DEPARTMENT OF HEALTH

GERSHON EFFICIENCY PROGRAMME 2004 - 2008

EFFICIENCY TECHNICAL NOTE

DECEMBER 2005

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1 PURPOSE OF THE EFFICIENCY TECHNICAL NOTE

The Efficiency Technical Note sets out the programmes and projects that will deliver efficiency savings included as part of the SR2004 settlement with Treasury following publication of the Gershon Report – Releasing resources to the Front Line.

It explains how efficiency benefits are likely to be realised through these projects, the specific measurement processes and formulae that will be used to calculate and validate these gains, and the processes and measures to ensure that efficiency related business change does not result in reduction in quality or service standards for NHS patients and other customers.

2 UPDATES TO THE TECHNICAL NOTE

DH published a high level Efficiency Technical Note in October 2004.

This update provides a greater level of detail on how we plan to deliver the targeted efficiency gains and how individual components of this will be measured and reported.

It also takes account of updates to the programme resulting from more detailed analysis by the main workstreams, latest expectations of some programme deliverables and more recently identified contributions as the scope and pace of system reform and service improvement strategies linked with efficiency continue to develop.

This version of the ETN now provides the substantive approach that will be used for measurement and assurance. Further updates may be made but will relate only to completion of current analysis and development work relating to a few individual measures, or the inclusion of measures appropriate to new efficiency enablers arising our ongoing strategy of continuous improvement in efficiency and value for money. Outstanding work and potential new project inclusions are noted in this version of the ETN.

3 THE HEALTH EFFICIENCY PROGRAMME

3.1 Overview of the Programme

As part of Spending Review 2004, the Department of Health agreed a target to achieve efficiency savings of at least £6.5 billion in annual efficiencies by 2007/8, of which at least half should be cashable.

The Department of Health operates within a system of devolved responsibility. In the NHS, for example, services are delivered through more than 600 statutory bodies. Our efficiency strategy recognises the fact that neither the NHS nor Personal Social Services are single "firms" that can, or should, be managed in detail from the centre.

With this is mind the efficiency strategy we have developed to achieve the required savings is set out below under its main workstreams:

- **Public Funding & Regulation**
  A slim central Department of Health. Achieve a total reduction of just over 720 civil service posts, reduce the staffing of arms-length bodies by at least 5,000 and be on course to relocate 1,110 posts out of London and the South East by 2010. Associated cost savings from reduced staffing levels also contribute to the Health efficiency financial target
- **Productive Time**
  Modernising the provision of front line services to be more efficient whilst also improving the quality of patient treatment and service by exploiting the combined opportunities provided by new technology, process redesign and a more flexible, committed and skilled workforce
- **Procurement**
  Make better use of NHS buying power at a national level to get better value for money in the procurement of healthcare services, facilities management, capital projects, medical supplies & other consumables and pharmaceuticals
- **Corporate Services**
  Ensure NHS organisations, particularly in primary care, can rationalise and where possible share back office services, such as finance, ICT and human resources
- **Social Care**
  Improve commissioning of social care and other cash releasing and non cash releasing gains from the design of social care processes by Local Authorities
- **Central Budgets**
  Reducing or eliminating centrally managed budgets where they do not provide value for money and releasing to front line NHS organisations

To underpin current and future delivery of efficiency gains through both the above programmes DH will develop and introduce a range of incentives, standards and structures to encourage the NHS to embed efficiency and value for money strategies within both local financial management and local service improvement plans. These include:

- fixed three year allocations and reduction in central and ring-fenced budgets enabling local organisations to take local decisions on most effective use of resources;
- the introduction of fixed prices for treatments based on a national tariff that will be adjusted for efficiency requirements and service changes;
- continued reform of the Health system and its management and accountability framework including SHA/PCT streamlining and moving to GP Practice Based Commissioning
- Development of a new local and national NHS financial strategy aligned to the current system reform programme
- NHS led development of an integrated framework for Service Improvement planning

3.2 Summary of Benefits

The following table shows the efficiency savings the Department of Health will deliver over the 2004 Spending Review years.

Efficiency Review Savings (£million)

	2005/6	2006/7	2007/8
Identified Savings	2500	4,400	6,500

The current expected contribution to the DH total from each workstream is as follows:

Efficiency Review savings by Workstream (£m)

Public Funding & Regulation	450
Productive Time (including Quality)	2700
Procurement	2100
Social Care	685
Corporate Services	60
Central Budgets	500

The target savings are expressed on a cumulative annual basis. The 2007/08 figure is the expected recurring annual benefit by the end of that financial year.

In line with initial submission guidelines provided by HM Treasury and Office of Government Commerce, the benefits expressed do not take account of non-recurring implementation and set up costs related to change projects and programmes during the three year delivery period. They do however take account of any recurring operational costs created by these projects.

3.3 Classification of Benefits

The Gershon Report requires a significant proportion of efficiency gains to be 'recyclable' – releasing resources directly to the front line or representing a direct increase in service output (local productivity gain).

Across the Health efficiency workstreams recyclable gains may be realised and reallocated in a number of ways:

- Cash released from non-front line services, in particular central departments, NHS support organisations and no-front line administration & management. This is recycled directly to increase future operating budgets for front line services
- Productivity and input cost gains realised directly by front line organisations through local change and management actions. In most instances, these resources are retained by the individual front line organisation that realises the benefit and redeployed to meet local priorities including increased capacity or improved services. Some process improvements achieving net efficiencies by reconfiguring patient pathways may result in recycling of savings between respective front line provider organisations. Gains realised by front line organisations will not result in a net cash reduction from front line services

We have classified the above as Recycled to Front Line and Recycled within Front Line respectively.

Other efficiency gains are non-cash releasing and therefore not recyclable. These relate to improved quality of inputs (for example greater time invested in direct contact and consultation with patients) and improved service quality outcomes as a result of process improvement changes.

3.4 Overview of Approach to Measurement

3.4.1 Factors Determining Measurement Approach

In developing appropriate, practical and robust measurement processes we have had to take into account:

- The dynamic and complex nature of healthcare provision – overall demand and case mix and developing treatments & models of care are constantly changing. Inputs and outputs therefore change for reasons other than planned and managed efficiency. This level of operational complexity and demand change is not replicated in any other area of public sector services
- The scope of Gershon efficiency – these include specific categories and definitions that do not align fully with existing efficiency and value for money measurement processes (see following section on NHS Productivity). The requirement to dissect and report efficiency gains aligned to individual projects and to provide regular in-year reporting at this level
- The inter-dependency and connectivity of change enablers that result in efficiency gain, particularly within front line service improvement (Productive Time) – this mitigates against project centred measurement
- Devolved accountability in the NHS whereby local NHS organisations are wholly responsible for the management of finances and allocation of resources. Many 'national' efficiency enablers are not mandatory and organisations have full flexibility on how they apply change. Foundation Trusts (currently accounting over 10% of NHS expenditure and likely to further increase significantly by 2008) have complete autonomy as long as overall financial balance is maintained
- Significant limitations on the nature and frequency of data collections from all NHS organisations and particularly for Foundation Trusts. Extended time lags for key data used to derive national efficiency gains

The overall impact of these factors has been to constrain level of detail of reporting and to modify approaches and formulae around what is available.

3.4.2 Measuring Efficiency and Value for Money in the NHS

Delivering efficiency / productivity / value for money has always been a requirement of the NHS to ensure that optimum use is made of finite resources where demand for services continues to grow at levels in excess of the potential to fund. Processes and measures exist at both local and national level to measure and assure these gains. At national level, measures have been produced in conjunction with HM Treasury, Office of National Statistics and independent experts and these continue to be developed to better take account of the complex nature of inputs and outputs.

The DH Gershon Efficiency Programme and its associated measurement approach will provide an aggregate value of annual efficiency gain based on the contribution of known major change enablers over the next three years. Measurement is specific to Gershon definitions. It should be recognised however that this outcome will not reflect total gains in the NHS. In particular, it will not reflect:

- The cumulative impact of many other local efficiency initiatives that may not be covered by the finite set of efficiency measures that we are able to track
- The cumulative impact of smaller elements of efficiency gain from the key service improvement enablers for which it is not feasible or practical to track performance

As part of its financial efficiency strategy DH will, in tandem with the assurance of Gershon targets, continue to measure and manage efficiency delivery against three other measurement approaches:

Local Cost Improvement Plans
NHS organisations produce and report against cost improvement plans as part of their annual financial planning. These will include local gains through opportunities outside of the major 'national' project enablers. They will only include hard financial gains realised locally. These are not audited and returns exclude Foundation Trusts.

ONS Health Productivity Articles
ONS now publish a series of Public Service Productivity articles, the first of which was published in October 2004 covering health. The calculation of NHS productivity takes the ratio of NHS outputs to NHS inputs after separating out the impact of pay and price increases. Although ONS are able to calculate a single central estimate of NHS outputs, this is not the case for NHS inputs. They therefore present a range of productivity estimates. The measures do not capture quality change. Calculations are 1-2 years in arrears so do not capture most recent changes in patient pathways (eg shift to out-patient settings). ONS and DH are working on alternative data sources and other enhancements to the measures

The DH Cost Efficiency Measure
To measure progress against our 2002 Spending Review value for money PSA target, DH has developed an interim value for money measure (cost efficiency measure. The cost efficiency measure is calculated by comparing increases in NHS expenditure adjusted for both input cost inflation and increases in expenditure on improving the quality of NHS services, with increases in NHS outputs as calculated by the NHS Output Index. This index is derived mainly using data published in the National Schedule of Reference Costs and in 2003/4 covered over 1,900 activity categories. This is an annual macro NHS calculation reported around eight months after the year end. The measure has been reviewed by leading academics and is recognised as an improvement over previous measures. It is still however an interim measure and further development work is in progress.

Each measure will inevitably provide a different value due to the nature and scope of their calculations. They will however provide enable comparison and correlation of trends in efficiency, productivity and value for money over the Gershon reporting period.

