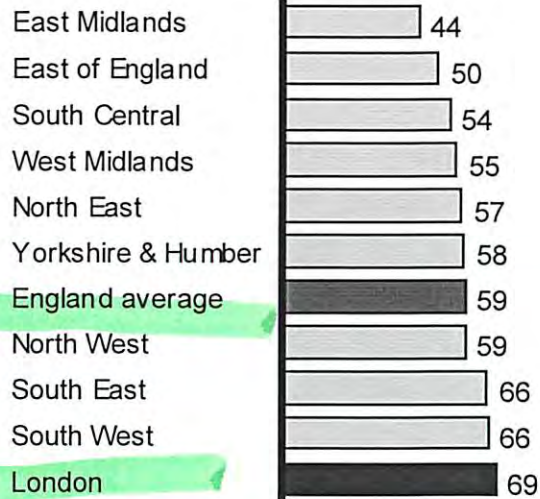


F Diagnostics - Bringing London diagnostics referrals 50-75% closer to England average could reduce diagnostics volume by 7-15%

*is this an improvement?
What evidence
Research
not
needed?*

Number of diagnostics per 1,000 weighted population

CT scans



% improvement if London reaches national average: 14 %

% improvement if London reaches 50-75% of national average: 7-11 %

MRI scans



% improvement if London reaches national average: 19 %

% improvement if London reaches 50-75% of national average: 9-14 %

Ultrasounds

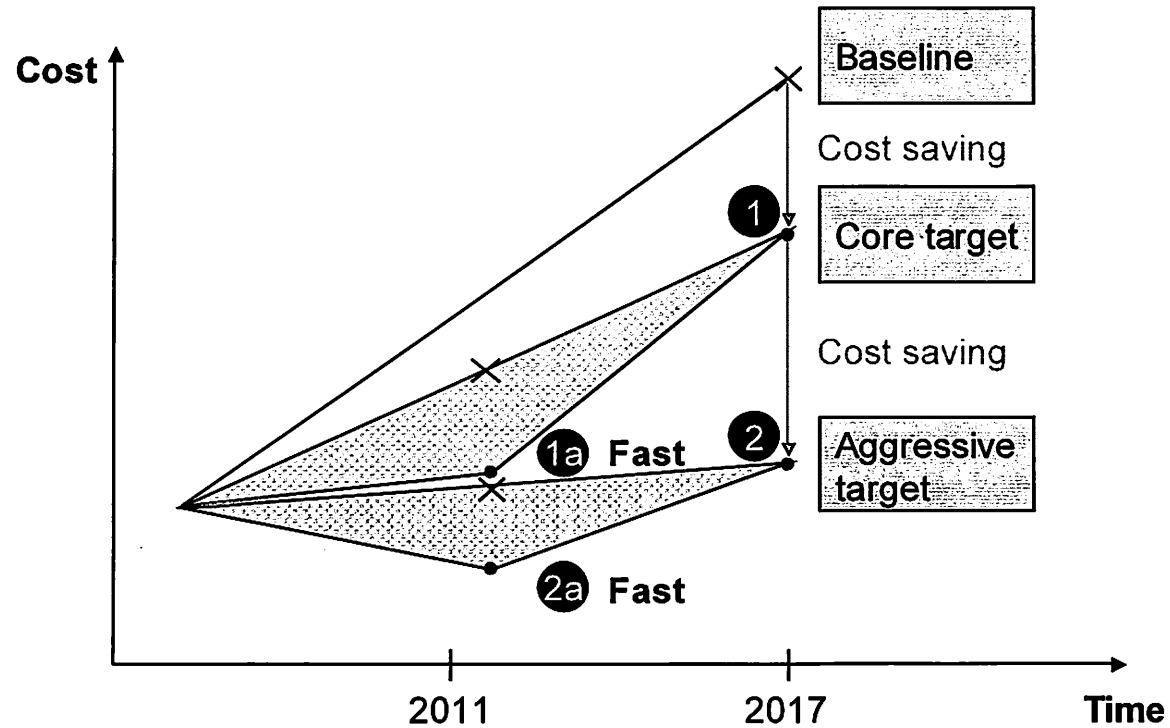


% improvement if London reaches national average: 20 %

% improvement if London reaches 50-75% of national average: 10-15 %

4 For each given scenario on the extent of implementation, we are developing two trajectories – ‘straight-line’ and ‘front-loaded’ (faster)

▨ Additional saving

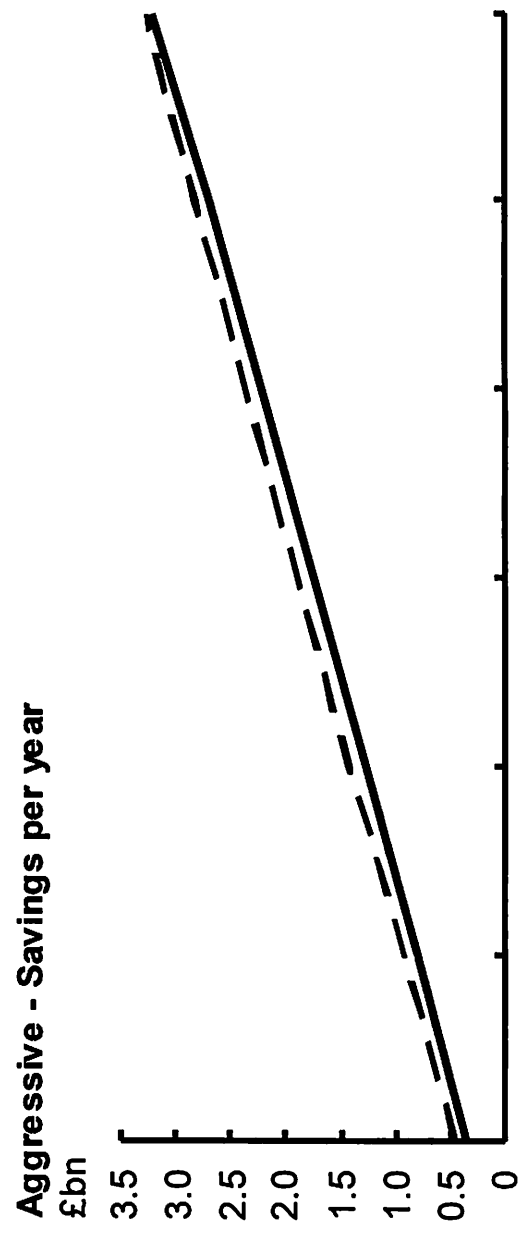
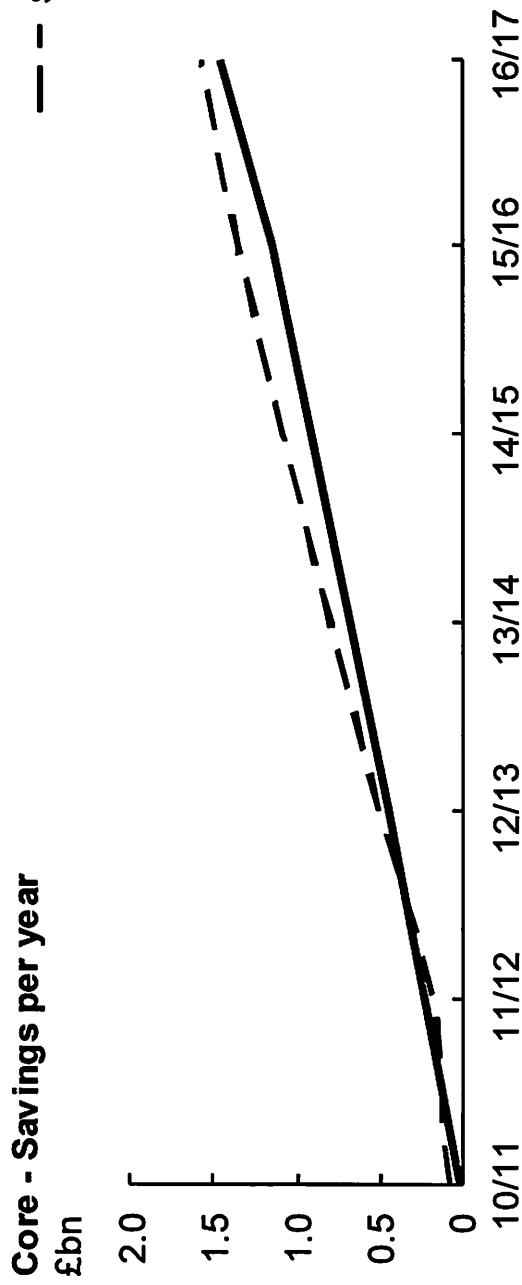


- 4 different cost scenarios to calculate with model

- ① Core target 2017 ② Aggressive target 2017
- ①a Core 'Fast' target 2011 ②a Aggressive 'Fast' 2011

Savings made by HfL implementation in core and aggressive scenarios

— Savings straight
 - - Savings front-ended



Contents

Context to the work

Broad model structure and 2007/8 pan-London starting point

Detailed pan-London assumptions

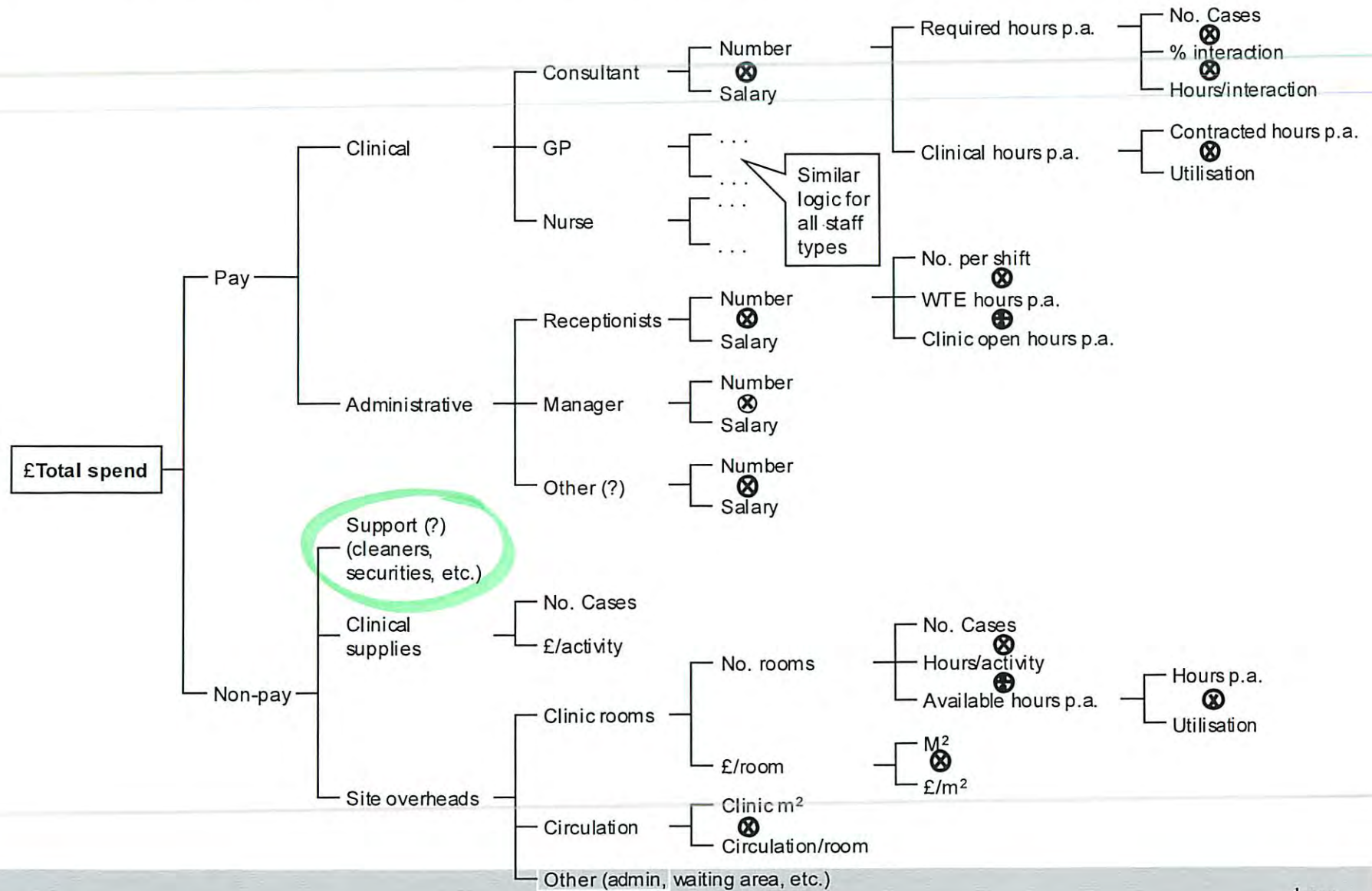
Detailed polysystem modelling assumptions and unit cost outputs

Implications for acute providers

Implications for out-of-hospital settings

Miscellaneous

Bottom-up costing methodology – Polysystem



Activities covered in the polysystem model

Included in space calculation

- Elective medicine activity shifted from acute
- Non-elective medicine activity shifted from acute
- Elective surgery activity shifted from acute
- Non-elective surgery activity shifted from acute
- Paediatrics shifted from acute
- Obstetrics shifted from acute
- Regular attendances shifted from acute
- Outpatients
- A&E shifted from acute
- Primary care
- Community care

Excluded from space calculations

- Mental health
- Learning disabilities
- Dental
- Optical
- Pharmacy
- Extended physiotherapy facilities (e.g. pool)
- Parking space
- Cafe/ restaurant

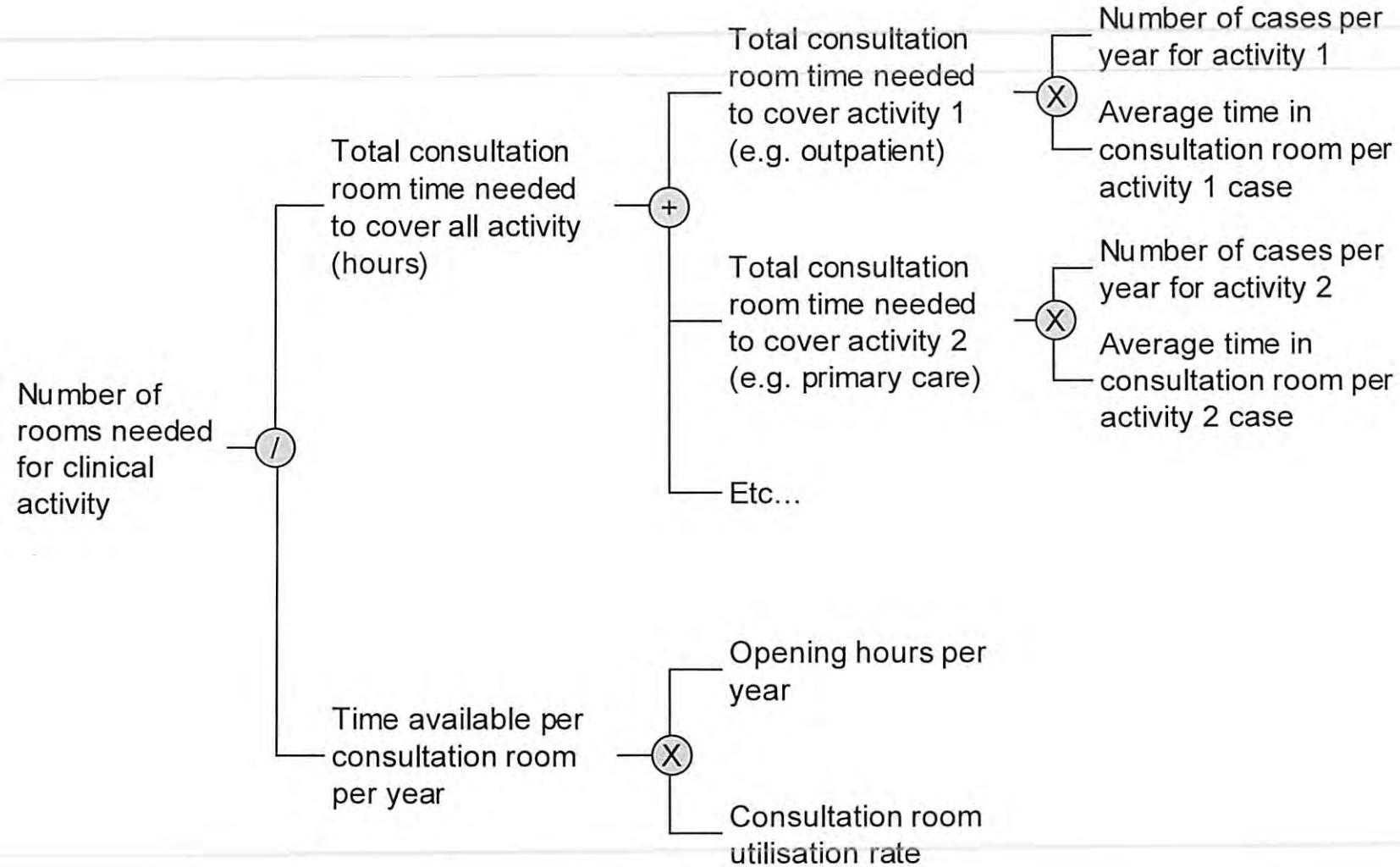
NB

Total size of polysystem calculation

Detailed further

			Core	Agg.	Comments
Clinical space	Consultation	Number of rooms	53.0	38.0	Driven by clinical activity
		Average size of rooms (m ²)	15.8	15.8	70% of 14m ² rooms, 30% of 20m ² rooms
			835	599	
	Diagnostics	10% of consultation space (m ²)	84	60	
Non-clinical space	Circulation & dead space	60% of consultation space (m ²)	501	359	
	Office, IT	50% of consultation space (m ²)	418	300	
	Waiting area	1.5 m ² /case/hour (m ²)	193	200	Driven by clinical activity
Total			2031	1518	

Numbers of room needed for clinical activity calculation



Polysystem bottom-up model (1/6)

Cost Model - Polyclinic bottom up costing

LEGEND AND STYLES

1. Legend and styles

Legend:	Legend:
Should not vary	Will vary
Inputs to this model	Input from activity model
LINKED values from elsewhere in the model	Inputs likely to change under moderate/radical
Interim calculations	Inputs that change with levers
Notes	Main outputs of this model

HIGH LEVEL MODEL SETTINGS AND OUTPUTS OF COST MODELS

2. High level model settings

London Population 2016/17	8,193,040
Set catchment population per Polyclinic	63,024
Number of Polyclinics in London	130

3. Outputs of Cost Model

Total cases at all Polyclinics per year	73,133,359
Cases per Polyclinic Centre per year	562,566
Total cost of all Polyclinics per year (£)	£ 4,746,460,872
Cost per Polyclinic per year (£)	£ 36,511,359
Unit cost of Polyclinic activity (£)	£ 64.90

ACTIVITY FIGURES (2016/17)

3. Activity provided in Polyclinic setting, and cases* per Polyclinic centre per year

Service line	Total London Activity* 2016/17	% Activity* provided in Polyclinics	Total Activity* at all Polyclinics	Activity to PC-Cases* conversion factor	Total PC-Cases* at all Polyclinics per year	PC-Cases* per Polyclinic Centre per year
Units: Acute spells, attendances	Acute spells, attendances	% Acute spells, attendances	Acute spells, attendances	PC-Cases* / acute activity	PC-Cases*	PC-Cases*
Elective Medicine						
- Complex	49,677		-	1.0	-	-
- Non complex	403,379	23%	93,124	1.0	93,124	716
- Long term conditions	7,010		-	1.0	-	-
- Under 17	19,172	10%	1,884	1.0	1,884	14
Non elective Medicine						
- Complex	60,991		-	4.0	-	-
- Non complex	284,235	11%	31,266	2.0	62,532	481
- Long term conditions	46,355	20%	37,806	4.0	151,224	1,163
- Under 17	8,428	4%	363	2.0	726	6
Elective Surgery						
- Complex	185,340		-	1.0	-	-
- High throughput	408,553		-	1.0	-	-
- Minor procedures	85,434	59%	50,406	1.0	50,406	388
- Under 17	57,380		-	1.0	-	-
Non elective Surgery						
- Complex	34,057		-	1.0	-	-
- Non complex	157,463		-	2.0	-	-
- Minor procedures	2,737	100%	2,737	1.0	2,737	21
- Under 17	14,004	4%	543	2.0	1,086	8
- Paediatrics	75,673	7%	5,001	2.0	10,002	77
- Neonatology	71		-	1.0	-	-
Obstetrics	273,571		-	1.0	-	-
SUBTOTAL - SPELLS (includes ALL service lines)	2,123,853	11%	223,131	1.7	373,722	2,875
Regular attendances	205,993	32%	66,132	1.0	66,132	509
Outpatients	9,739,051	41%	3,992,601	1.0	3,992,601	30,712
A&E	4,037,811	50%	2,018,906	1.0	2,018,906	15,530
Community care	12,505,079	100%	12,505,079	1.0	12,505,079	96,193
Primary care	54,176,919	100%	54,176,919	1.0	54,176,919	416,747
Total	82,837,382	88%	72,982,768	1.0	73,133,359	562,566
Notes	*Activity refers to equivalent activity at current setting (e.g. acute inpatient spells); PC-Cases* refers to equivalent activity in Polyclinic Centres					

Polysystem bottom-up model (2/6)

RESOURCE CALCULATION - SINGLE POLYCLINIC CENTRE PER YEAR

4. Average clinical time per case, and percentage of that time that staff and facilities are required on average

Service line	clinical time per case (hours)	Staff - % of total clinical time staff are required, on average				Facilities & Supplies			(place holder in calculations)
		GP	Consultant	Nurse Practitioner / Therapist	Staff Nurses	Time in consultation room (%)	clinical supplies & imaging (%)		
		Hours	Hours	Hours	Hours	Hours	Units/case	Hours	
Elective Medicine	- Complex	50%	10%	85%	5%	60%	100%	100%	100%
	- Non complex	50%	70%	10%	20%	60%	100%	100%	100%
	- Long term conditions	50%	70%	10%	20%	60%	100%	100%	100%
	- Under IT	50%	80%	15%	5%	60%	100%	100%	100%
Non elective Medicine	- Complex	50%	10%	85%	5%	60%	100%	100%	100%
	- Non complex	50%	70%	10%	20%	60%	100%	100%	100%
	- Long term conditions	50%	70%	10%	20%	60%	100%	100%	100%
	- Under IT	50%	80%	15%	5%	60%	100%	100%	100%
Elective Surgery	- Complex	50%	10%	85%	5%	60%	100%	100%	100%
	- High throughput	50%	70%	10%	20%	30%	100%	100%	100%
	- Minor procedures	50%	70%	10%	20%	75%	100%	100%	100%
	- Under IT	50%	80%	15%	5%	60%	100%	100%	100%
Non elective Surgery	- Complex	50%	10%	85%	5%	60%	100%	100%	100%
	- Non complex	50%	70%	10%	20%	60%	100%	100%	100%
	- Minor procedures	50%	70%	10%	20%	75%	100%	100%	100%
	- Under IT	50%	80%	15%	5%	60%	100%	100%	100%
	- Paediatrics	50%	80%	15%	5%	60%	100%	100%	100%
	- Neonatology	50%	0%	0%	0%	-	100%	100%	100%
	Obstetrics	50%	0%	0%	0%	-	100%	100%	100%
	Regular attendances	50%	10%	10%	10%	70%	100%	100%	100%
	Outpatients	50%	10%	55%	37%	60%	100%	100%	100%
	A&E	25%	60%	0%	40%	60%	100%	100%	100%
	Community care	50%	0%	0%	66%	33%	100%	100%	100%
	Primary care	25%	60%	0%	40%	-	100%	100%	100%

Notes: Total time per case averaged over all cases; % staff time required = total staff time required / number of cases

5. Average clinical time per case by staff type and facilities

Service line	Staff - average clinical time per case (hours)	Facilities & Supplies				Overheads (place holder in calculations)		
		GP	Consultant	Nurse Practitioner / Therapist	Staff Nurse		Time in consultation room per case (hours)	Consumption of clinical supply & imaging units
		Hours	Hours	Hours	Hours		Hours	Units/case
Elective Medicine	- Complex	0.1	0.4	0.0	0.3	0.5	36.6	0.5
	- Non complex	0.4	0.1	0.1	0.3	0.5	25.9	0.5
	- Long term conditions	0.4	0.1	0.1	0.3	0.5	28.6	0.5
	- Under IT	0.4	0.1	0.0	0.3	0.5	25.9	0.5
Non elective Medicine	- Complex	0.1	0.4	0.0	0.3	0.5	19.6	0.5
	- Non complex	0.4	0.1	0.1	0.3	0.5	15.6	0.5
	- Long term conditions	0.4	0.1	0.1	0.3	0.5	11.6	0.5
	- Under IT	0.4	0.1	0.0	0.3	0.5	15.6	0.5
Elective Surgery	- Complex	0.1	0.4	0.0	0.3	0.5	36.6	0.5
	- High throughput	0.4	0.1	0.1	0.5	0.5	28.5	0.5
	- Minor procedures	0.4	0.1	0.1	0.4	0.5	28.5	0.5
	- Under IT	0.4	0.1	0.0	0.3	0.5	28.5	0.5
Non elective Surgery	- Complex	0.1	0.4	0.0	0.3	0.5	36.6	0.5
	- Non complex	0.4	0.1	0.1	0.3	0.5	15.6	0.5
	- Minor procedures	0.4	0.1	0.1	0.4	0.5	26.9	0.5
	- Under IT	0.4	0.1	0.0	0.3	0.5	15.6	0.5
	- Paediatrics	0.4	0.1	0.0	0.3	0.5	12.5	0.5
	- Neonatology	-	-	-	-	0.5	1.2	0.5
	Obstetrics	-	-	-	-	0.5	22.9	0.5
	Regular attendances	0.1	0.1	0.1	0.4	0.5	65.1	0.5
	Outpatients	0.1	0.3	0.2	0.3	0.5	18.9	0.5
	A&E	0.2	-	0.1	0.2	0.3	12.4	0.3
	Community care	-	-	0.3	0.2	0.5	34.0	0.5
	Primary care	0.2	-	0.1	-	0.3	32.1	0.3

Clinical time per case by staff and facilities averaged over all cases; Relative consumption of clinical supplies = cost of supplies

Polysystem bottom-up model (3/6)

6. Total clinical time per year for all cases

Service line	Staff - total clinical time per year (hours)					Facilities & Supplies		
	GP	Consultant	Nurse Practitioner / Therapist	Staff Nurse	Time in consultation room per year (hours)	consumption of clinical supply & imaging units	Overheads (place holder in calculations)	
	Units: Hours	Hours	Hours	Hours	Hours	Units	Hours	
Elective Medicine	- Complex	-	-	-	-	-	-	
	- Non complex	251	36	72	215	358	18,585	
	- Long term conditions	-	-	-	-	-	-	
	- Under 17	6	1	0	4	7	376	
Non elective Medicine	- Complex	-	-	-	-	-	-	
	- Non complex	168	24	48	144	241	7,481	
	- Long term conditions	407	58	116	349	582	13,495	
	- Under 17	2	0	0	2	3	87	
Elective Surgery	- Complex	-	-	-	-	-	-	
	- High throughput	-	-	-	-	-	-	
	- Minor procedures	136	19	39	145	194	11,036	
	- Under 17	-	-	-	-	-	-	
Non elective Surgery	- Complex	-	-	-	-	-	-	
	- Non complex	-	-	-	-	-	-	
	- Minor procedures	7	1	2	8	11	565	
	- Under 17	3	1	0	3	4	130	
	- Paediatrics	31	6	2	23	38	962	
	- Neonatology	-	-	-	-	-	-	
	- Obstetrics	-	-	-	-	-	-	
Regular attendances	25	25	25	178	254	33,097		
Outpatients	1,536	8,446	5,682	9,214	15,356	580,754		
A&E	2,330	-	1,553	2,330	3,883	192,429		
Community care	-	-	31,744	15,872	48,097	3,274,314		
Primary care	62,512	-	41,675	-	104,187	13,368,793		
Total	67,414	8,618	80,958	28,486	173,214	17,502,104		

7. Clinical hours per year

Staff, facilities & clinical supplies	Contracted hours per year, FTEs (hours)			% Clinical hours / contracted	Clinical hours per year
	Units: Hours/week	Weeks/year	Hours/year		
GP	40	40	1,600	56%	896
Consultant	40	40	1,600	56%	896
Nurse Practitioner / Therapist	40	40	1,600	56%	896
Staff Nurses	40	40	1,600	56%	896
Consultation rooms	84	52	4,368	75%	3,276
Clinical supplies	1	1	1	100%	1
Overheads	168	52	8,766	100%	8,766

Notes: FTEs = Full time equivalents

8. Total number of staff, facilities & supplies required per year

Resource unit	Staff FTEs				Facilities & Supplies			Notes
	GP	Consultant	Nurse Practitioner / Therapist	Staff Nurses	Consultation rooms**	Clinical supplies & imaging	Overheads	
FTEs, facilities - unrounded	75.24	9.62	90.36	31.79	52.87	17,502,104.14	19.76	Overheads = Number of annual
Smallest possible unit	0.10	0.10	0.10	0.10	1.00	1.00	0.00	Smallest possible unit for the p
FTEs, facilities - rounded up	75.30	9.70	90.40	31.80	53.00	17,502,105.00	19.76	Number of staff FTEs, consult,
Cases / FTE, facilities*	7,471	57,997	6,223	17,691	10,614	0	N/A	Total number of PC-Cases per

Notes: FTEs = Full time equivalents; *Cases / FTE, facilities* calculated for all cases and service lines, irrespective of whether a particular staff type or facility is required for any service line; **Consultation rooms rounded at this stage, assuming

Polysystem bottom-up model (5/6)

10d. Overhead costs per year

i) Key values repeated from above

Opening hours / year (hours)	4,368	
Cases / year	562,566	
Notes	Figures are repeated here auditing - are referred to it	
	Hub & spoke	integrated
A&C Staff	5	1
Receptionist	6	2

ii) Pay costs - Support and administrative staff

Staff	Contracted hours per year, FTEs (hours)			Staff / shift	FTE	Annual salary	Total cost	
	Unit:	Hour/week	Week/year					Hour/year
A&C Staff		40	40	1,600	5	14	£ 60,000	£ 840,000
Receptionist		35	40	1,400	6	13	£ 30,000	£ 570,000
Other1		-	-	-	-	-	-	-
Other2		-	-	-	-	-	-	-
Other3		-	-	-	-	-	-	-
Total						33	£ 42,727	£ 1,410,000
Notes	Add support and administrative staff types as required							

iii) Additional Non clinical areas

	Consultation room area	% of Consultation room area	Circulation area	Cost / sqm	Total cost
Unit:	Sqm	%	Sqm	£/Sqm	£
Circulation area	835	60%	501	£ 315	£ 157,843
Unit:	Sqm	%	Sqm	Cost / sqm	Total cost
Other non clinical area (office space, IT, etc.)	835	60%	501	£ 315	£ 157,843
Unit:	Cases per opening hour	Area per case per	Area (Sqm)	Cost / Sqm	Total cost
Waiting area	129	1.5	193	£ 315	£ 60,883
Notes					

iv) Additional overhead costs dependent on number of cases, opening hours and per year

	Cost per unit	Total cost	Notes
Unit:	£/unit	£	
per case	£ 1.72	£ 967,614	Adjustment to match benchmark £4 / case total overhead cost (UK GP Practice)
per opening hour	-	-	
per year	-	-	
Total		£ 967,614	
Notes	Additional overhead (and facilities) costs on top of costs for consultation rooms, non clinical areas and non-clinical pay		

v) Total annual overhead cost

Total annual overhead cost	£ 2,754,183
----------------------------	-------------

COST CALCULATION - OUTPUTS

10e. Total annual cost of Polyclinic centre

Annual costs	Staff				Facilities & Supplies			Total
	GP	Consultant	Nurse Practitioner / Therapist	Staff Nurses	Consultation rooms*	Clinical supplies	Overheads	
Unit:	£ t/year	£ t/year	£ t/year	£ t/year	£ t/year	£ t/year	£ t/year	£ t/year
Total annual costs	£ 9,036,000	£ 1,184,000	£ 4,520,000	£ 1,272,000	£ 263,071	£ 17,502,104	£ 2,754,183	£ 36,511,359
Notes								

Polysystem bottom-up model (6/6)

11. Total annual costs attributed to service lines

Total Annual costs	Staff					Facilities & Supplies				Total
	GP	Consultant	Nurse Practitioner / Therapist	Staff Nurses	Consultation rooms*	Clinical supplies	Overheads			
	Units: £/year	£/year	£/year	£/year	£/year	£/year	£/year	£/year		
Elective Medicine	- Complex	-	-	-	-	-	-	-	-	-
	- Non complex	£ 33,606	£ 4,838	£ 3,999	£ 9,596	£ 544	£ 18,585	£ 5,695	£	76,863
	- Long term conditions	-	-	-	-	-	-	-	-	-
	- Under 17	£ 777	£ 147	£ 20	£ 194	£ 11	£ 376	£ 115	£	1,640
Non elective Medicine	- Complex	-	-	-	-	-	-	-	-	-
	- Non complex	£ 22,566	£ 3,249	£ 2,686	£ 6,444	£ 365	£ 7,481	£ 3,824	£	46,614
	- Long term conditions	£ 54,572	£ 7,856	£ 6,495	£ 15,583	£ 883	£ 13,495	£ 9,248	£	108,132
	- Under 17	£ 299	£ 57	£ 8	£ 75	£ 4	£ 87	£ 44	£	574
Elective Surgery	- Complex	-	-	-	-	-	-	-	-	-
	- High throughput	-	-	-	-	-	-	-	-	-
	- Minor procedures	£ 18,190	£ 2,619	£ 2,165	£ 6,493	£ 294	£ 11,036	£ 3,083	£	43,880
	- Under 17	-	-	-	-	-	-	-	-	-
Non elective Surgery	- Complex	-	-	-	-	-	-	-	-	-
	- Non complex	-	-	-	-	-	-	-	-	-
	- Minor procedures	£ 988	£ 142	£ 118	£ 353	£ 16	£ 565	£ 167	£	2,349
	- Under 17	£ 448	£ 85	£ 12	£ 112	£ 6	£ 130	£ 66	£	859
	- Paediatrics	£ 4,125	£ 779	£ 107	£ 1,031	£ 58	£ 962	£ 612	£	7,675
	- Neonatology	-	-	-	-	-	-	-	-	-
	- Obstetrics	-	-	-	-	-	-	-	-	-
	Regular attendances	£ 3,409	£ 3,436	£ 1,420	£ 7,950	£ 386	£ 33,097	£ 4,044	£	53,743
	Outpatients	£ 205,831	£ 1,140,794	£ 317,222	£ 411,421	£ 23,323	£ 580,794	£ 244,171	£	2,323,515
	A&E	£ 312,242	-	£ 86,706	£ 104,020	£ 5,897	£ 192,429	£ 61,794	£	763,028
	- Community care	-	-	£ 1,772,294	£ 708,729	£ 73,048	£ 3,274,314	£ 764,759	£	6,593,143
	Primary care	£ 8,378,947	-	£ 2,326,749	-	£ 158,235	£ 13,368,793	£ 1,656,619	£	25,889,343
	Total	£ 9,036,000	£ 1,164,000	£ 4,520,000	£ 1,272,000	£ 263,071	£ 17,502,104	£ 2,754,183	£	36,511,359
	Notes					1%	48%	5%		

