The Efficiency Map

Purpose

The Efficiency Map has been developed by the members of the Productive Time Delivery Board, which includes representation from the NHS, the Modernisation Agency, NHS connecting for Health, the Department of Health, HM Treasury and the Office of Government Commerce.

There are currently a number of key initiatives underway or on the cards to modernise service delivery, pay and workforce strategies, and IT systems within the NHS. It is important to understand that, even if they may be developed and introduced at different times, all these initiatives are interdependent and play a crucial part in maximising service improvement overall.

The key purpose of the Efficiency Map is to present these initiatives in a coherent way, highlighting expected benefits to front-line NHS of delivering the wider modernisation agenda, which ultimately will generate efficiency gains across all local health communities.

The map signposts tools, guidances and information channels, which will be useful to senior NHS management. It is presented as a draft document for discussion.

For more information visit our webpage at www.dh.gov.uk/productivetime. For comments, feedback and additional copies, please contact the Productive Time Team on: productive.time.team@dh.gsi.gov.uk

Context – The Efficiency Review

In recent years, the NHS has benefited from massive financial investment, rising from £37 bn in 1997 to £90 bn in 2007/08. Enormous progress has been made in improving service, but there is also a recognition that the service can improve still further. The Efficiency Map highlights the key IT, process and workforce enablers to maximise benefits realisation and places them in the context of the wider Efficiency Review.

The Gershon's Independent Review of Public Sector Efficiency (July 2004) requires Health, along with all other government department and public sector organisations, to deliver significant efficiency benefits as part of the Spending Review 2004. The review identified £20bn of achievable efficiency savings in the public sector by 07/08. The Health target is to deliver £6.5 bn per year by 2007/08, which equates to approximately 2.7% cumulative yearly savings, a third of which will be delivered through improved service and quality outcomes for patients (e.g. reduction of waiting times, better health outcomes for patients, improved patient experience). These efficiency savings are expected to be reinvested in service delivery.

Efficiency is about making best use of all available resources for the provision of public services and minimise any "waste" in the system.

The six main areas offering scope for efficiencies within the heath sector include:

- Potential for shared **corporate services**
- Securing excellence in **procurement** of outside services
- Releasing additional funds for front line service investment via the Department of Health and Arm's Length Bodies restructuring (**policy and regulation review**)
- Reduction in DH **central budget** to recycle to the front line
- Improved commissioning of **social care services**
- **Productive time**

Local health communities need to consider in particular three key areas: procurement, back-office, and front-line services.

Outside Services:
through Procurement

Back Office:
shared service

Patient Services:
through productive time

They also need to take on board the fact that the national payment tariffs will reduce annually by 1.7% from 2005/06, indirectly supporting a "best in class" value for money approach.

This will require health organisations to implement modernisation strategies to ensure that key service targets are achieved within financial balance. Individual benefits generated from this process will be recycled into providing increased capacity or service provision.

We hope the Efficiency Map will help health organisations identify ways in which implementing the wider modernisation agenda contributes to enhanced opportunities for improved service delivery.

Productive Time

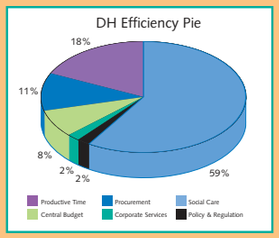
Productive Time is about making better use of staff time. It is not about getting staff to work harder, but about enabling staff to work smarter, spending more time on where it matters for them and for patients: quality direct contact care.

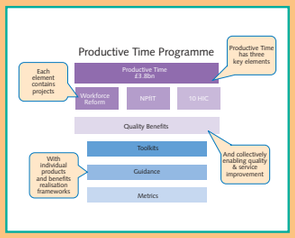
Productive Time is expected to yield **£3.8 bn yearly benefits by 2007/08 against a 2003/04 baseline**. This represents up to half of the total efficiency gains for Health and nearly a fifth of the cross-governmental efficiency review savings.

There are significant opportunities for both cost efficiency and quality improvement through the integrated implementation of the following change strategies:

- Process: High Impact Changes (HIC)
- People: Workforce Reform
- Technology: NHS Connecting for Health

Addressed locally as part of a whole-system approach, these strategies constitute the key enablers to maximising service improvement at an organisational level.