3.4.3 Overall Approach to Gershon Efficiency Measurement

Measurement calculations have been established for each reportable line of efficiency benefit by workstream based on key performance indicators and fixed calculation formulae. These are detailed in appendices together with supplementary information on data sources and validation, and an indication of whether the individual measure is expected to be a low (under £25m), medium (under £100m) or high (over £100m) contributor to the total delivery for Health

In the case of Productive Time a set of outcome indicators have been developed reflecting the collective contribution of project enablers. This approach is explained further in the Productive Time section of this ETN.

Benefits are calculated at 2008 prices. Deflators are therefore applied to benefits involving labour or commodity cost calculations with earlier year baselines and to procurement benefits where costs/prices are fixed for more than one year. GDP deflators will be used with the exception of Social Care where a specific deflator has been agreed with Treasury to reflect real inflation in costs of private sector social care procurement.

3.5 Assurance of Quality

The Gershon Review was centred around realisable efficiency gains and not cuts in service or quality. The Report therefore directed that a process of quality assurance is put in place to ensure that reported gains are not at the expense of quality.

For each workstream the agreed approach to assuring quality is explained. In establishing these approaches we have been mindful of the need to avoid imposing additional bureaucracy that creating and administering any new measures would entail and indeed the significant restrictions on data collection for both Foundation Trusts and the NHS as a whole. We have therefore looked to existing processes and measures to provide this assurance.

It should also be noted that within both front line NHS (Productive Time) and Social Care) modernisation and change programmes that will enable efficiency will at the same time result in positive improvements in quality, rather than just maintaining existing standards. The relevant workstream sections set out how this is being evaluated.

3.6 Outstanding Areas of Measurement

At the time of publication of this ETN the following areas of measurement have still to be finalised. Further details are provided within workstream sections:

Existing Projects

- Quantifying and valuing outcome quality gains for the NHS (Productive Time)
- Contribution from staff skill mix shift (Productive Time)
- Benefits arising from Procure21 process for capital build projects (Procurement)
- Procurement savings for goods & services outside of the National Contracts and Collaborative Hubs programmes
- Corporate Services (back office) savings achieved by organisations outside of the Shared Services Joint Venture

Potential or Known New Projects

- Reduced spend through reducing variation in clinical intervention rates
- Increased income from Reduction in Fraud
- Increased income from extending the Injury Cost Recovery Scheme
- Additional local organisation specific efficiency savings additional to those captured by national programmes and measurement processes
- The ongoing programme of front line service improvement innovation through the NHS Institute and the Integrated Service Improvement Programme (Productive Time)
- A more comprehensive evaluation of net efficiency impacts of shifts in patient pathways from reactive acute to proactive primary or community care. Current measurement accounts for emergency admissions but not elective admissions
- Utilisation of assets for example theatres and

In addition we have identified, in the ETN, further processes of development or validation for a few project measures to substantiate (and where necessary amend) the values to be used in calculations.

4 PRODUCTIVE TIME

4.1 Summary of the Programme

Productive Time relates to the provision and delivery of front line patient care spanning Community Care, GP Services, Treatment Centres, Acute Hospitals and Mental Health.

The aim of the Productive Time Programme is to provide leadership, strategic direction and an appropriate framework enabling improved service efficiency so that front line staff (clinical and managerial/administrative) can increase the amount of time they spend on activities that contribute to delivering better services for patients... It is the most significant contributor to the efficiency savings required from the DH/NHS by the Gershon Review.

4.2 How Productive Time Efficiencies will be Delivered

Improved service efficiencies are achieved by:
- changing how services are designed and organised
- effective ongoing management of existing services

whilst ensuring that patient care and service is maintained or improved

There are three main workstreams underpinning change:

i. Information and Communication Technology – NHS Connecting for Health () is overseeing the implementation of one of the largest technological revolutions anywhere in the World enabling vastly improved information and communication flows throughout the NHS. This technological transformation will allow improved decision making, process design and patient-centred outcomes. For more details about NHS Connecting for Health, go to www..nhs.uk.

ii. Workforce Reform – a major programme of workforce reforms including new contracts for Consultants, GPs and all clinical & support staff (Agenda for Change). These contracts and associated reforms address pay & conditions, incentivise & reward performance and, through a competency based career development framework, enable much greater flexibility in job design and workforce planning, meeting patient needs more efficiently and effectively. For more details about NHS Workforce Reforms, go to www.dh.gsi.gov.uk/workforce

iii. Process redesign – improvements in the way healthcare is designed and delivered to provide better outcomes and service quality for patients more efficiently and effectively. Opportunities include moving services to less costly care settings (eg health centres or GP surgeries), better utilisation of assets (eg more effective use of premises and equipment) and reducing variation in outputs and associated costs by identifying and spreading best practice. The Ten High Impact Changes launched by the former NHS Modernisation Agency are promoting best practice process changes. Potential efficiency gains are also being identified in the Ambulance Service Reform programme, and National Institute for Information and Improvement work on reducing variation in hospital length of stay for the most common in-patient treatments. For more details about ongoing High Impact Change work and further development on reducing length of stay, go to www.institute.nhs.uk.

The effective delivery of planned change requires these three enabling strands of People, Process and Technology to be integrated ie improvements in one are typically dependant on improvements in the others. Efficiency gains are being generated by NHS organisations through integrated service improvement planning which is supported by the Integrated Service Improvement Programme (ISIP) structured around 9 Care Delivery Principles. For more details about ISIP go to nww.isip.nhs.uk

What Efficiency Benefits will be Delivered?

Expected Productive Time benefits can be categorised into four types relating to Gershon definitions of efficiency

i. Service Improvement

Efficiencies are generated by changing the way services are designed, structured and provided. Costs may be reduced by processes being made simpler (requiring fewer 'inputs' in terms of staff or other resources), or reducing their frequency – eg fewer follow up appointments (better output)

ii. Input Costs

Services and processes may stay the same but some input costs could be reduced eg staffing or, supplies and consumables due to reduced usage.

iii. Time Releasing

Simplifying administrative procedures which could be achieved in a number of ways including implementation of new policies and/or new technology, may allow front line professionals to spend more time on activities related to improving services.

iv. Quality Improvement

The changes sought through the Productive Time Programme, in the way services are designed and delivered (through people/process/technology) together with policy changes and medical advances in treatment provision, should result in measurable improvements that are valued by patients. These are improvements in measured quality as distinct from maintaining quality and therefore contribute to Gershon efficiency gains.

For the purpose of classifying benefits:

Service Improvement and Input Costs are cashable (recycled within front line organisations)
Time Releasing and Quality Improvement gains are non-cashable

4.2 Benefits Measurement

The measurement of the benefits gained through the Productive Time Programme is based on the collective business cases of major national modernising, contributory Programmes and coordinated regional/local initiatives. Each such outcome benefit has defined measurement formulae and underpinning performance data sources. These are detailed in Appendix 1.

Some of the outcomes on which efficiency is calculated are also impacted by external factors in particular ongoing changes in service demand and healthcare case mix. We have defined formulae as far as possible to isolate these impacts. We have taken care within formulae definitions to further minimise the risk of double counting efficiency gains

The quality of historical returns for some NHS data is variable. Although data is validated and where necessary corrected by the NHS Information Centre, some volatility remains that may not reflect true performance. Where this is apparent, measurement has been based on a moving average to provide a more reliable calculation of efficiency delivery over the Gershon reporting period. This necessary approach may however result gains being understated.

For Time releasing benefits it is not practical to measure actual local gains across many organisations as they may variously choose to realise savings as cost reduction or service improvement. Our approach is to measure process implementation and apply a fixed saving calculation based on validated business cases or case studies.

For benefits relating to measurement of quality, work is being undertaken in conjunction with HM Treasury, Office of Government Commerce (OGC) and Office of National Statistics (ONS). Measurement will be based on the results of work commissioned from York University to provide improved measurement of the quality of health provision in line with the

recommendations of the "Atkinson Review of Measurement of Government Output (ONS 2005)".

For some process improvements in acute hospitals, it is recognised that efficiency savings within the hospital sector may be partially offset by increased costs in other sectors such as community or primary care. Calculated efficiency gains will be the net saving.

Summary of Current Benefit Measures

Service Improvement

- Shift from In Stay to Day Case Treatment
- Reduction in Length of Stay for Elective in-Patients
- Reduction in Emergency Bed Days
- Reduced patient Non Attendance (Hospitals/Clinics)
- Reduced Cancelled Operations
- Redesigned 999 Emergency Service Provision
- Redesigned Diagnostic Services

Input Costs

- Reduced Staff Sickness Costs
- Reduced level of Agency Staff Usage
- Improved Prescribing Practices (Drug Costs)

Time Releasing

- Administration of Patient Flows and Clinical Care Records
- Administration of Patient Bookings
- Administration of Orders and Results
- Administration of Prescribing
- Reduced GP Administrative burden

4.3 Assurance of Quality

We are required to demonstrate that cost efficiency savings do not reduce the quality of service delivered. Quality will therefore be assured primarily by the delivery of existing service improvement Public Sector Agreement (PSA) targets relating to waiting times, health outcomes and patient satisfaction. In addition Patient Re-admissions is an appropriate quality measure in relation to reducing the time spent by patients in hospitals.