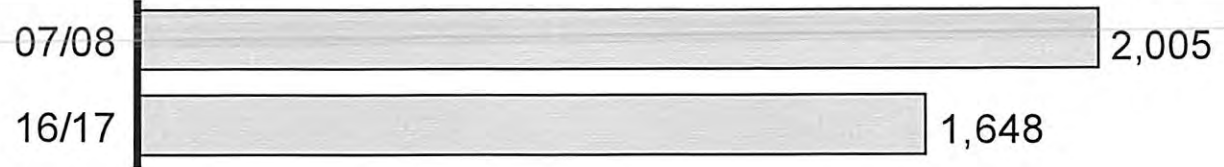
12. Unit costs by service line

Total Annual costs	Staff					Facilities & Supplies				Total
	GP	Consultant	Nurse Practitioner / Therapist	Staff Nurses	Consultation rooms*	Clinical supplies	Overheads			
	Units: £/case	£/case	£/case	£/case	£/case	£/case	£/case	£/case		
Elective Medicine	- Complex	-	-	-	-	-	-	-	-	-
	- Non complex	£ 46.91	£ 6.75	£ 5.58	£ 13.40	£ 0.76	£ 25.94	£ 7.95	£	107.30
	- Long term conditions	-	-	-	-	-	-	-	-	-
	- Under 17	£ 53.61	£ 10.13	£ 1.40	£ 13.40	£ 0.76	£ 25.94	£ 7.95	£	113.19
Non elective Medicine	- Complex	-	-	-	-	-	-	-	-	-
	- Non complex	£ 46.91	£ 6.75	£ 5.58	£ 13.40	£ 0.76	£ 15.55	£ 7.95	£	96.91
	- Long term conditions	£ 46.91	£ 6.75	£ 5.58	£ 13.40	£ 0.76	£ 11.60	£ 7.95	£	92.96
	- Under 17	£ 53.61	£ 10.13	£ 1.40	£ 13.40	£ 0.76	£ 15.55	£ 7.95	£	102.80
Elective Surgery	- Complex	-	-	-	-	-	-	-	-	-
	- High throughput	-	-	-	-	-	-	-	-	-
	- Minor procedures	£ 46.91	£ 6.75	£ 5.58	£ 16.74	£ 0.76	£ 28.46	£ 7.95	£	113.17
	- Under 17	-	-	-	-	-	-	-	-	-
Non elective Surgery	- Complex	-	-	-	-	-	-	-	-	-
	- Non complex	-	-	-	-	-	-	-	-	-
	- Minor procedures	£ 46.91	£ 6.75	£ 5.58	£ 16.74	£ 0.76	£ 26.85	£ 7.95	£	111.56
	- Under 17	£ 53.61	£ 10.13	£ 1.40	£ 13.40	£ 0.76	£ 15.55	£ 7.95	£	102.30
	- Paediatrics	£ 53.61	£ 10.13	£ 1.40	£ 13.40	£ 0.76	£ 12.50	£ 7.95	£	89.75
	- Neonatology	-	-	-	-	-	-	-	-	-
	- Obstetrics	-	-	-	-	-	-	-	-	-
	Regular attendances	£ 6.70	£ 6.75	£ 2.79	£ 15.63	£ 0.76	£ 65.06	£ 7.95	£	105.65
	Outpatients	£ 6.70	£ 37.14	£ 10.33	£ 13.40	£ 0.76	£ 18.91	£ 7.95	£	95.19
	A&E	£ 20.11	-	£ 5.58	£ 6.70	£ 0.38	£ 12.39	£ 3.98	£	48.33
	- Community care	-	-	£ 18.42	£ 7.37	£ 0.76	£ 34.04	£ 7.95	£	68.54
	Primary care	£ 20.11	-	£ 5.58	-	£ 0.38	£ 32.08	£ 3.98	£	62.12
	Total	£ 18.06	£ 2.07	£ 8.03	£ 2.28	£ 0.47	£ 31.11	£ 4.90	£	64.90
	Percentage of total costs	25%	3%	12%	3%	0.72%	47.3%	7.5%		100%

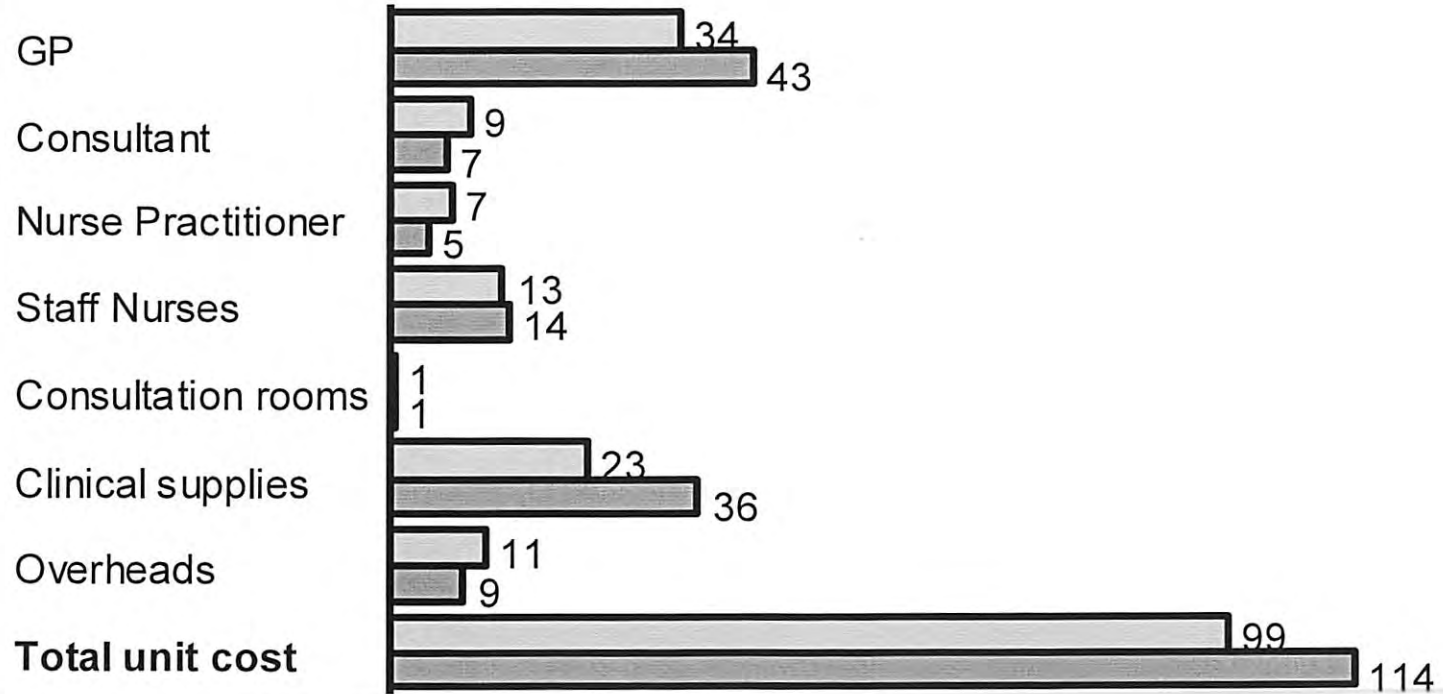
Inpatients unit costs in base case and in polysystems

Unit cost under aggressive scenario
 Unit cost under core scenario

Top-down based on tariff



Bottom-up costing

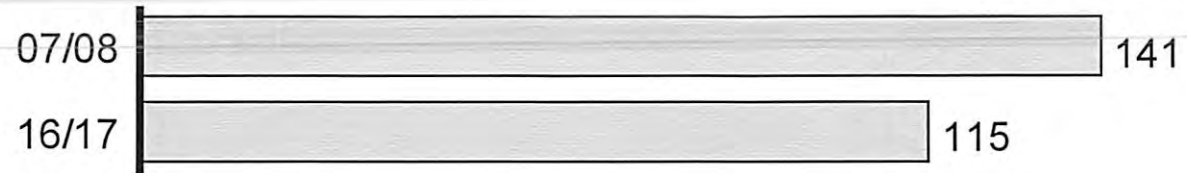


1 Assumes base case acute tariffs make 3.6% efficiency gains

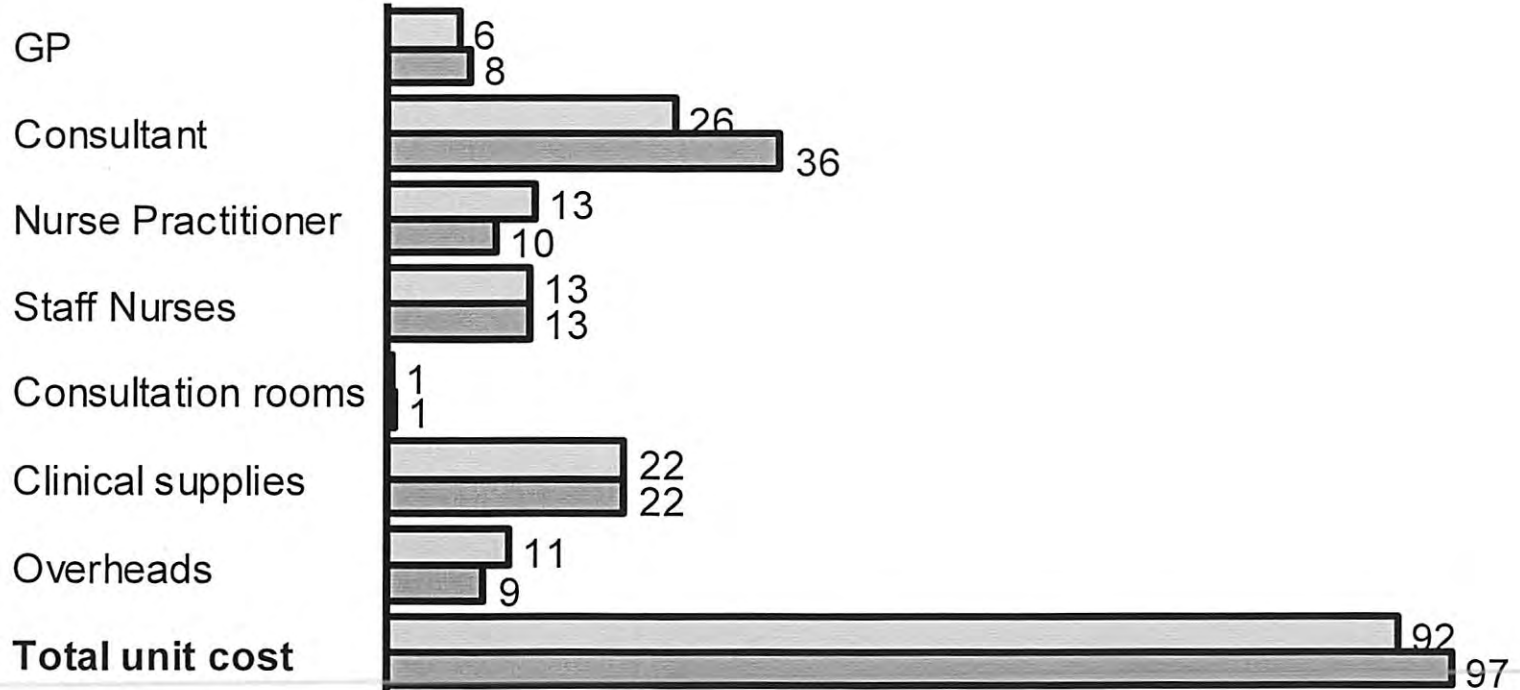
Outpatients unit costs in base case and in polysystems

Unit cost under aggressive scenario
 Unit cost under core scenario

Top-down based on tariff



Bottom-up costing

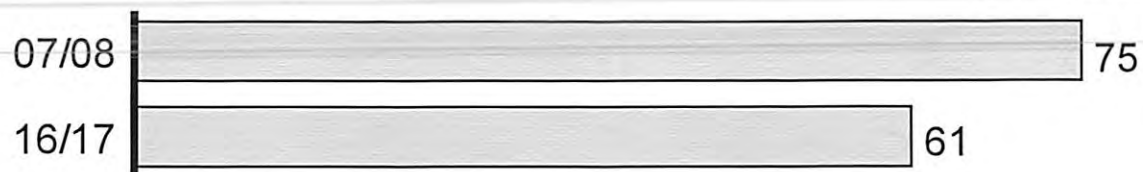


1 Assumes base case acute tariffs make 3.6% efficiency gains

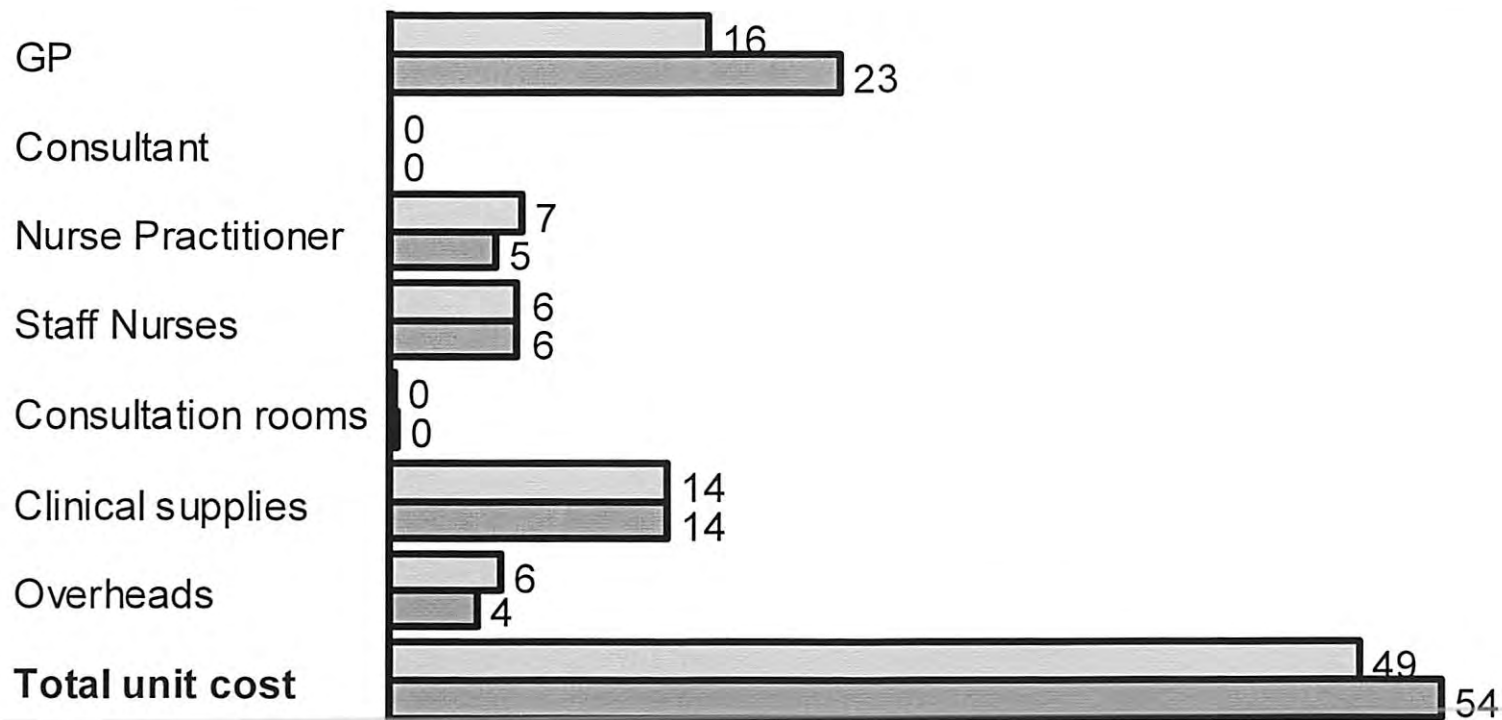
A&E unit costs in base case and in polysystems

Unit cost under aggressive scenario
 Unit cost under core scenario

Top-down based on tariff



Bottom-up costing

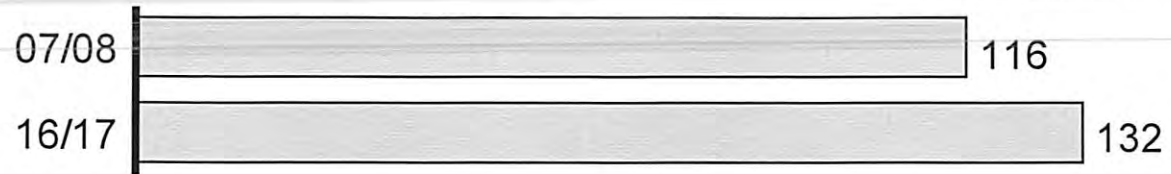


1 Assumes base case acute tariffs make 3.6% efficiency gains

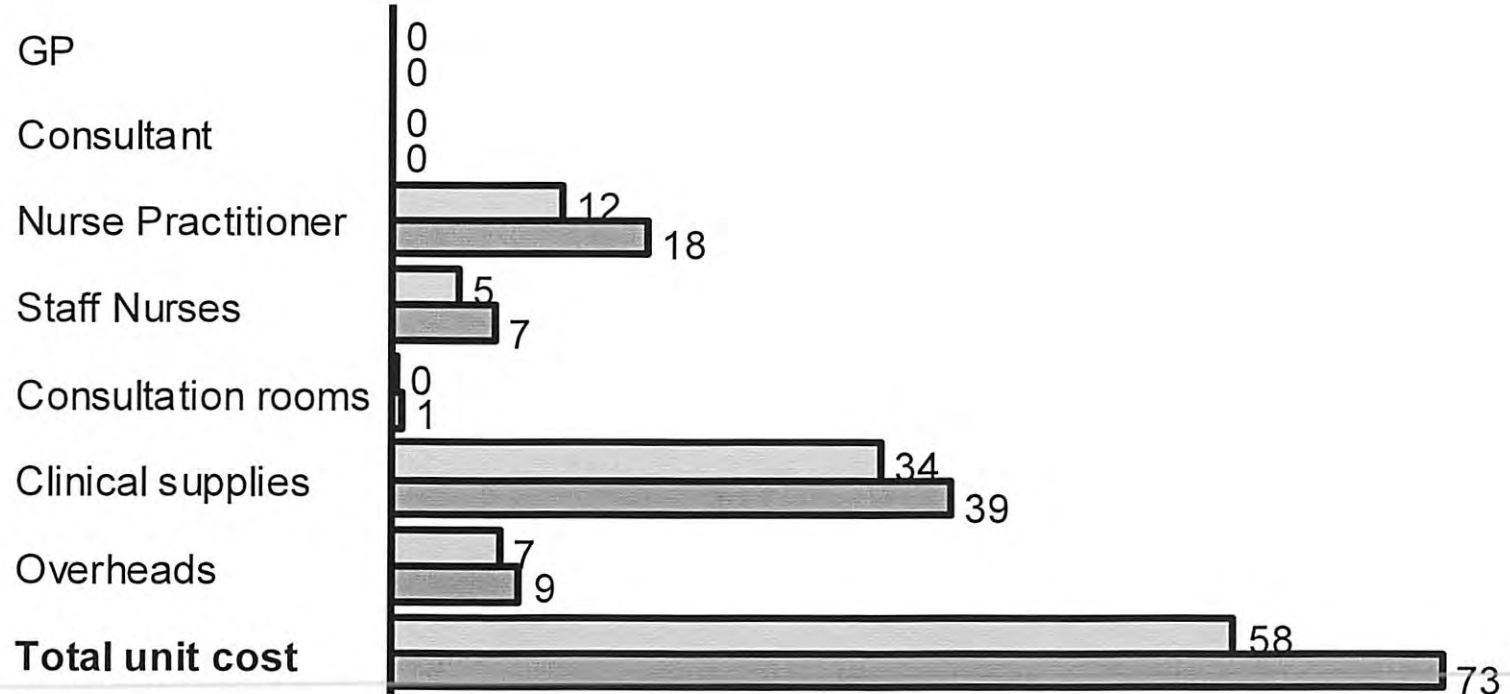
Community unit costs in base case and in polysystems

Unit cost under aggressive scenario
 Unit cost under core scenario

Top-down based on tariff (pre-efficiency savings outside of polyclinic)



Bottom-up costing

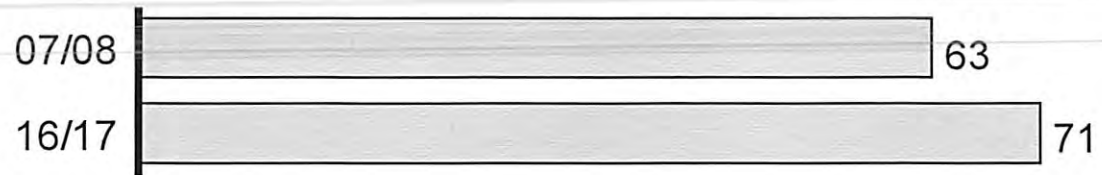


1 Assumes no efficiency gains in base case moderate and radical

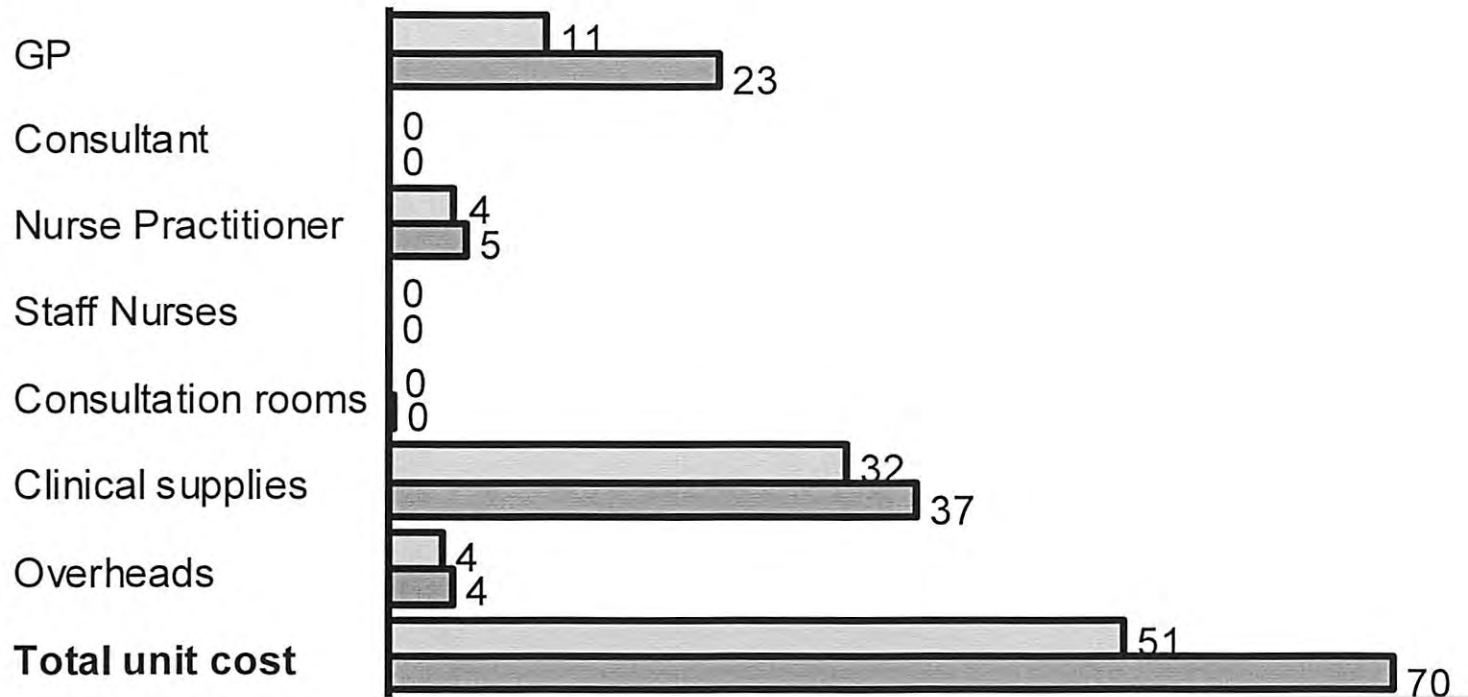
Primary unit costs in base case and in polysystems

Unit cost under aggressive scenario
 Unit cost under core scenario

Top-down based on tariff (pre-efficiency savings outside of polyclinic)



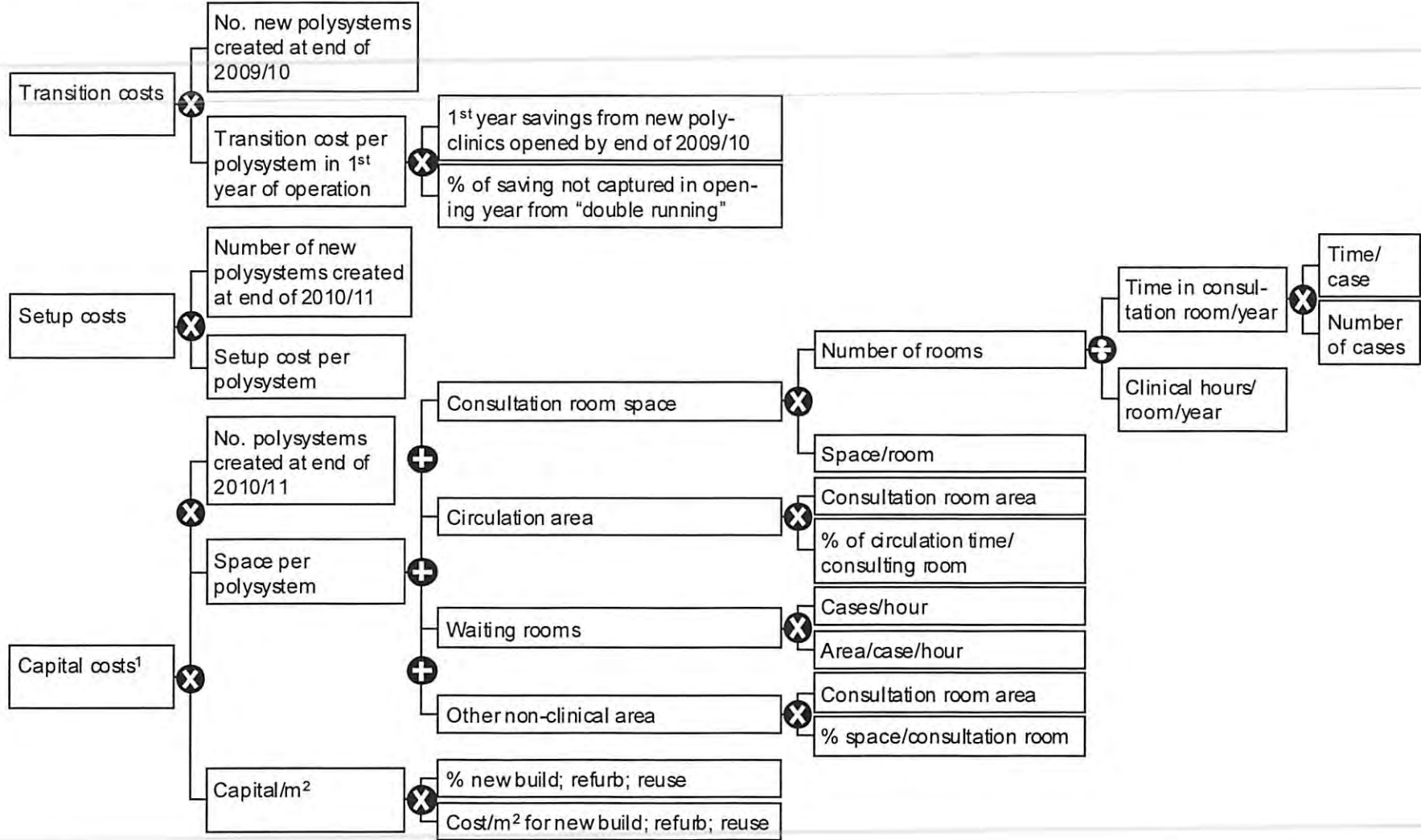
Bottom-up costing



1 Radical case assume net tariff uplift 0%, moderate assumes 3.6% efficiency gain, no efficiency gain in base case

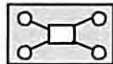
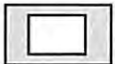
Modeling transition, setup costs and capital

2010/11 year example



Assumptions for capital expenditure, transition and set-up costs

Detailed facts/ assumptions provided

Base assumptions for capex, transition and double running costs			'Radicalness' of lever pull	
Capital efficiency parameters	Type of polysystem		Hub & spokes 	Consolidated 
	Space utilisation	75%		

Capex				
- New-built	£3250 /m ²		£3500 /m ²	
- Refurbish	£2100/m ²		£2300/m ²	
- Reuse	£200/m ²		£200/m ²	

Annual cost of space ¹				
- New-built	£380 /m ²		£400 /m ²	
- Refurbish	£260/m ²		£290/m ²	
- Reuse	£85/m ²		£84/m ²	

Set-up costs	~£1.0m per polysystem		~£1.0m per polysystem	

Transition costs	20% efficiency loss for 1 year + 30% residual acute activity for 1/2 year		20% efficiency loss for 1 year + 30% residual acute activity for 1/2 year	

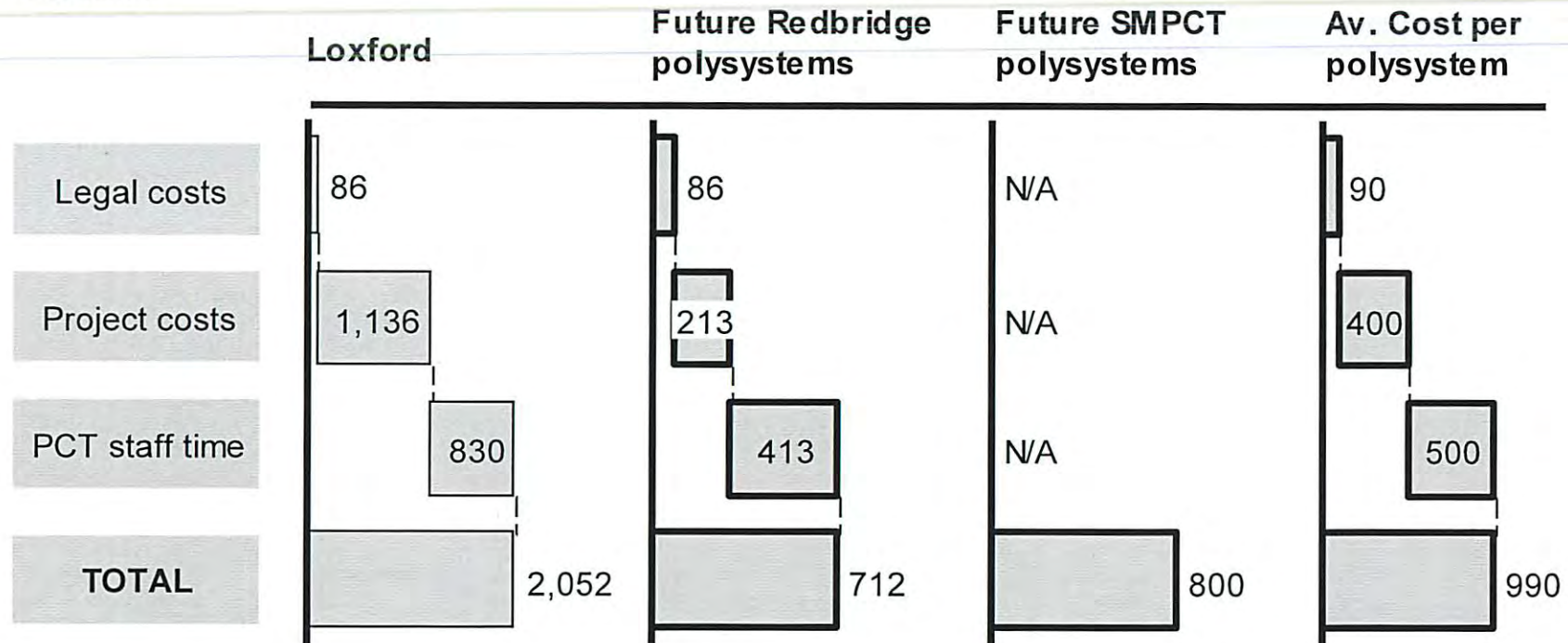
Core scenario	Assume 100% 'hub and spoke' with [15:75:10] new-built to refurbish to reuse ratio with base assumptions as listed in table
Aggressive scenario	Assume 100% 'hub and spoke' with [0:75:25] new-built to refurbish to reuse ratio Uses base assumptions with the following changes <ul style="list-style-type: none"> - 80% space utilisation, - Set up costs transitioning from £1.0m today to £0.5m - Transition costs 20% efficiency loss for 1/2 year + 15% residual acute activity for 1/2 year

Pace of implementation	
Straight line	Acute: Included in tariff shifts Polysystems: 1) constant balance of new build to leasing, implemented as per shift to lower cost settings; 2) set-up costs and transition costs transition achieved by 2016/17 in aggressive scenario
Front-end	Acute: Included in tariff shifts Polysystems: 1) all new builds completed first, then refurbishments, as per shift to lower cost settings; 2) set-up costs and transition costs transition achieved by 2011/12 in aggressive scenario

¹ including costs of facilities management, heating and lighting

Set-up costs are in the region of £1m per polysystem, with additional transition costs to be managed

£ million



In addition to the above transition costs, most PCTs will need to manage double running costs and ramp down at acute providers as they transfer over activity. For example, BHCH assumes that only 50% of OP activity will shift over in the first year. The acute provider and PCT will need to manage the cost base so no double running costs occur

Very low estimates

1 Two years at £2m/year total or £400k/site

Source: Redbridge PCT, Sutton and Merton PCT, BHCH Annex V

Transition costs: commissioners will only cover initial inefficiencies in the polysystems as well as residual activities from the acute system

Costs assumed carried by the commissioner

- A** Lack of efficiency in polysystem at the start compared to expectations
 - 20% efficiency loss (modelled as 20% increase in polysystem unit cost) for 1 year in core scenario
 - Same inefficiency but for 6 months in aggressive scenario
- B** Residual activity in acute setting due to patient self direction to hospital, wrong referral pathway (GP unaware of new polysystem pathway) or patient choice (prefer to go to hospital when some activity still provided there)
Occurs simultaneously to a lack of volume observed by the polysystem provider
Total effect modelled as:
 - 30% residual activity in acute cost setting for 6 months in core scenario
 - 15% residual activity in acute cost setting for 6 months in aggressive scenario
- C** Set up costs of £1m per polysystem in core scenario, transitioning from £1m to £0.5m per polysystem in aggressive scenario

Total pan-London costs carried by commissioners (£m)⁴

	Core	Aggressive
A	£ 1,040m	£ 420m
B	£ 165m ¹	£ 150m ¹
C	£ 130m	£ 95-110m
	-----	-----
	£ 1,335m	£ 665-680m

Other costs^{2,3} in acute and primary care should primarily be carried by providers; but a portion of those costs might be paid by commissioners to providers as an incentive to initiate change and increase productivity

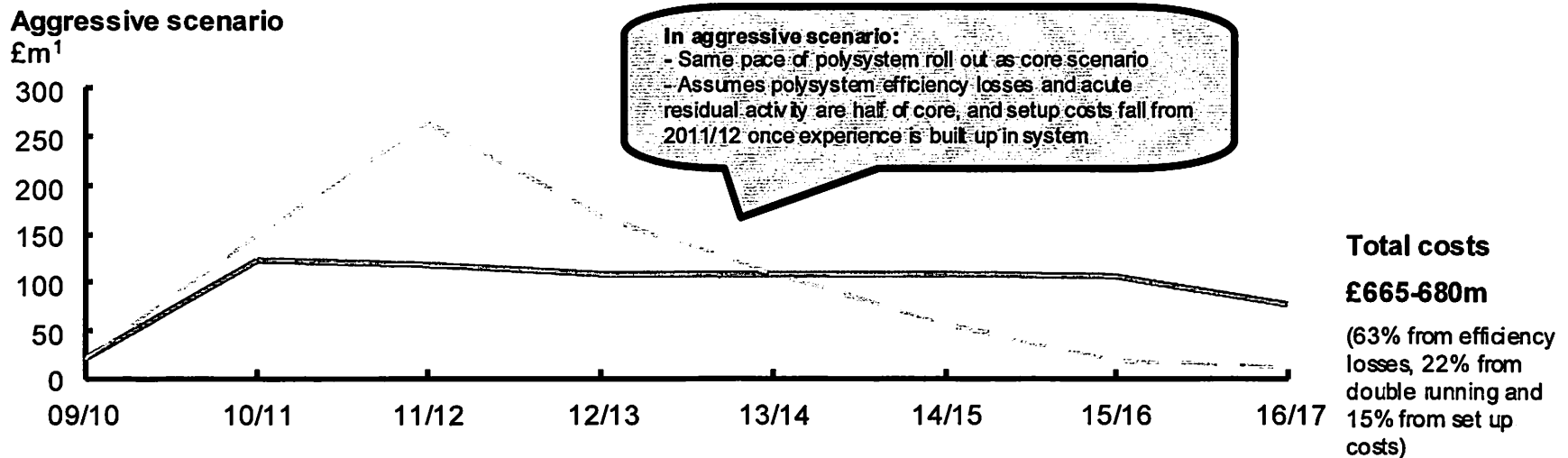
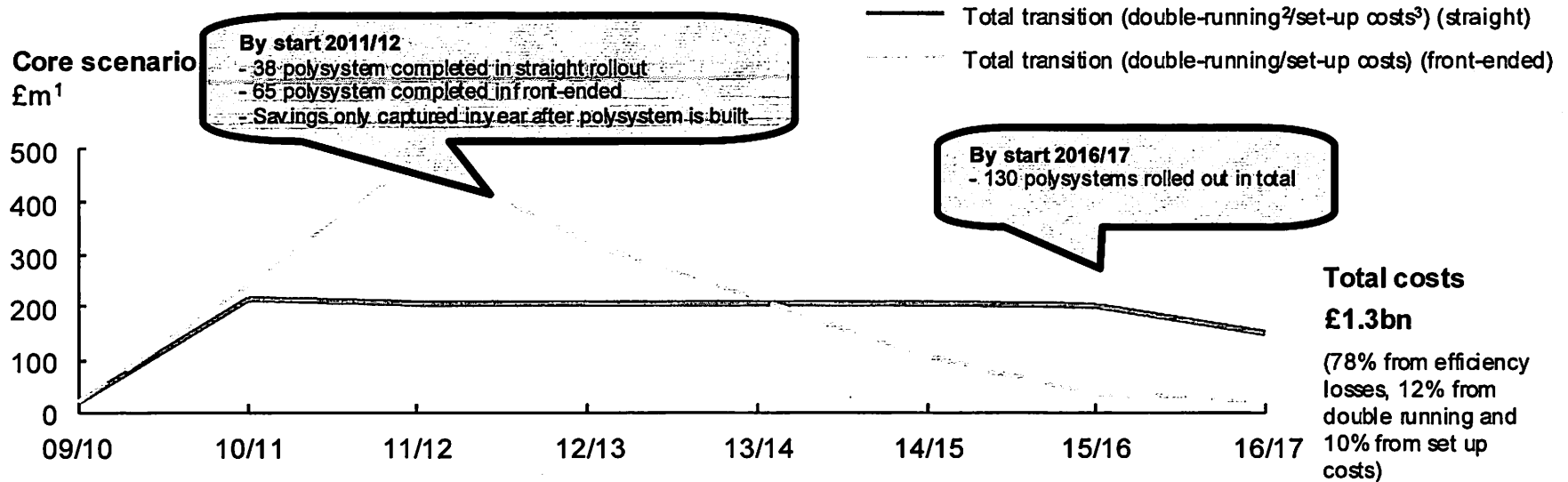
1 The residual activity costs are similar for the aggressive scenario than for the core scenario as a larger proportion of activity shifts from the acute setting into the polysystem delivery model in the aggressive case

2 Costs assumed carried by acute trust: Residual costs in admin (15% of total acute trusts costs), non-clinical costs (4%) and space (11%) that do not scale down completely as activity moves – estimates of those costs are £210m for admin (assuming 75% admin residual cost), £75m for non-clinical costs (assuming 100% residual costs) and £210m for space (assuming 100% residual costs), for a total of £0.5bn. Those costs are part of the semi-fixed costs the Trusts needs to eliminate (as covered in the implications for the acute sector section)

3 Additional costs in primary/community care: Residual costs due to failure to dispose of estate for those practices moving into a polysystem hub or consolidating into a larger polysystem spoke – assuming 50% of primary care practices can not dispose of their previous estates, those costs amount to ~£140m

4 In real terms (net of inflation i.e., excluding inflation), 2007/8 numbers

Transition costs: Moving to affordability will cumulatively require £0.7-1.3bn depending on implementation strategy (excluding capital costs)



¹ In real terms (net of inflation i.e., excluding inflation), 2007/8 numbers

² Transition costs modelled based on % of costs that will be duplicated and might need reimbursements by commissioner to compensate. For example, in acute in year polystem is opened, 50% of savings are foregone (20% due to admin, 10% to space and 20% to clinical staff) in Core case, falling to 25% in Aggressive case (which assumes faster transfer of staff with less double running). See back-up for more detail.