Process, People and Technology Modernisation

The fundamental objective of productive time is to maximise service improvement through linking the strategies for the modernisation of the key enablers of service delivery: Process, People and Technology.

Process Change

Process redesign can simplify the way some patient services are delivered. We know significant progress and development is taking place in organisations in this area. The 10 High Impact Changes provide a framework to highlight a number of significant and diverse process reduction opportunities.

Changes such as Day Case Admission (day surgery as the norm for elective surgery), Discharge and Diagnostic Process, Long-Term Conditions, will impact on length of stay, emergency admissions, cancelled operations, outpatient appointments etc. This may result in reduced labour requirement to deliver changed processes, a change in workforce mix, and/or the introduction of new or redesigned roles.

Realising the Benefits of Workforce Reform

New roles and skill-mix

Skill-mix changes may result in a lower net cost, increased output and/or improved quality (e.g. reduced treatment delay).

Maximising the potential contribution of all staff, by enhancing the roles of professionals and support staff in particular, will release clinicians time to increase their output and maximise patient contact time. This also leads to greater job satisfaction for staff, who perform more challenging and interesting work that allows them the opportunity to utilise their skills more effectively.

The Changing Workforce Programme has provided many tailored solutions, each with significant efficiency and quality benefits. Key opportunities to be maximised include the development of medical secretaries, nurse practitioners, assistant and advanced radiography practitioners, and emergency care practitioners. We are aware of considerable local progress with programmes and development tailored to local circumstances.

The most cost and service effective local solutions coming out of Hospital at Night and other projects to meet the European Working Time Directive have made extensive use of role redesign and skill-mix shift with less reliance on junior doctors. Benchmarking local solutions against best practice may offer efficiency opportunities for some trusts.

Managing Overhead Costs – Improving staff retention

Staff turnover incurs costs relating to recruitment, training and reduced productivity (less experienced staff). It is estimated that a reduction of turnover by 1% (to 13%) would result in annualised savings of £90m by 2007/08. Improved pay and better career opportunities through effective local application of Agenda for Change, together with local HR strategies, such as Improving Working Lives, should enable reduced turnover and cost savings. Many organisations are also using an increasing evidence base to develop progressive people management policy such as increase team working and staff involvement, which reduce stress, turnover and sickness absence and improve patient care.

Reducing Temporary Staff and Agency Costs

Improved retention should reduce the need for temporary staff. Assistant and advanced practitioner roles can help address key specialties shortage areas with high agency dependencies such as radiography. Empirical evidence shows that replacing temporary staff with experienced permanent staff also leads to increased productivity and better quality patient care.

Improving sickness management

HR management and workforce strategies should enable targeted reduction in sickness levels and cost overtime particularly for organisations above average benchmark.

E-Recruitment

Together with improved retention and cost saving through faster recruitment processes, e-recruitment can significantly reduce advertising and administration costs.

NHS Connecting for Health

NHS Connecting for Health is bringing modern computer systems into the NHS to improve patient care and services. Over the next ten years it is expected to connect over 30,000 GPs in England to almost 300 hospitals and give patients access to their personal health and care information, transforming the way the NHS works.

Information will move around more quickly with health care records, appointments, prescription information, and up-to-date research into illnesses and treatments accessible to patients and health professionals whenever they need it.

The new systems implemented through NHS Connecting for Health such as Electronic Patient Record, Choose and Book electronic appointment booking, Prescription Transmission, will enable further process redesign and save time for both clinicians and other staff so that they can increase their output and patient contact time.

Approach to Measurement

All organisations recognise the importance of having metrics and measures that demonstrate service improvements and highlight areas for development.

The scope of Productive Time is wide and we don't want to add a further need for data collection. It is important to ensure a consistent approach with a limited number of measures reflecting the broad scope of change whilst avoiding excessive bureaucracy. The initial measures identified in the map are in line with the HR Balanced Scorecard and the Healthcare Commission's current star rating system, and use existing data collection.