Outstanding and Future Work

At the time of publication of this ETN the following areas of measurement work are still under development:

- Calculation of quality improvement benefits based on the work commissioned from York University to implement the Atkinson Review recommendations
- Further analysis of emergency bed days to possibly differentiate between categories of beds with different occupancy costs – current calculations are based only on standard emergency beds and therefore provide a conservative savings value
- Agreement with OGC and Treasury on the specific calculation of offset costs relating to acute sector process improvements
- Calculation of cost efficiency gains relating to changes in workforce skill mix – increased proportion of patient care being provided by higher qualified nurses and healthcare assistants – this is a significant area underpinned by the introduction of a number of specific new clinical roles and the broader Agenda for Change/Career Framework

- A more comprehensive evaluation of net efficiency impacts of shifts in patient care from acute hospitals to primary or community care settings eg GP surgeries, health centres or community hospitals.
- Identification of a measure for reduced staff turnover that differentiates those leaving the NHS from those moving from one NHS organisation to another (subject to availability of national data)
- Re-evaluation of gains relating to the introduction of Emergency Care Practitioners. Initially we have used the most conservative results of early pilot studies

The Productive Time/Service Improvement programme is ongoing. The NHS is continually reviewing how patient care is delivered to provide better care and best efficiency/value for money contributing to meet both the current Gershon target and future NHS funding. Opportunities that will require measurement processes within the Gershon reporting period include:

- Development of a further set of best practice ‘high impact changes’ through the NHS Institute
- Reduced spend through reducing variation in clinical intervention rates
- Utilisation of assets for example theatres and clinical technology
- Further analysis of existing and new opportunities in Mental Health and Primary Care

5 PROCUREMENT WORKSTREAM

5.1 Summary of the Programme

The focus of the procurement programme is to reduce the cost of NHS inputs by reducing unit prices across the full range of medical supplies, consumables, services, facilities and capital construction costs that collectively account for around £20bn of annual expenditure by the NHS.

This is achieved by:

- The application of best practice in procurement
- Aggregating purchasing volumes to negotiate lower prices for higher volume with selected suppliers

The main contributing projects are:

1. National Contracts Procurement (NCP) – negotiation national framework agreements for products that can be procured nationally (ie all local organisations can use the same national suppliers). This is being completed in two waves of product blocks
2. Regional (Collaborative) Procurement Hubs (CPH) – development of a hub model, with procurement, clinical, supply chain and standard management functions, to be responsible for the health economy's non pay spend, supporting NCP and NHS Logistics and focussing on regional procurement
3. Logistics Outsource –- market testing potential outsource of NHS Logistics Authority with consumables procurement – transfer of a non-core activity to private sector and delivery of greater savings.

Collectively these three projects comprise the Supply Chain Excellence Programme (SCEP), led by DH Commercial Division and responsible for delivering the change in the NHS procurement infrastructure and establish the national frameworks over a three year period.

4. Other NHS Products – Around £1.5bn of NHS procurement of supplies is not currently envisaged. NHS Purchasing & Supply Agency (PASA) continues to manage these contracts directly , realising further savings through reduced prices on these products

5. Primary Care Pharmaceuticals (dispensed through High Street Pharmacists and Dispensing GPs). There are three lines of savings as a result of recently completed long term contracts:
   - An across the board reduction of 7% fixed until 2010 for all branded (PPRS drugs)
   - A fixed £300m reduction in prices for main categories of generic drugs, renewable annually
   - An earlier initial two stage price cut on four high volume generic drugs – the subsequent full range £300m reduction uses the lower prices of these drugs as its baseline)

6. Capital Construction & Facilities Management (Procure21) – this is an OGC sponsored procurement initiative to reduce the cost of new builds. Joint analysis is still underway to scope this deliverable
7. Contracts for Independent Sector Treatment Centre provision – the NHS is required to increase its use of IS provision to meet needs of additional capacity and to provide plurality. Previously IS provision, purchased locally by separate NHS organisations has been at a high premium. Setting guaranteed long term contracts for higher volume using OJEU procurement is resulting in significant reductions in this previous premium

5.2 Approach to Measurement

5.2.1 SCEP (NCP, CPH, Logistics) and other PASA products

Savings derive from the reduction in contract prices applied to volume of commodities (Old price less new price times volume)

NCP implementation is phased by product categories. or by region (CPH rollouts are phased by region being rolled out over the period to 2007 08. Each hub has a procurement cycle of categories regional hubs over two years. Savings for NCP and CPHs are based on prevailing prices at the commencement of each wave.

If the Logistics Outsource completes some existing products will transfer to the new supplier source. A separate tracking process with new baselines will be established to avoid any double counting of benefits. Where prices are fixed for more than a year GDP deflator is applied (if new prices include annual increments below inflation then the difference will be used)

Frameworks are not mandated - NHS organisations do not have to purchase through these contracts but NHS PASA monitors spend through supplier returns, takes appropriate action (uptake management etc) and reports to the SCEP Programme. A Benefits Integration tool is being developed providing information for PASA & DH Management and NHS clients.

5.2.2 Primary Care Pharmaceuticals

The Prescription Pricing Regulation Scheme (PPRS) secures a 7% saving across the total sales of PPRS drugs (except new drugs introduced after January 2005). Suppliers may vary price cuts between drugs and across the year but an annual reconciliation based on actual volumes results in reimbursement in line with the 7% saving. Risk to delivery is therefore minimal. The annual reconciliation will be used to confirm the actual level of saving

The Generics Drugs saving is similarly fixed in aggregate but again individual prices can vary. DH Medicines Pharmacy and Industry Group review volumes and prices quarterly and make necessary changes to re-align to the agreed aggregate saving. This is confirmed at the year end and the end of year reconciliation will be used to validate efficiency savings.

The earlier price cuts on the four generic drugs are now superseded by the new pricing regime but their lower prices form part of the new baseline. We have therefore calculated a fixed saving for these reductions based on their volume at March 2005.

Savings will be maintained for the duration of the Efficiency Programme so GDP deflator is applied to second and subsequent years

5.2.3 Capital Construction and Facilities (Procure21)

An appropriate approach to measuring and assuring benefits from this project will be developed when the deliverables are fully scoped and evaluated

5.2.4 ISTC Procurement

Prior to establishment of the ISTC Programme NHS organisations negotiated their own local contracts for independent sector supply as required (Spot Purchasing). Comprehensive analysis of 2003 and 2004 contracts showed prices an average ‘spot price’ of 40% above NHS equivalent prices.

The ISTC Programme has two waves. Wave 1, now almost fully operational, was established to enable more rapid growth in capacity than could be resourced by the NHS to enable further reductions in waiting time. For this programme, it has been agreed with HM Treasury that the basis of savings calculation is the difference between actual price paid for ISTC contracts and the price that would have been paid for equivalent local ‘spot purchase’.

Wave 2 comprises a more substantive number of contracts for diagnostics and electives, aimed at further increasing capacity but also to establish a sustainable longer term market of alternative providers.

It has been agreed with Treasury that efficiency savings for these contracts will only be reported where contracts cost less than the prevailing NHS equivalent price. Wave 2 also establishes a national price for optional additional local IS provision to meet short term needs (Extended Choice). This contract will replace ad-hoc 'spot' purchasing. The calculation for this contract will be the difference between actual price and the previous (40%) spot premium applied to the actual volume of Extended Choice.

Most Wave 1 and Wave 2 contracts have a minimum take up volume requirement. For the calculation of efficiency gains, the cost of any financial penalties for below minimum take up will be included in the actual cost calculation for each contract.

5.3 Assuring Quality

Maintained or improved product quality standards are inherent in procurement contracts. Suppliers are required to maintain standards agreed in product specifications or service level agreements that also set out assurance processes. NHS organisations would not continue to purchase goods or services where these standards are not maintained. No further specific measure of quality is therefore necessary to validate Gershon savings.

5.4 Outstanding Work

At the time of publication of this ETN, the following measurement work is still under development:

Other Procured Goods & Services
The Purchasing & Supply Agency (PASA) continue to negotiate improved prices for goods and services that are not currently included in the SCEP Programme (mainstream national contracts or regional collaborative hub programmes). PASA calculate and report on savings accrued as part of their internal reporting, but their methodology is not consistent with that used for the SCEP programme.

PASA systems will be reviewed and a calculation process developed for these products, whilst ensuring that there is no double counting with SCEP.

Procure21
Work is underway with OGC evaluate the potential of applying Procure21 processes to capital builds. This work will also confirm an appropriate measurement process.

6 ADULT SOCIAL CARE

6.1 Summary of the Programme

Local authorities have a target of delivering 2.5% annual efficiency gains for the period 2004/05 to 2007/08 on their overall expenditure. For these 150 Councils with Social Service responsibilities, Adult Social Care is the largest single department, typically accounting for 20-30% of total expenditure.

This proportion of spend, and the recognised scale and scope of best practice improvement opportunities in this area provide strong incentives to maximise the contribution provided by Adult Social Care.

How Efficiencies are Delivered

A comprehensive programme of opportunity analysis carried out by the Department's Care Services Efficiency Delivery Programme (CSED) has confirmed that there are significant opportunities through extension of current best practice and more substantive process improvement. Particular opportunities are evident both in the process of procurement and through the redesign of some care services processes.

The CSED Programme was set up to work in collaboration with Councils with Social Services Responsibilities (CSSRs) to help identify and deliver sustainable efficiency gains. In particular, the nine Regional Centres of Excellence act as the main change agents for local government efficiency, providing support to council led projects designed to achieve efficiencies.

Examples of how councils are achieving efficiency gains include:

- greater use of external providers for the provision of care
- use of longer term block or cost and volume contracts
- shift in services away from traditional residential care to home care and other alternatives (extra care, sheltered housing)
- use of single assessment process
- greater use and efficient operations of contact centre
- use of technology ranging from tablet PCs for conducting assessments at client's homes to electronic systems for monitoring home care and automatic invoicing
- increasing take-up of direct payments and individual budgets
- improved management of sickness absenteeism
- improved use of resources such as office space, recruitment costs

Councils are already looking for ways to deliver adult care services in a more cost efficient manner while improving overall service quality as part of the Audit Commission's Comprehensive Performance Assessment and Commission for Social Care Inspectorate's Performance Assessment Framework. Efficiency ideas are likely to comprise a mix of national, regional and local initiatives.

Each council undertakes different activities in order to achieve efficiency gains in this sector. Details of the activities undertaken in the past year, can be seen in the Backward Look Annual Efficiency Statements of each council (see www.odpm.gov.uk). Supplementary information is also provided in the Forward Look Annual Efficiency Statements (also at www.odpm.gov.uk).