³ Set-up costs assumed to be £1m/polystem (core), falling to £500k after 2011/12 (aggressive)

SOURCE: GLA demographic forecast, HES data, HAS data, reference costs, HfL growth assumptions; Q research; Monitor tariff guidance; current pdyclinic plans; acute / non-acute provider cost breakdowns for 2007/8

Contents

Context to the work

Broad model structure and 2007/8 pan-London starting point

Detailed pan-London assumptions

Detailed polysystem modelling assumptions and unit cost outputs

Implications for acute providers

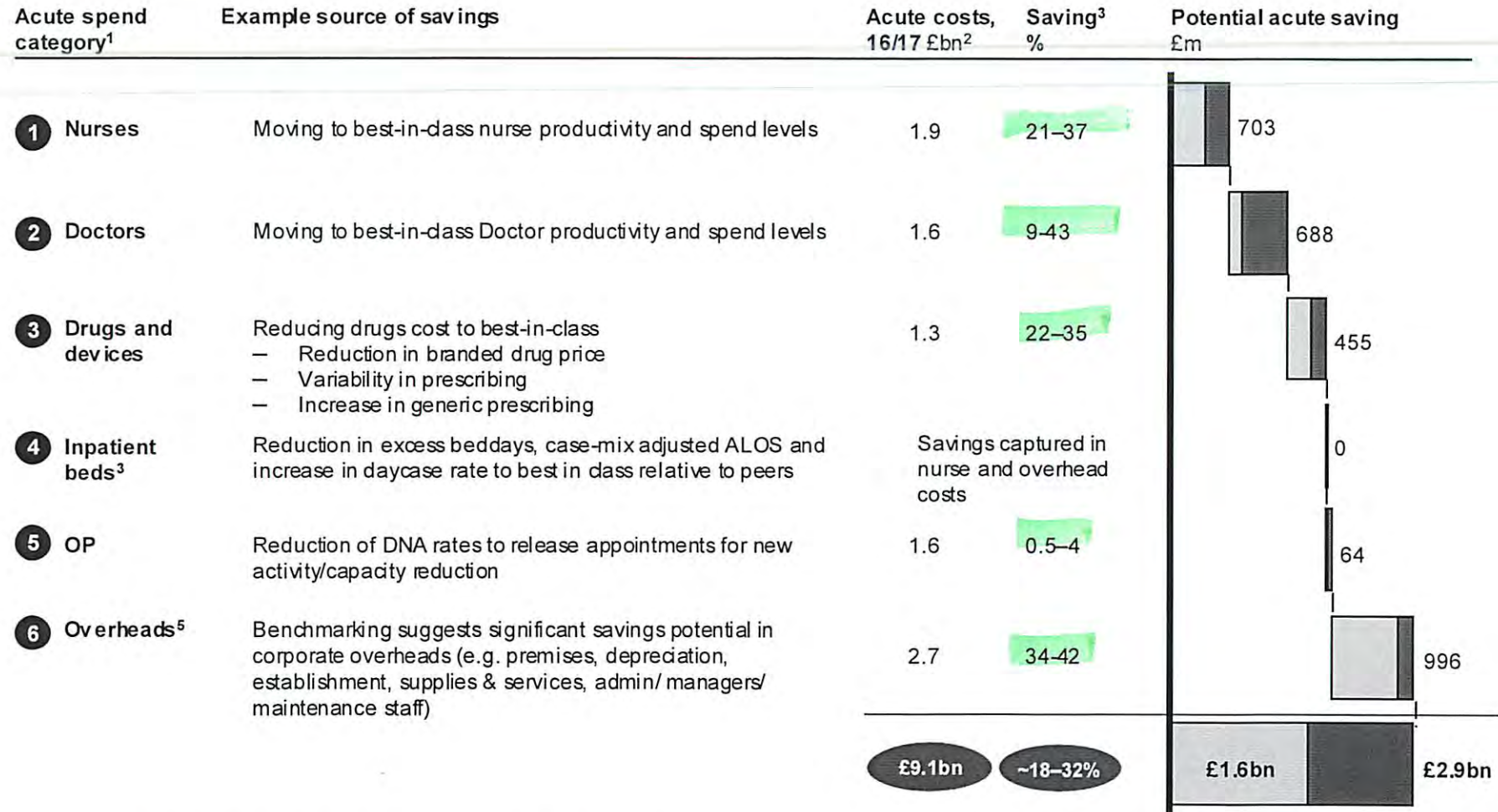
Implications for out-of-hospital settings

Miscellaneous

Saving £2.4bn in acute productivity is possible but challenging

ILLUSTRATIVE

■ Aggressive
■ Core



1 Not an exhaustive list. Additional savings may be made from imaging, pathology and theatres.

2 Adjusted for underlying base case activity growth and cost inflation to 2016/17

3 Potential savings incorporate studies from a range of sources, from individual acute London Trusts to National benchmarking of London as a whole

4 Assumed at £200 savings/bed day and 75% bed utilisation

5 Even in absence of activity shifts, realising all overhead savings would require site rationalisation

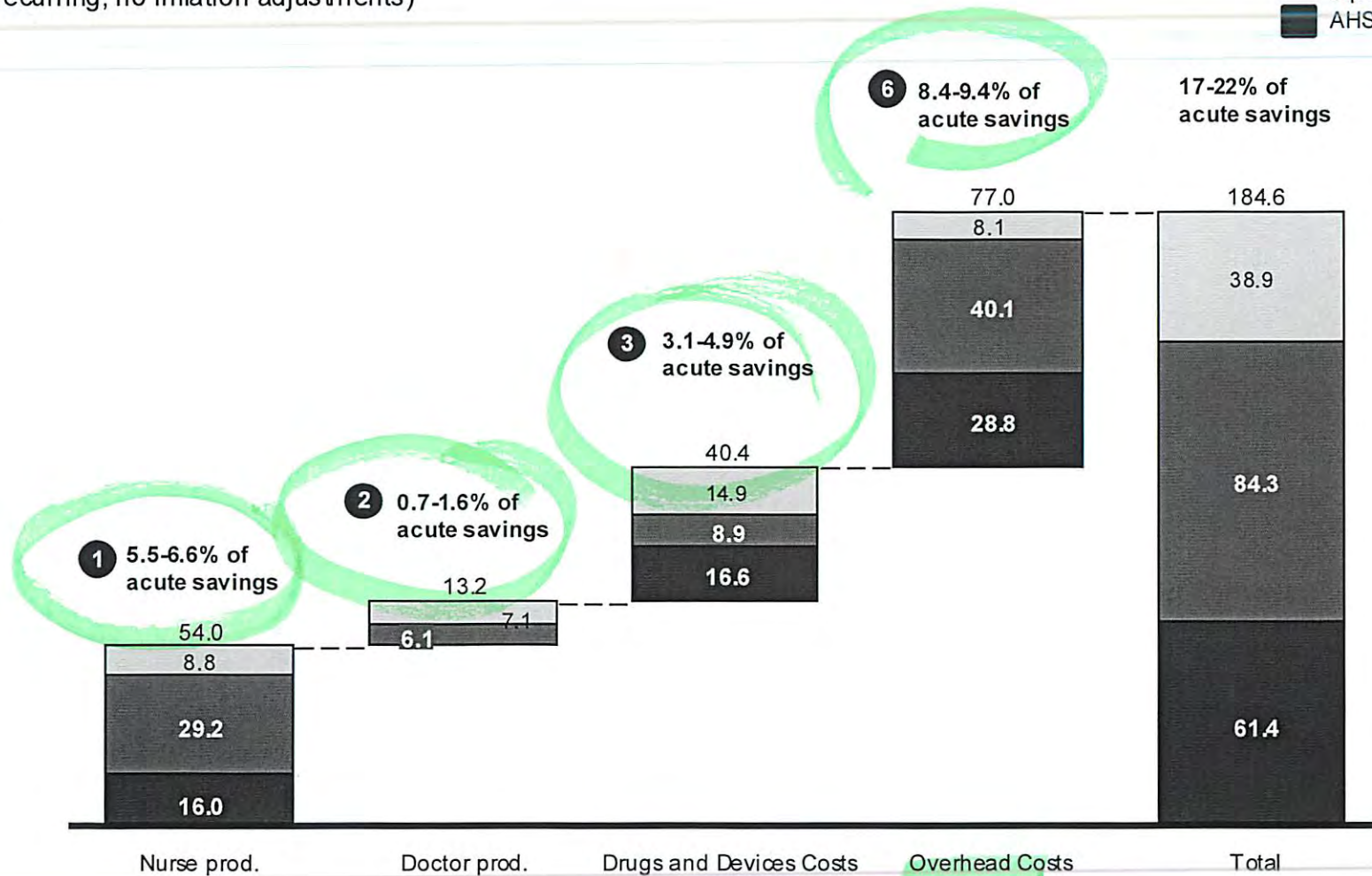
SOURCE: Laing and Buisson 2007/8, NHS Handbook 2007/8, National NHS productivity study, productivity analysis of an acute London provider

Some savings will be netted against losses from excess bed day income

Benchmarking of an acute London provider identified potential acute savings from moving to best in class

Full year impact
£m (recurring, no inflation adjustments)

- Additional gain from Best in class
- Additional gain from top decile
- AHSC average

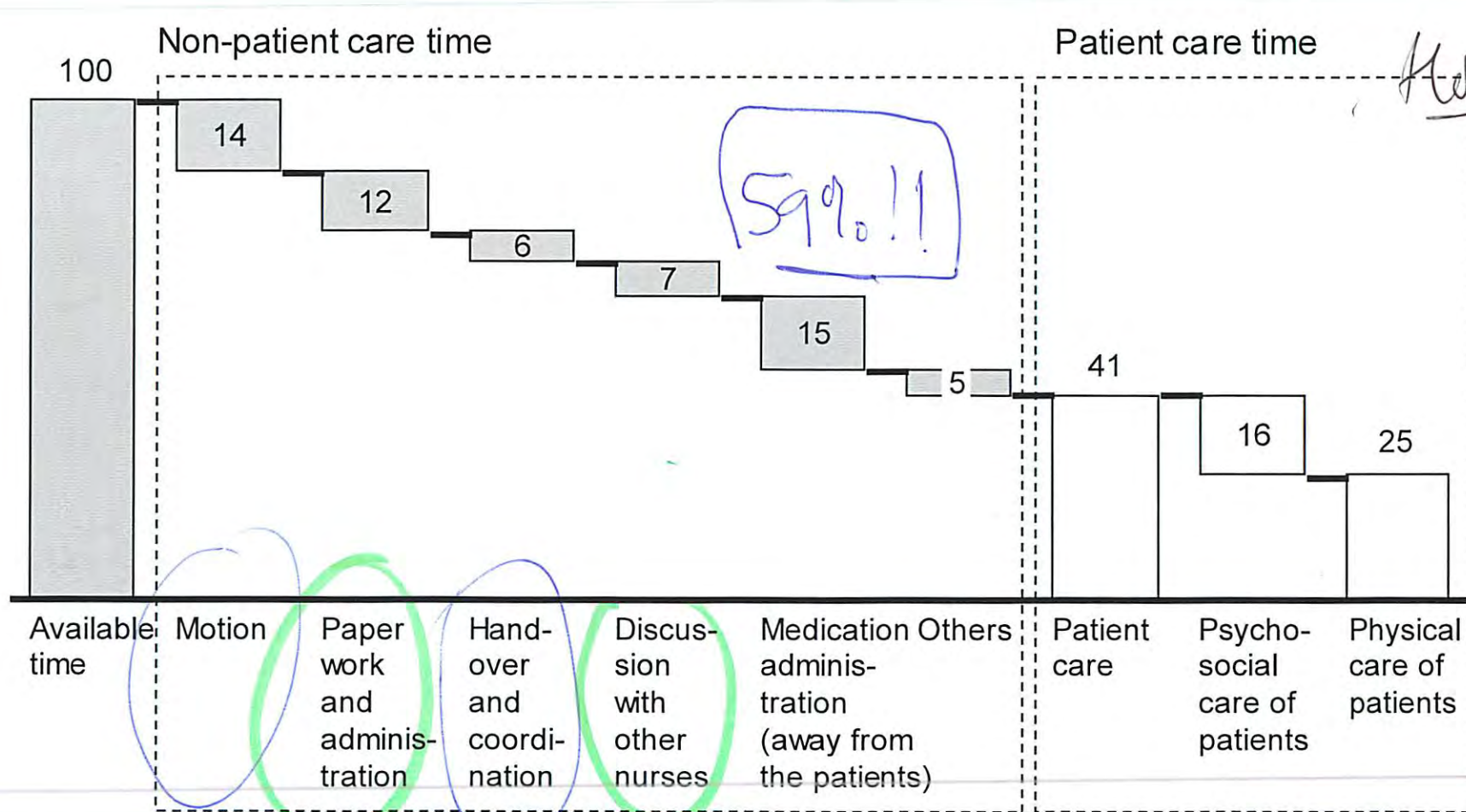


1 Acute providers – nurses spend only 41% of their time on patient care

NATIONAL

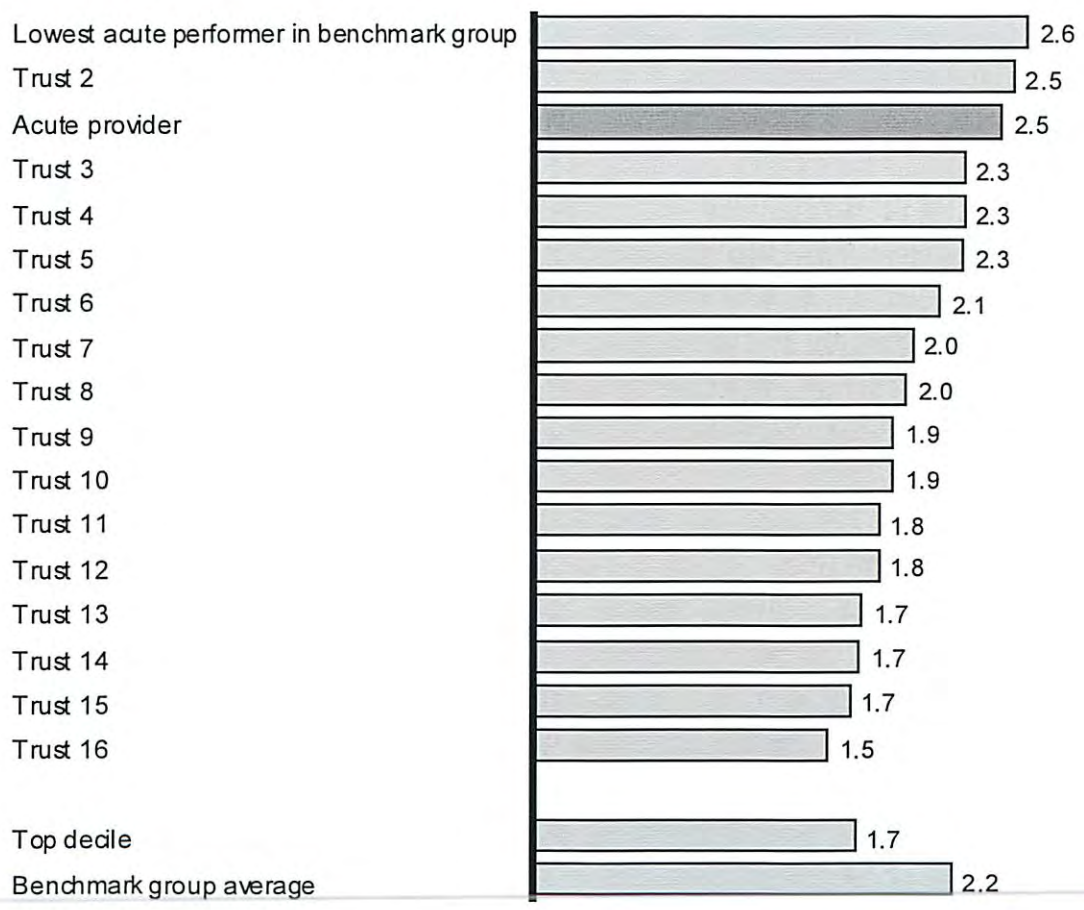
% of time spent by nurses on acute and general medicine wards

□ Direct patient care



1 Nurse productivity: An acute provider could save between £12.6m and £54m by reviewing nursing levels

Acute provider Nurse staffing versus benchmarks
WTE nurses per bed



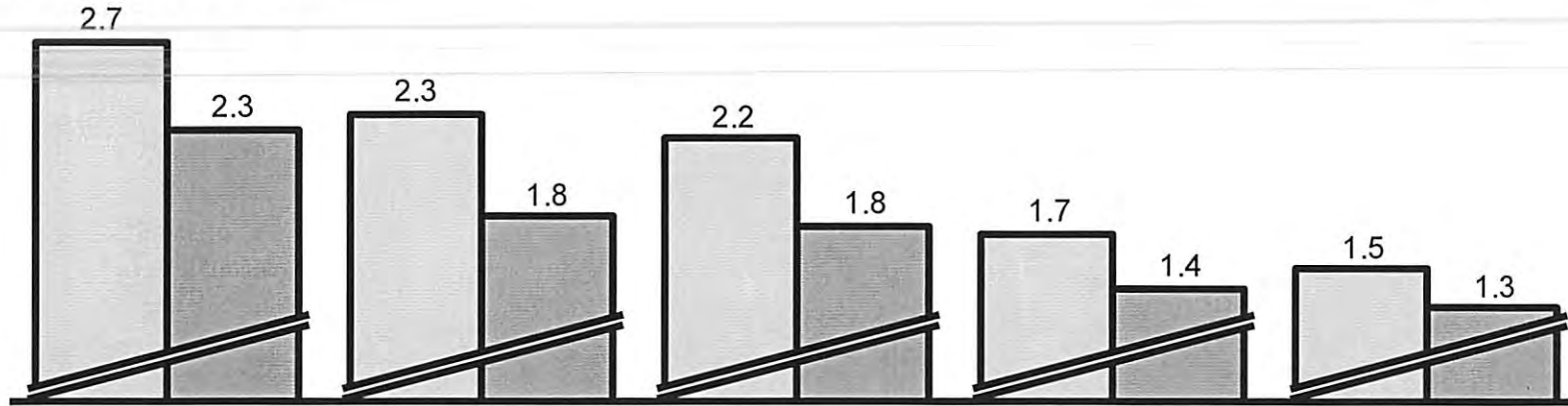
- Nurse headcount
 - Best in class (1.5 nurses / bed) would lead to 1,233 fewer nurses
 - Top decile (1.7) would lead to 1,033 fewer nurses
 - Benchmark group average (2.2) would lead to 287 fewer nurses

- Cost savings
 - Best in class: £54m
 - Top decile: £45.2m
 - Group benchmark: £12.6m

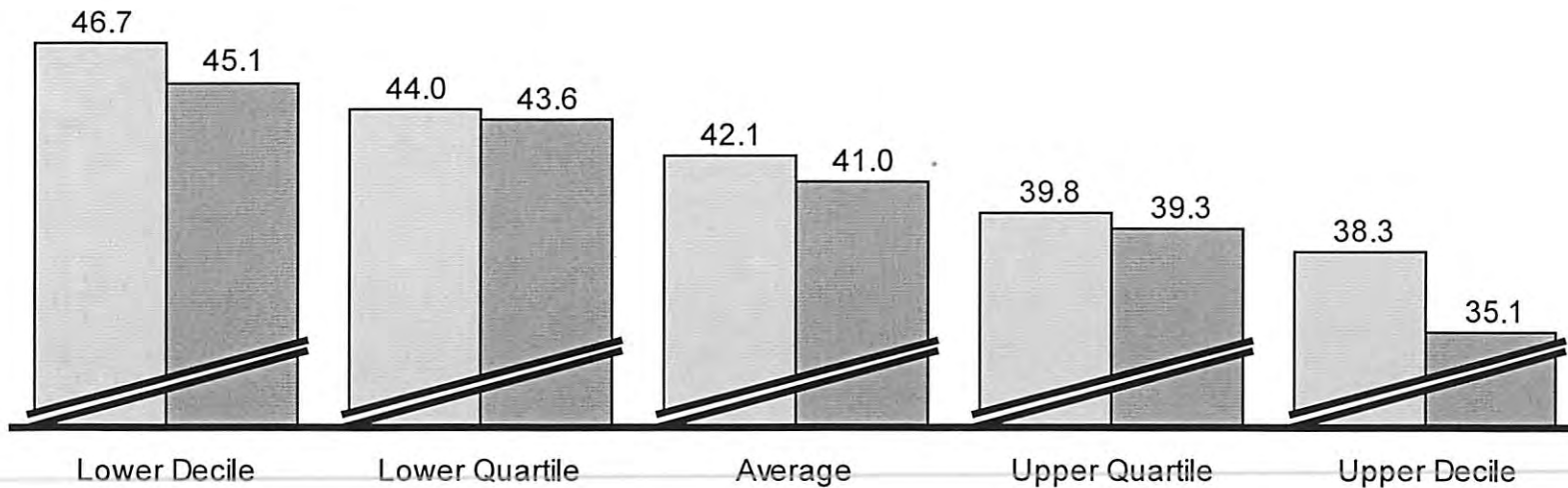
1 Within London, nurse utilisation KPIs imply below average performance compared to rest of UK

London¹
 National

Nurse FTE / Bed, 2007-08, #

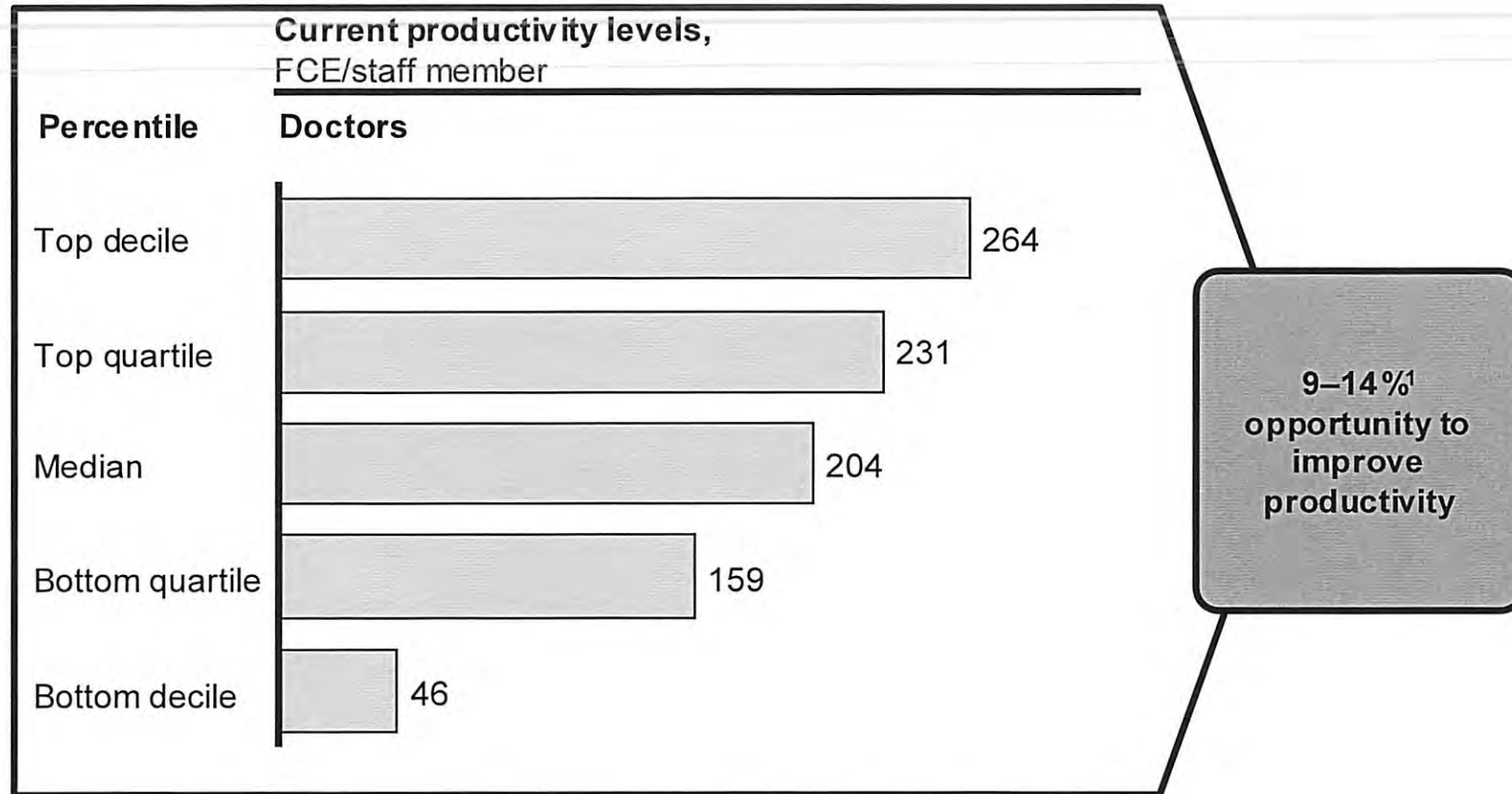


Nurse salary / Nurse FTE, 2007-08, £'000



1 Across 31 acute and foundation acute trusts

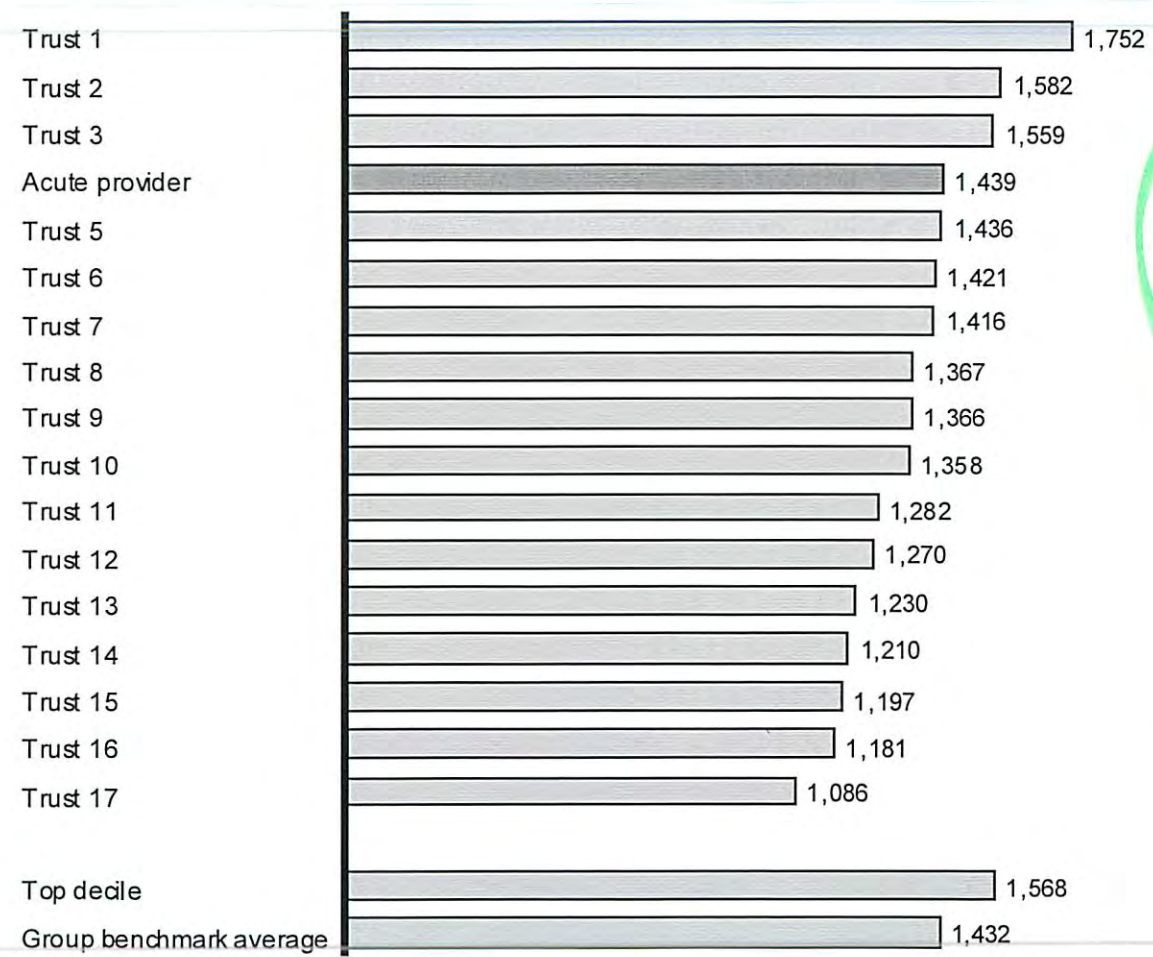
2 Doctor productivity – 9-14% of acute doctor spend can be saved if 50–80% of the potential improvement of stepping up to the median is achieved



¹Top 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)

2 Consultant productivity: Benchmarking income per consultant can identify further productivity enhancements

Income net of drug costs per consultant WTE
2007/08 £m

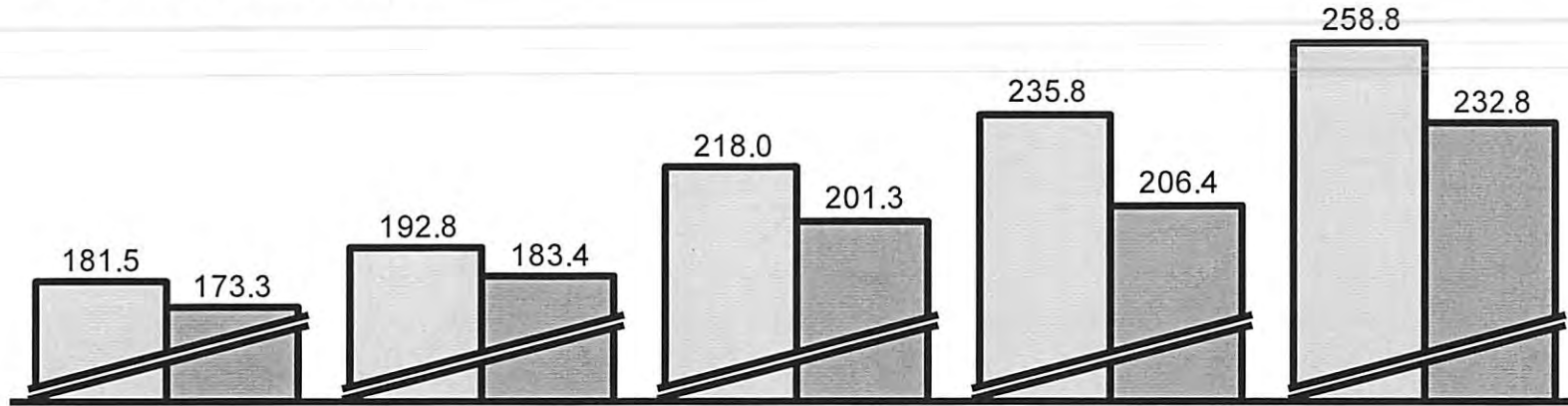


- **Consultant headcount**
 - Best in class (£1.75m income net of drugs per consultant) would allow for 93 fewer consultants
 - Top decile (£1.57m) would allow for 43 fewer consultants
- **Cost savings**
 - Best in class: £13.2m
 - Top decile: £6.1m

