Meeting the new waiting list challenge

Options for increasing capacity and reducing costs

Introduction

In this summary paper we set out the key points from our research into options for NHS Trusts to meet the new waiting list challenge.

What do we mean by 'The new waiting list challenge'?

Well, firstly we would summarise the old waiting list challenge as making impressive reductions in waiting times against a backdrop of significant year on year spending increases. As you can see from the chart below 80% fewer people wait longer than 18 weeks compared to two years ago.

The new challenge will be to maintain the current waiting list performance against a backdrop of a freeze in budgets.

This is a significant challenge for three reasons. Firstly, it is difficult for any organisation to improve or maintain performance when budgets are effectively falling in real terms.

"The new challenge will be to maintain the current waiting list performance against a backdrop of cuts in real spending."

Secondly, we believe volumes will continue to grow at somewhere around 4% per annum. Thirdly, the cost of meeting peaks in waiting lists is relatively high.

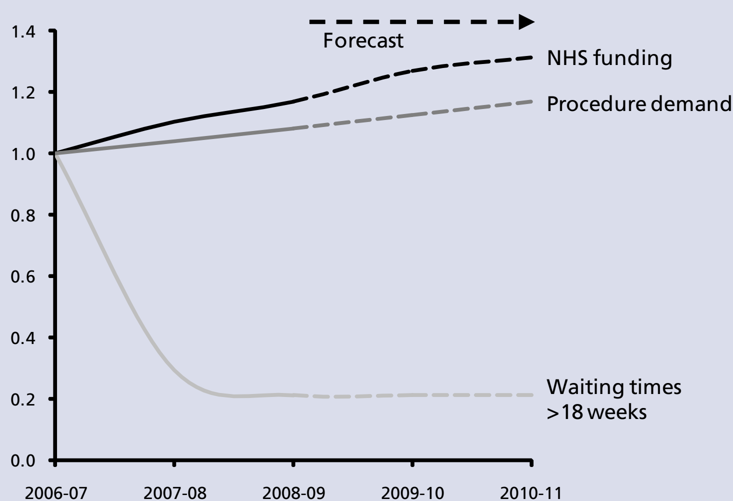
The chart below sets out the challenge in terms of budgets, waiting list times and procedure demand.

In this note we compare the three main options for adding incremental capacity and the extent to which they could reduce costs. Those options are: subcontract to an external supplier; extend in-hospital theatre hours; incorporate flexible capacity on-site.

We also set out some more radical options to meet this challenge on the final page of this paper. These options deserve greater analysis than they receive in our research, but needless to say they all require quite radical changes to the way that hospitals operate.

Spending, demand and waiting lists

Historic and forecast data for NHS funding, procedure demand and waiting time performance against the 18 week target is rebased to one for comparison



Source: Budget 2009, HES Online, Credo analysis

- Historic spending has been around 6% per annum in real terms for the last 10 years
- Spending is set to slow over the next two years, and thereafter to go flat in real terms
- Procedure demand set to continue at historic levels of 4% per annum for the foreseeable future
- Waiting list times have improved dramatically and the target is expected to remain at today's levels
- Cumulatively these factors will exert material pressure on NHS operations and finances

Options for increasing capacity to meet waiting list demand

Options	Sub-contract to external supplier	Extend hospital operating hours	Incorporate flexible on site capacity
Cost Reduction Levers	Improve contract terms Offer block contracts	Increase theatre utilisation Use overtime shifts	Improve contract terms Improve patient pathway
Financial	✓ • No fixed cost • Potential to save vs. tariff	✓ • No fixed cost • Higher variable cost	✓ • Incremental fixed cost • Potential to save vs. tariff
Cost Reduction Feasibility	✗ • External supplier resistance to contracts below tariff	? • Organisational challenge	✓ • Opportunities if well managed
Strategic Alignment/ Sustainability	✗ • Little control over care pathway	✓ • Maintain control • Not sustainable long term at current staffing levels	✓✓ • Maintain control • Flexible
Patient Experience	? • Cost - quality trade off • Supplier specific	✗ • Potential ‘end of day’ effect	✓ • Overall, positive feedback
Operational Continuity	✓✓ • Zero or minimal impact	✓ • Good if shifts managed effectively	✓ • Maintain care pathway, minimal logistics issues
Staff	✓ • All external	? • Resistance to after hours shifts • Working Time Directive	✓ • Extra shifts are within normal operating hours • Can use external staff
Assessment Summary	Effective tactical option Limited control of care pathway Cost-quality trade off?	Strategically the best option Control care pathway Organisational challenge often underestimated	Strategically good solution Control care pathway Potentially best opportunities for cost reduction

Choosing between options

NHS trusts have three broad options for managing waiting list demand peaks.