It has been recognised that actions to deliver efficiencies are inextricably linked with wider business change to deliver improved services in line with the Green Paper "Independence, Well-being and Choice" which was published by the Department of Health in March 2005.

6.2 Approach to Measurement

Each council has its own plans comprising diverse projects for improved efficiency. Guidance on measurement principles has been issued by Office of the Deputy Prime Minister (ODPM) relating to all Local Authority programmes. CSED have provided supplementary guidance for

Adult Social Care. Copies of the guidance documents for completing these Annual Efficiency Statements can be found on the national Regional Centres of Excellence web-site (www.rcoe.gov.uk)

The activities undertaken by local authorities achieve both cashable and non-cashable efficiency gains. Each council specifies the level of cashable and the amount of non-cashable efficiencies achieved in each sector. Work is in progress to develop a consistent measure of quality of adult social care which would be sophisticated and robust to enable a financial value to be assigned to improvements in quality. Current expectations are that a pilot may be initiated with a view to sharing the early findings with CSSRs at around April 2006.

Each council is required to produce a Backward Look Annual Efficiency Statement (AES), which sets out the efficiency gains achieved in the past year for each sector. The reported national sum is the total of that reported in the AESs. These AESs are auditable and must be signed off by the Council Leader, Chief Executive and Finance Director

A number of processes are in place to validate Annual Efficiency Statements:

- CSED have developed and distributed a Cost Weighted Activity Index (CWAI) tool which estimates aggregate change in net output weighted to account for changes in the relative share of expenditure for different categories of care. Councils are encouraged to use this evaluation as a cross check to their aggregate measured efficiency benefits. The CWAI can also be found on www.rce.gov.uk
- Councils' initial returns are examined by Departments and consultation takes place to improve these returns where necessary. CSED will correlate local delivery against the main national business opportunities in their Efficiency Delivery Programme
- The Audit Commission appoints auditors to review Statements. The auditors review the process by which the Council has satisfied itself that adequate, question whether supportable information was considered in preparing the efficiency statement and determine if there is an adequate, supportable basis for the statements made.
- The Commission for Social Care Inspection (CSCI) receive and review efficiency plans as part of Delivery and Improvement Statements submitted by Councils as part of their performance assessment process.
- ODPM reserves the right to hire advisers to conduct a further review of the Statements and supporting information to those Statements.

6.3 Assurance of Quality

Cashable efficiencies can only be counted if these are sustainable to 2007/08 and do not result in a reduction in service quality. To assist in the evaluation of this process, each sector of councils' Annual Efficiency Statement return includes a quality cross-check and descriptive box for further service quality information.

Councils are required to input values for at least one quality cross-check per sector – the "primary" indicator for that indicator. This cross-check is required to be relevant to the efficiencies being claimed. A set of cross-checks has been recommended by the Department of Health and are listed in the guidance documents, but use of these is not mandatory – where an alternative is chosen the council has to justify its choice.

6.4 Outstanding Work

Completion of the measurement process for improved service quality is being developed by the University of Kent. This will provide a more robust method for calculating non cashable service quality benefits declared in Annual Efficiency Statements and will be included in the Local Authority toolkit for use in 2006.

7 PUBLIC FUNDING & REGULATION (PFR)

7.1 Summary of the Programme

The Public Funding & Regulation (PFR) workstream addresses efficiency opportunities through the reduction in the size, scope and resulting operating costs for administration of the NHS. There are three tiers of support, all of which are undertaking restructuring programmes within the timescales of the Gershon Efficiency Programme:

Department of Health
The DH Change Programme initiated in March 2003 and substantively completed by March 2005 has reduced gross headcount and associated operating costs by 38%, through a streamlining of its role and operating functions in line with the strategy of devolving responsibilities to the NHS. Whilst some of these resources have transferred to other NHS support organisations, there is a significant net central cost saving contributing that will be recycled into increased funding of front line services. As this programme commenced in early 2003, an earlier baseline of March 2003 has been agreed with Treasury for the measurement of cost efficiency savings and headcount reduction.

Arms Length Bodies
A restructuring programme was launched in April 2004 to review and streamline the roles and operating functions of the tier of organisations providing support and regulatory functions for the NHS (Arms Length Bodies). Savings will be delivered by reducing regulatory functions, merging organisations (economies of scale and reduced Board/management costs), process redesign of remaining functions, and a comprehensive shared services strategy for back office (corporate) functions) across the sector. Savings will accrue from reduced funding of ALBs by the Department and by reduced cost of services provided by some organisations to the front line NHS (efficiencies in service provision from organisations transferring from the defined ALB sector (eg Special Health Authorities) will also contribute to this saving. The changes take effect progressively from March 2005 and will be complete by March 2008.

Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs)
A restructuring programme has been announced and commenced in July 2005 to further streamline the role and operating functions of SHAs and PCTs. This planned restructuring will provide appropriate structures and management support appropriate to the continuing strategy of devolved accountability to the front line NHS, and the next phase of the NHS System Reform strategy. The changes are currently undergoing a consultation period and will be implemented. Implementation schedules have not yet been confirmed by changes should be complete by March 2008.

7.2 Approach to Measurement & Quality Assurance

The core measure of 'efficiency' saving is the reduction in operating costs as a consequence of restructuring and reduced headcount in line with changes to functional responsibilities and process efficiencies. Savings are net of transfers to other non-front line organisations.

Non–recurring costs of implementing the changes (redundancy and other transition costs) will be excluded

Department of Health
The basis of measurement for DH is the reduction in Department Administration Cost Limit. This will be adjusted for transfers of staff and operating cost to NHS support organisations not forming part of front line service to patients.

Arms Length Bodies
The main measure of saving is reduced Grant in Aid from DH. The 2003/04 baseline is adjusted for transfers of organisations out of the sector and exceptional (minister directed) new policy driven increases. Non recurring costs of transition will be excluded

Achievement of efficiency savings resulting in reduced costs to the NHS for service provision by some ALBs will need to be calculated separately for each change. Reduced NHS prices will provide confirmation of the saving

SHA/PCT Restructuring
The development of the SHA/PCT programme is still being scoped and a specific measure will be identified at a later date. The basis of this measurement will be the net change in SHA/PCT operating (management and administration) budgets.

7.3 Assurance of Quality

Maintained quality of Department of Health service will be assured through existing measures of performance relating to Ministerial and Parliamentary support and Customer queries

Maintained quality of ALB service provision to the NHS will be assured by the continued use of Annual Accountability Agreements. These are agreed with the respective DH ALB sponsor and set out the organisation's business plan and service agreement. ALB Chief Executives are held to account for delivery of these objectives by the Sponsor.

7.4 Outstanding Work

Development of measures to capture benefits from the recently launch SHA/PCT restructuring programme.

8 CORPORATE SERVICES

8.1 Summary of the Programme

The Corporate Services workstream addresses efficiency opportunities within services and functions of front line NHS organisations that are not patient/customer facing. Primarily these comprise Finance, HR & Payroll, Facilities Management IT and Estates.

It is difficult to separate fully those functions in front line organisations that are 'front line' ie patient centred for example the administration of appointments and bookings. To avoid double counting it has been assumed that any efficiencies enabled by Connecting for Health technology sit within Productive Time. Other changes sit within NHS Corporate Services.

Detailed data and performance information relating specifically to back office functions is limited within DH and therefore constrains the scope of measured benefits. Only those changes delivered through nationally led projects and initiatives can be captured at this time so the true value of benefits accruing to the NHS is almost certainly understated. This is the case particularly the case where local initiatives and improvements are undertaken (for example shared services provision separate from the DH led Joint Venture). Work is continuing to identify an appropriate method of capturing the full scope of back office efficiencies.

Benefits reported in this workstream do not include those relating to more efficient corporate (shared) services in the Arms Length Body (ALB) sector. Those substantial savings are reported as part of the overall ALB operating cost savings win the PFR workstream.

The main programmes delivering back office efficiency savings for the NHS for which benefits can currently be captured are:

Microsoft Enterprise Wide Agreement (EWA)
The procurement of an EWA for Microsoft Office in Autumn 2004 resulted in a significant reduction in the cost of MS operating licenses plus a significant increase in capacity and free access to future upgrades to improve capability.

Electronic Staff Records (ESR)
The implementation of ESR results in significant reduction in administrative processes relating to staff records, releasing time from HR Departments. ESR also provides improved management information to support improved management of staff sickness but these and related productivity benefits are captured within the Productive Time workstream. ESR is rolling out progressively between 2005 and 2008.

Electronic Recruitment
NHS organisations using the recently launched Electronic Recruitment system, linked to a national web site, for advertising and administering vacancy recruitment are able to reduce significantly the costs of advertising in professional publications and reduce costs of postage and other materials. Over 100,000 posts are advertised each year and the majority can be managed through the electronic system.

Shared Services (Joint Venture Company)
DH recognises the significant opportunities for back office efficiencies through pooling these processes between organisations so to enable reduced costs through economies of scale. DH has established a Joint Venture company in April 2005 thus drawing on the additional expertise and capacity of an external specialist provider. The JV covers finance processes (except management accounts) and has a development plan to broaden its scope into payroll and procurement support.

Although the savings are significant, and these are being promoted strongly, the sign up of any NHS organisation is optional. Some may already have local arrangements or may have plans to do so. The expectation is that up to half of NHS organisations will move to the JV Shared Services facility by 2008.

8.2 Approach to Measurement

Microsoft Contract
This is a completed procurement and efficiency benefits (reduced cost of inputs) are reported in line with the procurement business case. These are fixed beyond the 2008 end date for the Efficiency Programme.

Electronic Staff Records
Savings are based on the confirmed process time savings at staff rates driven by the number of staff live on the system as it rolls out. Decisions on how this released time is utilised are local organisation decisions and cannot be captured at national level.
There is a separate small contribution from net savings accruing from the elimination of costs of maintaining legacy systems

Electronic Recruitment
Savings are based on cost reductions in advertising, postage and materials confirmed in analysis of early implemented sites. Aggregate saving is calculated by applying this savings value to the number of posts advertised through the national Electronic System

Shared Services (Joint Venture Company)
Savings are based on an organisation specific audit before sign up confirming current actual costs of the services to be transferred less the agreed cost of JV provision. Other savings accrue from the repayment to DH of 60% of any subsequent profits from the JV operation in the form of a dividend, and the savings accruing from the procurement of an EWA for Oracle operating system.

