AGENDA ITEM 7

EAST OF ENGLAND STRATEGIC HEALTH AUTHORITY

PUBLIC BOARD MEETING / 14 SEPTEMBER 2006 / FOR DISCUSSION

Scope for Cost Savings

Report of Dr Paul Watson, Director of Commissioning

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1 PURPOSE

1.1 East of England SHA is operating in an environment of great financial challenge and needs to identify rapidly areas of spend where resources could be released.

1.2 This paper is to inform the Board of three major areas where there is unnecessary expenditure at present, and where commissioner-based savings could be made without impacting on the quality of clinical care provided to patients:-

- Converting the majority of patients currently prescribed a non generic statin to the generic Simvastatin
- Reducing the ratio of outpatient follow ups to first outpatient attendance
- Reducing length of stay for patients of 65 and over with non elective admissions, thus reducing excess bed day charges under PbR

1.3 It also gives details of how the SHA will be working with commissioners to implement action plans to achieve specific targets associated with each of the three areas.

2 STATINS PRESCRIPTION

2.1 The patent for Simvastatin has now expired, and it is now available as a generic version. It is the cheapest available statin for the NHS. Its clinical efficacy has been shown to fulfil the requirements of national guidance, in terms of reducing cholesterol and impact on LDL and HDL levels. This section of the paper considers the potential cost savings in respect of patients who are currently taking a statin.

2.2 There are still considerable volumes of non generic statins prescribed. Pravastatin is available generically and is relatively inexpensive, but the non generic statins, Atorvastatin, Fluvastatin and Rosuvastatin are considerably more expensive. Figure 1 below shows the current ratio of prescription across the three old SHA areas, and the average cost for each of the non generics and generics. It should be noted that there is considerable variance in the price paid by each PCT for drugs. For the last quarter of 2005/06, cost per

prescription at PCT level ranges from £2.54 to £5.75 for Simvastatin and £19.08 to £45.83 for Atorvastatin. This suggests that there is considerable scope for more effective prescribing arrangements.

Figure 1 Ratio and average cost of generic and non generic statins. Current statins prescriptions

Area	% Simva	Av cost Simva	% Atorva	Av cost Atorva	% Fluva	Av cost Fluva	% Prava	Av cost Prava	% Rosuva	Av cost Rosuva
B&H	53	£3.39	38	£28.20	1	£17.06	5	£3.83	3	£26.91
Essex	43	£3.38	41	£27.45	1	£17.60	12	£5.14	3	£24.20
NSC	49	£3.60	34	£24.52	1	£14.20	8	£5.27	7	£19.22

Data source – PPA – Quarter 4 2005/06

Achieving cost savings

2.3 As will be seen from Figure 1 above, there are very substantial differences in the price of drugs and still significant volumes of patients on non generics, despite the higher price. There is no good clinical reason why the majority of patients currently taking non generics should not be treated with Simvastatin. It will not be possible to achieve total 100% Simvastatin prescribing rates as some patients cannot tolerate it, there are some for whom it is clinically contra-indicated, and some patients where the necessary levels of lipid control cannot be achieved with Simvastatin.

2.4 Some PCTs across the country have managed to achieve switch of non generics to generics, to the extent that 80% of their patients on statins are now being prescribed the generic Simvastatin. Therefore, 80% is a reasonable target, for which EoE SHA should aim.

2.5 The expected financial savings from achieving Simvastatin prescriptions as 80% of all prescriptions are shown in figure 2 below.

2.6 In view of the size of task involved, especially for PCTs and GP practices, the conversion could be phased by concentrating initially on patients taking Atorvastatin, then the other expensive non generics, Fluvastatin and Rosuvastatin. Pravastatin patients can be left until last, in view of the relatively low cost of Pravastatin.

Figure 2 Expected financial savings if 80% of prescriptions are for Simvastatin – by the 3 old SHA areas. Current statins prescriptions

Area	Savings
B&H	£6.1M
Essex	£8.5M
NSC	£9.2M
Total for EoE	**£23.8M**

Effecting the change

2.7 Statins prescriptions are generated by both secondary and primary care physicians. The reasons for wanting to convert current patients to Simvastatin, and for 'new' patients to be prescribed Simvastatin rather than one of the non generics, will need to be properly communicated. This will require the preparation of clinically validated action plans for effecting the change, but also explanation for clinicians of the reasons of the need for change. It is also essential that there is clear communication to patients of the reasons for change.