Nationally, the calculation of the overall efficiency gain at macro NHS level will be done through indices of cost efficiency and service effectiveness (quality) gain. Within the cost efficiency index, unit labour cost provides an overall measure of productive time benefit. We recognise that this is imperfect as it does not currently cover primary care (work is planned this year to develop this).

These measures will be supplemented with a number of proxy progress indicators available in-year – for example day case rates, vacancy rates –, which will provide indicators of progress on the key programmes. These will be drawn from existing data sources.

At SHA level, the directors of service improvement are working with the Department of Health to develop a common set of indicators linked to each programme within a single benefits realisation framework.

These indicators will be those that SHAs see as important for them to oversee and manage progress towards delivery of Service Improvement. They will not however be formal targets. This will be in place later this year. As it evolves, there may be further indicators that can be pulled into the national monitoring dataset.

Discussion

The Efficiency Map has been developed as an evolving and dynamic tool. We want to limit its size so it is meaningful and hopefully easy to follow, but this means it is not comprehensive.

We have not been able to reflect all the linked developments, but want to ensure we have the 'big ticket' issues and the issues that matter most locally. We would welcome views on whether we have got the balance right, what should be in, and what could be left out.

Uses

We hope that the Efficiency Map will be useful in its present form to Chief Executives, Directors, Senior Managers, and HR and service improvement staff.

We recognise that the language used is not necessarily 'clinician friendly'.

You may wish to use this map as a template to develop local benefit realisation map highlighting local developments and how they link together, helping to build a picture of service improvement initiatives locally.

268509 1P 2k May 05 (STE)