8.3 Assurance of Quality

The Microsoft Contract provides improved functionality with contractual guarantees around service. No further quality measure is required.

The ESR Programme monitors levels of service provision and system reliability. A specific appropriate quality assurance measure from these implementation support processes has still to be confirmed.

NHS organisations can choose whether to use the Electronic System for their recruitment. Service quality and reliability are key factors in this choice. Reduced quality will be reflected directly in lower utilisation and lower reported benefits. No further measure of quality is therefore required.

The Shared services contract has a service level agreement and provides for penalty payments to contracted NHS customers in the event of these standards not being maintained

8.4 Outstanding Work

Although a significant proportion of NHS organisations are expected to transfer to the Shared Services JV, other organisations are achieving year on year savings in corporate services functions through local change or alternative local shared service approaches. These efficiency savings are not captured in current measurement processes. Reliable national data on these savings is not currently available but work is continuing to identify and capture these through a separate agreed measurement process.

9 CENTRAL BUDGETS

9.1 Summary of Programme

During 2005/06 the Department will be undertaking a comprehensive review of programme budgets held and administered by DH to deliver projects and programmes in the NHS.
These will be assessed to determine whether value for money is being obtained from this spend. Where they are not contributing directly to improved patient care and service they will be terminated and the funds released directly to the operating budgets of front line organisations to deliver increased service and capacity needs

The review will take place in Autumn 2005 with cash transfers effective from April 2006 on a recurring basis.

9.2 Approach to Measurement

Savings are calculated by aggregating the value of all eliminated budgets.

Only those budgets where stopping the centrally funded work is confirmed not to have an impact on front line service will contribute to the benefit calculation

9.3 Assurance of Quality

DH and OGC will be working jointly to ensure that there are no resulting adverse impacts on Front Line quality.

9.4 Outstanding Work

Development and evaluation is underway around two opportunities to increase income generated for recycling to the NHS Front Line through current policy initiatives. These comprise:

- Increased income through the expansion of injury cost recovery from road traffic accidents to all areas covered by personal or employer insurance
- Improved working practices reduce the costs of Fraud within the NHS.

Appropriate processes for benefit calculation will be developed for these projects.

Appendix 1

Measurement Templates

Productive Time

Service Improvement Measures

Efficiency Benefit	**Shift from In-Stay to Day Case Treatment**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement
How the efficiency is achieved	Patients previously treated as inpatients moved to day cases. Efficiency savings generated as costs of an overnight stay are no longer incurred.
Care Delivery Principle	Care provision in the right setting
Delivery enablers	Process: High Impact Change (HIC)1 (day surgery), HIC 10 (role redesign) Technology: CRS (PAS Bed Management) CRS (Theatre Management) System Reform: NHS and IS Treatment Centres Day case High Impact Change study
Benefit measure	Day case rate = % of all elective admissions that are treated as day cases
Benefit calculation	Change in day case rate x current year number of elective admissions x cost of a bed day excluding any treatment costs #
Measurement baseline	2003/2004 elective activity day case rate #
Use of deflator	GDP deflator applied annually to cost of an overnight stay excluding treatment costs
KPI data source	Hospital Episode Statistics (HES)
Validation	NHS Data Returns validated by Health & Social Care Information Centre
Data frequency and time lag	Collected quarterly. Available 2 months in arrears.
Scale of Benefit	High

Further work is being undertaken with the British Association of Day Surgery to investigate the possibility of presenting savings for a range of procedures' which offer maximum potential for improved value for money through switching from inpatient to day case activity.

Efficiency Benefit	**Reduction in the Average Length of Stay (LOS) of Elective In-Patients**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement
Care Delivery Principle	Care provision in the right setting
How the efficiency is achieved	Savings generated through reducing length of stay as a result of, for example, better turnaround of diagnostic tests, fewer adverse drug reactions, smoothed admissions and discharges, reduction in hospital infections
Delivery enablers	Process: HICs1 (day surgery), 7 (Long term conditions), 10 (role redesign) Workforce: new workforce contracts Technology: CRS (PAS Bed Management) CRS (Theatre Management), Healthspace, Choice, ETP System Reform: Practices commission based on demand NHS and IS Treatment Centres
Benefit measure	The difference in days between the date of admission and discharge where the patient is accounted for at midnight.
Benefit calculation	Change in average LOS for elective inpatients excluding day case procedures x current no. of elective admissions x cost of an overnight stay #
Measurement baseline	Three-year average Length of Stay is used as the 2003/4 baseline due to doubts about quality and volatility of data. Three year-moving average LOS will be used for subsequent years for consistent comparison with baseline.
Use of deflator	GDP deflator applied annually to cost of an overnight stay
Validation	NHS Data Returns validated by Health & Social Care Information Centre
KPI data source	Hospital Episode Statistics (HES)
Data frequency and time lag	Data collected quarterly. Initial data available two month in arrears, fully validated data six months in arrears
Scale of Benefit	High

Calculation likely to be an underestimate because an increasing proportion of activity performed as day cases is likely to be achieved by the simplest elective (planned) inpatient procedures being switched to day cases, therefore, increasing the length of stay of remaining elective activity. This is only partially accounted for by adjusting for the new mix of procedures performed,

Efficiency Benefit	**Reducing Emergency Stay Bed Days (EBDs)**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement
How the efficiency is achieved	Savings are generated by reducing EBDs through the improved care of Long Term Conditions (LTCs) and improved access to diagnostic services.
Care Delivery Principle	Timely, convenient and responsive care including preventative interventions and diagnostics
Delivery enablers	Process: HIC 2 (diagnostics), HIC 10 (Role redesign) Workforce: new ways of working, new workforce contracts Technology: PACS & RIS, 'Remote' / consolidated reporting, Choice, N3, CRS, PAS System Reform: Practice based commissioning, Capital Investment in additional capacity, IS Expansion project is specifically addressing diagnostic procurement in wave2
Benefit measure	Number of emergency bed days
Benefit calculation	Change in the number of emergency bed days x cost of a hospital bed including treatment #
Measurement baseline	Number of emergency bed days required in 2003/04
Validation	NHS Data Returns validated by Health & Social Care Information Centre
Use of deflator	GDP deflator is applied to the cost of an overnight stay including treatment
KPI data source	Hospital Episode Statistics
Data frequency and time lag	Data collected quarterly. Initial data available two month in arrears, fully validated data six months in arrears
Scale of Benefit	Low

Differentiation has not yet been made between different 'levels' of emergency bed (eg standard, high dependency, intensive care. Benefits calculated on the lowest (standard) bed cost. Work in progress to identify differentiated bed usage.

Efficiency Benefit	**Reduced Patient Non-Attendances (Did Not Attends, DNAs)**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement
How the efficiency is achieved	The number of patient non-attendances for initial and follow-up outpatient appointments is reduced, thereby, reducing the amount of clinical and admin time wasted.
Care Delivery Principle	Services delivered and input costs managed in most efficient and effective way possible
Delivery enablers	Process: HICs 7, 10 Workforce: new workforce contracts, Modernising Medical Careers, NHS Career Framework Technology: Choose and Book, Care Records, Demand management System Reform: Practices to commission more appropriately eg diagnostic testing in Primary Care environment
Benefit measure	% of first and follow-up outpatient appointments that result in non-attendances as a proportion of all outpatient appointments booked.
Benefit calculation	% change in outpatient non-attendances from previous year x current number of outpatient appointments x cost outpatient appointment)
Measurement baseline	2003/04 patient non-attendances as a proportion of all outpatient appointments
Use of deflator	GDP deflator applied annually to cost of an initial and follow-up non-attendance.
Validation	NHS Data Returns validated by Health & Social Care Information Centre
KPI data source	KH09, a statistical return received from trusts
Data frequency and time lag	Quarterly, one quarter in arrears
Scale of Benefit	Low

Efficiency Benefit	**Reduced Cancelled Operations for Non Medical Reasons**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement
How the efficiency is achieved	Reducing cancelled operations lessens the amount of wasted clinical/admin resource and increases patient treatment time thereby improving efficiency.
Care Delivery Principle	Services delivered and input costs managed in the most efficient and effective way possible
Delivery enablers	Process: HICs 2 (diagnostics), 3 (discharge), 4 (admissions), Workforce: new workforce contracts Technology: Demand management, Choice System Reform: Payment by results
Benefit measure	% of operations cancelled at the last minute for non-clinical reasons #
Benefit calculation	Change in % of operations cancelled at the last minute for non-clinical reasons x number of operations planned in the current year x cost of a cancelled operation
Measurement baseline	% of operations cancelled at the last minute for non-clinical reasons in 2003/04
Use of deflator	GDP deflator is applied to the cost of a cancelled operation
Validation	NHS Data Returns validated by Health & Social Care Information Centre
KPI data source	Quarterly Monitoring of Cancelled Operations (QMOP)
Data frequency and time lag	Data collected quarterly, available two month in arrears
Scale of Benefit	Low

A Last Minute Cancellation is one that is cancelled on the day of the operation or, if earlier, the day a patient was due to arrive in hospital for the operation.