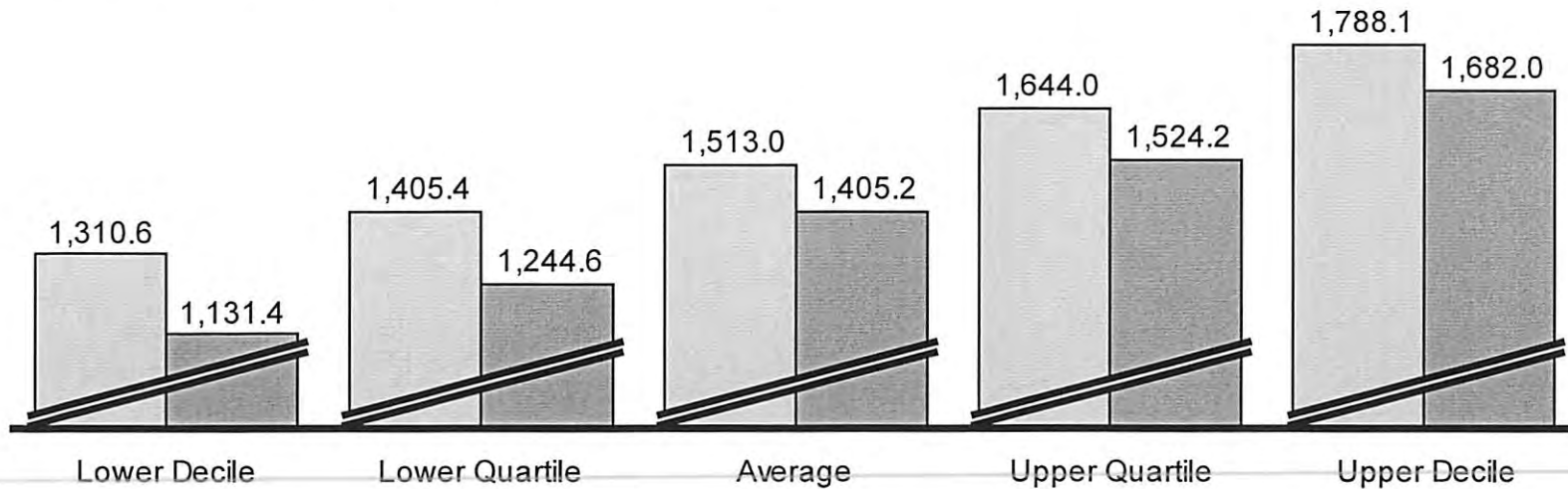
1/2 Although London acute providers on average generate more income per FTE, there is still scope to improve

Income / Nurse FTE, £'000, 2007-08

London¹
National



Income (less drug costs) / Consultant FTE, 2007-08, £'000



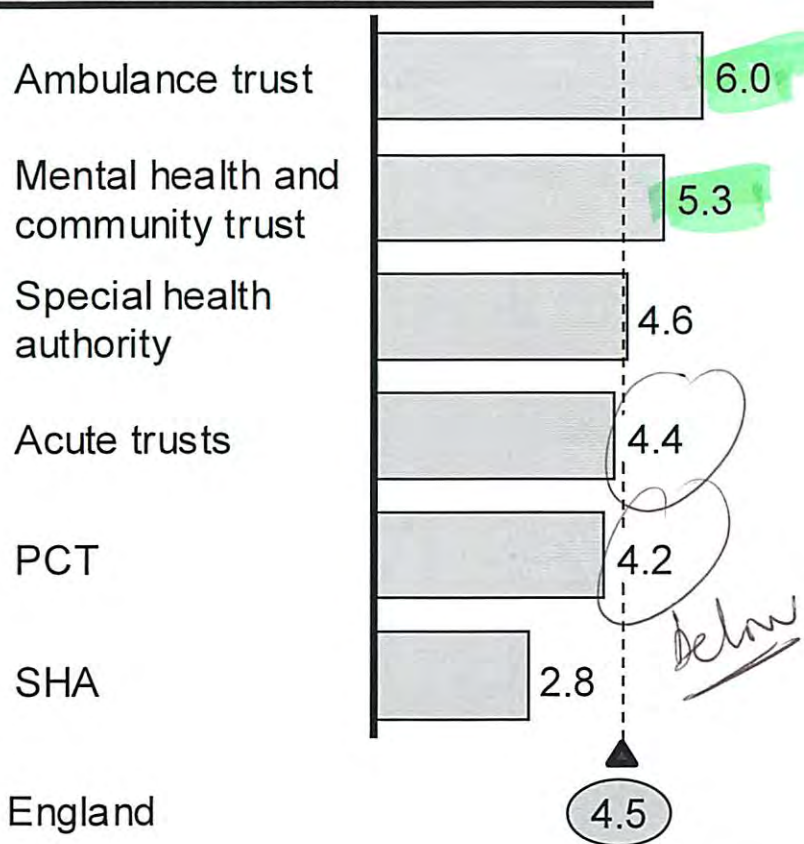
1 Across 31 acute and foundation acute trusts

1/2 Acute providers – Variability of sickness rate highlights opportunities for increase staff productivity

NATIONAL

Sickness rate¹ 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

3 Drugs and Devices: Three levers have helped others to reduce drugs spend by ~10%

Need to audit current Acute provider procurement practices

Drugs: Detailed procurement savings levers

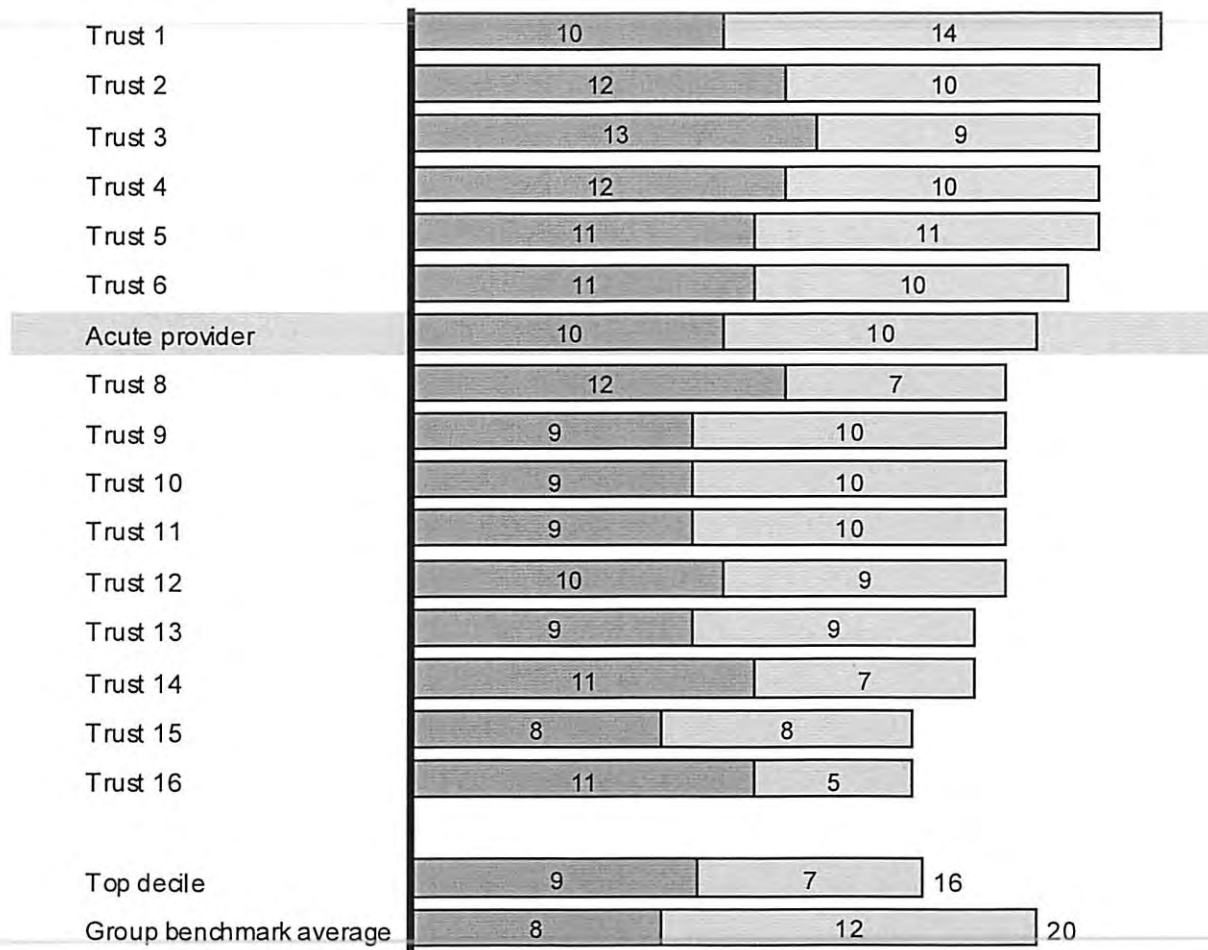
	Levers	Description	Potential savings impact, %
Purchasing power	Competitive tenders and price negotiations	Run tender exercises on drug classes with several therapeutic or generic alternatives	Up to 3-5
	Purchasing consortia	Leverage increased buying power of purchasing consortia	
	Parallel imports	Capture the lowest possible prices from cross border drug trade while guaranteeing supply and quality	
Demand changes	Control of therapeutic creep	Ensure that drugs are used within guidelines	Up to 3-5
	Therapeutic substitution	Switch to most cost-effective product in drug classes with several therapeutic alternatives	
	Generic substitution	Switch to most cost-effective generic alternative	
	IV to oral switches	Optimise intravenous vs. oral delivery routes	
Enforcement of policies for TTA* and outpatient drugs	Enforce compliance with policies for TTA* and outpatient prescriptions		
Process changes	Income control for drugs with special reimbursement	Ensure full reimbursement for drugs that can be specifically charged for (e.g., improved coding)	Up to 1-3
	Waste reduction	Optimise use of patients' drugs and avoid waste	
	Optimised distribution channels	Optimise use of home-delivery options and dispensing of drugs in community pharmacies	
	Improve order-to-payment process	Ensure full contract compliance and avoid overpayment for drugs	

7 – 13% savings achievable

3 Drugs and Devices: Reducing drugs costs to best in class could yield savings of £17-40m

Drugs
 Clinical supplies

Drugs and clinical supplies cost, as a % of income, 2007/08



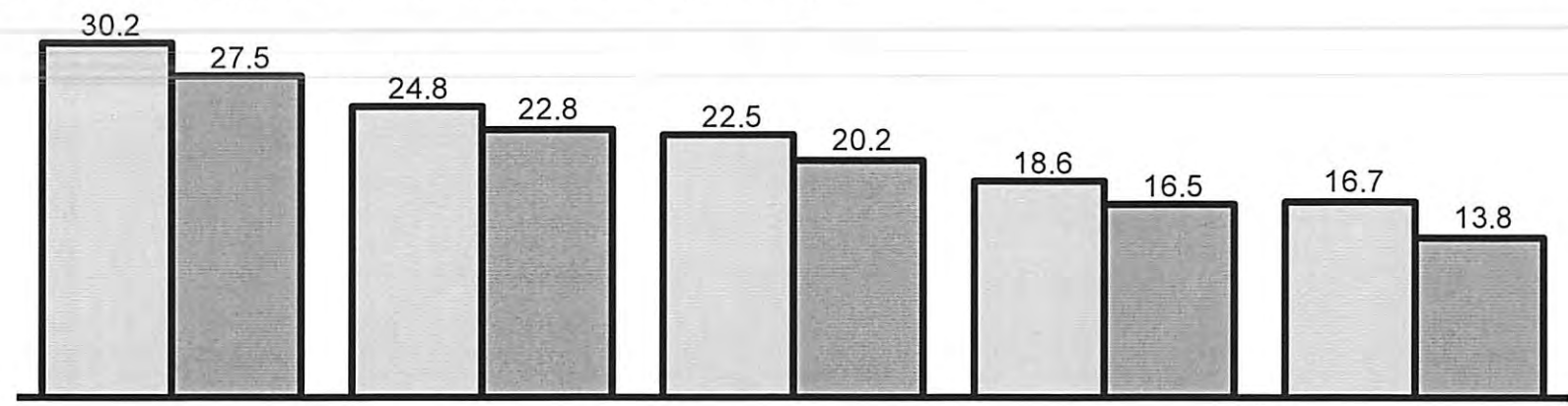
Drug costs present a significant opportunity

- Moving to best in class, i.e., 5% of income, could yield annual savings of ~£40.4m
- Moving to top decile drug costs, i.e., 7% of income, could yield annual savings of ~£25.5m
- Achieving the group benchmark average of 8% could yield £16.6m in savings
- N.B., It is important to understand if Acute provider clinical mix is materially different to peers

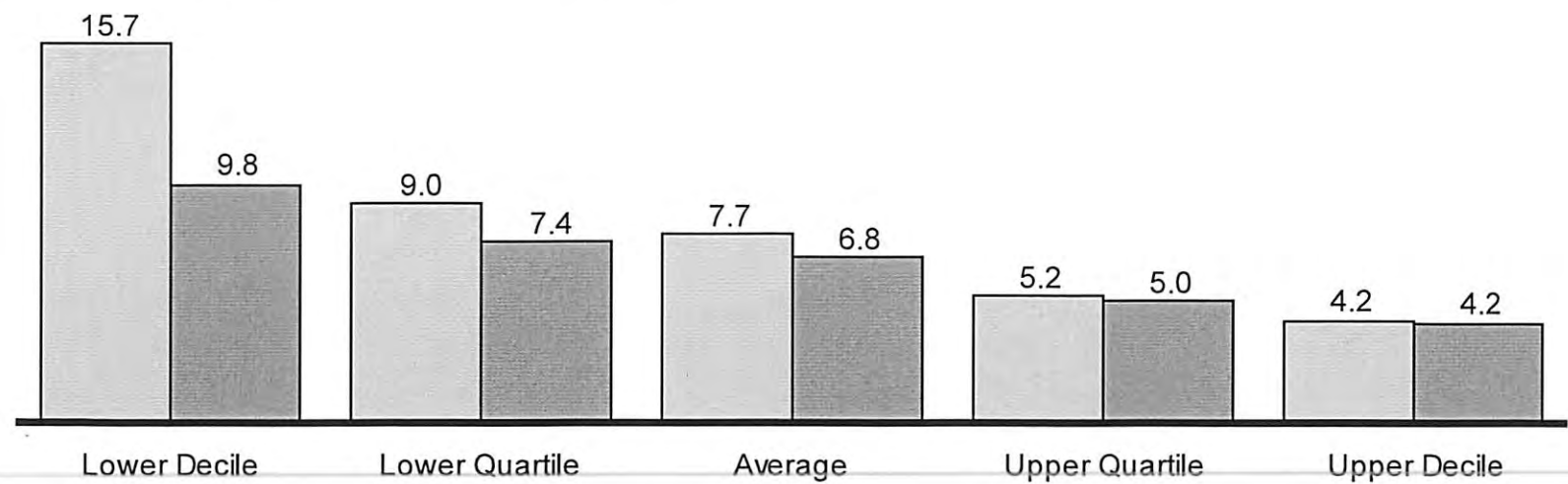
3 Within London, acute providers proportionally spend more on drugs and clinical supplies than their rest of UK counterparts

London¹
 National

Drug and clinical supplies as share of total income, 2007-08, %



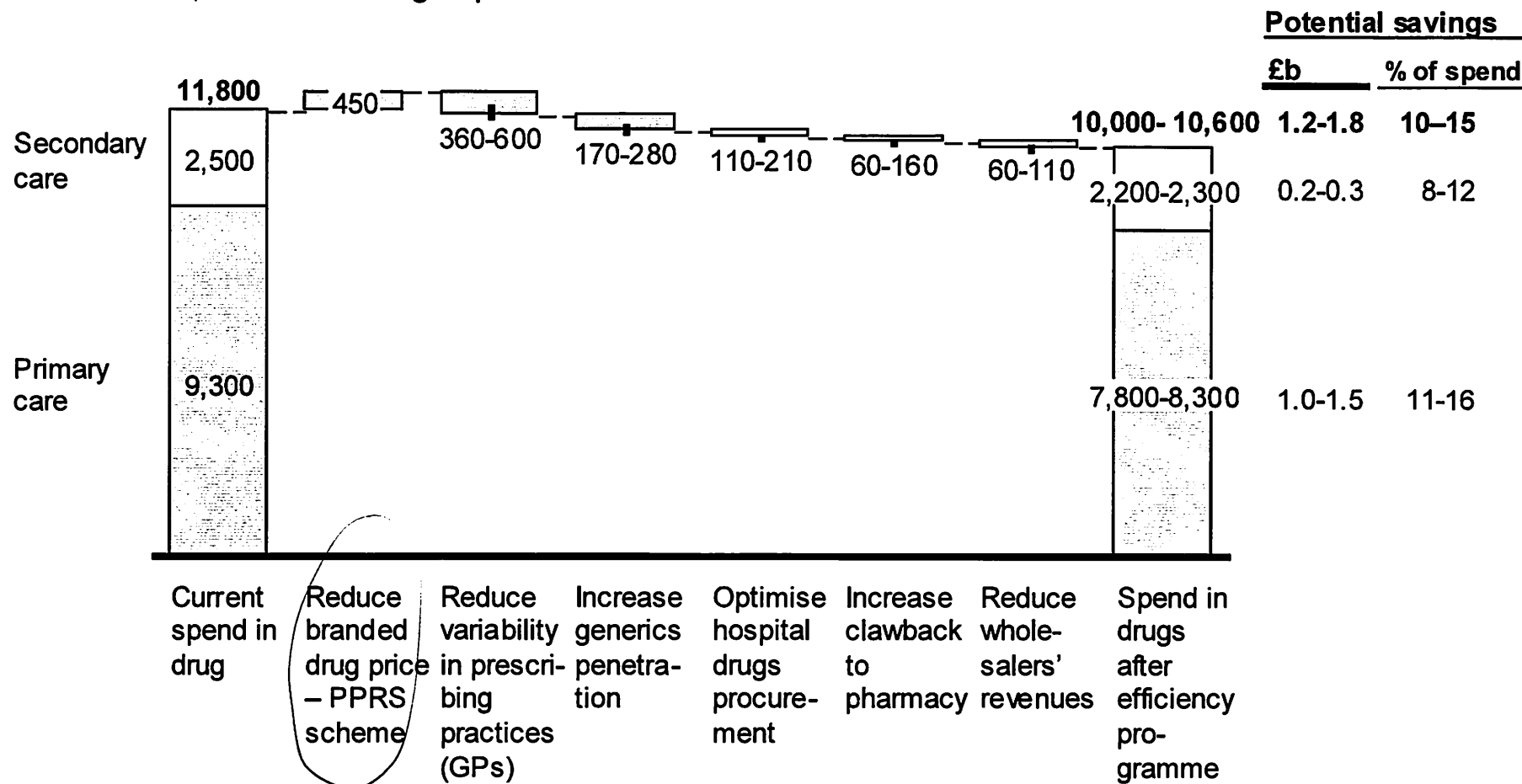
Drug cost as share of total expenditure, 2007-08, m²



¹ Across 31 acute and foundation acute trusts

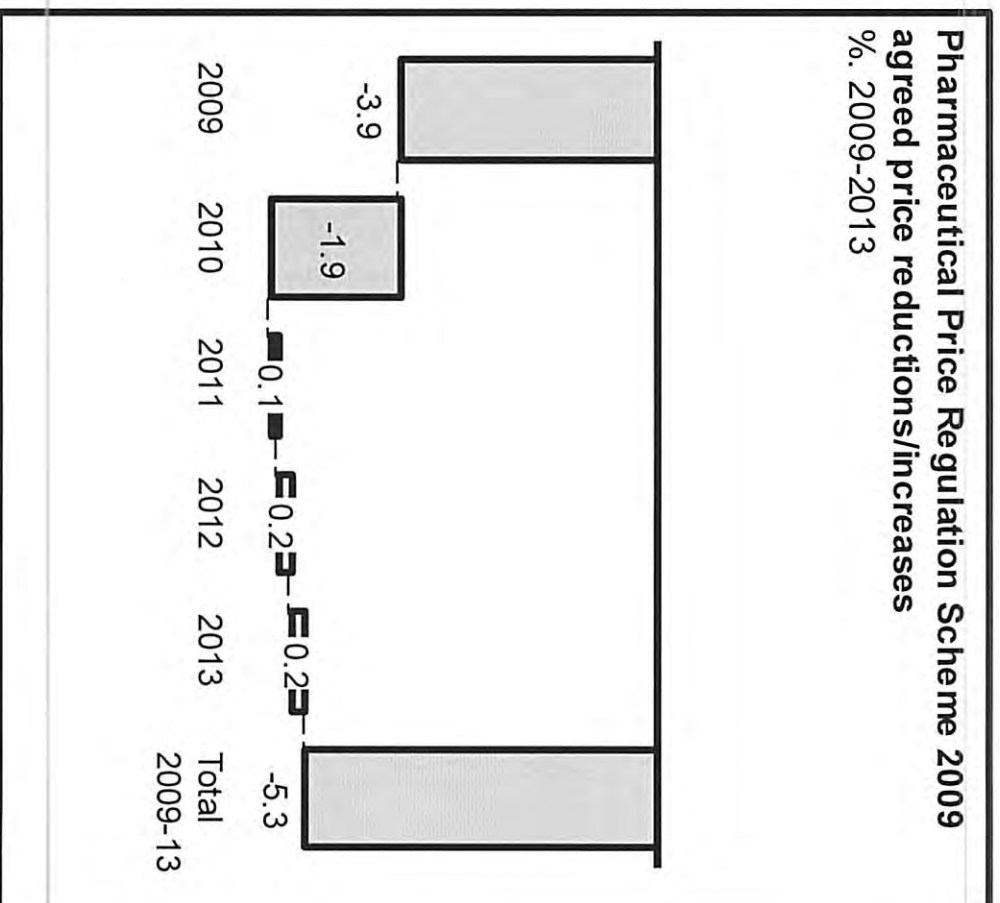
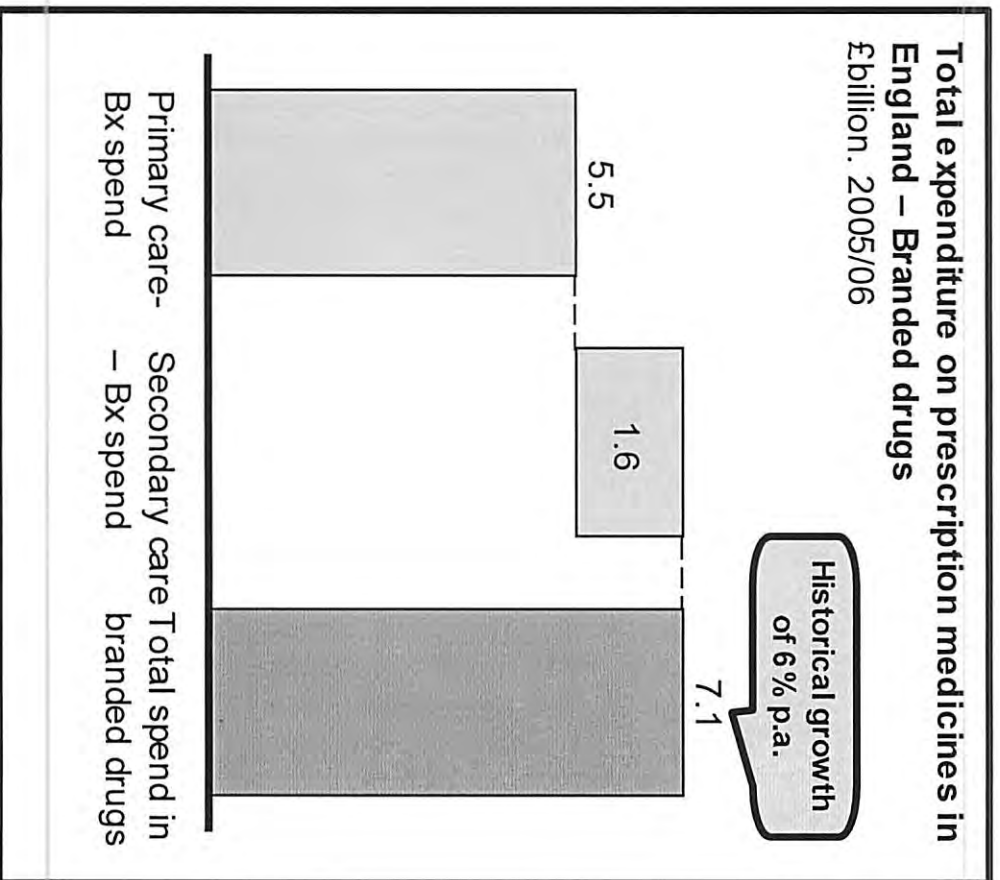
3 Drug spend – Potential savings of £1.2–1.8b nationally through pulling different price and volume levers NATIONAL

£million, 2008/09. Drugs spend



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

NATIONAL

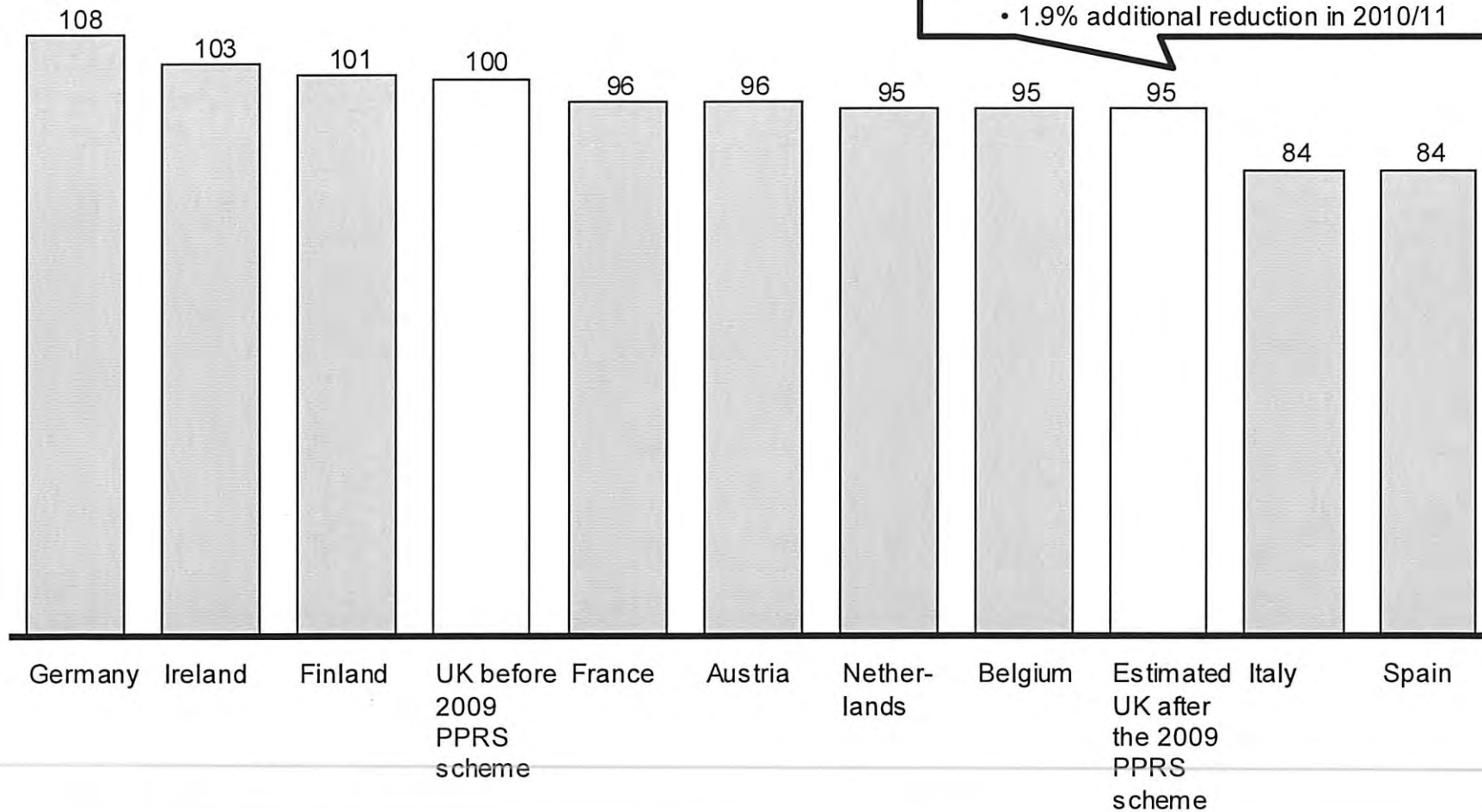


3 Drug spend – After the recently negotiated PPRS scheme, the U.K. branded drugs prices would be more aligned with the rest of Europe

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

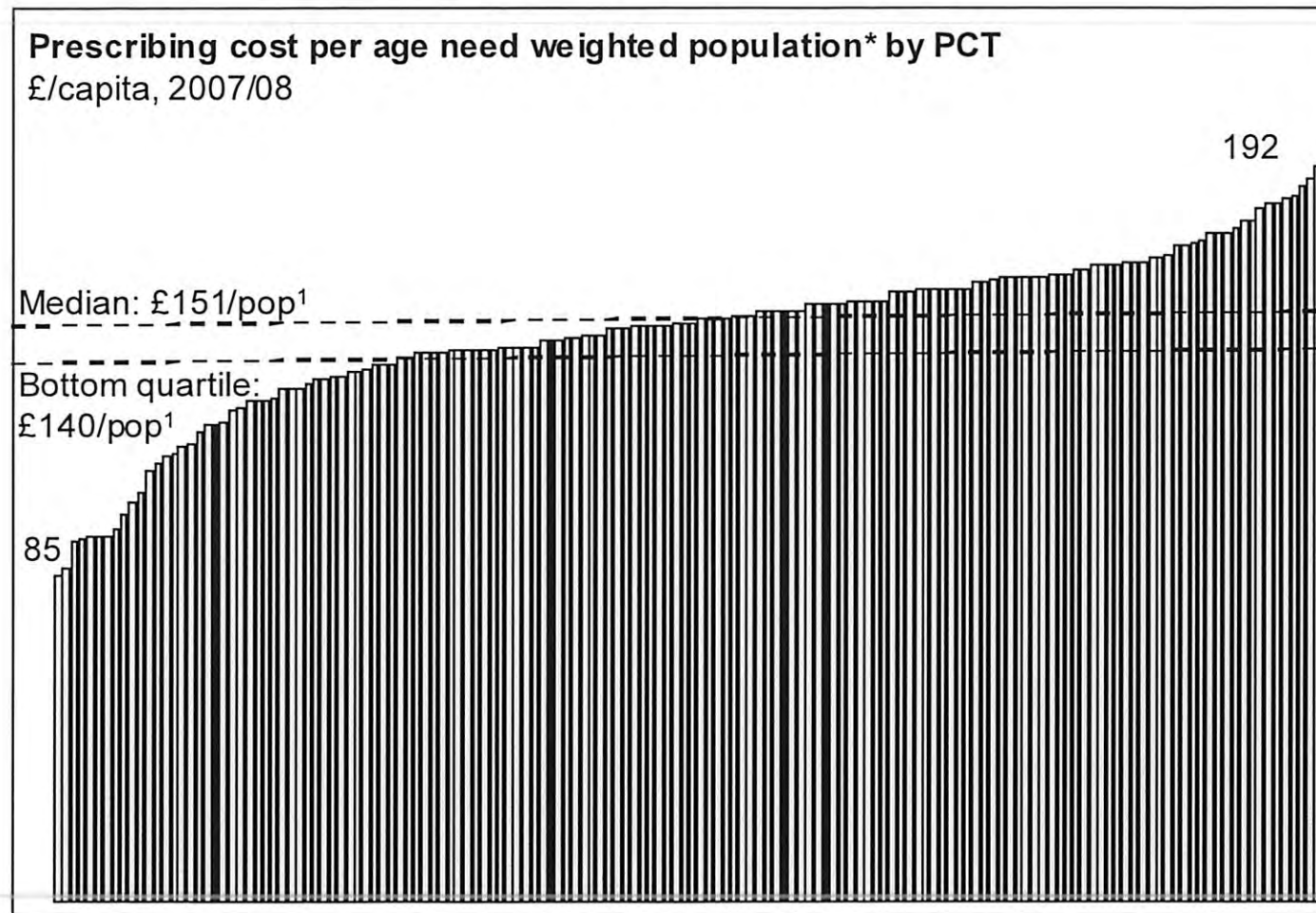
PPRS scheme recently agreed with the industry with a

- 3.9% reduction in 2009/10
- 1.9% additional reduction in 2010/11



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

NATIONAL



Typical sources of inefficiencies

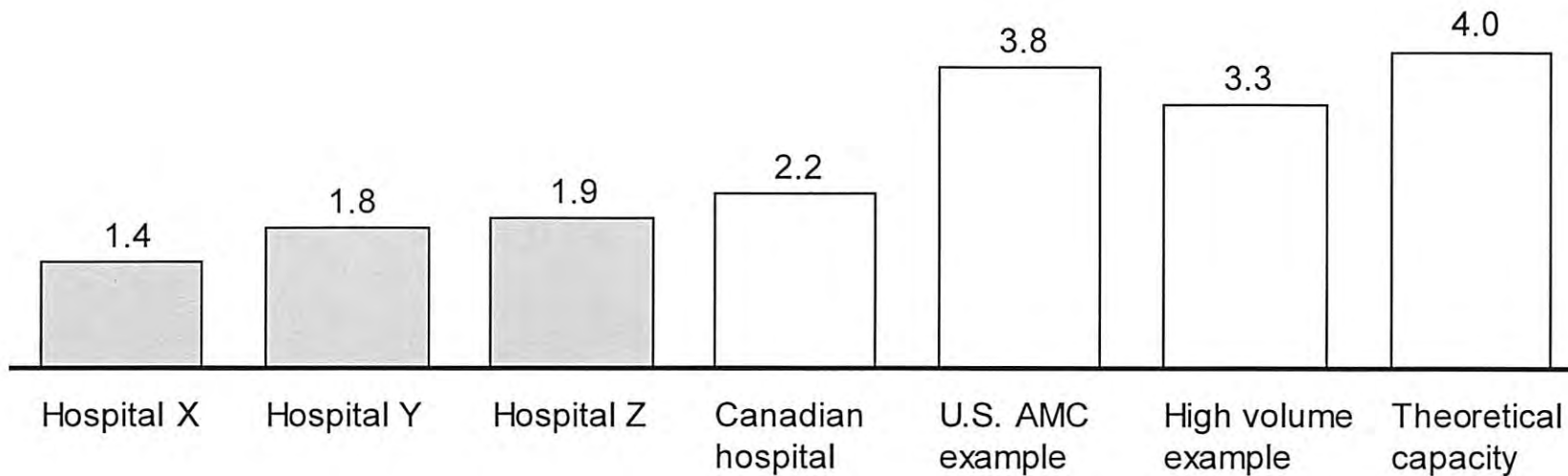
- Unexploited switches to cheaper alternatives with identical outcomes
- Avoidable specialist and restricted drug spend
- Waste reduction
- Lack of formulary
- Supply chain inefficiencies