Programme Area	Workstream	Projects	£ yeafy[3]	Key Benefits to Front Line NHS: Efficiency Benefits – Scope	Key Benefits to Front Line NHS: Quality Improvement – Scope	Measures and Assurance: Key Project Indicators* (provisional) (*) for collection at organisation level	Measures and Assurance: National Measures (provisional) and related information	Information and communication: Website / Tools & Guidance / Others
Front Line Service Improvement (Productive Time)	NHS Connecting for Health (formerly NPfIT)	Choose & Book[2]	£2.6bn Efficiency Benefits across all Front-Line Service Improvement Projects £1.2bn Quality Improvements across all Front Line Service Improvement Projects	•Reduced cost of referral (reduced admin and clinical time in processing referrals, fewer DNAs) •Increased capacity (better use of the resources of GP, admin and clinical staff in hospitals)	•Improved clinical effectiveness (better planning and management information) •Improved patient choice •Improved staff and patient experience	•Length of referral process •DNA •Staff and patient satisfaction surveys	Efficiency benefits measures: •Unit Labour Cost (Aggregate Measure) •Day Case rates •Length of Stay •DNAs •Staff sickness Cost • Staff Turnover • Agency Spend •Skill Mix Measure Quality improvement measures: •Health Outcomes •Readmission Rates •Waiting Times •Choice •Patient Satisfaction •Environment •Staff Opinion Survey Cross reference with: Healthcare commission star rating measures for 04/05: Compounded workforce indicator including sickness absence, junior doctors, IWL. HR Balanced Scorecard Measures and assurance websites of interest: •Healthcare Commission www.chai.org.uk •Modernisation Agency Measure Tools (e.g. skill-mix tracker) www.portal.modern.nhs.uk/sites/NWW/measures Academic studies of interest: •Impact of the Skills Escalator (UMIST) •Relationship between HR practices and Morbidity Rates in acute hospitals (ASTON)	**www.connectingforhealth.nhs.uk** (general information) • Implementation guidance • SHA communications toolkit • Clinical engagement leads • Data from regional clusters • People stories (implementation in action) **www.connectingforhealth.nhs.uk/programmes/booking** (Choose and Book)
		NHS Care Records Service (NHS CRS)[1]		•Increased clinical productivity (availability of accurate patient info 24/7) •Reduced admin costs and time from cutting out paper-based transactions, filing and storage and duplication of record-keeping •Reduced unnecessary diagnostic procedures	•Increased consistency and continuity of care •Improved patient safety •Improved patient & staff experience	•No of repeat tests •Staff & patient satisfaction surveys		**www.connectingforhealth.nhs.uk/programmes/nhscrs** (NHS Care Records Service)
		Picture Archiving and Communication Systems (PACS)[1]		•Increased capacity of diagnostic services (time saved on film reporting and management) •Reduced expenditure on films, chemicals, transport and storage •Reduced re-testing •Quicker discharge •Fewer appointments and operations postponed	•Easier and faster access to test results and diagnoses •Improved image quality •Improved patient and staff safety (reduced exposure)	•No of repeat tests •Avoided costs (chemicals, transport)		**www.connectingforhealth.nhs.uk/programmes/pacs/** (PACS)
		Electronic Transmission of Prescriptions (ETP)[1]		•Increased capacity (reduced no of visits for repeat prescriptions) •Reduced GP admin workload	•Improved patient safety •Improved quality of care •Improved patient choice	•Prescription volumes (through ETP)		**www.connectingforhealth.nhs.uk/programmes/etp/** (Electronic Transmisionr of Prescriptions)
		N3 – The National Network[1]		•Increased clinical productivity (availability of accurate patient info 24/7) •Reduced telephony costs •Potential for reduced staff travel costs	•Wider access to care (specialist care available locally through remote diagnosis) •Faster and more efficient treatment •Increased operational flexibility	•Annual network (& telephony) costs		**www.connectingforhealth.nhs.uk/programmes/n3/** (The National Network)
		Map of Medicine[2]			•Improved quality of care •Increased consistency and continuity of care •Improved access to knowledge	•Map of medicine usage (e.g. no. of active users, no. of hits, etc...)		
		Contact[2]		•Reduced training requirements •Reduced running costs	•Improved quality of care •Improved communication between healthcare professionals	•Savings from non-renewal of local email contracts/ service		**www.connectingforhealth.nhs.uk/programmes/contactmail/** (Contact – secure e-mail directory service)
	High Impact Changes	Diagnostics Process[2]		•Effective use of capacity	•Improved access to care •Improved patient flow •Improved treatment time •Reduced waiting times (up to 25 million weeks saved) •Reduced waiting list numbers	•Waiting times •Waiting list nos		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC2/HIC2.htm** (HIC 2) **www.healthcareworkforce.org.uk** Diagnostics Workforce Information Resource Pack