Efficiency Benefit	**Redesigned 999 Emergency Service Provision**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement
How the efficiency is achieved	Redesign of the emergency service provision results in fewer ambulance and crew dispatches as Emergency Care Practitioners (ECPs) attend some 999 calls instead. Efficiencies are generated by saving on the cost of dispatching an ambulance and crew over the costs associated with dispatching an ECP alone as well as saving on the cost of treatment at the Emergency Department (ED).
Care Delivery Principle	Care provision in the right setting
Delivery enablers	Process: HIC 7, 10, Ambulance Service redesign Workforce: new workforce contracts, introduction of ECPs, Modernising Medical Careers, NHS Career Framework Technology: PACS / ETP System Reform: Practices to commission more appropriately eg in Primary Care environment
Benefit measure	The increase in the number of Whole time Equivalent ECPs throughout the year
Benefit calculation	Increase in the number of WTEs ECPs in the year x annual cost saving associated with an ECP over an ambulance and crew dispatch plus treatment at an ED.
Measurement baseline	Number of WTE ECPs employed in March 2003/2004.
Measurement validation	Annual saving per ECP extracted from a study carried out by Hampshire Ambulance Service building on research work by the former NHS Modernisation Agency. Further validation of value will be undertaken as the ECP initiative develops under revised emergency care provision arrangements.
Use of deflator	GDP deflator applied to the annual saving per ECP.
KPI data source	Department of Health, New Practitioner Programme
Data frequency and time lag	Data collected monthly
Scale of Benefit	Medium

Efficiency Benefit	**Redesigned Diagnostic Services**
Benefit Type	Recyclable within Front Line Organisations - Process Improvement #
How the efficiency is achieved	Introduction of the Picture Archiving and Communication System (PACS) • Eliminates the need for film and chemicals (cost saving) • Eliminates need for chemical waste disposal (COSHH costs) • Results of diagnostic tests no longer stored as hard copies freeing up space. Clerical staff no longer required to handle hard copies • Reduction in time wasted searching for medical images Streamlined process lessens the amount of wasted clinical/admin resource and increases patient treatment time Faster turnaround of tests reduces inpatient bed days. Avoidance of hospital admissions for diagnostic tests alone Outpatient Did Not Attends are reduced thus reducing the amount of clinical and administration time wasted. Improved access to diagnostic services eliminates delays in diagnosis and the patient is treated earlier. Waiting times are also reduced
Care Delivery Principle	Timely, convenient and responsive care, including preventative interventions and diagnostics
Delivery enablers	Process: Diagnostic Tests; Role Redesign; Pathology, Endoscopy & Radiology modernisation; Radiology Programme; Pathology Service Improvement Framework; CHD Collaborative; National Radiology Programme Workforce: New workforce contracts; 4-tier radiographer framework; Healthcare Science career framework Technology: PACS & Radiology Information Systems; Additional MRI capacity; ; CRS PAS
Benefit measure	Number of departments that have implemented PACS
Benefit calculation	Increase in the number core radiology departments that have implemented PACS x projected saving per diagnostics change programme
Measurement baseline	2003/04 number of departments that have implemented PACS
Measurement validation	Post implementation review to validate saving per diagnostics programme conducted by the NHS Integrated Service Improvement Programme (ISIP)
Use of deflator	GDP deflator
KPI data source	CFH deployment tracking database
Data frequency and time lag	Quarterly
Impact	Low

Diagnostic Services change results in both process and cost savings. These have been aggregated to simplify benefit management & measurement

Input Costs

Efficiency Benefit	**Reduced Staff Sickness Costs**
Benefit Type	Recyclable within Front Line Organisations
How the efficiency is achieved	Reducing staff sickness results in increased staff productivity
Care Delivery Principle	Individual staff supported, engaged and rewarded Interventions to support individual well being
Delivery enablers	Process: HIC 10 Leadership & Learning workstream – establishing a Patient-Led Culture and clinical engagement Technology: improves effectiveness and efficiency of staff work improving staff satisfaction and patient care Workforce: new workforce contracts, Improving Working Lives, Knowledge and Skills Framework, NHS as a healthy employer
Benefit measure	% of Whole Time Equivalents (WTEs) lost through sickness absence
Benefit calculation	% change in the number of WTEs lost through sickness absence on previous year x current year number of WTEs employed x average salary of an NHS employee
Measurement baseline	2003/04 % of WTEs lost through staff sickness
Measurement Validation	NHS Data Returns validated by Health & Social Care Information Centre
Use of deflator	GDP deflator applied to average annual salary
KPI data source	NHS Health and Social Care Information Centre Annual Sickness Absence Survey
Data frequency and time lag	Collected annually, available 2 months in arrears
Scale of Benefit	Medium

Efficiency Benefit	**Reduced Level of Agency Staff Use**
Benefit Type	Recyclable within Front Line Organisations - Process Inputs
How the efficiency is achieved	Reducing the use of agency staff results in a direct saving in unit costs in addition to increasing productivity
Care Delivery Principle	Services delivered and input costs managed in the most efficient and effective way possible
Delivery enablers	Process: HIC 10 Workforce: new Workforce contracts Technology: electronic staff records, e-recruitment Service reform: Shared services ventures, Agency Cost Project
Benefit measure	Agency spend, Number of bank staff, Number of establishment staff.
Benefit calculation	Agency spend in current year – (% increase in no. of bank/establishment staff x current year staff numbers x percentage of agency unit costs associated with use of bank/establishment staff x unit costs of agency staff). Unit costs premia on establishment staff rates have been assessed as 35% for Agency and 10% for Bank staff
Measurement baseline	Agency staff spend in 2003/4.
Measurement validation	Existing validation arrangements in place for NHS Workforce Census and Trust Financial Returns.
Use of deflator	GDP deflator applied to unit costs of agency staff
KPI data source	Agency spend detailed in the Trust Financial Returns, the number of bank and establishment staff in post are taken from the NHS Workforce Census
Data frequency and time lag	Annual, 6 months in arrears
Scale of Benefit	High

Efficiency Benefit	**Improved Prescribing Practice (Drugs Costs)**
Benefit Type	Recyclable within Front Line Organisations – Process Inputs
How the efficiency is achieved	Reducing the cost of drugs prescribed through formulary management and guidance provided by PAS Clinicals functionality
Care Delivery Principle	Services delivered and input costs managed in the most efficient and effective way possible
Delivery enablers	Technology: CRS (PAS Clinicals) Process: Formulary management disciplines
Benefit measure	% of hospitals deploying LSP PAS Clinicals functionality
Benefit calculation	% of Hospitals * Reduction in Drug Costs #
Measurement baseline	% of Hospitals deployed at March 4004
Measurement validation	Post implementation review conducted by the NHS Integrated Service Improvement Programme (ISIP)
Use of deflator	GDP deflator applied annually to cost of drugs.
KPI data source	deployment tracking database
Data frequency and time lag	Quarterly, 3 months in arrears
Impact	Low

Initially based on Wirral Formulary Management paper which shows savings of between 1% and 5% of the drugs bill, subject to further validation.

Time Releasing

Efficiency Benefit	**Administration of Patient Flows & Clinical Care Record**
Benefit Type	Non Recyclable - Time Releasing
How the Efficiency is Achieved	Clinicians and admin support staff are given the information to move patients more efficiently through the care pathway. Patient records, clinical notes and discharge summaries are automated. Operational processes are improved to minimise the costs of variation in demand patterns to make better use of scarce resources
Care Delivery Principle	Services delivered, and input costs managed, in the most efficient and effective way possible
Delivery Enablers	CRS Patient Administration System with the following functionality: • appointment scheduling • real time bed management • clinical noting support High Impact Changes: • No 3: variation in patient discharge • No 4: variation in patient admission process • No 8: reduction in number of (clinic and theatre) queues Significant role changes for clinicians, coders and other administrative support staff.
Benefit Measure (KPI)	Deployment of CAB technology integrated with secondary care PAS systems
Benefit Calculation	No of CAB/PAS integrations x agreed time savings by staff group x weighted labour cost
Measurement Baseline	Zero based as most of the technology and emphasis on High Impact Changes is deployed after 2003/04
Measurement Validation	Post implementation review conducted by the NHS Integrated Service Improvement Programme (ISIP) to validate time savings estimated in the business case
Use of Deflator	GDP deflator applied to labour cost savings after 2003/04
KPI Data Source	deployment tracking database
Data Frequency & Time Lag	Available quarterly. No assumed time lag.
Scale of Benefit	Medium

Efficiency Benefit	**Administration of Patient Bookings**
Benefit Type	Non Recyclable - Time Releasing
How the Efficiency is Achieved	Clinicians and admin support staff are given the information to choose and the technology to book directly for secondary care treatment. Net administrative time savings realised across provider processes
Care Delivery Principle	Services delivered, and input costs managed, in the most efficient and effective way possible
Delivery Enablers	Choose and Book (CAB) functionality linked to hospital Patient Administration Systems High Impact Changes: • No 8: reduction in number of (clinic and theatre) queues Role changes in GP practices and in hospital administration
Benefit Measure (KPI)	Referrals made through CAB as % of total referrals
Benefit Calculation	% of CAB referrals x agreed time savings by staff group x weighted labour cost
Measurement Baseline	Zero based as the technology is deployed after 2003/04
Measurement Validation	Post implementation review conducted by the NHS Integrated Service Improvement Programme (ISIP)
Use of Deflator	GDP deflator applied to labour cost savings after 2003/04
KPI Data Source	deployment tracking database
Data Frequency & Time Lag	Available quarterly. No assumed time lag.
Scale of Benefit	Medium

Efficiency Benefit	**Administration of Orders & Results**
Benefit Type	Non Recyclable - Time Releasing
How the Efficiency is Achieved	Electronic support for placing clinical orders, e.g. diagnostic tests, and online viewing of results; elimination of chasing for results and repeating lost results.
Care Delivery Principle	Services delivered, and input costs managed, in the most efficient and effective way possible
Delivery Enablers	CRS Patient Administration System with the following functionality: • order comms • direct entry of referral data into departmental systems ▪ online viewing of results & patient records Role changes for some hospital staff
Benefit Measure (KPI)	% of hospitals deploying Order Comms technology
Benefit Calculation	% of hospitals deploying x time saving x weighted labour cost
Measurement Baseline	Number of sites at March 2004 with relevant functionality: 20%
Measurement Validation	Post implementation review conducted by the NHS Integrated Service Improvement Programme (ISIP)
Use of Deflator	GDP deflator applied to labour cost savings after 2003/04
KPI Data Source	deployment tracking database
Data Frequency & Time Lag	Available monthly.
Scale of Benefit	Medium