2.8 PCTs will need to draw up project plans to ensure that they have made the necessary agreements with secondary and primary care. There will need to be arrangements put in place for checking full lipid profiles 1-3 months after the change of drug. The follow up paper to this will contain more details on the mechanics of effecting the change.

Cost implications of increasing the numbers of patients who are prescribed a statin

2.9 There is a national requirement for GP practices to implement and manage registers for the primary prevention of cardiovascular disease, which will include identification of patients with raised cholesterol levels, who should be prescribed a statin.

2.10 The financial impact and affordability of these additional prescriptions has not yet been calculated, but it is clear that emphasis must be placed on prescribing Simvastatin, where clinically appropriate, to these patients from the outset.

3 OUTPATIENT FOLLOW-UPS

3.1 Many patients attend for one or more follow-ups subsequent to their first outpatient appointment or after discharge from hospital, which incur PbR charges. Comparison with national upper quartile and decile ratios of follow-ups to first outpatient attendance shows that there is considerable scope for cost savings, as shown in Figure 3 below, if outpatient follow-ups are reduced to the level of the best quartile or decile. This will also help to free up additional clinic slots, which may enable sufficient capacity to meet reduced waiting times without the need for new clinics.

Figure 3 estimated savings if follow ups reduced to best quartile/decile

Area	Savings if top quartile F/U rates achieved	Savings if top decile F/U rates achieved
Beds & Herts	£8.7M	£12.0M
Essex	£12.8M	£17.7M
NSC	£15.8M	£22.0M
EoE Total	**£37.3M**	**£51.7M**

Data source – national benchmarking for top quartile/decile. Follow ups 2005/06

Are follow-ups clinically appropriate?

3.2 The reasons why so many patients are having one or more follow-ups have not yet been explored, and although some of these will be clinically appropriate, significant numbers are not clinically necessary. However, even for those that are clinically appropriate, less expensive follow-ups would be possible in a primary or community care setting for many patients.

Actions required to reduce the number of Outpatient Follow Ups

3.3 Commissioners need to set clearly defined parameters for the ratio of follow ups to first appointments, for example for major surgery, minor surgery and chronic conditions - and set maximum caps within SLAs with acute providers. The ratio stated within these caps should be at, or close to, the follow up ratio for the top national quartile, and in subsequent years, progress should be made towards top national decile. It needs to be recognised that some organisations in EoE are already at top decile level for some HRGs.

3.4 Particular attention should be paid to 'follow ups to follow ups'. SLAs should clearly stipulate agreed pathways for each specialty, agreed ratio of follow ups to first outpatient attendance and performance management arrangements.

3.5 For patients with chronic conditions, their treatment plan should be reviewed at their next routine follow up, and then they should be discharged to the care of their GP, unless there is a treatment plan in place and agreed by the consultant.

4 EXCESS BED DAYS

4.1 PbR for non elective admissions was introduced for all acute Trusts in April 2006. The impact of excess costs for patients who exceed trim points under PbR is considerable. It will not be feasible to release all these costs, as some patients may not be medically fit for discharge by the trimpoint. Also, the PbR tariff guidance states that if delayed discharge fines have been imposed on local authorities, that PCTs should not be liable for any further outlier payments.

4.2 However, as can be seen from figure 4 below, the estimated non elective excess bed day charges, for patients of 65 and over, for 2006/07 are very significant, across each of the three old SHA areas. 2006/07 tariff prices were used.

Commissioner monitoring of length of stays

4.3 The reasons for patients staying over trim points are complex and variable. For example, for some HRGs where excess bed day charges amount to over 10% of total PbR costs, these additional costs are incurred because of just one patient. For others, there is a greater proportion of patients staying over the trimpoint. There does not appear to be a direct correlation between high

volume (in terms of admissions) HRGs and high excess bed day costs. Commissioners will need to undertake work such as identifying the reasons for long stay patients, how care pathways need to be implemented, speeding processes (diagnostics, therapies etc) within hospital, and consultant teams that have long stays out of proportion to other teams covering the same specialty.