		Day Cases[2]		•Inpatient capacity freed (nearly 0.5 million inpatient bed days each year)	•Reduced MRSA rates •Decreased waiting list numbers •Improved patient satisfaction	•Waiting list nos •MRSA rate		**www.modern.nhs.uk** (link to Web Information Sharing Environment or WISE portal: **www.content.modern.nhs.uk/cmsWISE/HIC/HIC+Intro.htm)** • 10 High Impact Changes (Sept 2004) • PCT guide to applying the 10 HIC – Guide from NatPCT) • 10 HIC webcasts • Workshops & Conferences (national & regional) **www.content.modern.nhs.uk/cmsWISE/HIC/HIC1/HIC1.htm** (HIC 1)
		Hospital Discharge[2]		•Improved availability of beds •Reduced length of stay	•Improved patient flow •Timeliness of discharge •Reduced A&E wait •Improved patient experience	•Length of stay •A&E wait time •Cancellation rate •No of outliers		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC3/HIC3.htm** (HIC 3)
		Patient Admission[2]		•Improved availability of beds •Reduced cancelled operations (up to 40% reduction in the 70,000 operations cancelled each year for non-clinical reasons)	•Improved patient flow •Timeliness of assessment and treatment •Reduced A&E wait •Improved patient experience	•A&E wait time •Cancellation rate		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC4/HIC4.htm** (HIC 4)
		Follow-ups[2]		•Reduced number of follow-ups (up to 0.5 million saved appointments in Orthopaedics, ENT, Ophtalmology and Dermatology) •Reduced DNAs	•Improved treatment time •Reduced waiting times •Reduced waiting list numbers •Improved patient experience	•Waiting times •Waiting list nos •DNA rate		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC5/HIC5.htm** (HIC 5)
		Care Bundles[2]		•Reduced length of stay in critical care (up to 14,000 bed days released)	•Improved health outcomes •Reduced complications, deaths, MRSA •Improved care of patients with long-term conditions	•Length of stay •Readmission rate •MRSA rate •Death rate		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC5/HIC5.htm** (HIC 6)
		Long Term Conditions[2]		•Reduced emergency admissions •Reduced readmissions •Reduced length of inpatient stay •Reduced Primary Care contacts	•Improved treatment •Reduced complications	•No. of acute admissions •Length of stay •Complication rate •Readmission rate •Primary care measures		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC7/HIC7.htm** (HIC 7)
		Reduced Queues[2]		•Effective use of capacity	•Improved access to care •Improved patient flow (need for additional FFCE required to hit elective target reduced by 165,000) •Improved treatment time •Reduced waiting time •Reduced waiting list numbers	•Waiting times •Waiting list nos		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC8/HIC8.htm** (HIC 8) **www.healthcareworkforce.org.uk** Long Term Conditions Workforce Information Resource Pack
		Process Templates[2]		•Effective use of capacity (up to 15-20% of current capacity could be freed to address waiting times) •Reduced cancellations/DNAs	•Improved access to care •Improved patient flow •Reduced waiting time	•Waiting times •Cancellation rate •DNA rate		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC9/HIC9.htm** (HIC 9)
	Workforce Reform	Role Redesign (HIC 10)[2]		•Improved recruitment and retention •Reduced sickness absence •Reduced agency/locum costs	•Improved access to care (could free up to 1,500 WTEs of GP/consultant time, creating 80,000 extra patient interactions per week) •Improved quality of care •Improved use of staff skills along the patient journey •Improved staff satisfaction	•Staff sickness rate •Staff turnover •Agency spend		**www.content.modern.nhs.uk/cmsWISE/HIC/HIC10/HIC10.htm** (HIC 10) **www.modern.nhs.uk** (New Ways of Working, Changing Workforce Programme. European Working Time Directive, Hospital at night, Career Framework) **www.skillsforhealth.org.uk** **www.healthcareworkforce.org.uk** • Efficiency and Productivity Workforce Information Resource Pack • Competency Based planning using the Christmas Tree approach • Labour Market Intelligence – how to modelling guide
		Agenda for Change[1]		•More patients being treated more quickly •Improved recruitment and retention •Reduced sickness absence	•Improved quality of care •Shorter care pathways •Fewer adverse incidents reports •Extended availability of services to patients •Improved career development for staff •Fair Pay (see wording in Annex E) •Higher staff morale	•December 2004 Final Agreement - Annex E (Partnership Agreement success criteria). Incl. staff turnover, sickness absence, agency spend, redesigned roles or skill mix change, use of KSF		**www.dh.gov.uk** (Agenda for Change, Knowledge and Skills Framework) • Benefits Realisation framework • The NHS Knowledge and Skills Framework and Development Review Guidance **www.modern.nhs.uk** (Agenda for Change) • Early Implementers case studies • Further case studies to be produced (likely to be per SHA) • SHA AFC leads network • Benefits Realisation Workshops
		Consultant Contract[1]		•Increased consultant output (due to improved utilisation of consultant time) •Additional consultant time secured more cost-effectively •Improved recruitment and retention	•Increased patient contact •Improved health outcomes (due to consultant led service improvement)	•Content of job plans •% of programmed time for direct clinical care (aim: 75%) •Staff turnover		**www.modern.nhs.uk/consultants** • Consultant Contract Job Planning Guidance and Toolkit • Effective Job Planning: a concise guide for consultants • Job Planning Roadshows • Consultant Contract Benefit Realisation team collecting and sharing best practice • SHA Consultant Contract Leads network