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

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

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

NATIONAL



*Trying to cut use of CT + other scans
→ sell other*

Key levers to increase throughput

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

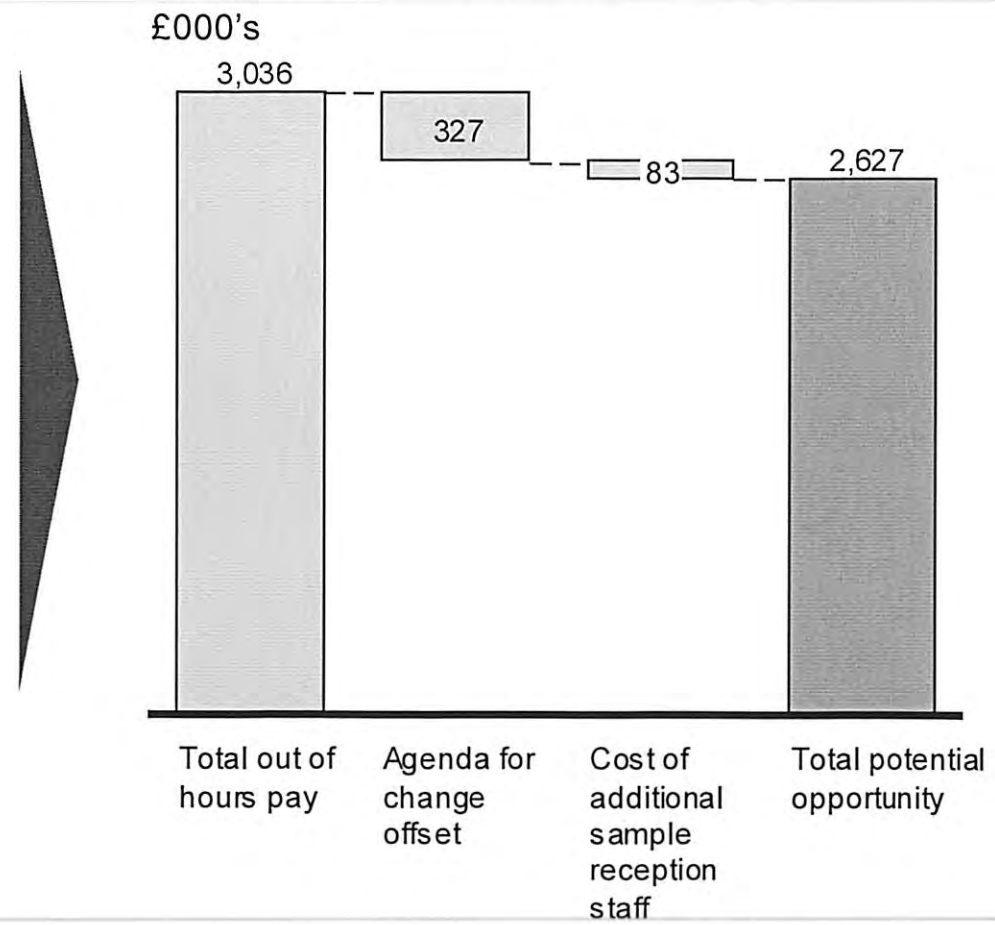
3 Pathology: Moving to a 24 hr shift pattern could release £2.6m annually

SANITISED EXAMPLE

Considerations defining assessment of opportunity

- Demand for out of hours services currently met by existing staff
- Replacing existing out of hours arrangements with 24 staffing cycle unlikely to require employment of new scientists or to free capacity
- Under Agenda for Change guidelines, staff working night shifts would still be entitled to 33% premium pay
- Optimal delivery of 24 hour service would require employment of sample reception staff to maximise productivity of scientists

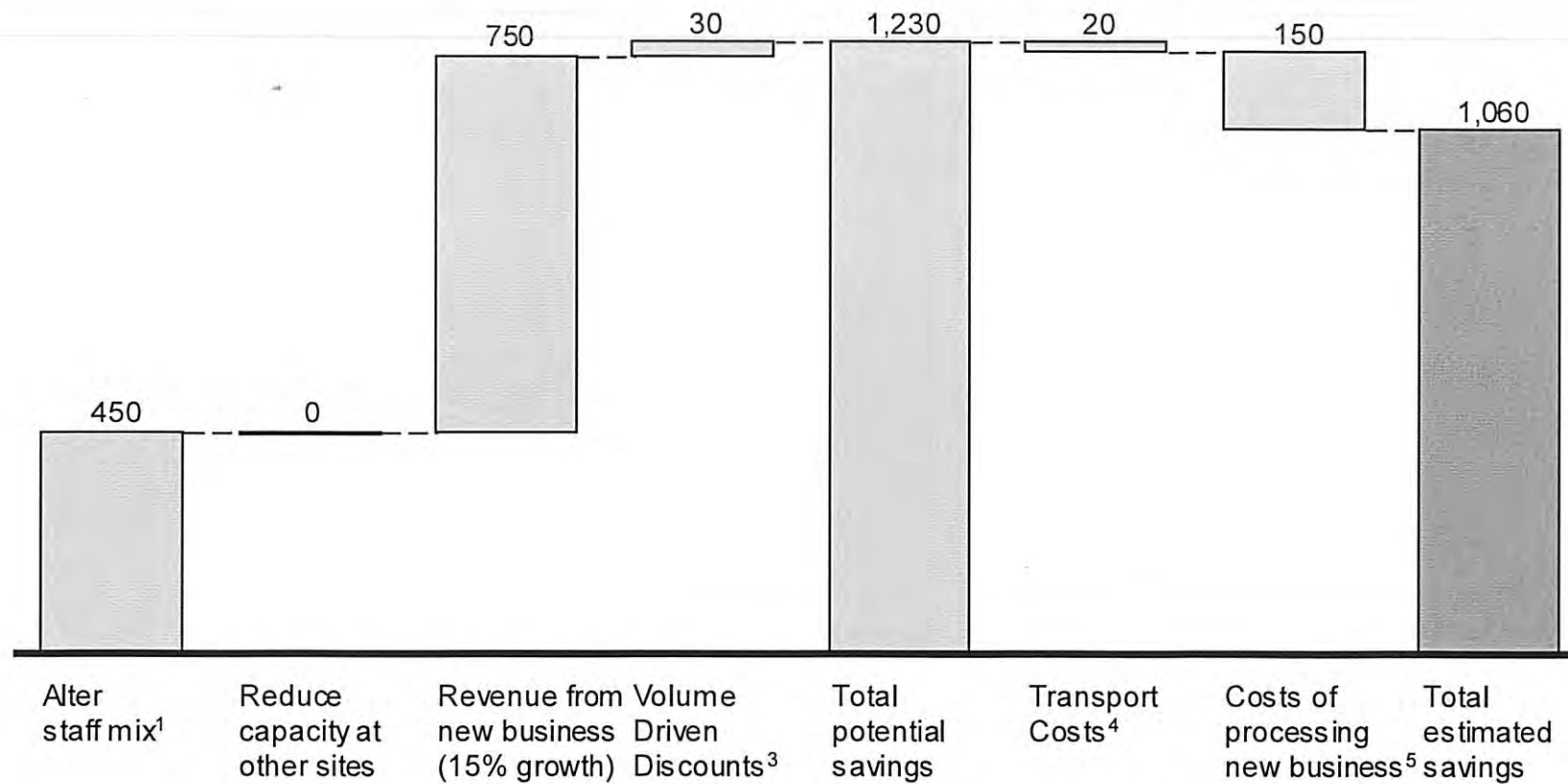
Maximum opportunity of £ 2.6 m, p.a.



3 Pathology: The potential financial opportunity for Autolab utilisation is £1m

SANITISED EXAMPLE

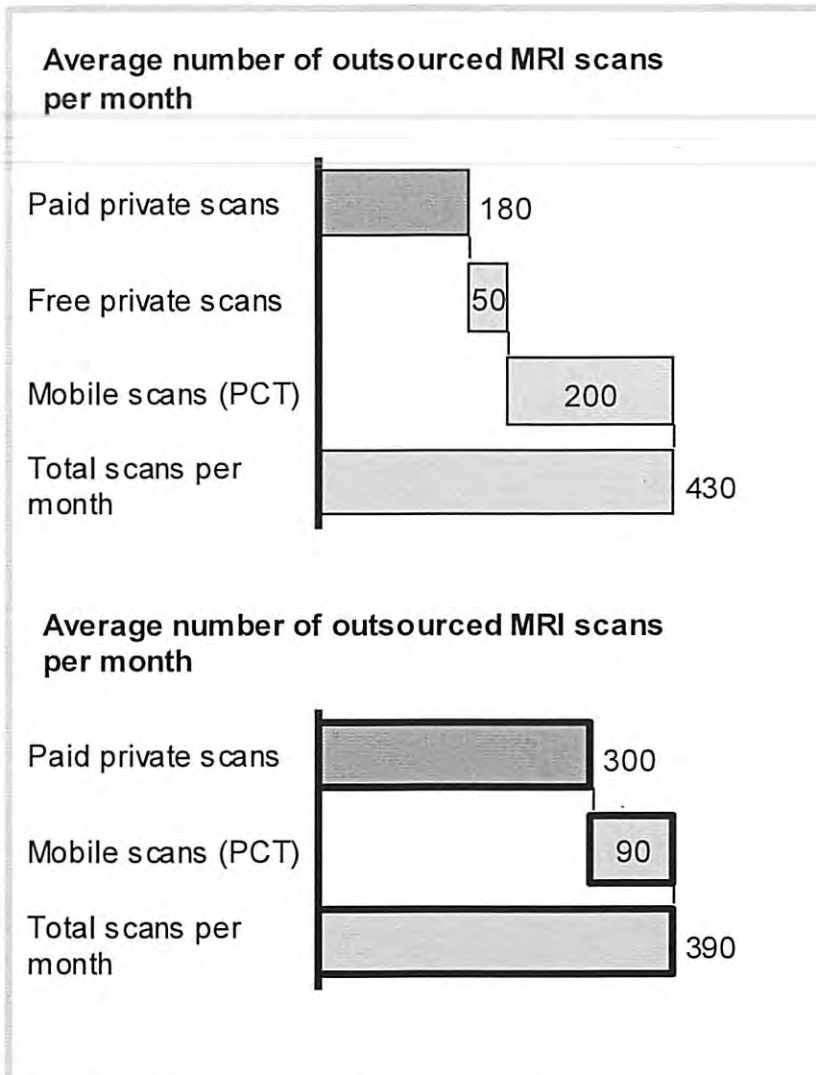
£ (000)



- ¹ Assumes xx of band 7 clinical chemists could be replaced by band 4 staff, and XX of band 8 haematologists replaced by band 6 staff
- ² Assumed that 24 hour service could be effectively provided with addition of 1 additional sample receptionist at C&W, SMH and HH; 3 at Cx
- ³ Assumes x% increase in monthly auto transport (not applied to bike couriers)
- ⁴ Assumes X new staff (band 4 cc, band 6 haem) and reagent charge calculated by applying average reagent cost per order to incremental orders with X% markup to capture plastics, processing and other expenses

3 Imaging: Absorbing outsourced MRI scans would save £1m

SANITISED EXAMPLE



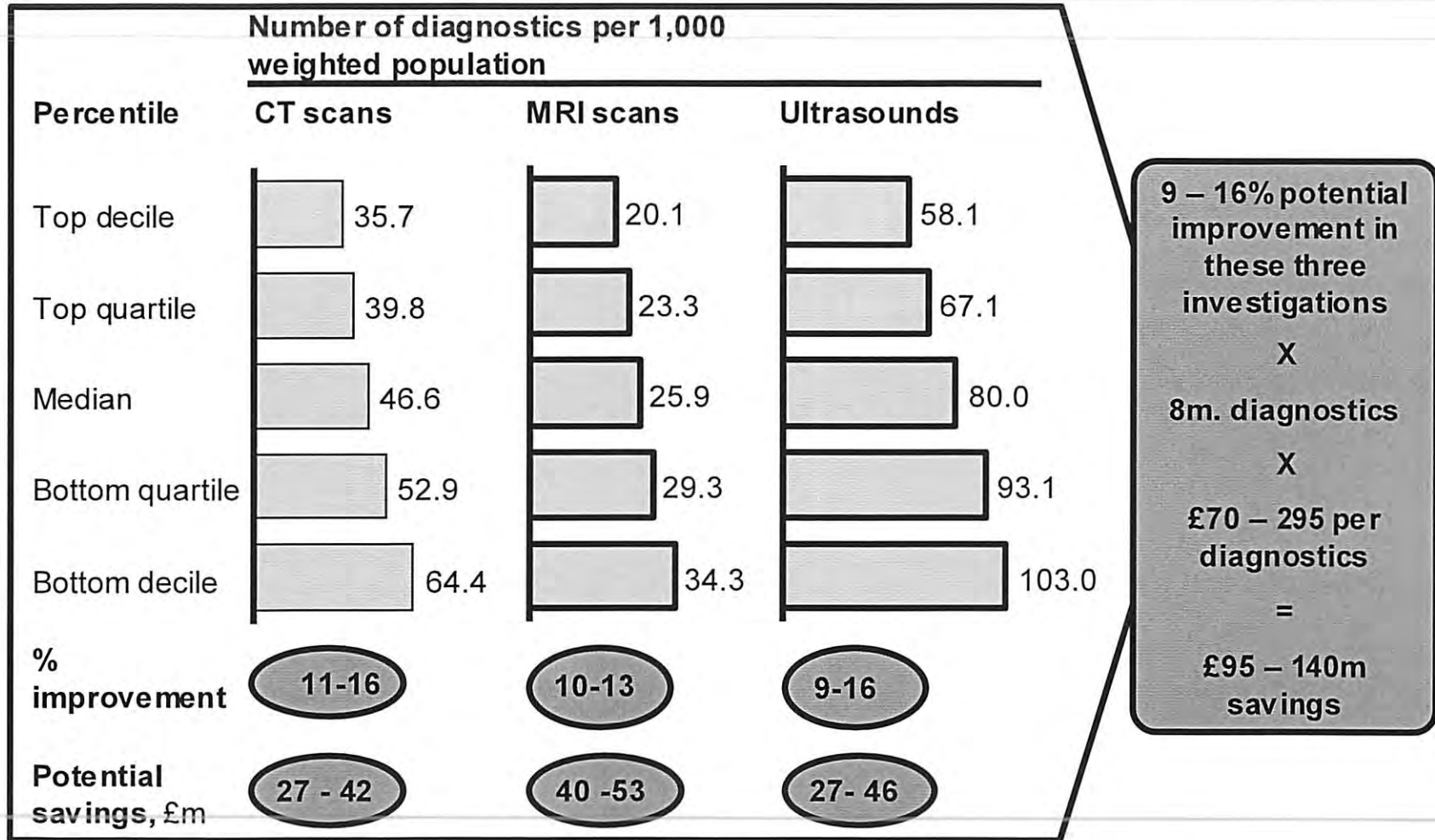
- £1m could be saved by bringing the activity back in house
- This assumes that improvements in efficiency will free up capacity for the activity

1 Assumes £100-200 per outsourced scan

3 Imaging: potential savings of £95-140m by reducing variation in three types of imaging referrals

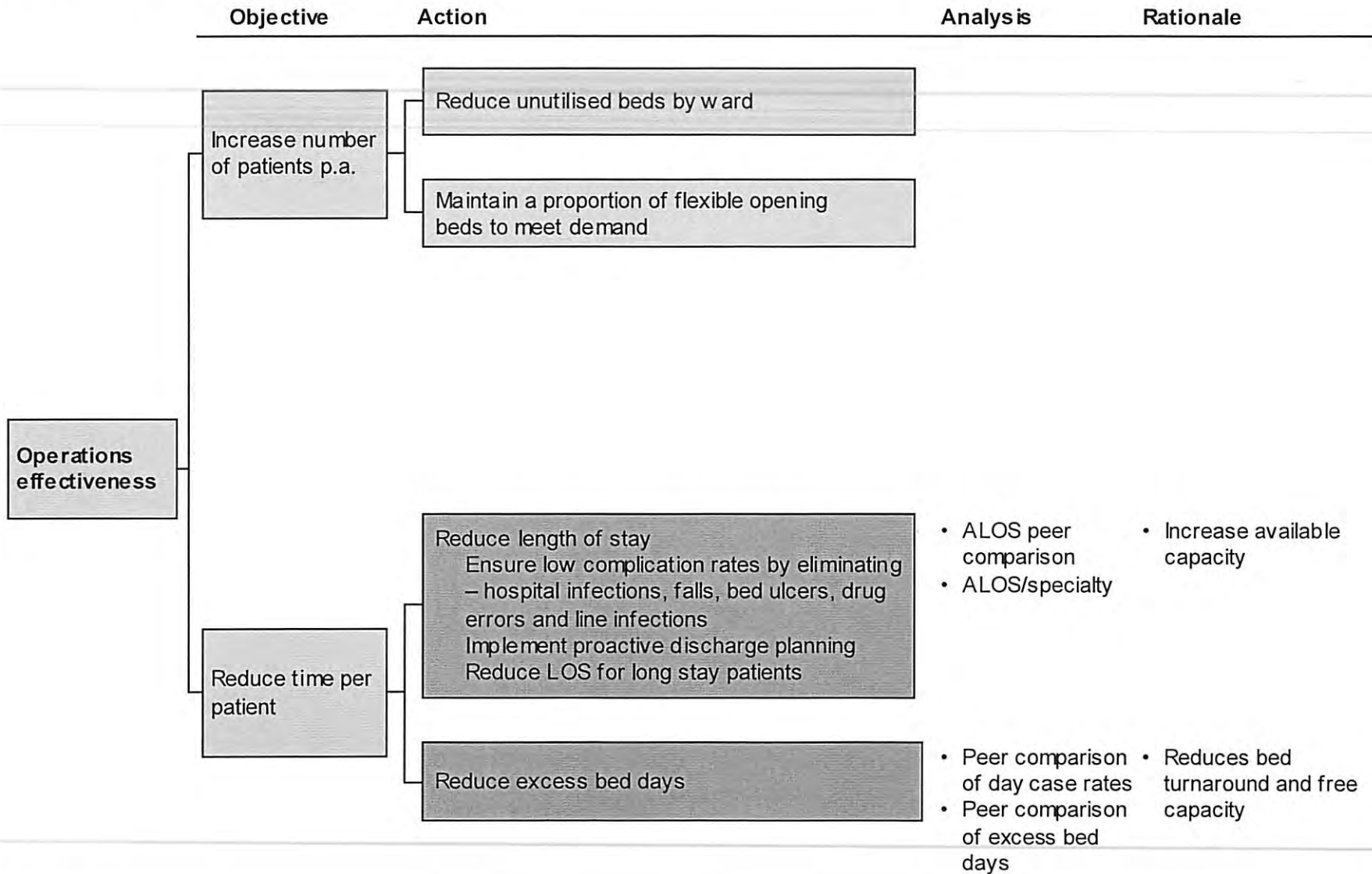
NATIONAL

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



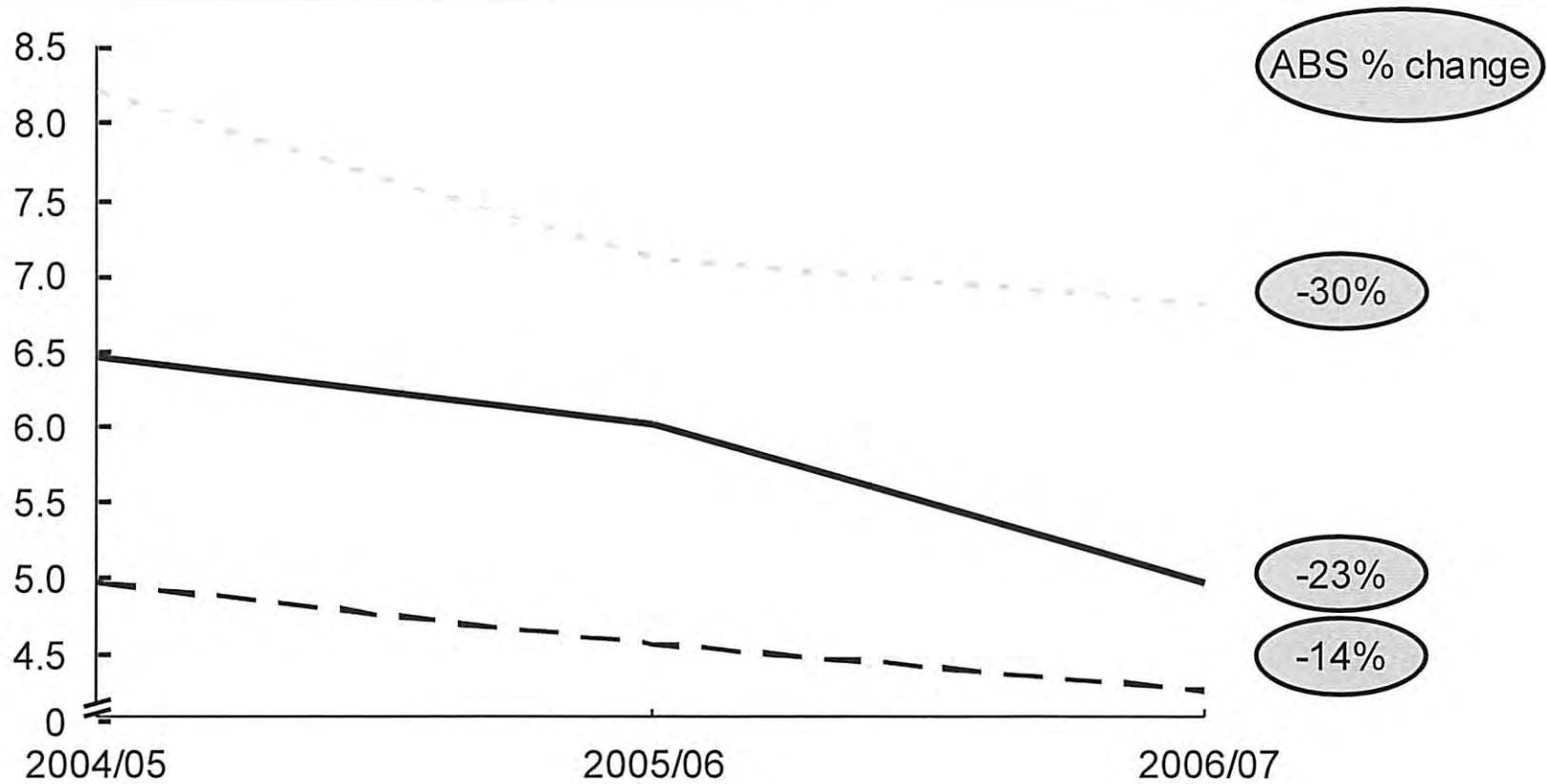
4 Inpatient beds

Key levers



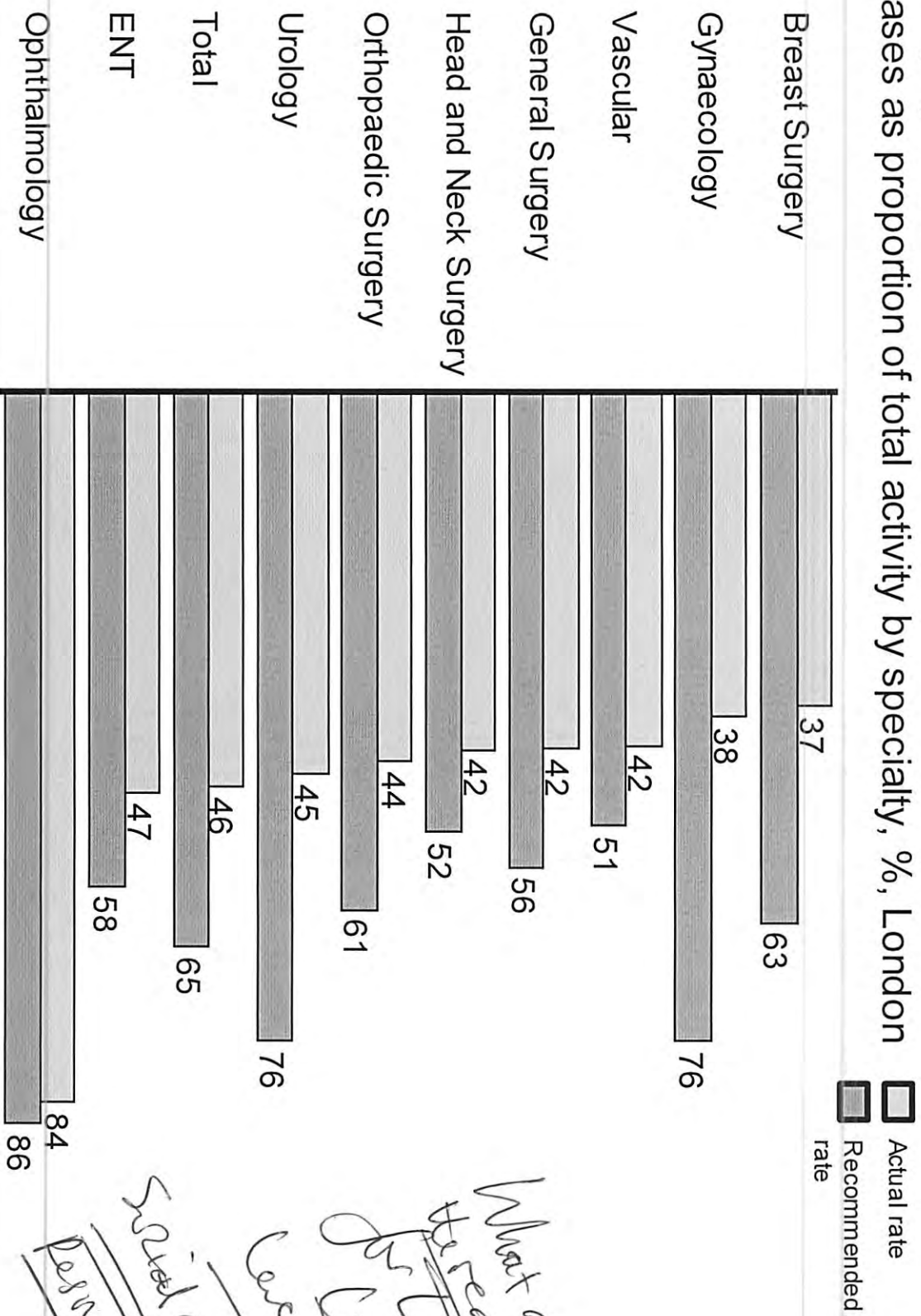
4 ALOS has improved significantly in London and NEL but is not yet at Upper quartile levels

— ALOS - NEL
- - ALOS - UQ
- - - ALOS - London



4 In addition, acute providers in London have an opportunity to increase day surgery rates

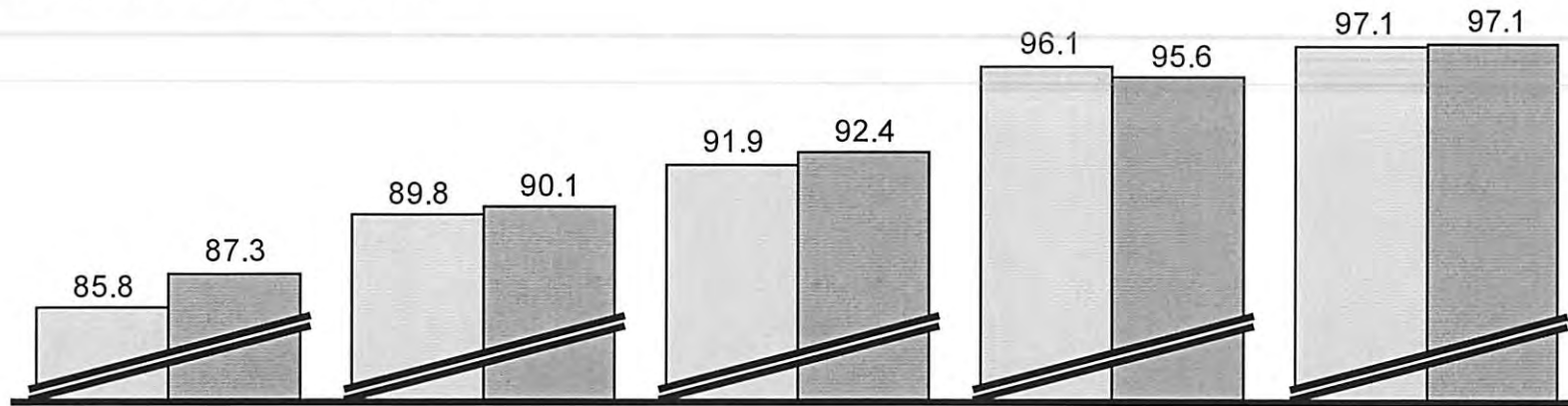
Day cases as proportion of total activity by specialty, %, London



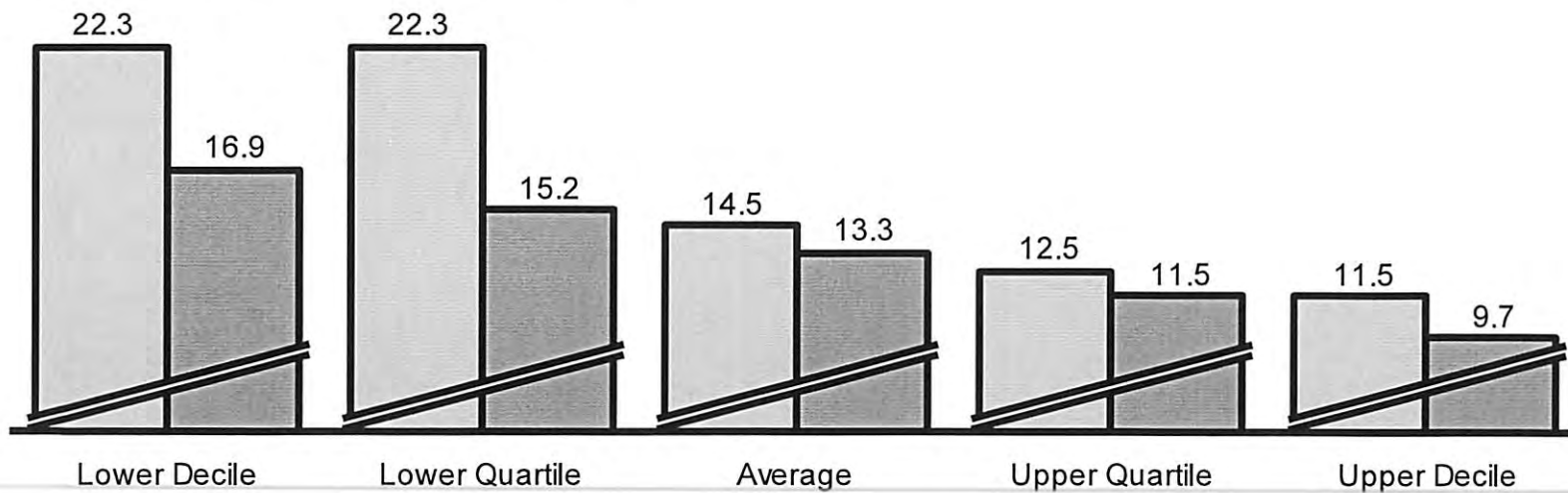
4 Although London acute provider DOSA is broadly in line with national figures, EBD's are higher

Day of surgery admission (DOSA), %

London¹
National



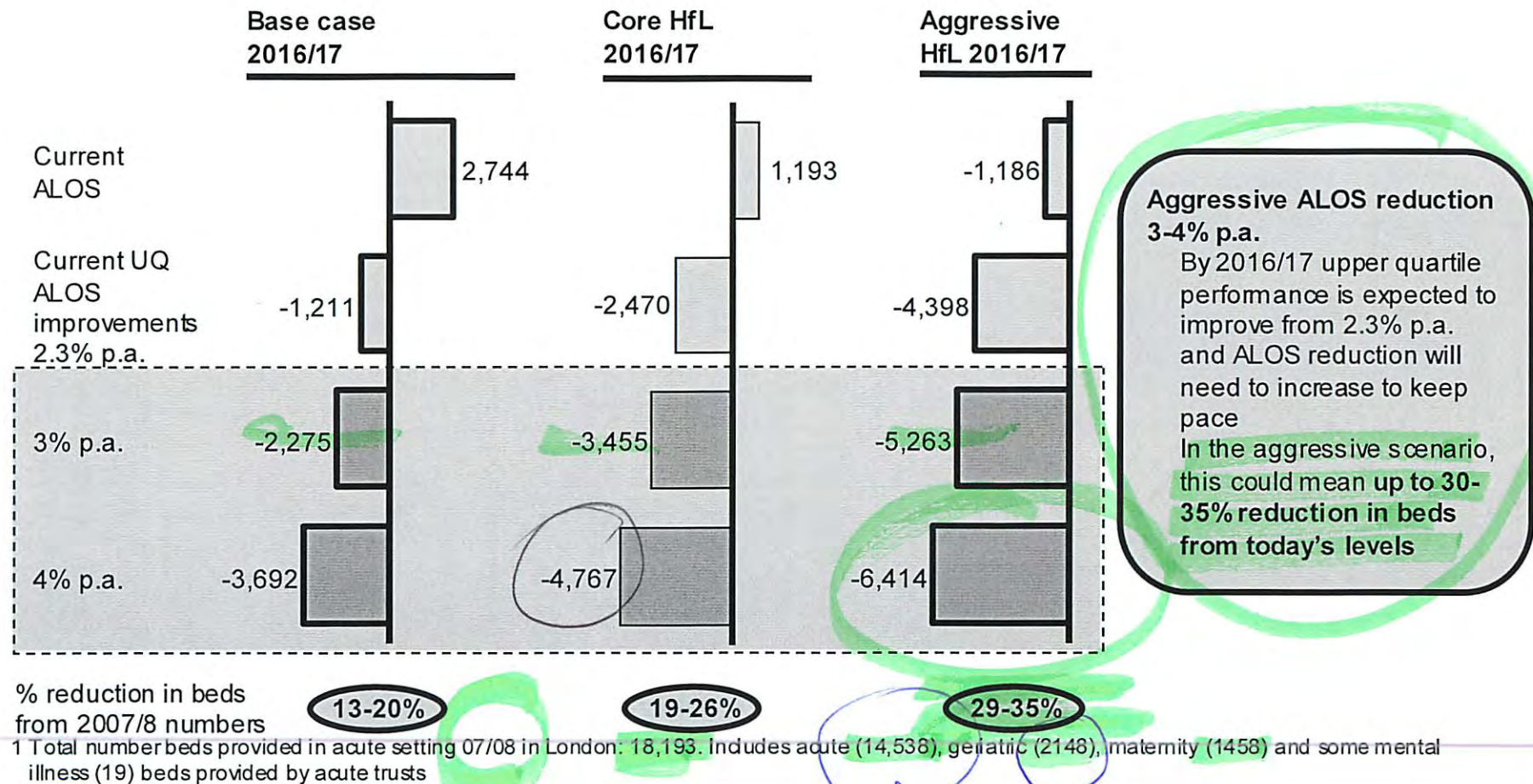
Excess bed days (EBD) as share of total bed days, %




1 Across 26 acute provider trusts

4 Achieving productivity gains in ALOS and implementing HfL will substantially change capacity requirements in the acute sector

Change in number of beds from 2007/8 to 2016/17 across London, versus 2007/8 current bed numbers¹
#



4 Theatres

 Keylevers

Objective	Action	Analysis	Rationale	
Operations effectiveness	Increase number of patients p.a.	Ensure all theatre slots are booked and reduce cancellations and DNAs	<ul style="list-style-type: none"> • Overall theatre efficiency and cancellations • Additional capacity could bring in additional income 	
		Increase number of operating sessions per day and extend operating days		
	Reduce time per patient	Increase session time utilisation Start sessions on time Avoid early finishes	<ul style="list-style-type: none"> • Minutes wasted during sessions 	<ul style="list-style-type: none"> • Especially with specialties with a short time per case
		Reduce emergency readmissions within 28 days	<ul style="list-style-type: none"> • Peer comparison of emergency readmissions 	<ul style="list-style-type: none"> • Key quality indicator used by commissioners
	Reduce cost per time unit	Reduce clinical staff costs Improve clinical staff mix Reduce number of staff		
		Shift procedures from day care to procedure rooms		