Efficiency Benefit	**Administration of Prescribing**
Benefit Type	Non Recyclable - Time Releasing
How the Efficiency is Achieved	Electronic support for transfer of prescriptions between prescriber, pharmacy and the Prescription Pricing Authority; improved processes for the patient to receive the right drugs and the authorisation / dispensing of repeat prescriptions.
Care Delivery Principle	Services delivered, and input costs managed, in the most efficient and effective way possible
Delivery Enablers	Electronic Transfer of Prescriptions (ETP) technology coupled with changed operational processes for clinicians and pharmacists
Benefit Measure (KPI)	GP Practices deploying Release 2 ETP technology linked to local pharmacies
Benefit Calculation	No of GP Practices deploying Release 2 ETP x agreed time savings x weighted labour cost
Measurement Baseline	Zero based as ETP technology is deployed after 2003/04
Measurement Validation	Post implementation review conducted by the NHS Integrated Service Improvement Programme (ISIP) to validate time savings
Use of Deflator	GDP deflator applied to labour cost savings after 2003/04
KPI Data Source	deployment tracking database
Data Frequency & Time Lag	Available quarterly. No assumed time lag.
Scale of Benefit	Medium

Efficiency Benefit	**Reducing GP Bureaucracy**
Benefit Type	Non Recyclable - Time releasing
How efficiencies are achieved	Joint DH/Cabinet Office 'Making a Difference' reports contain a series of practical solutions reducing the amount of red tape for frontline staff, in particular GPs, thereby freeing up more time for GPs to concentrate on treating patients and address new ways of working eg practice based commissioning, choice etc.
Care delivery principle	Services structured and delivered in the most efficient and effective way possible
Delivery enablers	Process: removing unnecessary administrative processes as set out in Making a Difference – GP1 and 2, widen nurse prescribing. Workforce: new GMS contract, Agenda for Change,
Benefit measure (KPI)	Processes/policy changes already fully implemented – no ongoing measure of delivery required
Benefit calculation	Benefits were calculated based on time savings converted into money using average GP and other Practice Staff salaries. Appointment savings based on 10 minute units. Savings from 'Making a Difference' based on 50% take up (approved by Cabinet Office) to allow leeway in calculating the effectiveness of the outcomes.
Measurement baseline	The savings have been calculated based on red tape reductions since April 04.
Measurement validation	Validation already completed with approval of the approach by Cabinet Office (part of wider government bureaucracy initiative in 2004)
Use of deflator	GDP deflator
KPI Data source	n/a
Data frequency and time lag	n/a
Scale of Benefit	Medium

Appendix 2

Measurement Templates

Procurement

Benefit (Capability)	**Procurement – National Contracts**
Benefit Type	Recyclable within front Line Organisations
How the Efficiency is Achieved	National Contracts Team negotiate reduced prices for groups of commodities in waves. NHS organisations purchase these products through PASA contracts.
Care Delivery Principle	Reduced Input Costs
Delivery Enablers	National Contracts Programme and NHS PASA
Benefit Measure (KPI)	Volume of products procured at National Contract price (by commodity)
Benefit Calculation	Volume of products (by commodity) * price reduction
Measurement Baseline	Date of price change for each commodity group– based on average of prices for previous financial year
Measurement Validation	PASA and SCEP validate sales volume returns
Use of Deflator	GDP deflator applied to second subsequent years if price fixed (i.e. zero inflation) for more than one year
KPI Data Source	SCEP Benefits Integration Tool
Data Frequency & Time Lag	Collated monthly and reported quarterly, 6-8 week time lag
Scale of Benefit	High

Benefit (Capability)	**Procurement – Collaborative Hubs**
Benefit Type	Recyclable within front Line Organisations
How the Efficiency is Achieved	Established collaborative hubs by region, negotiate reduced prices for regionally procured purchased commodities
Care Delivery Principle	Reduced Input Costs
Delivery Enablers	Collaborative Procurement Hubs
Benefit Measure (KPI)	Volume of products procured through Hubs (by commodity)
Benefit Calculation	Volume of products (by commodity) * price reduction
Measurement Baseline	Date of establishment of each Hub. Product prices based on average of prices for financial year prior to each Hub go-live
Measurement Validation	PASA and SCEP validate sales volume returns
Use of Deflator	GDP deflator applied to second subsequent years if price fixed (i.e. zero inflation) for more than one year
KPI Data Source	SCEP Benefits Integration Tool
Data Frequency & Time Lag	Collated monthly and reported quarterly, 6-8 week time lag
Scale of Benefit	High

Benefit (Capability)	**Procurement – Primary Care Branded Drugs**
Benefit Type	Recyclable to Front Line
How the Efficiency is Achieved	Agreement of 7% price reduction through Pharmaceutical Price Regulation Scheme (PPRS), prices are monitored during the year and reconciled at year end
Care Delivery Principle	Reduced Input Costs
Delivery Enablers	PPRS agreement
Benefit Measure (KPI)	Volume of branded drugs (excludes new drugs introduced after January 2005)
Benefit Calculation	Volume of branded drugs * price reduction by product
Measurement Baseline	Date of agreement (January 2005)
Measurement Validation	Purchase volumes and prices charged during year are reconciled by DH Pharmacy Group and companies are required to reduce prices if 7% saving is not secured
Use of Deflator	GDP deflator applied to second and subsequent years savings
KPI Data Source	Annual audited reconciled summary
Data Frequency & Time Lag	Annual (calendar year), five months after the year end [DN companies supply data by end of Feb, review completed in May]
Scale of Benefit	High

Benefit (Capability)	**Procurement – Primary Care Generic Drugs 1**
Benefit Type	Recyclable to Front Line
How the Efficiency is Achieved	Two phase price reduction for four high volume generic drugs
Care Delivery Principle	Reduced Input Costs
Delivery Enablers	Reduced Tariffs
Benefit Measure (KPI)	Volume of purchase of named generic drugs
Benefit Calculation	Reimbursement value of named drugs at March 2005 * price reduction
Measurement Baseline	Date of price reductions (Dec 2003 and Sept 2004)
Measurement Validation	Purchase volumes and prices charged during year are reconciled by DH Pharmacy Group
Use of Deflator	GDP deflator applied to second and subsequent years savings
KPI Data Source	FHS Dispensing data through PPA / H&SC Information Centre
Data Frequency & Time Lag	Fixed saving already captured
Scale of Benefit	High

Benefit (Capability)	**Procurement – Primary Care Generic Drugs 2**
Benefit Type	Recyclable to Front Line
How the Efficiency is Achieved	Overall price reduction for reimbursement of main categories of generic drugs agreed as part of the Community Pharmacy Contractual Framework. Annual review of Community Pharmacy Contractual Framework
Care Delivery Principle	Reduced Input Costs
Delivery Enablers	Reduced Tariffs and Pharmacy Contract
Benefit Measure (KPI)	Volume of purchase of Category A & D generic drugs
Benefit Calculation	Volume of drugs * price reduction by product
Measurement Baseline	Generic Drug Prices March 2005
Measurement Validation	Purchase volumes and prices charged during year are reconciled by DH Pharmacy Group. Prices are adjusted quarterly to ensure that agreed £300m saving is being delivered
Use of Deflator	GDP deflator applied to second and subsequent years savings
KPI Data Source	MHS Dispensing data through Prescription Pricing Authority and H&SC Information Centre Annual audited reconciled summary
Data Frequency & Time Lag	Annual Approx 2 month time lag to analyse costs and reconcile to year end contractual saving
Scale of Benefit	High

Benefit (Capability)	**Independent Sector Treatment Centres (ISTCs) Wave 1**
Benefit Type	Non Cashable
How the Efficiency is Achieved	National contracts for ISTC provision negotiated to replace local spot purchasing
Delivery Enablers	National contracts at prices lower than previous spot price
Benefit Measure (KPI)	Volume of contracts operating at national fixed prices
Benefit Calculation	Difference in cost of ISTC contracts (agreed tariff and other related costs) and the alternative cost at previous Spot Price (40%)
Measurement Baseline	2003 & 2004 Spot Price average
Measurement Validation	ISTC monitor levels of actual take up against minimum contractual volumes. Benefit valid only if minimum take up achieved.
Use of Deflator	GDP deflator if prices fixed beyond one year
KPI Data Source	ISTC Programme tracking of contract take up
Data Frequency & Time Lag	Collated monthly and reported quarterly. Four week time lag for collation
Scale of Benefit	Medium

Benefit (Capability)	**Independent Sector Treatment Centres (ISTCs) Wave 2**
Benefit Type	Non Cashable
How the Efficiency is Achieved	High volume national contracts for Independent Sector provision of specific procedures results in tariff costs below the NHS equivalent cost National contracts for ISTC provision negotiated to replace local spot purchasing
Delivery Enablers	National contracts at prices lower than NHS equivalent or previous spot price
Benefit Measure (KPI)	Volume of contracts operating at national fixed prices
Benefit Calculation	Difference in cost of ISTC contracts (agreed tariff and other related costs) and the prevailing NHS Equivalent Cost For Extended Choice only - Difference in cost of ISTC contracts (agreed tariff and other related costs) and the alternative cost at previous Spot Price (40%)
Measurement Baseline	NHS Equivalent tariffs at time of contract negotiation 2003 & 2004 Spot Price average (Extended Choice only)
Measurement Validation	ISTC monitor levels of actual take up against minimum contractual volumes. Benefit valid only if minimum take up achieved.
Use of Deflator	GDP deflator if prices fixed beyond one year
KPI Data Source	ISTC Programme tracking of contract take up
Data Frequency & Time Lag	Collated monthly and reported quarterly. Four week time lag for collation
Scale of Benefit	Medium