		Modernising Medical Career[2]		•Reduced costs to Trusts and Deaneries due to new recruitment procedures reducing the number of applications submitted	•Increased workforce capacity (streamlined consultant training) •Better trained doctors (competency-based training) •Improved recruitment to general practice and shortage specialties (early exposure) •Improved career opportunities and better use of non-consultant career grades (NCCGs)	•Evaluation of implementation of Foundation Programmes. •Progress with the profession in the development of streamlined specialty training programmes •Establishment of new arrangements and negotiation of new contract for NCCG doctors.		**www.healthcareworkforce.org.uk** • Modernising Medical Careers Workforce Information Resource Pack **www.mmc.nhs.uk**
		Temporary Staffing and Agency Costs[2]		•Reduced labour cost •Improved productivity	•Improved quality of care	•Agency spend		**www.dh.gov.uk** (NHS Professionals) **www.nhsprofessional.nhs.uk**
		Improving Working Lives (IWL) Pledge to practice[1] Practice Plus[2]		•Improved retention and recruitment •Reduced sickness	•Improved quality of care •Wider access to care •Improved staff involvement	•Baseline self assessment for IWL and peer review		**www.dh.gov.uk** (Improving Working Lives) **www.nhsemployers.org** • Good practice database • National IWL contacts • IWL Publications • Various support and guidance
		E-recruitment (NHS Jobs)[2]		•Reduced recruitment costs (reduced advertising costs and HR administrative costs) •Reduced use of temporary staff (due to faster recruitment)	•Improved access to care due to faster treatment •Wider access to NHS jobs (modern 24/7 recruitment) •Improved HR recruitment practice	•Recruitment spend adjusted by activity •No of appointments made		**www.dh.gov.uk** (National Recruitment Campaign) **www.nhs.uk/careers** **www.jobs.nhs.uk (part of NHS Careers)**
		nGMS Contract[1] nPMS[2] APMS[2] PCTMS[2]			•Improved access to primary care professional •Increase in choice of primary care provider •Improved quality of care	•LDP markers for CHD •Practice register for cancer and Mental Health •PC professionals per 100,000 population •Smoking prevalence •Key Quality and Outcome Framework markers for diabetes and asthma •No of secondary care consultations carried out by primary care staff •Patient Experience score for PCT core Qs No of GPs and PC nurses •Access to a primary care professional		**www.dh.gov.uk** (Primary Medical Care Contracting) **www.natpact.nhs/primarycarecontracting** (address will change in future) **www.npdt.org** • New GMS Contract • Delivering Investment in General Practice • GMS, PMS, APMS, PCTMS Regulations and guidance • Model GMS contract • APMS toolkit and model contract (being developed) • Stakeholder Groups • Training, conferences and events run by NatPaCT, NPDT and NAPC
Procurement	Supply Chain Excellence Programme	Collaborative Procurement Hubs (development of regional hubs) [1]	£2.7bn across all Other Service Improvement Projects	•Reduced unit cost of supplies to NHS	•Improved quality of goods & services procured	•Under development		**www.pasa.nhs.uk/scep/**
		National Contracts Procurement[1]		•Reduced unit cost of supplies to NHS on contracts negotiated by NHS PASA	•Improved quality of goods & services procured	•Actual uptake on contracts compared with baseline		
	Independent Sector Treatment Centre			•Reduced price paid for elective procedures and diagnostics	•Improved access to care, diagnosis and treatment •Reduced waiting times •Sustainable Independent Sector market	•Savings on procurement measured as the difference between contract and spot market prices		**www.dh.gov.uk** (Independent Treatment Centres) **www.modern.nhs.uk** (Independent Treatment Centres)
Social Care		Care Services Efficiency Programme[2]		•Improved procurement of adult social care as part of an end-to-end care process	•Improved quality of appropriate care provided by improving the procurement and other aspects of the care management process	•Number of staff employed by DH	•Range of appropriate Performance Assessment Framework (PAF) reflecting, effectiveness, quality and value for money	**www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthAndSocialCareArticle** (Care Services Efficiency Delivery Programme) **www.changeagentteam.org.uk/** (Care Services Efficiency Delivery Newsletter on Change Agents website)
Policy & Regulation		DH Restructuring[1]		•Additional funds released for front line service investment		•Number of staff employed by and number of ALBs	•Departmental running costs	
		ALB Restructuring[1]					•ALB running costs	
Reduction in central budget	DH central budget programme			•Reduced amount of DH central budgets to recycle to the front line		•Level of central budgets held by DH		
Corporate Services		NHS Shared Business Services[1]		•Reduced cost of finance, HR and IT corporate service functions			•Spend on corporate services adjusted for increase in activity	**www.sbs.nhs.uk**
		Electronic Staff Record[1]						**www.esrsolution.co.uk**

[1]Mandatory Project [2]Recommended Project [3]Estimates by07/08 against 03/04 baseline