4 Theatres: Improving utilisation across sites could release 4.5-6.5 theatre equivalents

SANITISED EXAMPLE

	Hours	Session equivalents ³	Theatre equivalents ³	Costs ⁴	Cost savings opportunity, £m
Late starts	6000 ¹	1500	3.0	Pay cost per session: 2402	3.6
	3000 ²	750	1.5		1.8
Early finishes	7000	1800	3.5	Pay cost per session: 2402	4.2
	6000	1500	3.0		3.6
Overruns	3000	N/A	N/A	Nurse pay cost hour: 252 Anaesthetist pay cost per overrun session: 1128	0.9 – 1.3
Turnover time	TBD				

Total opportunity: 4.5-6.5 theatre equivalents or £6.3-9.1m

1 Assumes start time is knife to skin
 2 Assumes start time is anaesthetic conduction
 3 Assumes 4 hour session length, 2 sessions per theatre per day, 5 days per week, 50 weeks per year. Each theatre's capacity is roughly 500 sessions
 4 Pay costs are for anaesthetists, nurses, assistants, admin only. No surgeon costs are included. No non-pay costs are included (e.g., supplies). For overruns, assumes anaesthetists receive session compensation for overruns > 2 hours

5 Outpatients

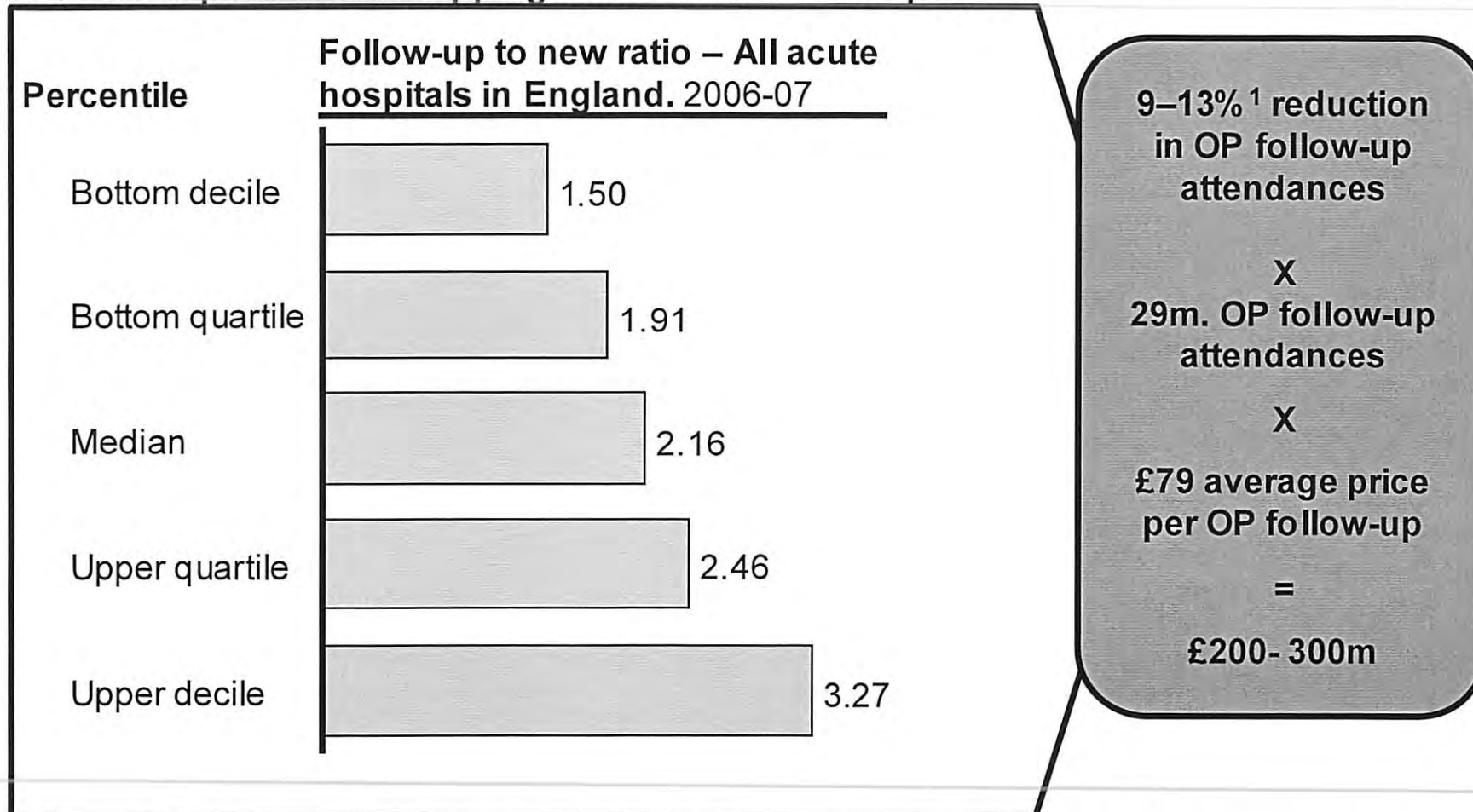
■ Key levers

Objective	Action	Analysis	Rationale	
Operations effectiveness	Optimise use of clinic room and space			
	Increase number of patients p.a.	Reduce cancellations	• Cancellation rate	• Wasted capacity • Patient experience • Administrative costs
		Extend hours and days of operation		
		Reduce DNAs	• DNA rate	• Wasted capacity
	Reduce time per patient	Increase session time utilisation Start sessions on time Avoid early finishes Reduce mid-session wasted time		
		Reduce new to follow-up ratio	• New to follow-up ratio	• First visits generate more revenue • Financial risk if PCTs cap payments for follow up visits
	Reduce out-patient cost per time unit	Reduce clinical staff costs Improve clinical staff mix Reduce number of staff		
		Implement alternating telephone consultations for long term conditions		

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

NATIONAL

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



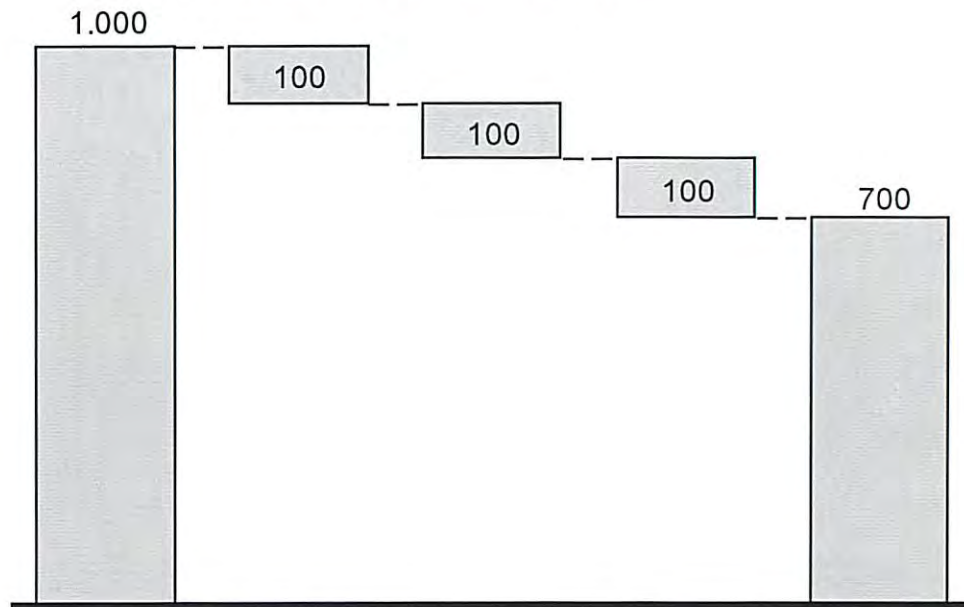
¹ Top of range: underperformers achieve 80% of the potential improvement of stepping down to bottom quartile. Bottom of the range: underperformers step down to the median

5 Outpatients: Reducing DNA rates could release appointments for new activity or capacity reduction

SANITISED EXAMPLE

Outpatient appointment cancellations overview, 2007/08

Number of outpatient \ appointments, 000s



	Appointments	Patient cancellations	Hospital cancellations	DNAs	Attendances
Acute provider % of total		8	6	12	74
Best				6.5	90
Top decile				7.2	87

- Cancellations lead to unnecessary rework for administrative and clerical staff, and to unused consultant and space capacity
- Reducing DNA rate from 12% to the top decile and best in class, could provide additional income assuming these slots were refilled.
- In addition, reducing cancellation rates and DNA rates could have a cost saving for administrative and clerical staff

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

Clinical room usage

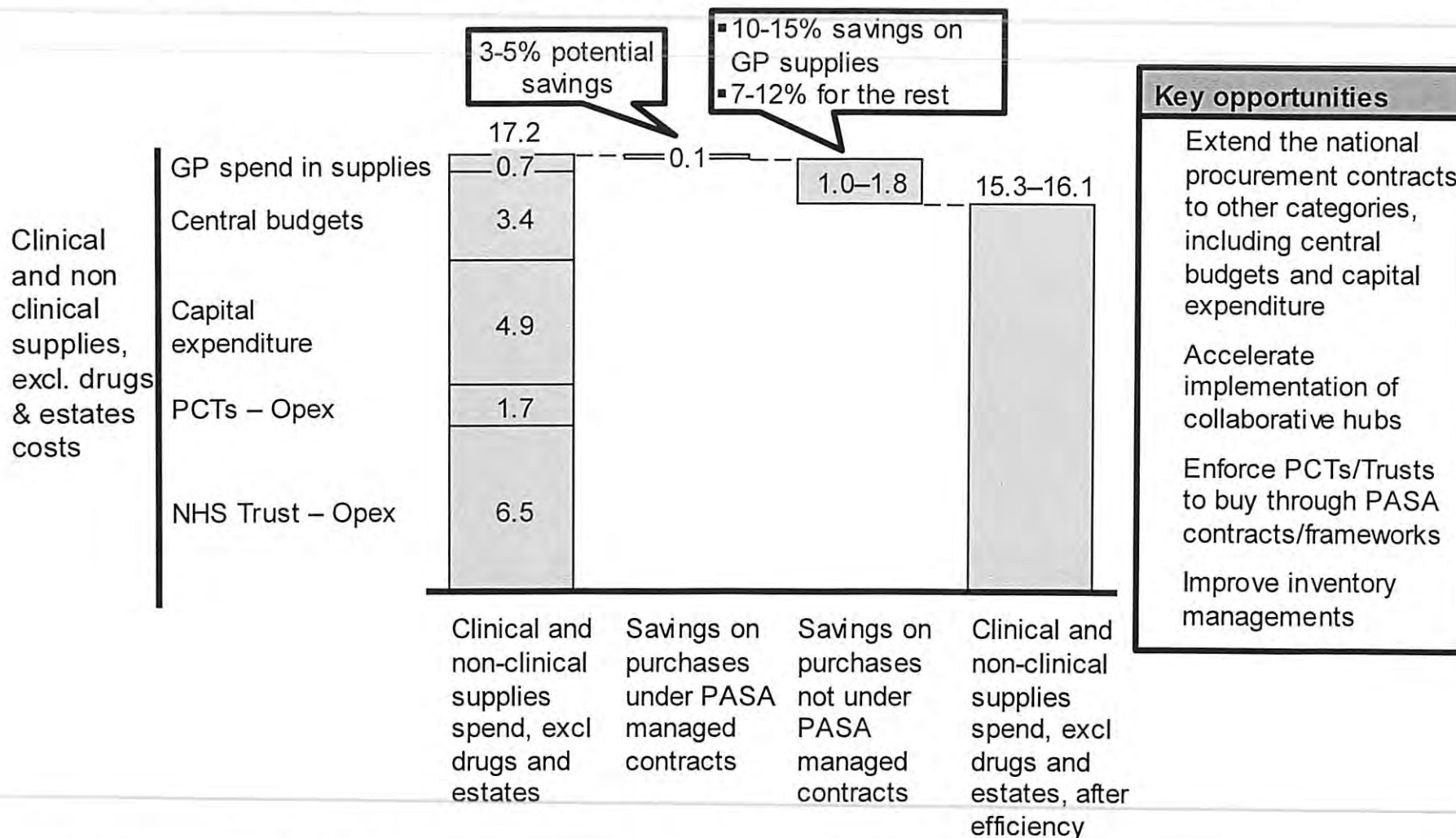


		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Clinic room A	Morning	75%	35%	53%	91%	34%	45%	10%
	Afternoon	80%	60%	85%	45%	56%	45%	15%
	Evening	80%	60%	65%	45%	56%	45%	5%
Clinic room B	Morning	75%	35%	53%	91%	34%	45%	10%
	Afternoon	80%	60%	85%	45%	56%	45%	15%
	Evening	80%	60%	65%	45%	56%	45%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

1 Assumes target utilisation 80% or more

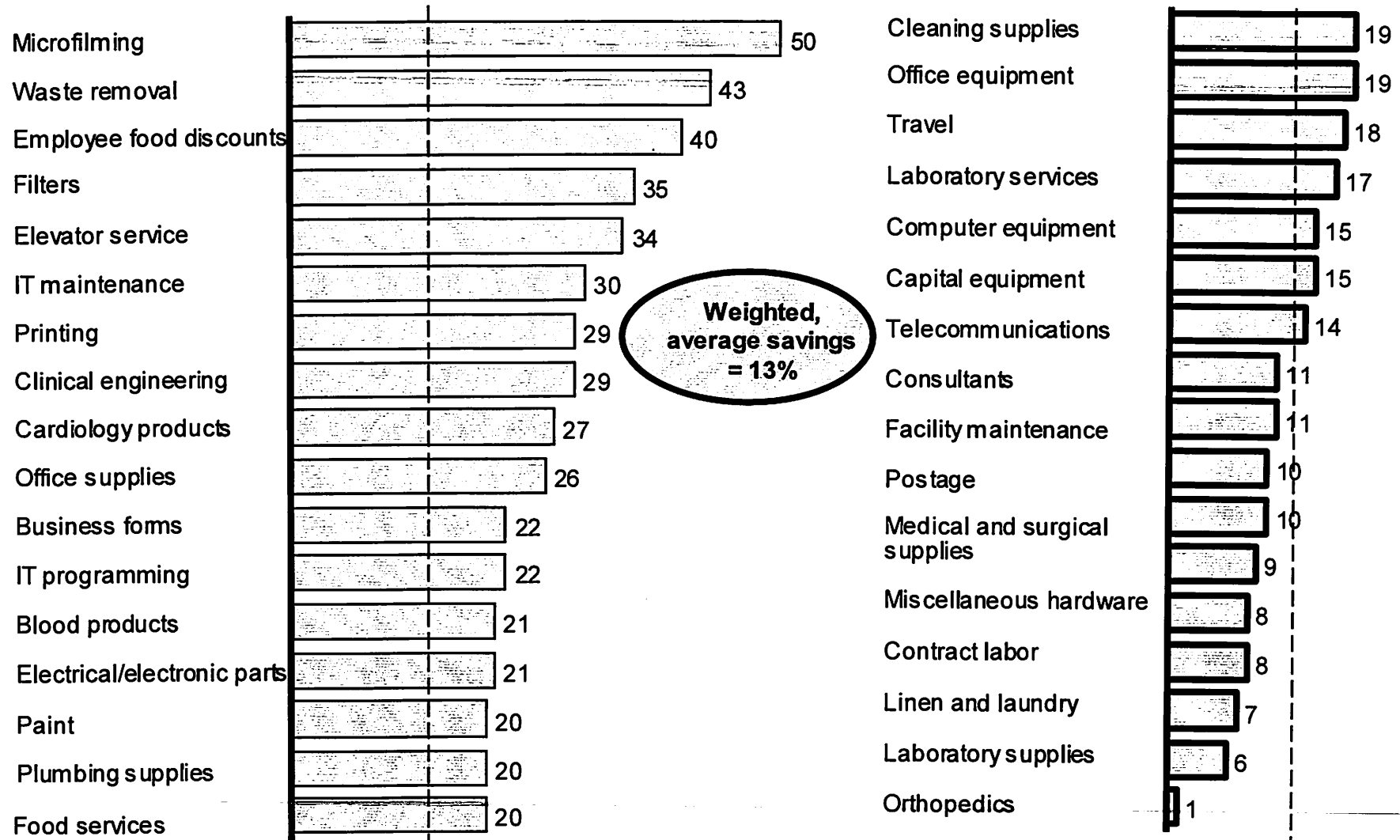
6 Supply chain/procurement: although significant savings already captured, there is still an opportunity estimated at £1.1–1.9b NATIONAL

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



6 10% to 15% savings on external spend can be typically achieved through a comprehensive procurement project NATIONAL

Percent savings based on 75 projects since 1997



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

NATIONAL

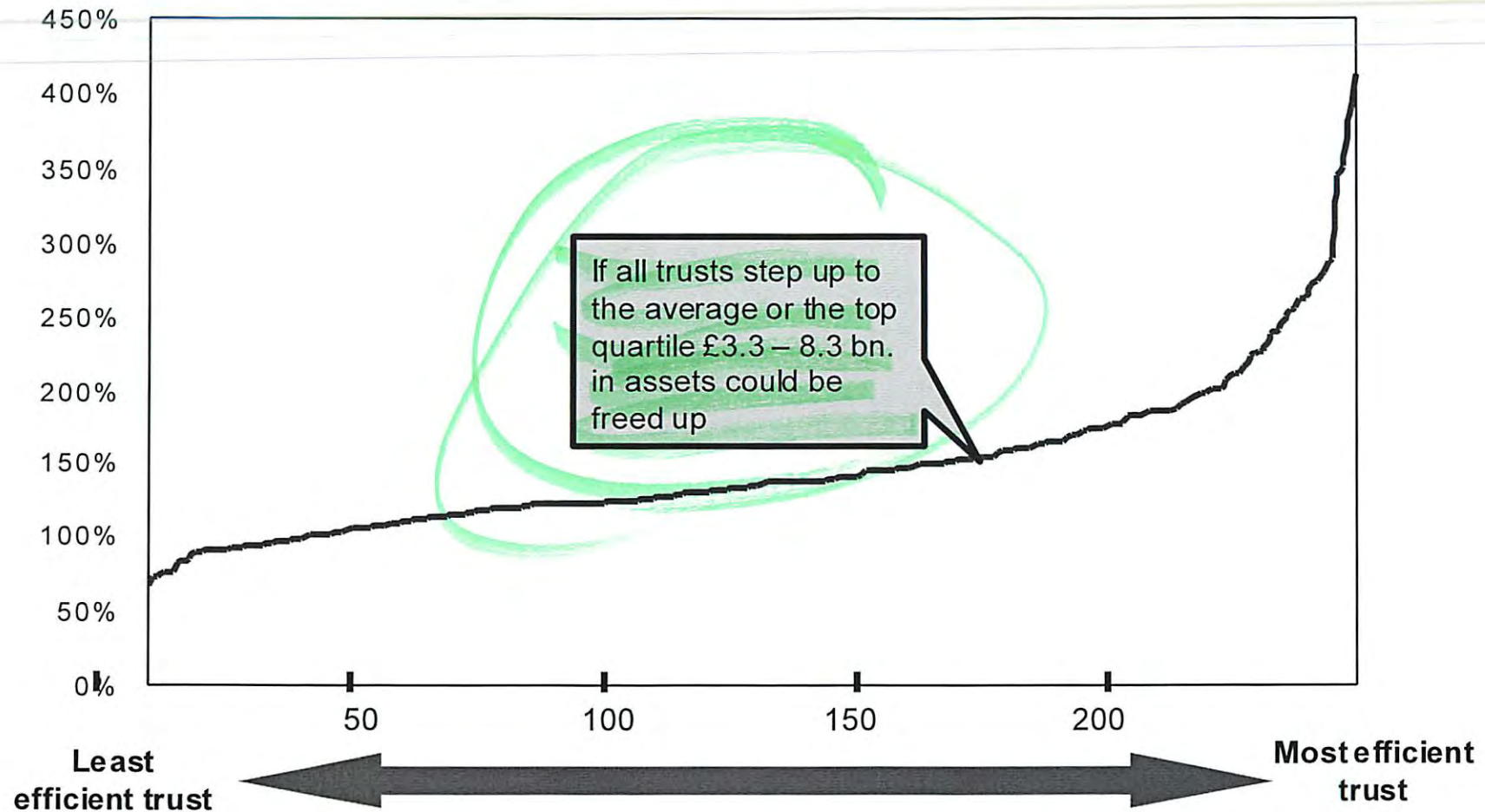
	Initial savings estimate - 2004	New targeted savings - 2005	Final savings achieved – 2007/08
National Contracts Procurement¹	240	407	240
Collaborative Procurement Hubs	270	326	270
Total	510	733	510

1 Includes expected savings from Wave 1 and Wave 2

6 Estates costs – Trusts' asset utilisation varies sixfold

NATIONAL

Revenue to fixed asset by trust¹, average 2002/3 – 2004/5. Percent



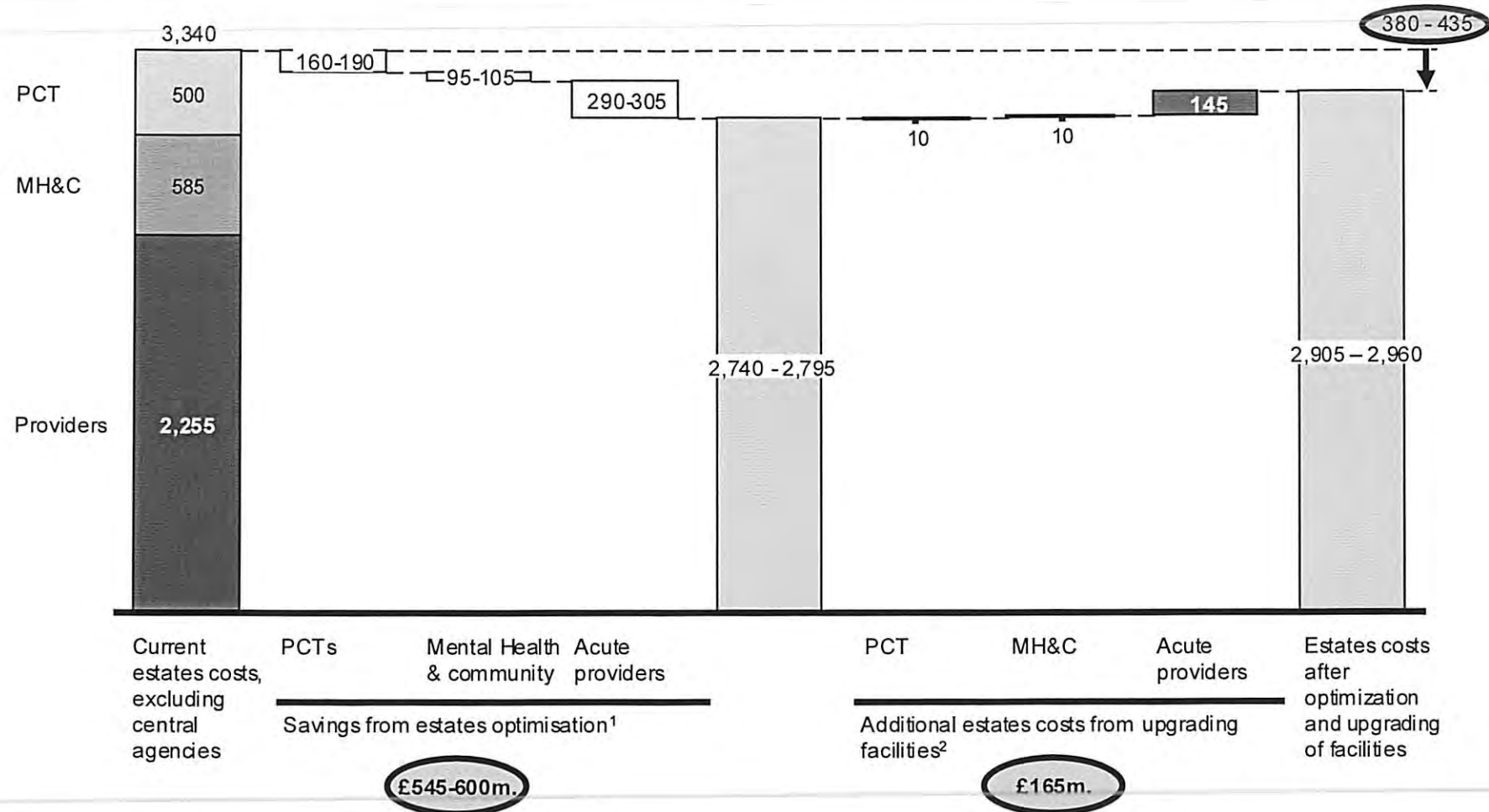
¹ Acute and mental health trusts

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

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

NATIONAL

£million. 2007/08. Estates costs



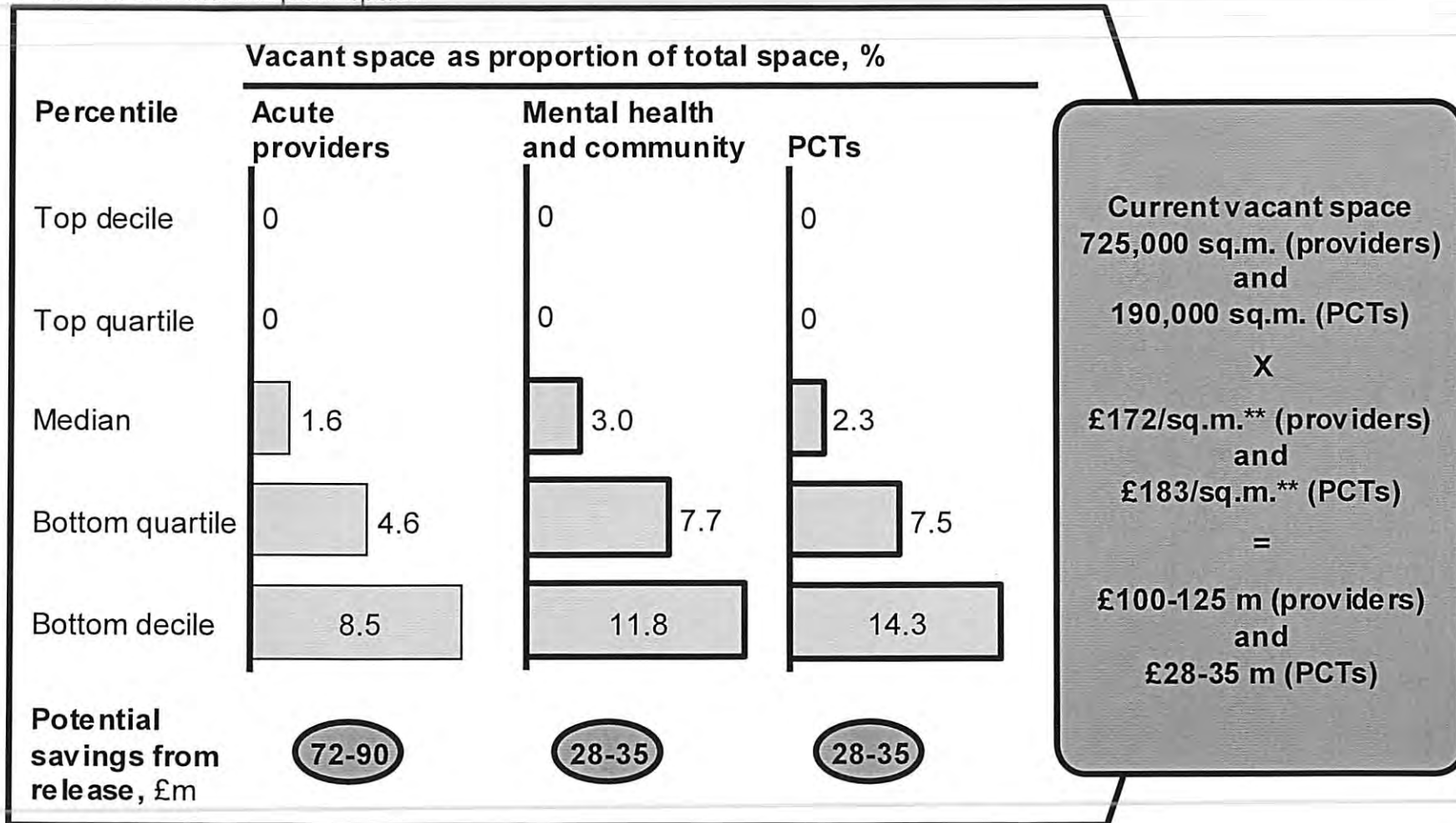
1 Calculated as trusts below median reaching median or 80% of top quartile value in sq.m. per bed or sq.m. per WTE. Same assumption applied to capture savings from vacating currently unused space

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

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

NATIONAL

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



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

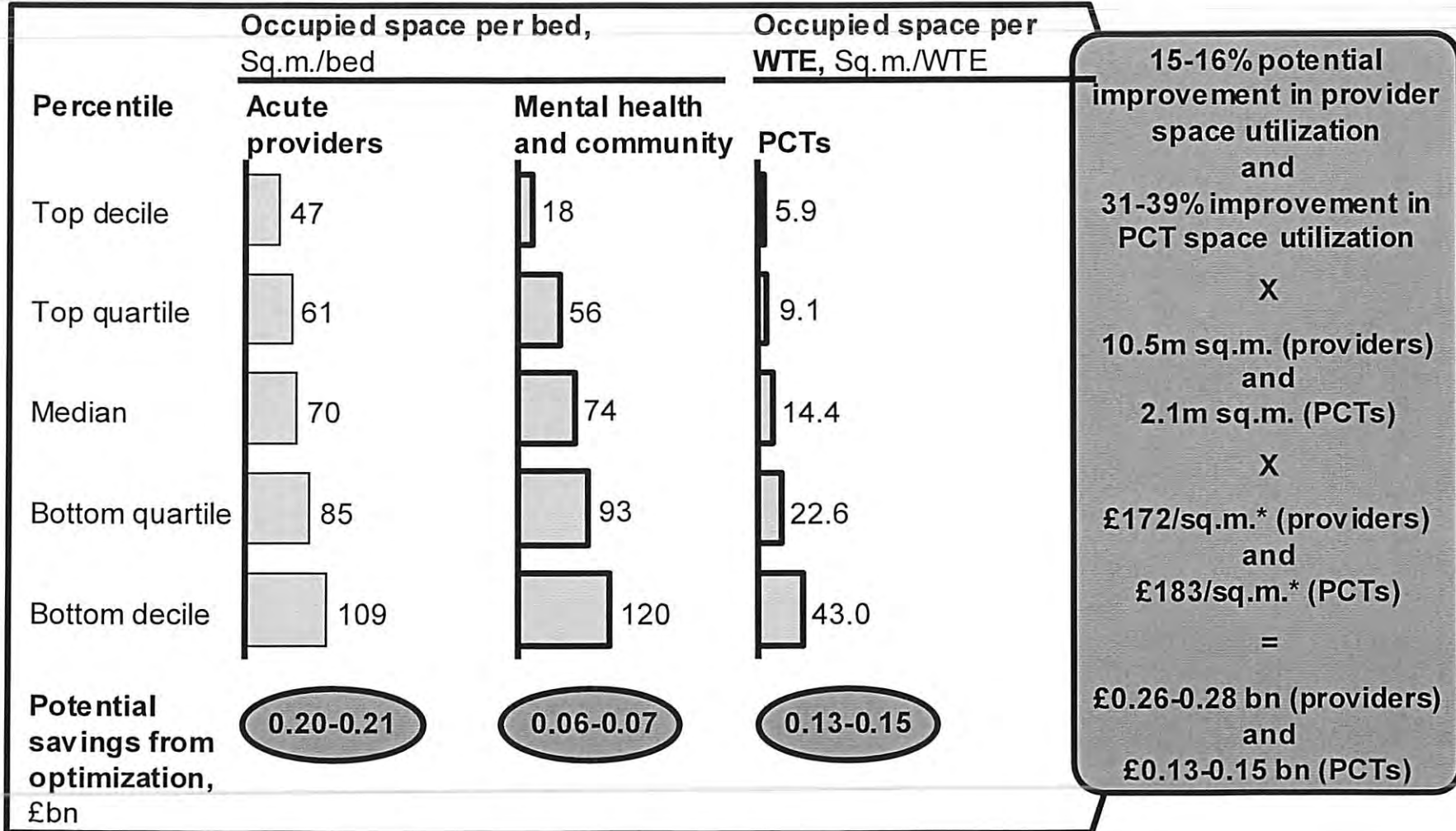
** Extremely conservative as costs generally taken to be £300-400/sq.m.

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

6 ... and additional potential savings of £0.4bn from better use of providers' and PCTs' estates

NATIONAL

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

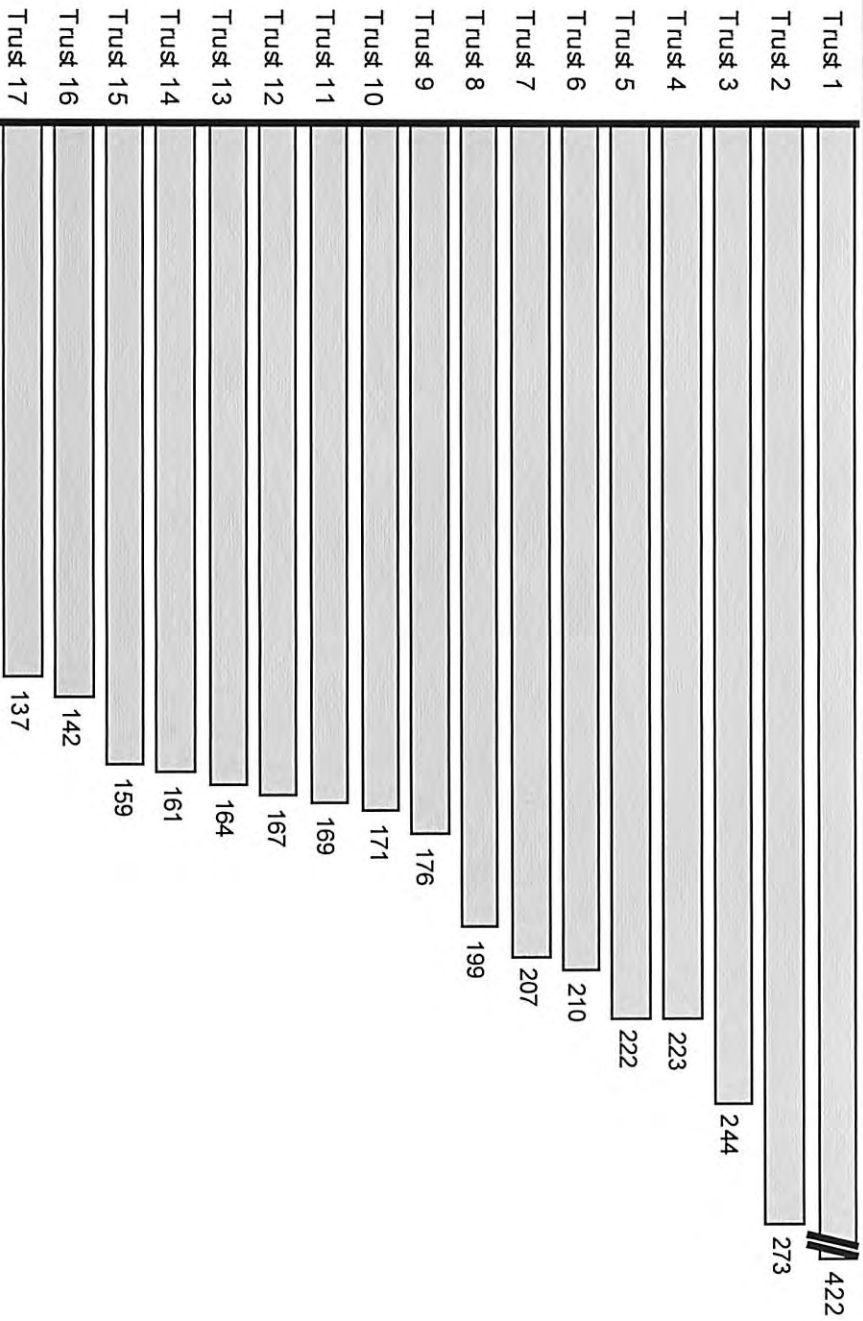


* Extremely conservative as costs generally taken to be £300-400/sq.m.