These options are:
- Subcontracting to external suppliers
- Extending hospital operating hours
- Incorporating flexible on-site capacity

In our tables we compare these options against a set of six key criteria and the results are set out on the summary table opposite. So what is the answer? Well to some extent it is a case of 'horses for courses', and none of the options are a panacea.

Sub-contracting provides an effective, tactical option that is quick to turn on and off. It is difficult to monitor quality and the cost of failure has proved high where contracts have underperformed.

Extending in-house theatre hours uses fixed assets effectively, and has the advantage of being a fully in-house solution. However, trusts report cost and operational issues in adding after hours shifts.

Using on-site capacity allows Trusts to retain control of the patient pathway and experience. It also offers the potential to be the lowest cost option if set up and managed effectively.

You will also see below we have shown the extended comparison table for the financial criterion. This reveals some interesting results, especially against the challenge of reducing the cost of any of the three options.

We do not believe there is much room to negotiate below tariff deals with suppliers. The main reason for this is that, although private suppliers gain some benefit from offsetting their fixed costs, they pay their consultants by the procedure, typically at or near private consulting rates.

Similarly, for those NHS Trusts that have experimented with extended in-house theatre hours, the incremental costs and organisational challenges of providing after hours support and consultants are typically greater in practice than envisaged.

For the final option, using temporary on-site capacity, the fixed and variable cost economics work the other way around.

There is a cost for the incremental theatre capacity. However, on the variable cost side, because the capacity is used during normal working hours, there are opportunities for cost savings versus the other options.

Overall, this option could operate below tariff if properly managed.

Focus on the financial criteria

Options	Sub-contract to external supplier	Extend hospital operating hours	Incorporate flexible on site capacity
Surplus	Potential if: • Below tariff rates • Low contract admin costs	Potential if: • Extra variable costs do not outweigh fixed cost benefit	Potential if: • Fixed costs below tariff • Variable cost benefit
Fixed costs *(mostly theatre capacity cost)*	• All in price	• Marginal cost negligible	• Marginal cost at or below tariff
Variable costs *(mostly nurses, doctors, portering, phsyio, etc.)*	• All in price	• Marginal cost high due to higher remuneration for overtime	• Marginal cost at or below tariff
Cost of failure *(depends on service quality)*	• Can be high	• Quality may decrease due to extended working hours	• No change from hospital average
Indicator	✓ • No fixed cost • Potential to save vs. tariff	✓ • No fixed cost • Higher variable cost	✓ • Incremental fixed cost • Potential to save vs. tariff

Looking at more radical options

Hospital portfolio restructure

Description
Redirect demand to efficient hospitals by closing or downsizing inefficient hospitals. This will increase the incentive for hospitals to become more efficient and also ensure more procedures are performed at higher efficiency

Our view
A large scale restructure of the NHS with high implementation costs and severe repercussions politically

Centres of excellence

Description
Create centres of excellence where hospitals will begin to specialise in particular treatments and/or operations.

Hospitals can then ensure efficient asset utilisation for their chosen speciality. This would be particularly effective for procedures which either have high fixed costs associated or are rarely performed.

Our view
Requires significant planning to ensure all procedures are accessible by the whole population

Likely to require high investment to create centres of excellence and may create redundant personnel or equipment at neighbouring hospitals

Pathway redesign

Description
Re-engineer the care pathway to improve asset utilisation and create extra capacity within existing assets

Our view
This requires significant resources for planning, trialling and testing solutions and is very difficult to perform in a live environment without negatively effecting operations

Flexible on site capacity could be used as a test bed for new systems to eliminate the detrimental effects of tests

The core assessment criteria

Financial
What are the financial implications and cost reduction opportunities

Feasibility
How feasible is it to implement the option and achieve cost reduction

Strategic alignment/ sustainability
How will the solution align with national strategy for healthcare and is it a sustainable strategy

Patient experience
How will the solution affect the experience of patients during and after it is implemented

Operational continuity
How will the solution impact the current day to day operations and service delivery

Staff
How will this solution effect staff and are the required staff available to achieve the objective

Small Print

Sources: HM Treasury, Budget 2009 and Public Expenditure Outturn Update, 2009; Headline Data, HES Online, 1999-2007; Further Doubts Over the Performance of Treatment Centres in Providing Elective Orthopaedic Surgery, Journal of Bone and Joint Surgery; Comprehensive Spending Review 2007; Department of Health publications; NHS institute for innovation and improvement publications; Office for National statistics; The King's Fund publications; Credo industry interviews, Credo analysis

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