Appendix 3

Measurement Templates

Adult Social Care

Efficiency Benefit	**Adult Social Care**
Benefit Type	Cashable (Recycled) and Non-Cashable
How the Efficiency is Achieved	Individual Councils identifying and delivering programmes of efficiency improvements drawing on local opportunities and if appropriate regional collaboration and sharing of good practices
Delivery Enablers	Efficiency assumptions in local authority funding settlements in the period to 2008 Best practice opportunities supported and promoted by the Care Services Efficiency Delivery Programme Achieving compliance with the "Use of Resources" focus in the Audit Commission's Comprehensive Performance Assessment .
Benefit Measure (KPI)	Local Authority Annual Efficiency Statements showing aggregate savings achieved through local projects and actions. These identify separately both cashable and non cashable gains
Benefit Calculation	Specific to each individual local project in line with measurement guidelines & principles provided by Social Care Efficiency Team and Office of Deputy Prime Minister
Measurement Baseline	2003/04 PSS EX1 return and RAP data.
Measurement Validation	The Cost Weighted Activity Index (CWAI) provides local authorities with confirmation of the overall impact of their efficiency projects. Social Care Efficiency Team use the CWAI as cross check to validate benefits provided in Annual Efficiency Statements Local Authority calculation and accounting of delivered efficiencies are subject to audit and are part of the Comprehensive Performance Assessment (CPA) from 2005/06 Commission for Social Care Inspection review of efficiency initiatives and resulting benefit statements
Use of Deflator	PSS Pay & Price Index calculated by DH.
KPI Data Source	Annual Efficiency Statements submitted by councils to ODPM. PSS EX1 and RAP data submitted annually by councils to DH.
Data Frequency & Time Lag	Forward looking Annual Efficiency Statements twice a year (mid April, mid November) Backward looking Annual Efficiency Statements once a year (mid June) PSS EX1 and RAP data once a year (around August)
Scale of Benefit	High (aggregate contribution from multiple local projects)

Appendix 4

Measurement Templates

Public Funding & Regulation (PFR)

Efficiency Benefit	**Reduction in the size of DH Arms Length Bodies**
Benefit Type	Recycled to Front Line
How the Efficiency is Achieved	The savings will be achieved by: - reducing the number of ALBs from 38 to 20 and the number of staff by 25% through merger and abolition - reduced level of regulation and inspection - redesigned processes and other internal efficiencies - comprehensive shared back office services across sector
Delivery Enablers	A formalised business planning process has been set up for the ALB sector. All ALBs have to complete the following: 1. Annual Accountability Agreements – These are profiles that have to be signed by sponsors, ALBs and Business Change Managers agreeing the work of the ALB for the year. 2. Business Plans (yearly & 3 yearly) – All ALBs have to provide a clear business plan outlining their work and how all the targets of the ALB Programme will be met. 3. In-year monitoring – The ALB Team will monitor ALBs on a regular basis during the year seeing how they are doing against their targets and intervening if and when required.
Benefit Measure (KPI)	Annual Grant in Aid to ALBs Value of efficiency savings resulting in reduced payment for ALB services by the NHS (reduced NHS income to ALBs)
Benefit Calculation	The total Grant in Aid for ALBs in 2003/04 compared to 2007/08 adjusted for transition costs, inflation, transfers from the sector and exceptional costs of new policy support Organisation specific calculation of savings accruing from reduced cost of services provided to NHS for frontline services
Measurement Baseline	2003/04 ALB spend for GIA. 2005/06 costs of frontline services to the NHS.
Measurement Validation	ALB accounts will be audited
Use of Deflator	GDP
KPI Data Source	ALB Programme tracking of in year expenditure against GIA budgets Returns from ALB service providers confirming service cost savings Annual audited ALB accounts
Data Frequency & Time Lag	In year expenditure collated monthly (reported quarterly). Six weeks in arrears Fully audited annual accounts around 6 months after the year end
Scale of Benefit	High

Efficiency Benefit	**Reduction in the size of the Department of Health**
Benefit Type	Recycled to Front Line
How the Efficiency is Achieved	Reducing the number of posts in DH Reducing staffing and associated operating cost budgets
Delivery Enablers	Departmental Change Programme managing the reduction in number of posts and better ways of working Reduced operating cost budgets
Benefit Measure (KPI)	DH Admin Costs (Dept Administration Cost Limits)
Benefit Calculation	DH Admin Costs (adjusted for transfers out to other organisations) in 2007/8 compared to 2003/4
Measurement Baseline	2002/03 DH Admin costs
Measurement Validation	Figures for DH admin costs are audited each year and published in the Departmental Report
Use of Deflator	GDP
KPI Data Source	DH accounts
Data Frequency & Time Lag	In year expenditure collated monthly (reported quarterly). Six weeks in arrears Fully audited annual accounts around 6 months after the year end
Scale of Benefit	Medium

Appendix 5

Measurement Templates

Corporate Services

Efficiency Benefit	**Administration of Staff Records (ESR)**
Benefit Type	Recyclable within Front Line
How the Efficiency is Achieved	Introduction of Electronic Staff Records (ESR) system simplifies the maintenance of staff records relating to recruitment, development, absence and leaving/transfer reducing required labour input by local NHS HR teams When ESR is implemented, costs of existing HR legacy systems are eliminated
Care Delivery Principle	Staff Supported, Engaged & Rewarded Services Delivered in Most Efficient & Effective Way Reduced Input Costs
Delivery Enablers	Electronic Staff Records implemented Reconfiguration of HR Processes in local NHS Organisations
Benefit Measure (KPI)	Number of Staff administered through ESR System
Benefit Calculation	Number of Staff administered * Time Saved 8 Weighted Staff Cost *Calculation of legacy system benefits to be confirmed*
Measurement Baseline	March 2004 (zero staff on ESR at this time)
Measurement Validation	Time study analysis in early pilots/prototypes Planned case study analysis in early sites
Use of Deflator	GDP deflator applied to 2003/04 labour cost rates
KPI Data Source	ESR Programme implementation tracking
Data Frequency & Time Lag	Returns available quarterly six weeks in arrears
Scale of Benefit	Low

Efficiency Benefit	**Microsoft Contract**
Benefit Type	Recyclable within Front Line
How the Efficiency is Achieved	New NHS wide contract for Microsoft operating systems licenses reduces costs and provides additional functionality and capacity
Care Delivery Principle	Input Costs reduced
Delivery Enablers	Microsoft Contract
Benefit Measure (KPI)	Annual value of new contract savings
Benefit Calculation	Procurement business case calculation of annual savings
Measurement Baseline	Date new contract becomes operational (October 2004)
Measurement Validation	Confirmation of business case
Use of Deflator	GDP deflator applied to second and subsequent years
KPI Data Source	Microsoft Contract business case
Data Frequency & Time Lag	Not applicable – fixed saving already accruing
Scale of Benefit	Low

Efficiency Benefit	**Shared Financial Services**
Benefit Type	Recyclable within Front Line
How the Efficiency is Achieved	Multiple local NHS organisations outsource administration of finance and payroll functions to specialist large scale provider with charges less than retained in-house cost
Care Delivery Principle	Reduced Input Costs Services delivered in Most Efficient & Effective Way
Delivery Enablers	Establishment of Joint Venture (JV) provider (Xansa) Local NHS organisations contract to Xansa
Benefit Measure (KPI)	Summary of Savings in Xansa Benefits model)
Benefit Calculation	Sum of: ▪ Organisation specific operating cost saving (in-house vs Xansa) ▪ Profit dividend accruable from the JV to DH ▪ Savings accruing from EWA license for Oracle
Measurement Baseline	March 2005 (first organisations contracted to Xansa)
Measurement Validation	Savings are calculated and agreed with each organisation before they sign up to the JV Xansa accounts are auditable
Use of Deflator	GDP deflator applied to calculated savings after first year
KPI Data Source	Xansa benefit tracking model
Data Frequency & Time Lag	Quarterly two months in arrears
Scale of Benefit	Low

Efficiency Benefit	**Increased use of E - Recruitment**
Benefit Type	Non Recyclable - Time releasing
How the Efficiency is Achieved	Labour costs are reduced through faster, more efficient and effective electronic recruitment arrangements. The service increases HR team efficiency in administering recruitment campaigns and for front line recruiting managers. Efficiency is also delivered through shorter times to fill meaning departments are more likely to be fully staffed.
Care Delivery Principle	Services delivered, and input costs managed, in the most efficient and effective way possible
Delivery Enablers	Increased use of www.jobs.nhs.uk to recruit staff
Benefit Measure (KPI)	Anticipated savings from reduced recruitment advertising and administrative costs
Benefit Calculation	No. of posts recruited to by e-rec multiplied by difference in costs between “conventional” admin/advertising costs and admin/advertising costs of using e-rec
Financial Assumptions	Estimate of average £240 savings per post filled by e-rec (2003/4 prices)
Measurement Baseline	March 2004. No of posts filled by e-rec.
Measurement Validation	Based on assumptions outlined in business case approved by DH E-rec Board. To be updated based on more extensive study
Use of Deflator	GDP deflator
KPI Data Source	SHA returns via NHS Employers
Data Frequency & Time Lag	Available 6 monthly.
Scale of Benefit	Low

Appendix 6

Measurement Templates

Central Budgets

Benefit (Capability)	**Reduction in Central Programmes**
Benefit Type	Recycled to Front Line
How the Efficiency is Achieved	Ceasing funding for central programmes not required to meet NHS objectives Reducing the number of DH central budgets and reallocating to front line services
Delivery Enablers	Review of central budgets carried out by DH Confirmation that reducing or eliminating these budgets will not impact on NHS objectives or other measures of service quality
Benefit Measure (KPI)	Reduction in central programme budget spend from 2005/06 to 2006/07
Benefit Calculation	Total value of central budgets ceasing from end of 2005/06
Measurement Baseline	2004/5 central budget programme
Measurement Validation	OGC confirmation that reductions do not have impact on NHS objectives or front line service quality
Use of Deflator	GDP deflator after 2006/07
KPI Data Source	DH central budget programme
Data Frequency & Time Lag	Final confirmation in March 2006
Scale of Benefit	High