6 For example, there is significant variation in estate size relative to bed base across different providers

SANITISED EXAMPLE

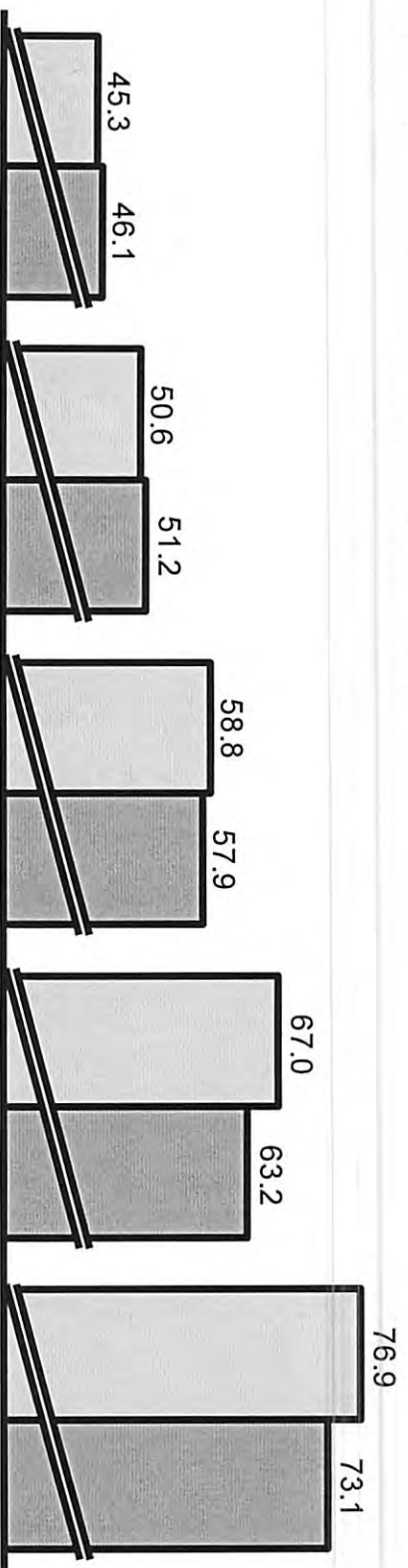
m² of floor area per bed



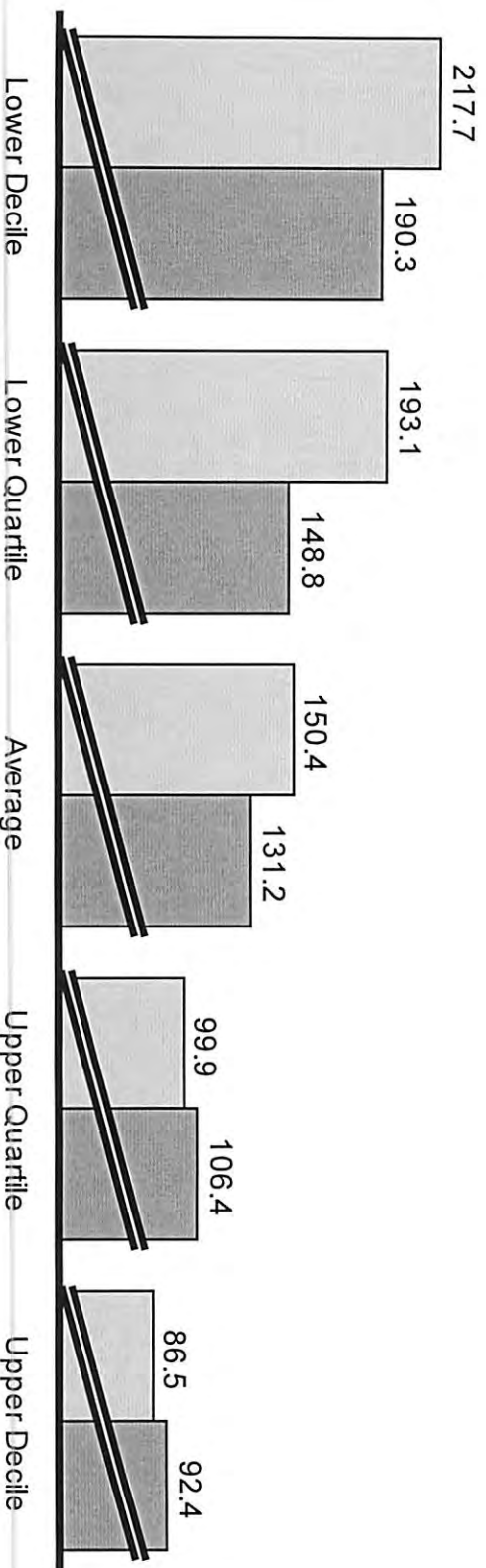
6 With London also demonstrating significant variation in space utilisation

Patient occupied space as share of total, 2007-08, %

London¹
National



Floor space / bed, 2007-08, m²



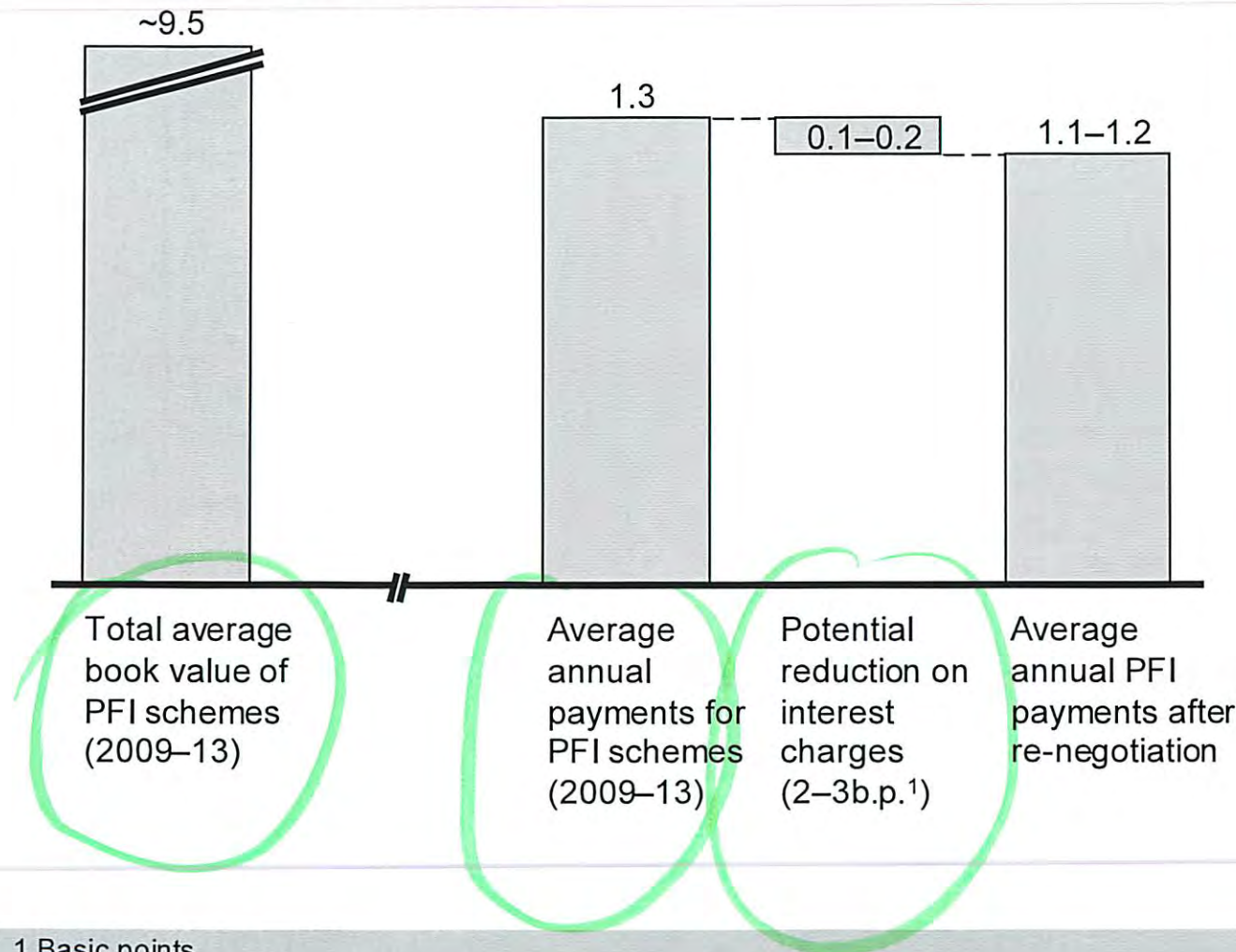
¹ Across 31 acute and foundation acute trusts

SOURCE: NHS Trusts and Foundation Trusts

6 PFI restructuring – renegotiating the interest charges of 80% of the PFI schemes by 2–3bp¹ could reduce financing cost by £0.1–0.2b. nationally

NATIONAL

£ 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

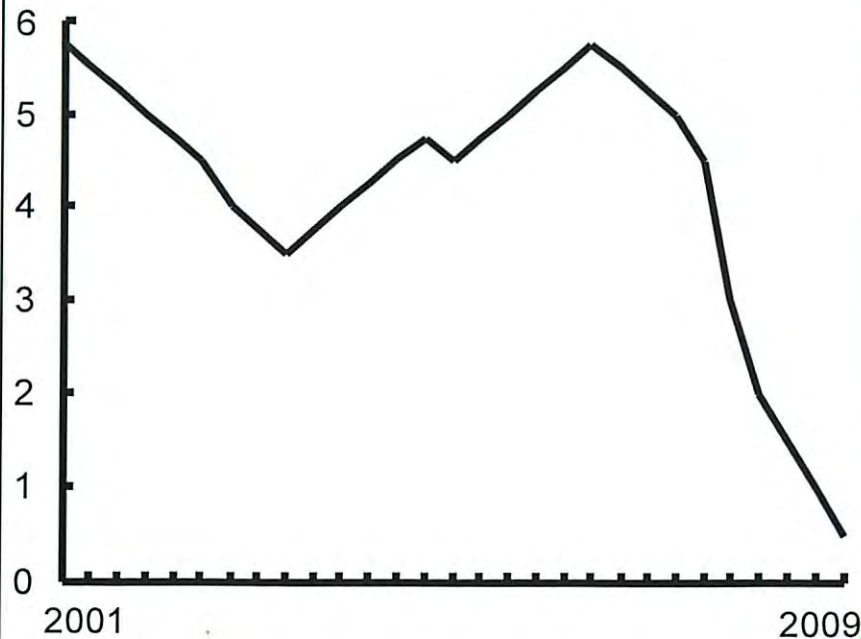
? is that all?

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

NATIONAL

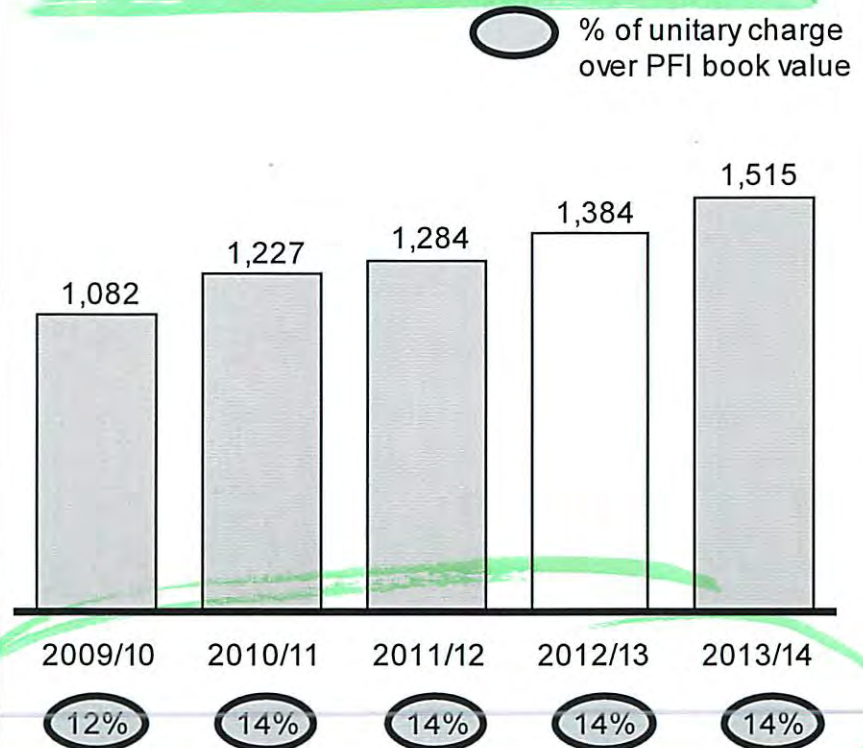
Majority of PFI schemes negotiated in times of high interest rates, typically paying 6-8% interest rate, and everybody could borrow money

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



Contents

Context to the work

Broad model structure and 2007/8 pan-London starting point

Detailed pan-London assumptions

Detailed polysystem modelling assumptions and unit cost outputs

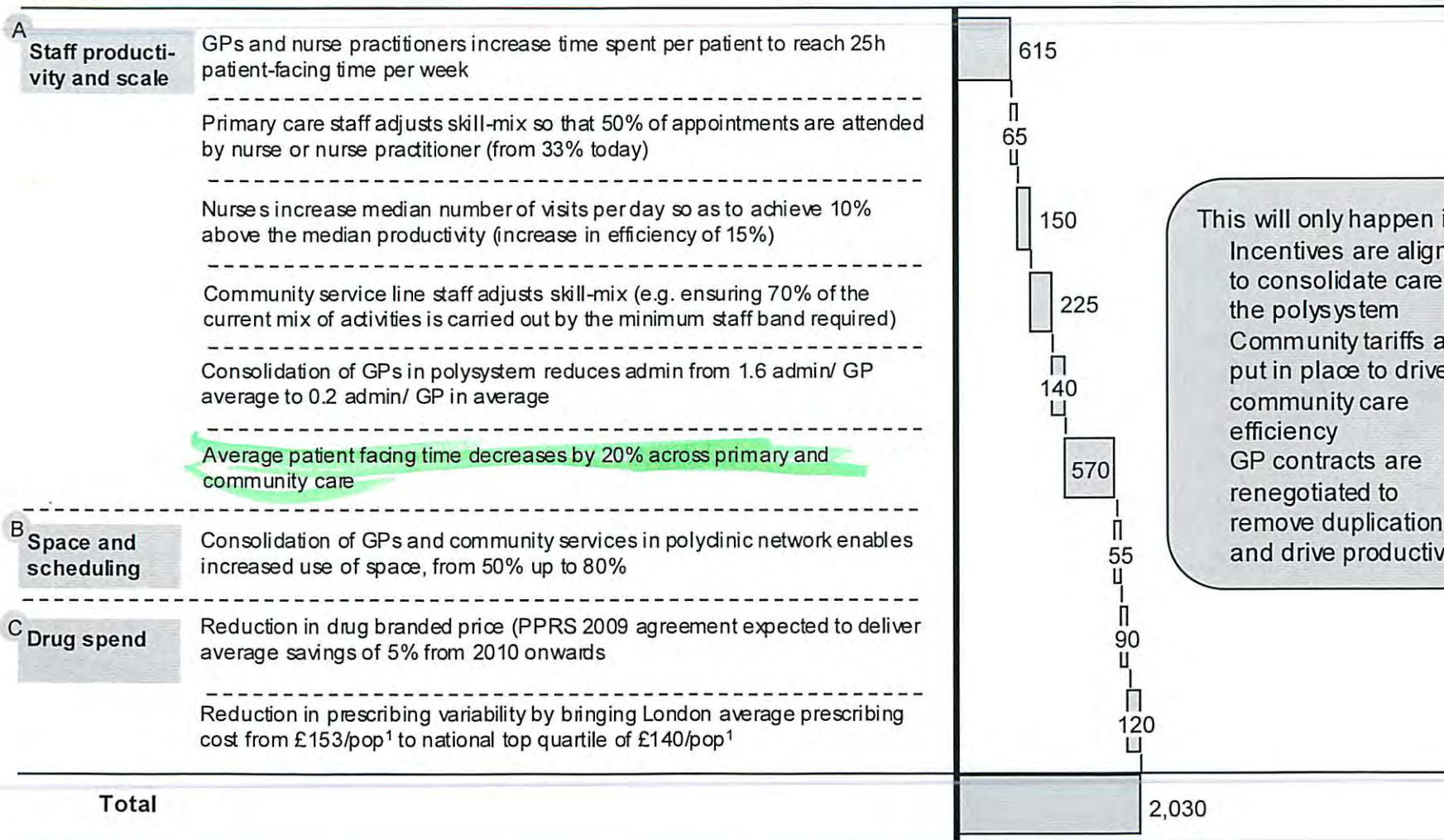
Implications for acute providers

Implications for out-of-hospital settings

Miscellaneous

Productivity improvements in the non-acute sector will come primary from staff productivity, the effects of scale and drug-related spend

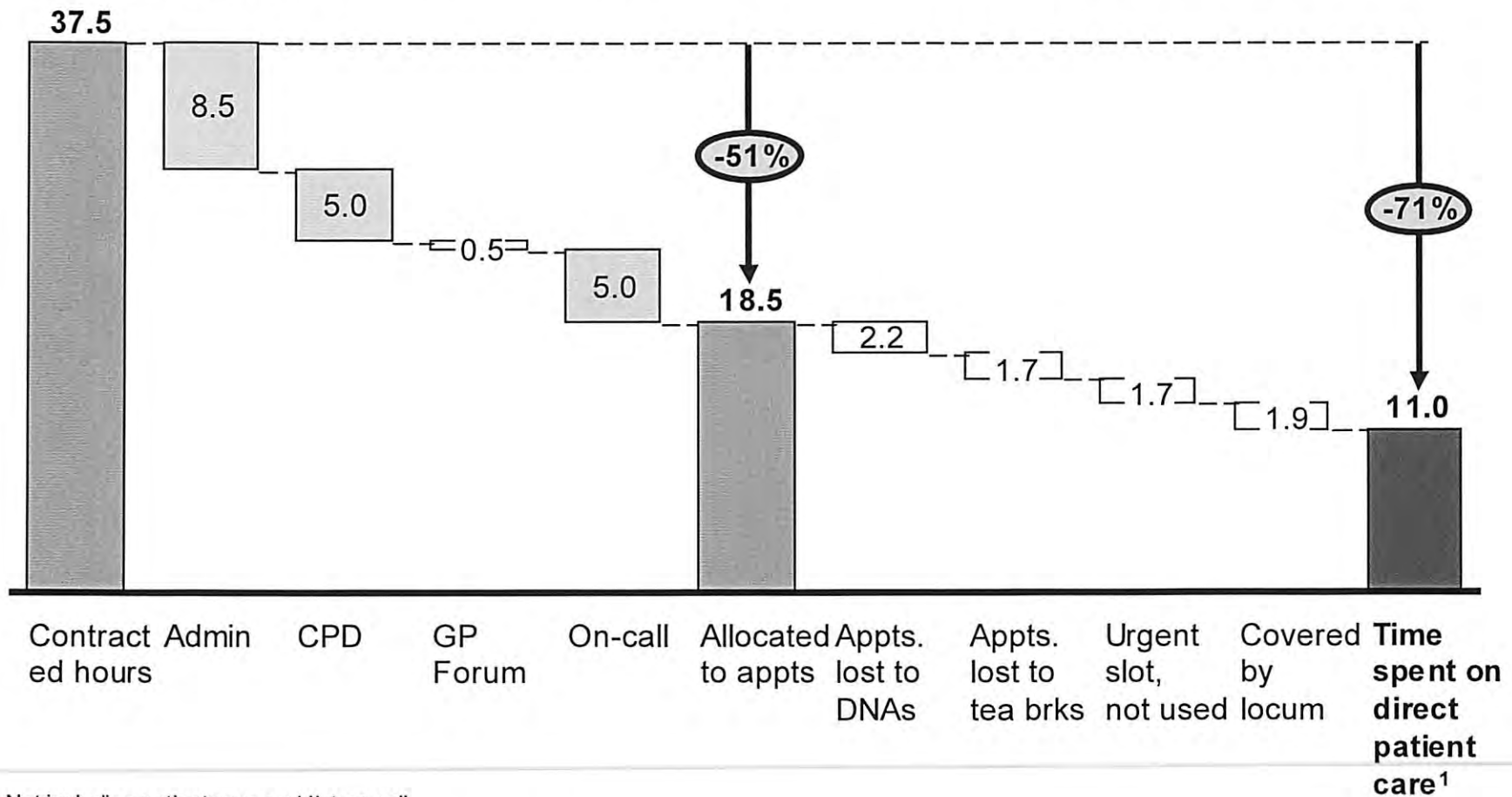
Potential savings for London, 2016/17
(from efficiency improvements) £m



This will only happen if
Incentives are aligned to consolidate care in the polysystem
Community tariffs are put in place to drive community care efficiency
GP contracts are renegotiated to remove duplication and drive productivity

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

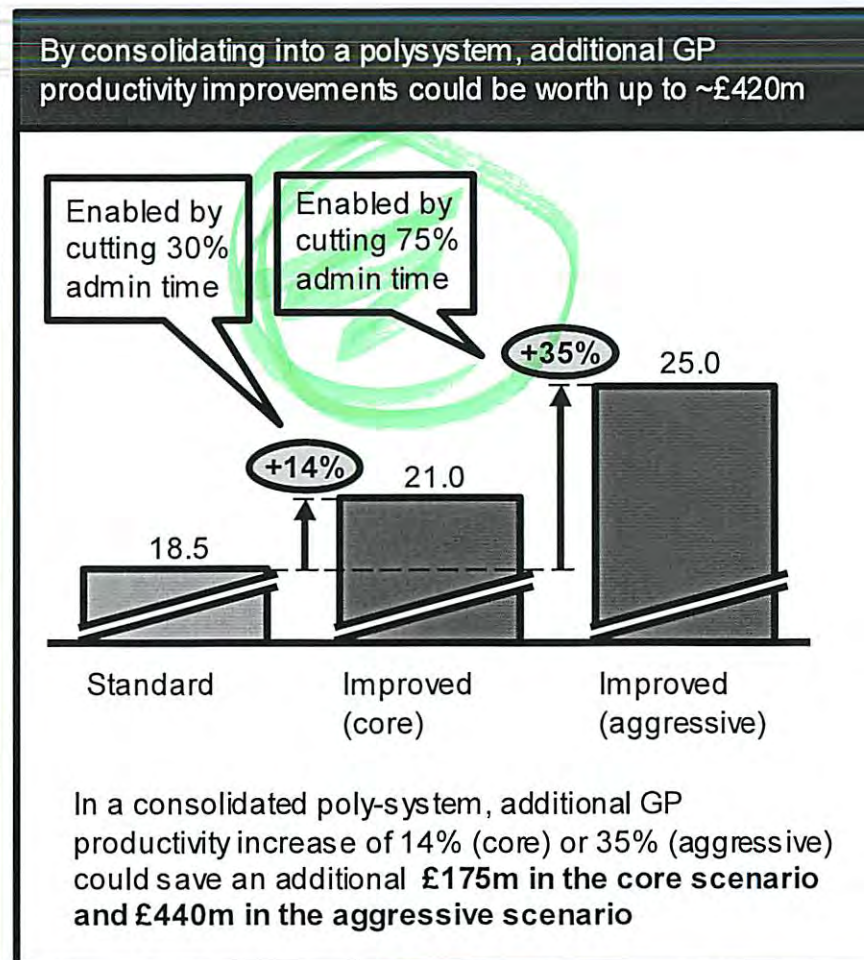
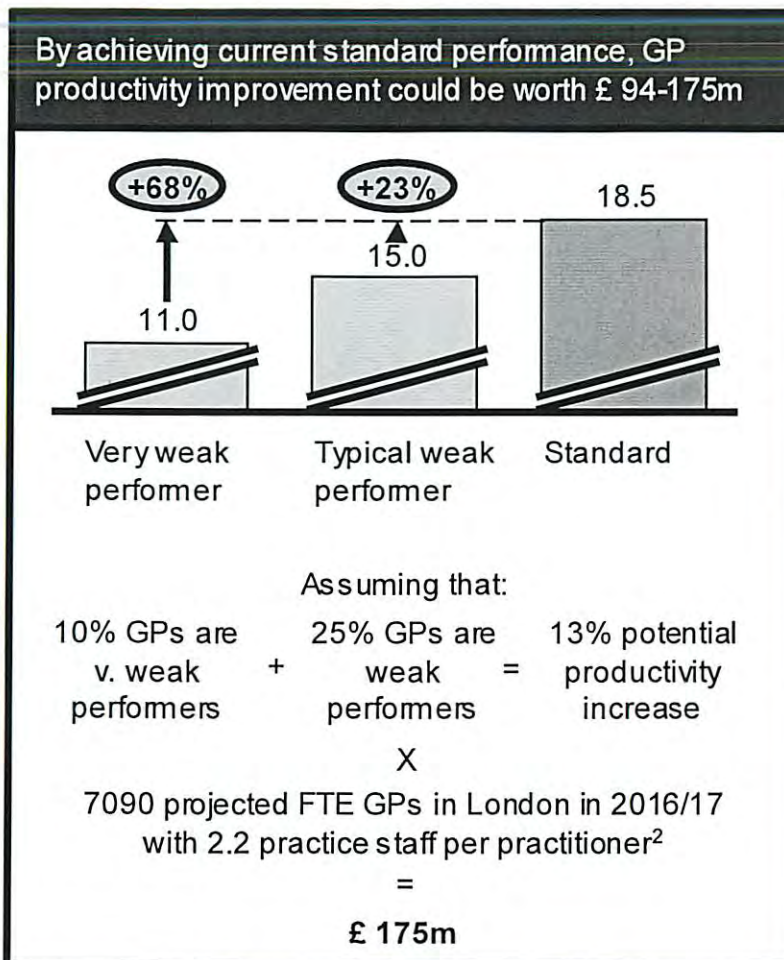
Number of hours



¹ Not including patients seen whilst on-call

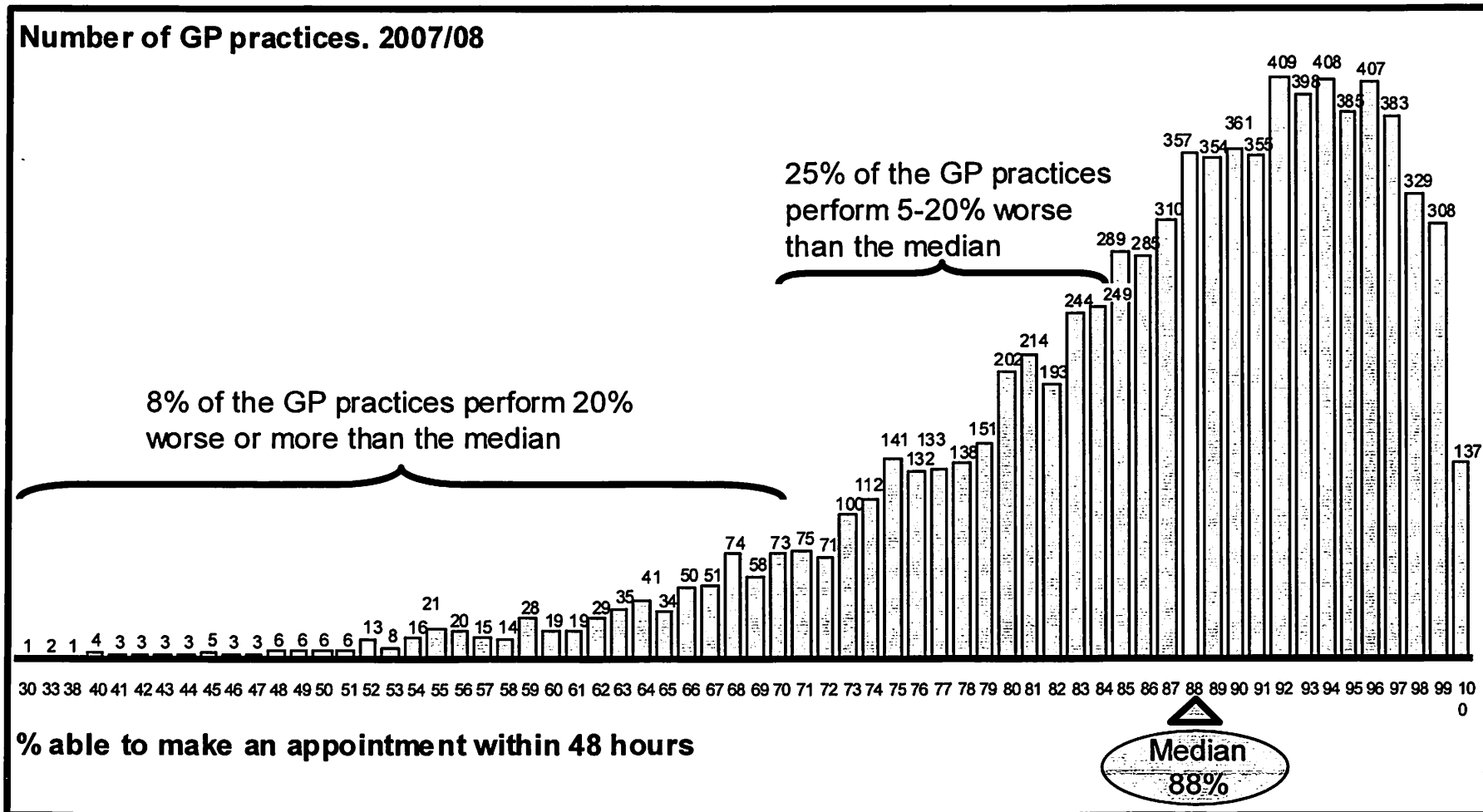
A Potential GP productivity improvement could be worth £0.4bn to £0.6bn, enabled through the polyclinic setting

Number of hours sent on direct patient care¹



¹ Not including patients seen whilst on-call; ² Assumes current ratio of 17 admin staff per GP and 0.5 Nurse practitioner per GP; ³ Assumes average annual salaries in 2016/17 of £119k for GPs, 55k for nurse practitioners and 25k for admin

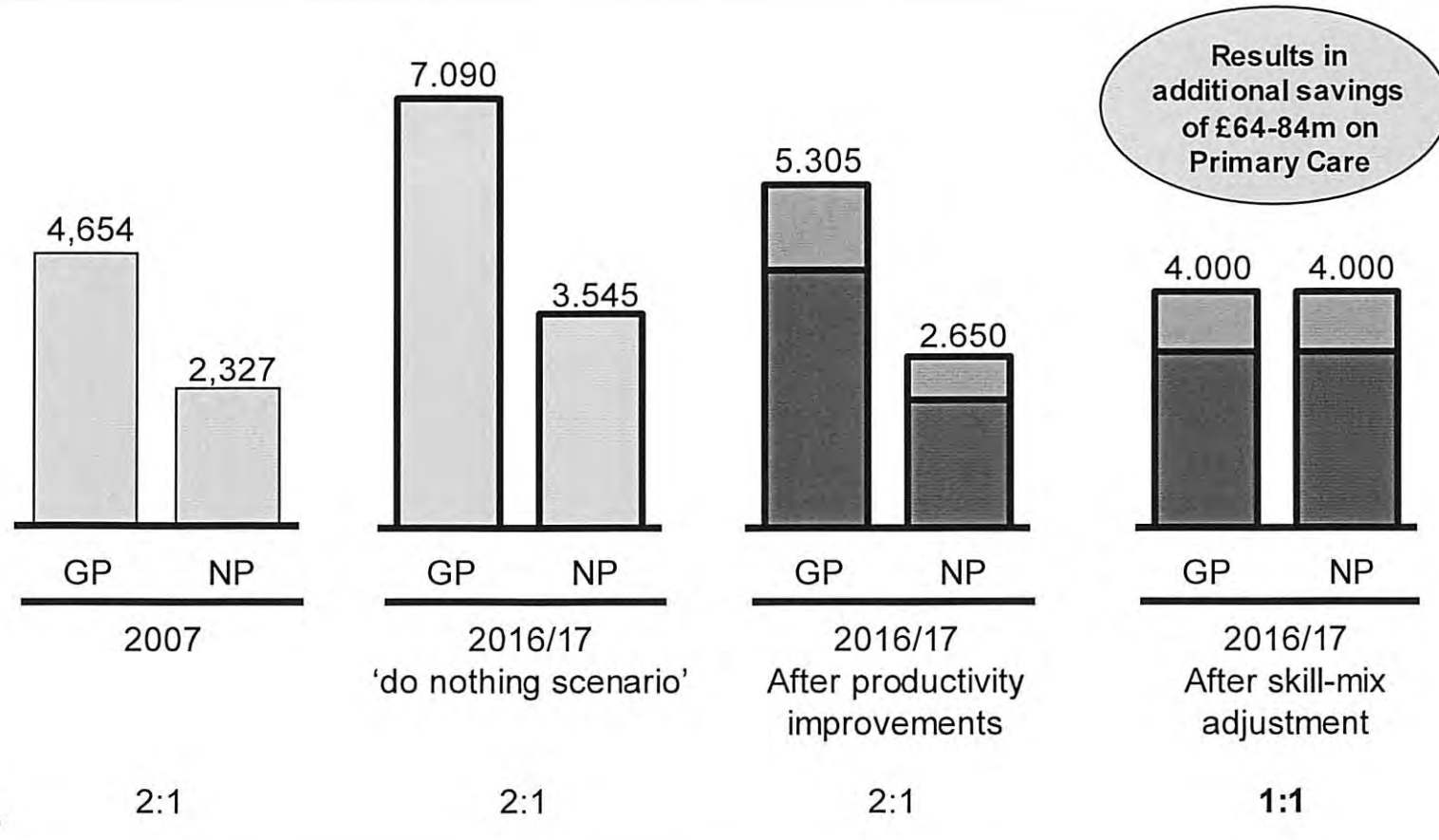
A Current poor performance in patient facing time is also evidenced by performance in access