4.4 Even if only 25% of these excess bed days charges could be avoided, the savings would still be highly worthwhile. Commissioners should implement some simple initiatives immediately. These should include senior staff from PCTs visiting wards weekly to review plans for patients staying over 28 days, and the commissioners making/chasing necessary arrangements to expedite discharge.

4.5 Family choice appears to be a major reason for delays in discharge, and thus clear protocols about where a patient should expect to be discharged to, and when, need to be communicated to both patients/families and staff. It is probable that many of these protocols will need to be re-written.

Figure 4 Estimated excess bed day charges non elective admissions 2006/07, 65+

Area	Excess Bed Day charges	% of total PbR cost	Total PbR cost non elective 65+	Total spells	25% saving
Beds & Herts	£12.5M	10%	£122.1M	47512	£3.1M
Essex	£19.1M	12%	£159.1M	58963	£4.8 M
NSC	£22.6M	10%	£222M	83310	£5.6M
EoE Total	£54.2M	11%	£503.2M	189785	£13.5M

Data source – B&H and NSC, Dr Foster derived data April 2005 to March 2006
Essex, ClearNET data January to December 2005

4.6 There are two other major areas of work around PbR costs that should be undertaken in the short term:

Zero day length of stay patients

4.7 Approximately 20% of emergency admission patients of all ages across all 3 of the old SHAs, have stays of 24 hours or less. Whilst this means that most of them will incur a lower, short stay tariff than full PbR cost, this high volume of patients who can be discharged within 24 hours suggests that many will have had admissions that were not clinically required. The potential cost savings available from avoiding some of these admissions will be a highly contributory factor to work that needs to be undertaken around utilisation management and carrying out diagnosis before a decision to admit rather than post admission.

3-5 day length of stay patients

4.8 Examination of the reasons patients stay between 3 and 5 days should also be undertaken by commissioners. These patients will incur full tariff, but it should be clinically possible to reduce the length of stay for many so that they have <2 day LOS and thus short stay tariff. Clinical advice indicates that conditions which may be particularly amenable to this are:

- Kidney and urinary tract infections
- Medical abdomens
- Chest pain
- Heart failure

5 ACTION PLANS TO ACHIEVE SAVINGS

5.1 These three areas of statins prescription, outpatient follow ups and excess bed days have the potential to bring about very substantial commissioner-based cost savings for East of England. Figure 5 summarises the total potential savings that would be available, if all the savings could be released. Capacity would also be freed up to enable delivery of key targets and objectives e.g. 18 week wait. Even partial release of these savings would pay significant dividends. As 2006/07 is well advanced, only part of these savings will be achievable by the end of this financial year and there are also requirements for some changes to SLAs between commissioners and providers, that may not be be effected until the early months of 2007/08..

Figure 5 total potential commissioner-based savings

Beds & Herts	Essex	NSC	EoE Total
£31M	£45M	£54M	**£130M**

5.2 Figure 6 shows the savings in respect of statins and excess bed days at individual PCT level. Figure 7 shows outpatient follow up savings. Although outpatient follow up savings are commissioner-based, the outpatient follow up data is held at provider level. These savings do not include any in respect of outpatient follow ups from providers outside EoE.

Figure 6 Statins savings, if converted to 80% generic, and excess bed day cost savings (non electives 65 and over), at individual PCT level