A In addition, changing the current skill-mix could save an additional £64-84m

Staff WTE

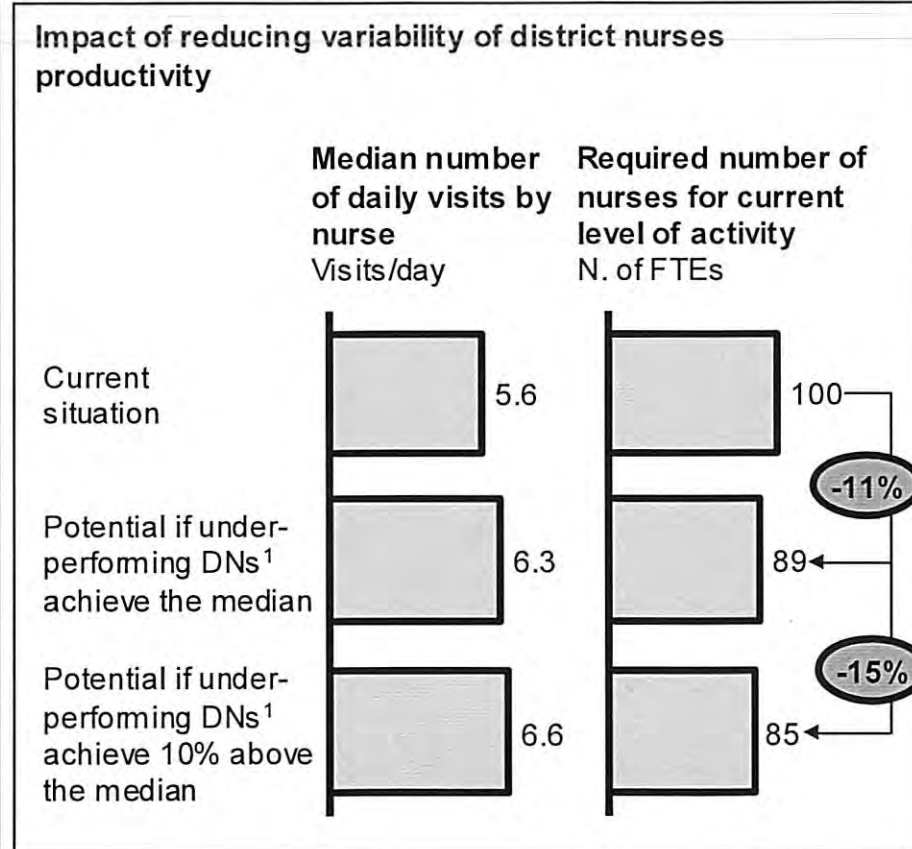
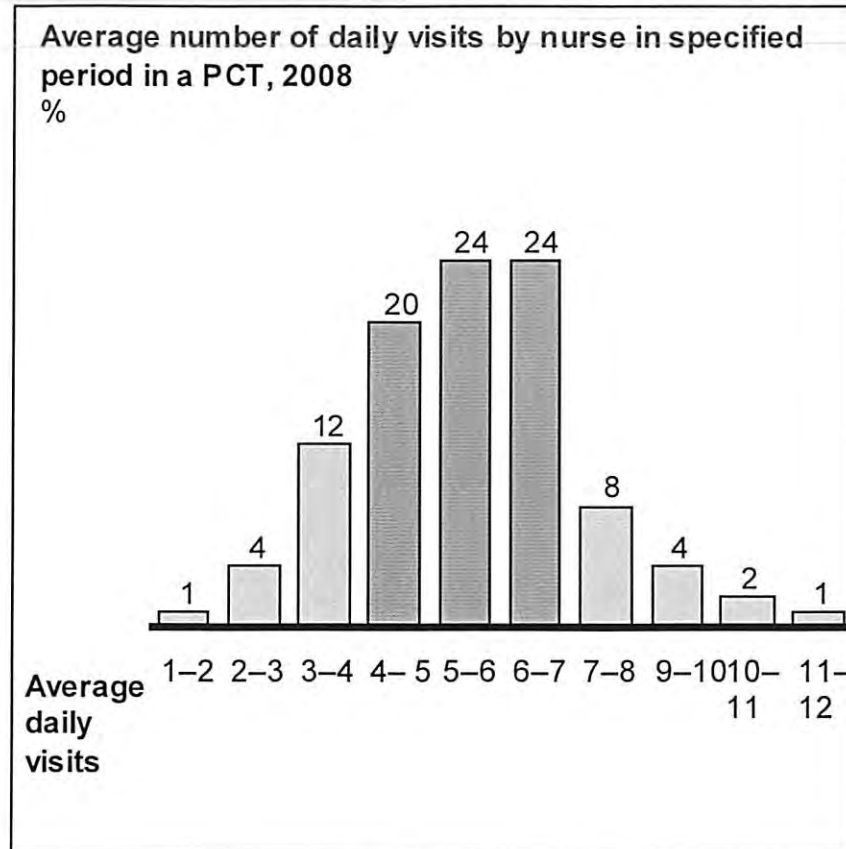
Core
Aggressive



1 Assumes average annual salaries in 2016/17 of £119k for GPs, 55k for nurse practitioners

A In Community care, there could be the potential to deliver same level of activity with 11–15% less staff

PCT EXAMPLE



Assuming that Staff pay represents 60% of community care costs², a 15% staff reduction would represent £150m savings

1 District nurses

2 £1.65 bn in the 'do nothing' scenario by 2016/17

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

A And specifically in community care, one PCT has identified a set of initiatives to increase efficiencies of service line services by c. **15%** PCT EXAMPLE

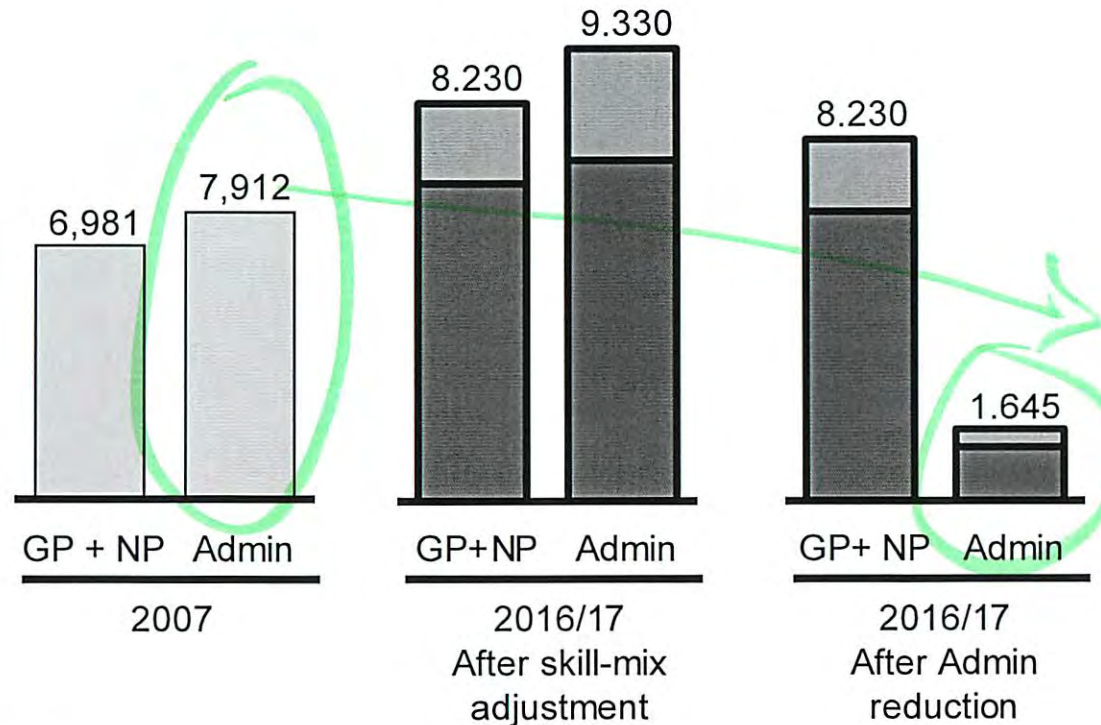
Efficiency improvement initiatives	Share of savings % of budget 08
① Adjust skill-mix of Service line staff	8.0
② Reduce administrative time by employing more admin. staff and intro of lean processes	3.3
③ Reduce management time of lower band staffs	1.0
④ Streamline travel routes of clinical staff	1.0
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

This can represent an additional £225m savings

A Consolidating GPs in polyclinics should enable a lower use of admin staff and savings of £145-195m

Staff WTE

■ Core
■ Aggressive



Ratio of GP+ NP to Admin

0.9:1

0.9:1

0.2:1

Consolidation in a polyclinic should allow GP practices to share resources more efficiently and to reduce admin staff by a factor of 4. This could bring savings of £145-195m

Why?

How many jobs?

6,300

1 Assumes average annual salaries in 2016/17 of £119k for GPs, 55k for nurse practitioners and 25k for admin staff

A Reducing appointment times by 30% would provide an additional £570m savings

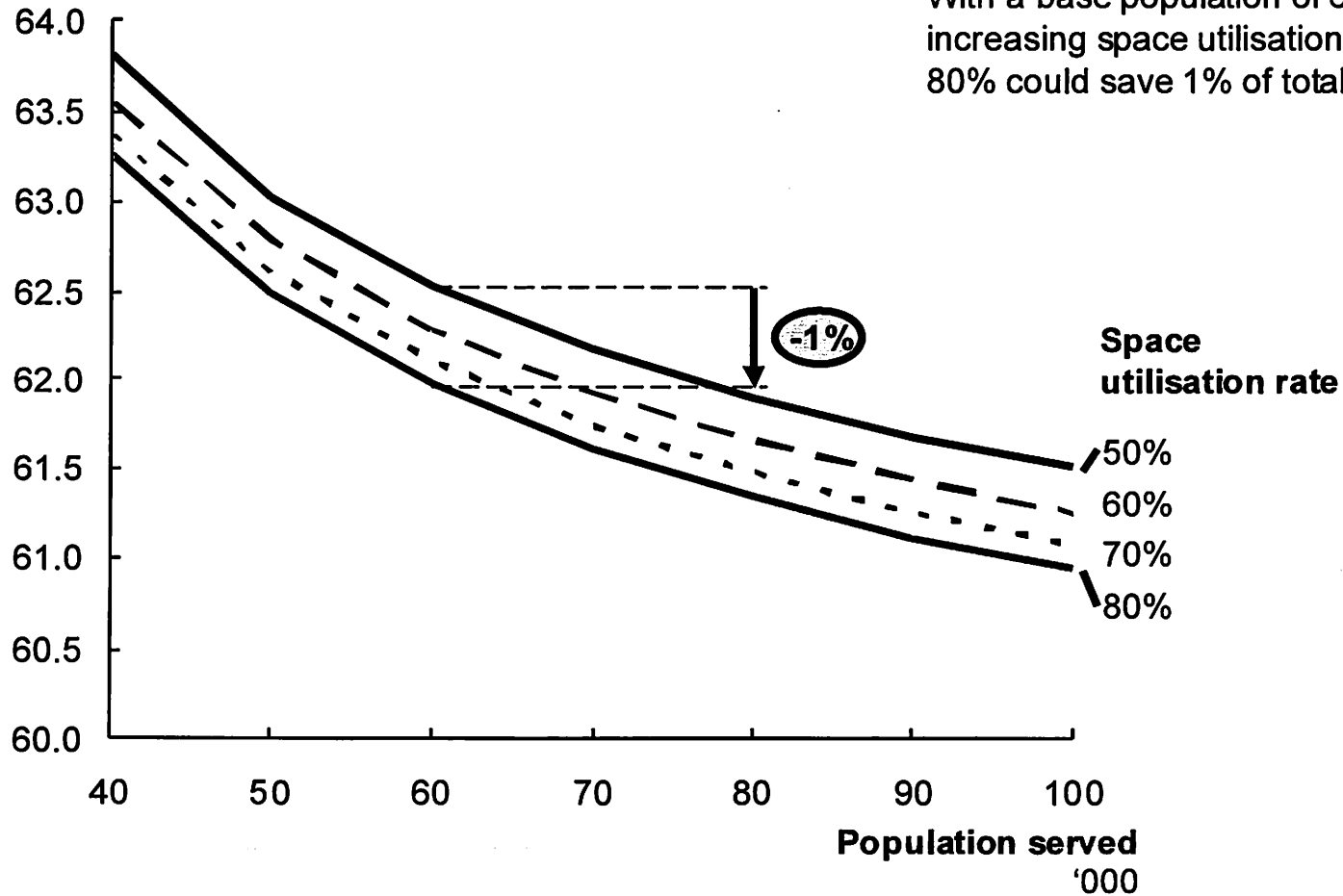
Additional 30% reduction in appointment time impact on	Savings (£m)
Primary care staff	£250 m
Community service staff	£300 m
Overheads	£20 m

Total	£570m

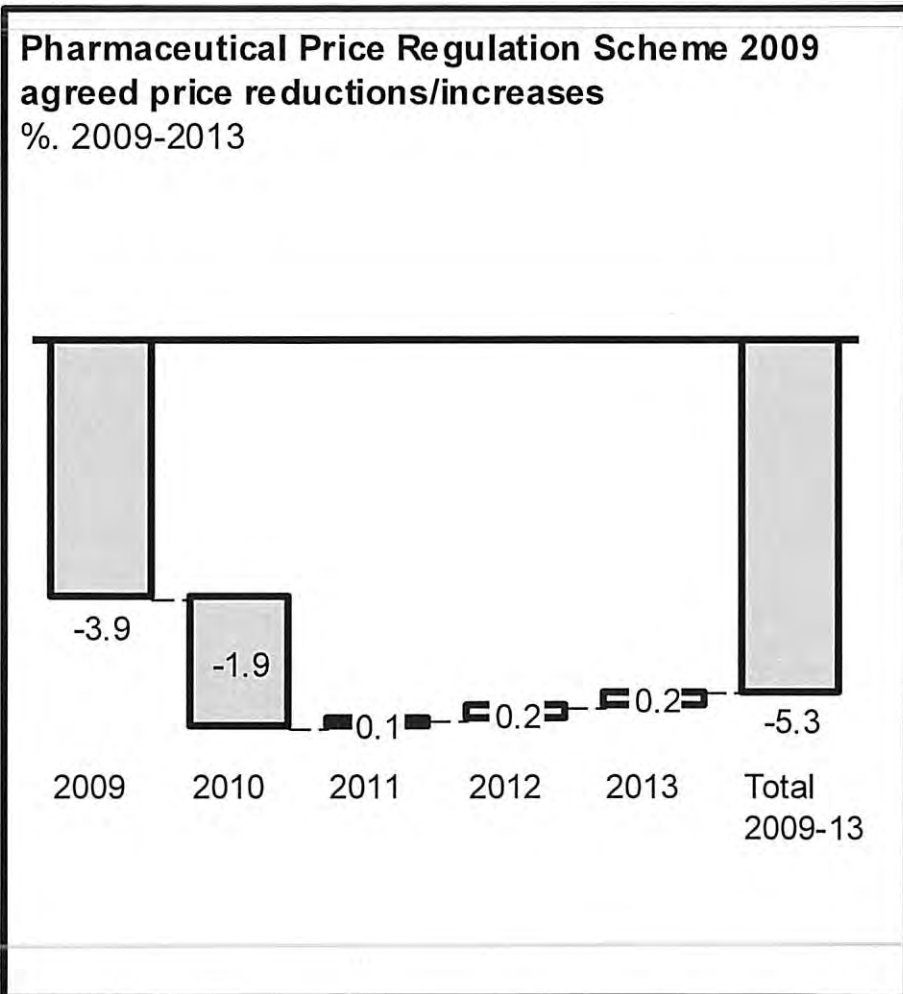
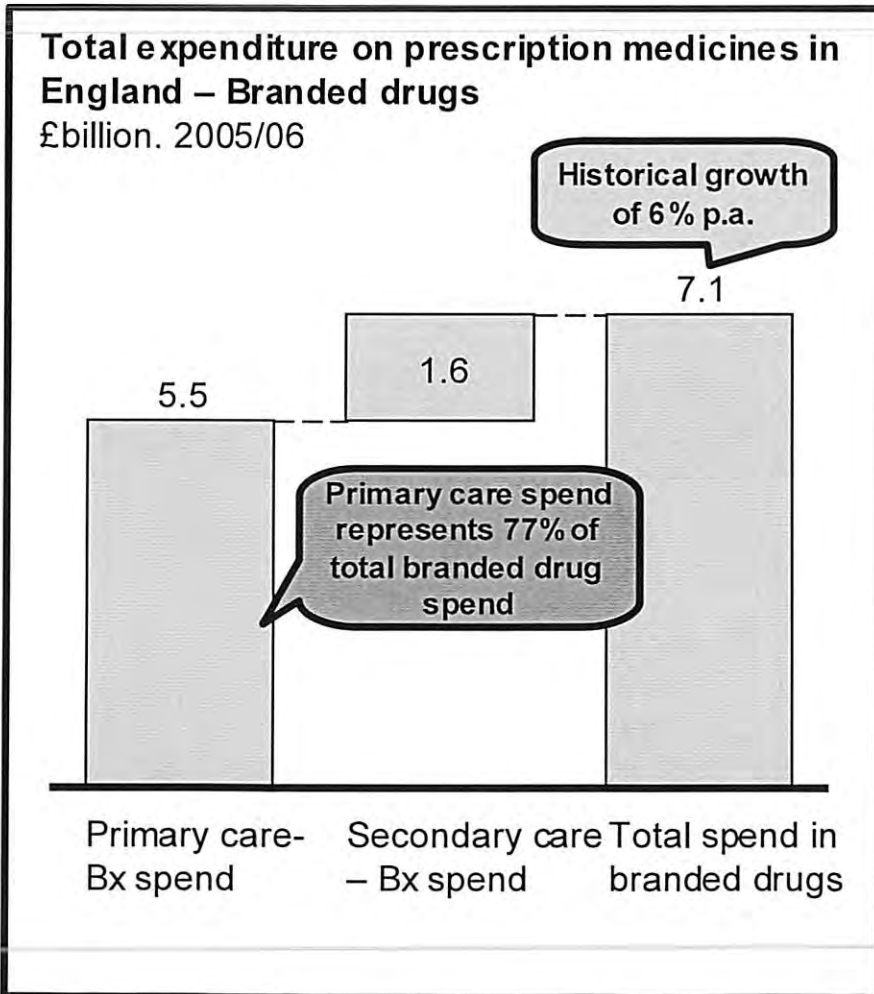
Impact on quality?

B Increasing space utilisation reduces the unit cost of attendance in primary and community care

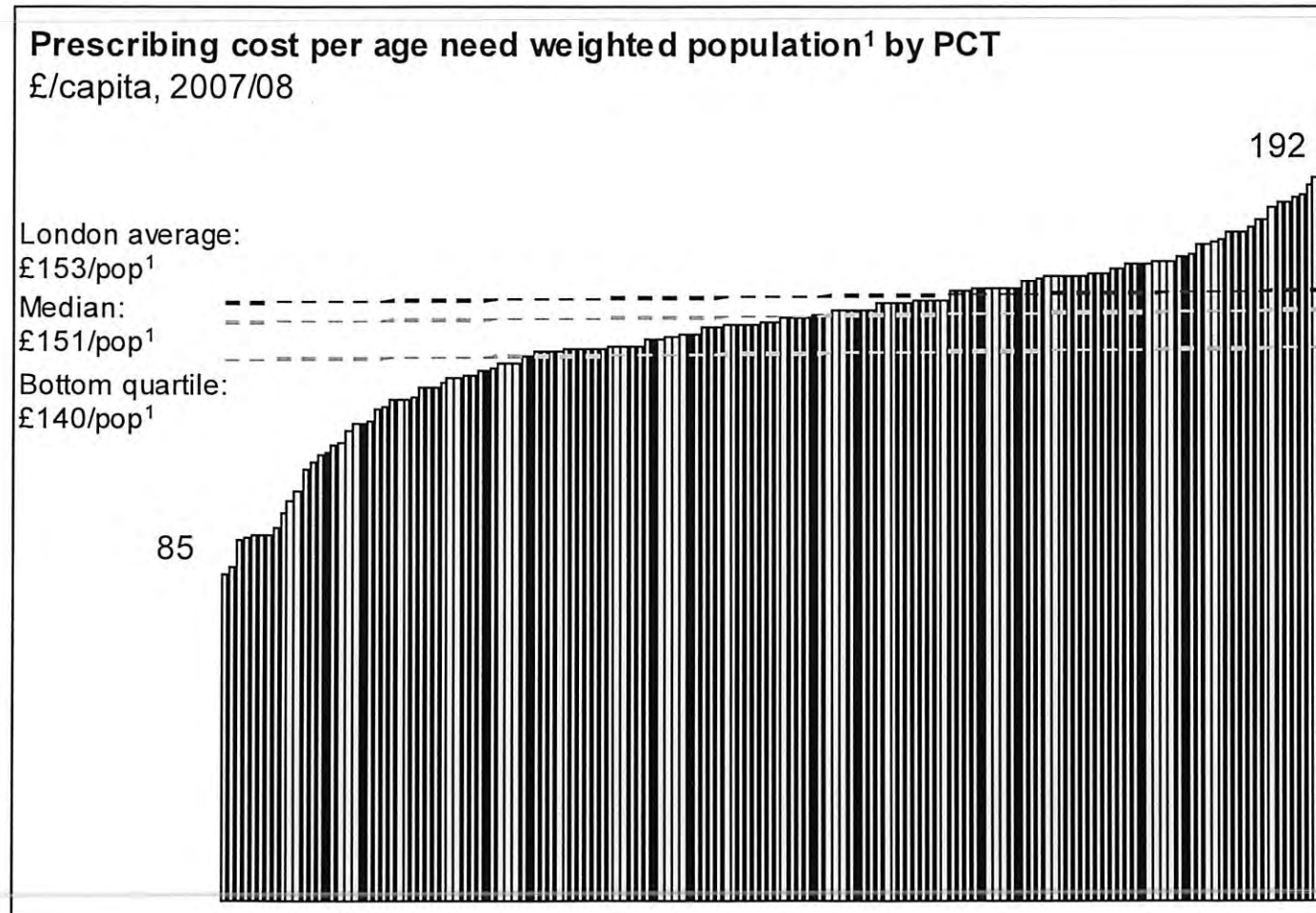
Unit cost/ attendance
£



C Within drug spend, the PPRS 2009 agreement expected to deliver savings of 450m p.a. from 2010-11 onwards



C With potential savings of £0.4-0.6bn in PCT's prescribing costs, if PCTs achieve the median or 80% of the potential of stepping down to bottom quartile



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

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

Contents

Context to the work

Broad model structure and 2007/8 pan-London starting point

Detailed pan-London assumptions



Detailed polysystem modelling assumptions and unit cost outputs

Implications for acute providers

Implications for out-of-hospital settings

Miscellaneous

The main sensitivities as a commissioner are how the acute tariff will be set externally, growth, and primary/community integration into polysystems

 Increase in spend
 Decrease in spend

Potential expenditure in 2016/17
 (aggressive HfL; base case activity growth)
 £12.1bn
 (vs £12.7bn funding low case)

Factors affecting cost savings	Aggressive case assumes	But if it was...	Potentially because...	Change in expenditure			
				£m	%		
Overall growth in activity	4% CAGR, £12.1bn cost	5.5% CAGR, £13.1bn or 1.4% CAGR, £11.0bn	Supply-led demand increases plus demographic growth	-1,119	968	-9.3	8.0
Acute growth rate	c. 0.9% CAGR growth	c. 3.5% CAGR	Higher demand for IP-related services, particularly A&E, OP		655		5.4
Non-acute growth rate	c. 4.9% CAGR growth	c. 6.1% CAGR	Higher latent demand as access improves		682		5.7
Reduction in acute tariff	3.7% overall CAGR efficiency requirement	1.8% overall CAGR	Future efficiency targets are reduced		1,112 ²		7.2 ²
IP shift to lower cost settings	17% shift	8.5%	Only half activity shifts (e.g., rollout of only 1/2 polysystems)		295		2.5
OP shift to lower cost settings	55% shift	27.5%	Only half activity shifts (e.g., rollout of only 1/2 polysystems)		87		0.7
A&E to lower cost settings	60% shift	30%	Only half activity shifts (e.g., rollout of only 1/2 polysystems)		19		0.2
1° integration into polysystem	100% integration	50%	Only half of 1° integrates with lower unit cost of polysystem		590		4.9
CHS integration into polysystem	100% integration	50%	Only half of CHS integrates with lower unit cost of polysystem		490		4.1
Removing duplication of services	EH, OH, MIU duplication removed	None	Inability to renegotiate contracts/ incentivise GPs to remove duplication		30		0.2
LTCs	40% of acute LTC, 10% complex, 30% non-complex prevented	Only half is prevented	Poor targeting or ineffective interventions for proportion of patients		103		0.9
Prevention	10% emergency medicine prevented	5% of emergency medicine prevented	Poor targeting or ineffective interventions for proportion of patients		58		0.5
Decommissioning	7% all elective procedures, 30% OP, 10% A&E, 10-15% diagnostics	Only half is decommissioned	Lack of strict adherence to protocols		225		1.9

¹ In 2007/8 prices

² Calculated base on acute activity levels before activity shift in order to be comparable to £2.1bn tariff saving. If calculated following shift increase in spend is £620m (5.2%) due to lower activity levels in acute settings

SOURCE: Team analysis

Key sensitivities behind the savings in non-acute setting are time/case, admin support levels and drug costs

BACK-UP

Potential spend in 2016/17
(aggressive HfL) £11.6bn
(vs £12.1bn funding low case)
Change in spend¹

Factors affecting cost savings	Aggressive case assumes	But if it was...	Due to...	Change in spend ¹	
				£m	%
Time/case in polysystem	Acute/1%/Comm/A&E 30/10/20/15 mins	Acute/1%/Comm/A&E 40/15/25/20 mins	Staff spend 5-10 more minutes/case than estimated	625	5.4
Admin staff	0.3 FTE/dinical staff (inc. GPs, nurses, consultants)	0.8 FTE/dinical staff (inc. GPs, nurses, consultants)	More admin staff are required despite consolidation of activity	356	3.1
Drug costs	15% reduction in new setting	0% reduction in new setting	Gains from switch to generics, prescribing less and new tariff not made	323	2.8
Staff mix	GP:Consultant:Nurse OP (0%:40%:50%) Primary (50%:0%:50%)	GP:Consultant:Nurse OP (10%:80%:10%) Primary (80%:0%:20%)	Nurses take on a lower proportion of work from doctors in the new settings	286	2.5
GP utilisation	66%	50%	GPs do not reach upper-quartile utilisation rates	220	1.9
Nurse utilisation	66%	50%	Nurses do not reach upper quartile utilisation rates	205	1.8
Diagnostics	Weighted av. unit cost £13	Weighted av. unit cost £45 (current tariff)	Polyclinic does not improve unit costs from current tariff	159	1.4
Supply costs in polyclinic		20% more expensive	Supply costs in 2016/17 are 20% higher in real terms	64	0.6
Space utilisation	80%	50%	Inefficient scheduling reduces utilisation	24	0.2
Polyclinic size	1,520m ²	2,030m ²	Average size of polydclinic is larger than estimated	15	0.1

¹ In 2007/8 prices

² Includes savings generated from activity shifting from acute to non-acute setting as well as primary and community productivity savings

SOURCE: Team analysis

Summary: the funding gap at 2016/17 for the different growth and PCT funding allocating assumptions (straight-line implementation)

###/###/### = "Status Quo"/ Core HfL scenario / Aggressive HfL scenario

Gap between expenditure and PCT funding allocation (includes capitalised operation/transition/setup costs) £b (positive number = funding surplus ¹ ; negative number = funding gap ²), 2016/2017 ^{3,4}				Associated cumulative capital and transition costs 2007/8-2016/17 £m	
	Lower case PCT funding allocation	Base case PCT funding allocation	Higher case PCT funding allocation	Total capital costs	Total transition costs
Lower range growth	-1.0/0.2/1.7	-0.3/1.0/2.4	0.3/1.6/3.0	0/430/260	0/950/520
Base case growth	-2.7/-1.2/0.5	-2.0/-0.5/1.3	-1.3/0.1/1.9	0/560/330	0/1,200/610
Higher range growth	-4.1/-2.4/-0.4	-3.4/-1.7/0.3	-2.8/-0.9/0.9	0/620/370	0/1,350/700

1 i.e., PCT's funding allocation > PCT's expenditure

2 i.e., PCT's funding allocation < PCT's expenditure

3 In real terms (net of inflation i.e., excluding inflation), 2007/8 numbers

4 Fifteen polysystems rolled out in year 16/17 straight-line implementation scenario (130 total)

SOURCE: GLA demographic forecast, HES data, HAS data, reference costs, HfL growth assumptions; Q research; Monitor tariff guidance; Laing & Buisson trust income and costs data for 2007/8; team analysis

Summary: the funding gap at 2016/17 for the different growth and PCT funding allocating assumptions (front-ended implementation)

###/###/### = "Status Quo" / Core HfL scenario / Aggressive HfL scenario

	Gap between expenditure and PCT funding allocation (includes capitalised operation/transition/setup costs) £b (positive number = funding surplus ¹ ; negative number = funding gap ²), 2016/2017 ^{3,4}			Associated cumulative capital and transition costs 2007/8-2016/17 £m	
	Lower case PCT funding allocation	Base case PCT funding allocation	Higher case PCT funding allocation	Total capital costs	Total transition costs
Lower range growth	-1.0/0.3/1.7	-0.3/1.0/2.4	0.3/1.7/3.1	0/430/260	0/950/520
Base case growth	-2.7/-1.1/0.6	-2.0/-0.4/1.3	-1.3/0.2/1.9	0/560/330	0/1,200/610
Higher range growth	-4.1/-2.3/-0.4	-3.4/-1.6/0.3	-2.8/-0.9/1.0	0/620/370	0/1,350/700

In front-ended scenario less transition costs incurred in year 16/17 due to fewer polysystem launches toward end of period

1 i.e., PCT's funding allocation > PCT's expenditure

2 i.e., PCT's funding allocation < PCT's expenditure

3 In real terms (net of inflation i.e., excluding inflation), 2007/8 numbers

4 Two polysystems rolled out in year 16/17 front-ended implementation scenario (130 total)

Summary: the funding gap at 2011/12 for the different growth and PCT funding allocating assumptions (straight-line implementation)

###/###/### = "Status Quo" / Core HfL scenario / Aggressive HfL scenario

	Gap between expenditure and PCT funding allocation (includes capitalised operation/transition/setup costs) £b (positive number = funding surplus ¹ ; negative number = funding gap ²), 2011/2012 ^{3,4}			Associated cumulative capital and transition costs 2007/8-2011/12 £m	
	Lower case PCT funding allocation	Base case PCT funding allocation	Higher case PCT funding allocation	Total capital costs	Total transition costs
Lower range growth	-0.3/0.0/0.5	0.0/0.3/0.8	0.1/0.4/0.9	0/130/80	0/285/155
Base case growth	-0.7/-0.4/0.1	-0.4/-0.1/0.5	-0.3/0.0/0.6	0/170/100	0/360/180
Higher range growth	-1.1/-0.8/-0.2	-0.7/-0.5/0.2	-0.6/-0.2/0.3	0/190/110	0/400/210

1 i.e., PCT's funding allocation > PCT's expenditure

2 i.e., PCT's funding allocation < PCT's expenditure

3 In real terms (net of inflation i.e., excluding inflation), 2007/8 numbers

4 Nineteen polysystems rolled out in year 11/12 straight-line implementation scenario (thirty-nine in total by 2011/12)

SOURCE: GLA demographic forecast, HES data, HAS data, reference costs, HfL growth assumptions; Q research; Monitor tariff guidance; Laing & Buisson trust income and costs data for 2007/8; team analysis

Summary: the funding gap at 2011/12 for the different growth and PCT funding allocating assumptions (front-ended implementation)

###/###/### = "Status Quo" / Core HfL scenario / Aggressive HfL scenario

	Gap between expenditure and PCT funding allocation (includes capitalised operation/transition/setup costs) £b (positive number = funding surplus ¹ ; negative number = funding gap ²), 2011/2012 ^{3,4}			Associated cumulative capital and transition costs 2007/8-2011/12 £m	
	Lower case PCT funding allocation	Base case PCT funding allocation	Higher case PCT funding allocation	Total capital costs	Total transition costs
Lower range growth	-0.3/-0.2/0.4	0.0/0.1/0.7	0.1/0.2/0.8	0/220/130	0/480/260
Base case growth	-0.7/-0.7/0.0	-0.4/-0.4/0.3	-0.3/-0.3/0.4	0/280/165	0/600/300
Higher range growth	-1.1/-1.0/-0.3	-0.7/-0.7/0.0	-0.6/-0.2/0.1	0/310/190	0/680/350

In front-ended scenario more transition costs incurred in-year 11/12 due to more polysystem launches

1 i.e., PCT's funding allocation > PCT's expenditure

2 i.e., PCT's funding allocation < PCT's expenditure

3 In real terms (net of inflation i.e., excluding inflation), 2007/8 numbers

4 Forty-five polysystems rolled out in year 11/12 front-ended implementation scenario (sixty-five in total by 2011/12)

London commissioner expenditure from 2007/8 to 2016/17 including inflation, activity growth and HfL implementation

	2007/08 Expenditure	Impact of activity growth only	Total 2016/17 expenditure from activity growth only	Impact from incremental cost inflation	Total 2016/17 expenditure from incremental inflation and activity growth	Impact from tariff changes	Total 2016/17 expenditure from activity growth, increment al inflation and tariff reduction	2016/17 Radical HfL expenditure	2016/17 Moderate HfL expenditure
Acute	5.7	0.7	6.5	0.9	7.4	-2.1	5.3	3.4	4.1
Primary care	2.2	1.2	3.4	0.5	3.9	0.0	3.9	2.7	3.7
Community	1.0	0.4	1.4	0.2	1.7	0.0	1.7	0.7	0.9
Other Non-acute (acute shifted to polysystem)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.5
Mental Health	1.6	0.4	2.0	0.3	2.3	-0.4	1.9	1.9	1.9
Learning disabilities	0.3	0.1	0.4	0.1	0.5	0.0	0.5	0.5	0.5
Prescribing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pharmacy	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1
Dental	0.4	0.1	0.5	0.1	0.5	0.0	0.5	0.5	0.5
Optical	0.1	0.0	0.1	0.0	0.1	0.0	0.1	0.1	0.1
Tertiary and specialist commissioning	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1
Adjustment ASF vs RRL and MFF change 09/10	0.2	0.0	0.2	1.2	1.4	0.0	1.4	1.4	1.4
Total	11.5	3.0	14.5	3.2	17.8	-2.4	15.3	12.0	13.8

Activity Growth

Overall activity acute and non-acute: 1.4% (low), 4% (Base), 5.5% (high) CAGR

Acute: 0.9% CAGR

Non-Acute: 4.9% CAGR

Cost inflation

1.45% CAGR cost inflation assumed from 2007/8 to 2016/17 across all services and average of 3.65% CAGR efficiency requirement assumed from 2007/8 to 2016/17 in acute (2.4% 2008/09, 3% 2009/10, 3.5% 2010/11, 4% 2011/12 year-on-year to 2016/17)

Average of 3.65% CAGR efficiency requirement assumed from 2007/8 to 2016/17 in acute (2.4% 2008/09, 3% 2009/10, 3.5% 2010/11, 4% 2011/12 year-on-year to 2016/17)

Forecasting

Mental health and Other costs are not modeled with detailed growth assumptions.

Mental health is scaled according to overall increase in acute and non-acute expenditure and is subject to efficiency requirements of reduced tariff, Other costs are scaled to overall increase in acute and non-acute expenditure but not subject to efficiency requirements of reduced tariff

Savings required by 2017/18 and 2010/11 in different scenarios

2016/17	Net acute tariff reduction	Shift of acute activity to lower cost setting	LTC, Prevention, Decommissioning	Non -acute reduced unit costs in polysystem	Total
Core savngs	2.4	0.4	0.3	0.8	3.9
Radical savings	2.4	0.5	0.8	2.0	5.7

2010/11 straight-line implementation	Net acute tariff reduction	Shift of acute activity to lower cost setting	LTC, Prevention, Decommissioning	Non -acute reduced unit costs in polysystem	Total
Core savngs	0.7	0.1	0.1	0.2	1.2
Radical savings	0.7	0.2	0.2	0.6	1.7

2010/11 front-ended implementation	Net acute tariff reduction	Shift of acute activity to lower cost setting	LTC, Prevention, Decommissioning	Non -acute reduced unit costs in polysystem	Total
Core savngs	1.2	0.2	0.2	0.4	2.0
Radical savings	1.2	0.3	0.4	1.0	2.9

Polyclinics cost reconciliation

Item	Change	Operating costs
Initial HfL polysystem		~ £20m
Number of polysystems	From 150 to 130, which implies larger catchment area and larger activity: +15% costs	~ £23m
Increased primary care activity	From 75% to 100% of primary care activity included in polysystem +£ 6 million per polysystem	~ £29m
Increased community care activity	From 50% to 100% of community care activity included in polysystem +£ 4 million per polysystem	~ £33m
Decreased staff efficiency	From 75% to 55-75% +£ 3 million per polysystem	~ £36m