PCT	Current statins spend	Saving on 80% generic	Current excess bed day charges	% of PbR spend non elective 65+	Savings if 25% reduction	Savings if 50% reduction	Savings if 75% reduction
South West Essex	£4.2M	£2.0M	£6.7M	18%	£1.7M	£3.4M	£5.1M
South East Essex	£3.5M	£1.6M	£3.9M	11%	£1.0M	£2.0M	£2.9M
Mid Essex	£3.3M	£1.7M	£2.1M	7%	£0.5M	£1.0M	£1.5M
West Essex	£3.2M	£1.7M	£3.2M	13%	£0.8M	£1.6M	£2.4M
North East Essex	£3.1M	£1.5M	£3.1M	9%	£0.8M	£1.6M	£2.4M
West Herts	£3.8M	£1.2M	£4.0M	10%	£1.0M	£2.0M	£3.0M
East & North Herts	£4.1M	£1.4M	£5.1M	13%	£1.3M	£2.6M	£3.8M
Luton	£2.1M	£1.2M	£1.1M	8%	£0.3M	£0.5M	£0.8M
Bedfordshire	£4.2M	£2.2M	£2.3M	8%	£0.6M	£1.2M	£1.7M
Gt Yarmouth & Waveney	£1.8M	£0.5M	£1.8M	7%	£0.5M	£0.9M	£1.4M
Suffolk	£6.4M	£2.8M	£8.2M	14%	£2.1M	£4.1M	£6.2M
Norfolk	£7.1M	£3.0M	£5.6M	7%	£1.4M	£2.8M	£4.2M
Cambridgeshire*	£4.1M	£1.6M	£5.2M	11%	£1.3M	£2.6M	£3.9M
Peterborough*	£2.3M	£1.2M	£1.7M	11%	£0.4M	£0.8M	£1.3M
Total EoE	**£53.3M**	**£23.8M**	**£54.2M**	**11%**	**£13.5M**	**£27.1M**	**£40.6M**

***** boundaries of new PCTs not coterminous with old PCTs, but no adjustment to figures made in this respect

Figure 7 Outpatient follow up commissioner-based cost savings, analysed at provider level

Provider	Savings to commissioners if top quartile achieved	Savings to commissioners if top decile achieved
Southend	£2.8M	£4.0M
Basildon & Thurrock	£3.5M	£4.4M
Essex Rivers	£1.4M	£2.3M
Mid Essex	£3.6M	£4.8M
Princess Alexandra	£1.6M	£2.3M
Bedford	£2.0M	£2.8M
Luton & Dunstable	£0.2M	£0.7M
West Herts	£2.0M	£2.8M
East & North Herts	£4.5M	£5.8M
King's Lynn & Wisbech	£1.0M	£1.7M
Papworth	£0.4M	£0.5M
Peterborough	£2.4M	£3.5M
James Paget	£2.3M	£3.1M
Ipswich	£1.5M	£2.5M
West Suffolk	£1.2M	£1.7M
Cambridge	£2.1M	£3.2M
Norfolk & Norwich	£4.2M	£5.1M
Hinchingbroke	£0.6M	£0.7M
Total EoE	**£37.3M**	**£51.7M**

Implementing action plans and targets for savings

5.3 The SHA will be giving commissioners detailed guidance on how to draw up action plans to achieve savings in each of the three areas, together with model protocols etc. This guidance will include specific targets and timescales for achievement. Commissioners will be required to submit their proposed action plans to the SHA for sign off. The key targets are set out below:

5.4 **Statins** - guidance to be issued September 2006
Commissioners to achieve generic simvastatin prescription of 80% of total statins prescriptions. This target is to be achieved by 31 March 2007. .

5.5 **Outpatient follow ups** – guidance to be issued September 2006
Commissioners will be required to achieve outpatient follow up rates of no more than the top quartile nationally by 30 September 2007, and no more than the top decile nationally by 31 March 2008. This will allow time for any necessary adjustments to SLAs/contracts between commissioners and providers.

Excess Bed Days

5.6 Identifying the multi-faceted reasons that contribute to patients exceeding trim points under PbR will be the subject of a dedicated project, to be carried out over the next two to three months. Detailed guidance to commissioners will be issued at the conclusion of the project.

5.7 There are also major opportunities for cost savings in respect of provider costs. Initial estimates suggest that £10 million across EoE could be saved by reducing pre-operative length of stay and increasing day case surgery rates. There will therefore be further guidance to providers on releasing costs.

6 RECOMMENDATION

6.1 The Board is asked to discuss the issues set out in this paper.

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31 August 2006