HSD59

How the NHS can Optimise Health Outcomes in a Time of Financial Constraint

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Introduction

- Over the past two decades, the National Health System (NHS) England aimed to shift healthcare delivery from hospitals to local services. However, the Darzi Report revealed a significant rise in acute hospital expenditure alongside stagnation or reduction in community and primary care funding.[1]
- The NHS faced growing efficiency challenges, higher demand for services, and reduced return on investment (ROI).
- This study analyses NHS productivity trends and evaluates population health strategies conducive to sustainable healthcare delivery

Objectives

To measure NHS productivity potential, unmet chronic condition needs, prevention ROI, and key factors for implementation.

Method

- Data from NHS acute sector, NHS England reports, and UK parliament submissions estimated productivity and prevention ROI using spend, activity, and workforce data.
- Healthcare resource savings were analysed by comparing similar populations and by assessing risk reduction through clinical guideline adherence and addressing disease causes.
- This analysis was based on CF HealthStrata© Population Health Intelligence that allows clinical stratification analyses of multimorbidity clusters with complete population visibility across NHS England.

Results

- Over the past decade, productivity in the acute sector has dropped by 10-14% since 2013/14 (Figure 1A). Since 2018/19, the productivity loss amounts to £17-18 billion (Figure 1B).
- The decline in productivity was measured from its initial drop in 2018/19, finding a reduction of 17-18%, whether measured by weighted activity unit per nurse, doctor or per pound spent (Figure 1B).
- Optimising treatment may reduce HCRU costs and mortality across cardiovascular-renal-metabolic (CVRM) conditions and dementia, with potential gross savings between £870 million to £4.8 billion in each of the five conditions (Figure 2B).
- Redirecting the current mandated prevention spend (~£5 billion per year) to higher-performing interventions could yield an additional £11 billion in value (Figure 3).
- Capturing these gains will require targeted investment in diagnostics, prescribing, and community-based care, especially in primary care and pharmacy services.

Conclusion

Realising the potential of £12-18 billion in acute productivity gains, £3.4-5.0 billion from reducing variation in chronic disease management, and £6.1-9.2 billion by addressing care gaps could collectively unlock £15-27 billion in opportunities to improve resource utilisation within the acute care sector alone.

To capitalise on these opportunities, the NHS should enhance clinical workforce productivity, prioritise early patient interventions, standardise care protocols to close gaps, and invest wisely in prevention, backed by data, funding, evidence, evaluation, and regulation.

Figure 1. Changed in indexed acute productivity[2]

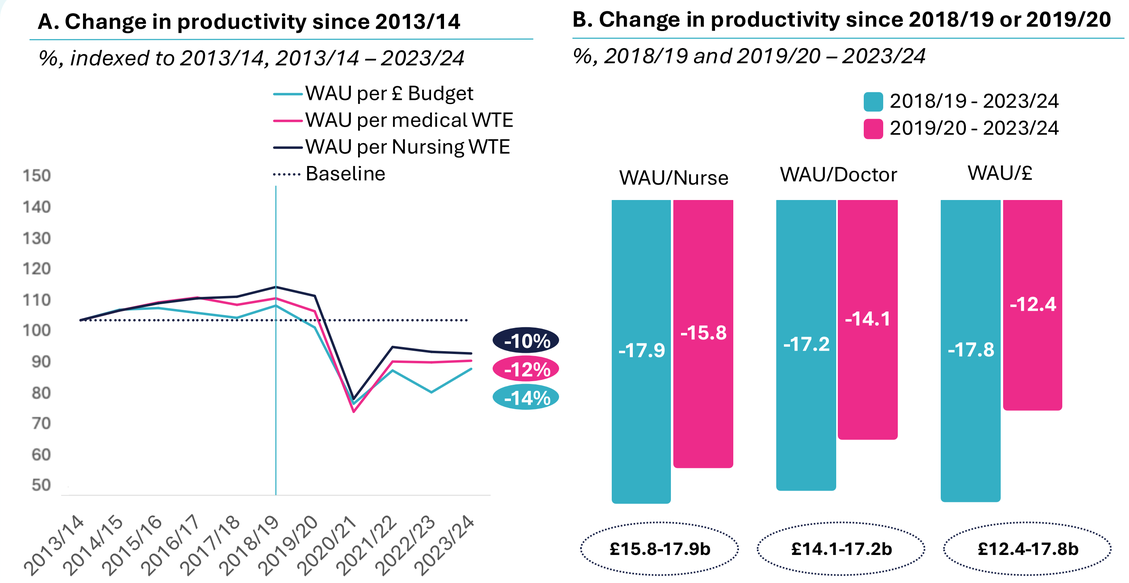


Figure 2. HCRU savings from treatment optimisation[3]

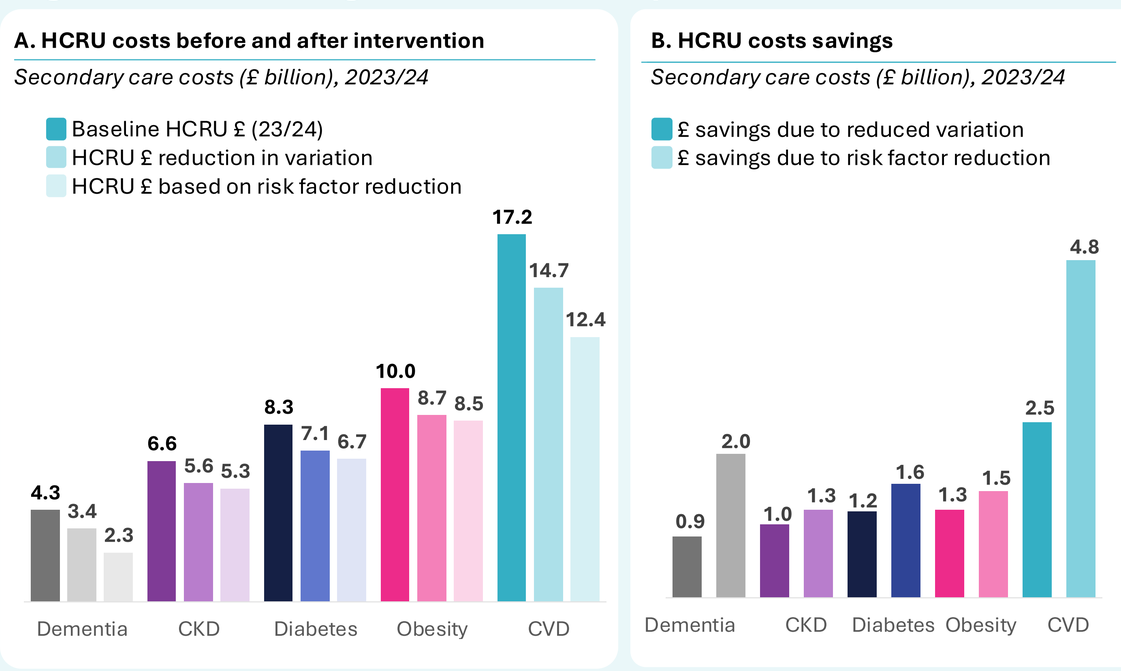
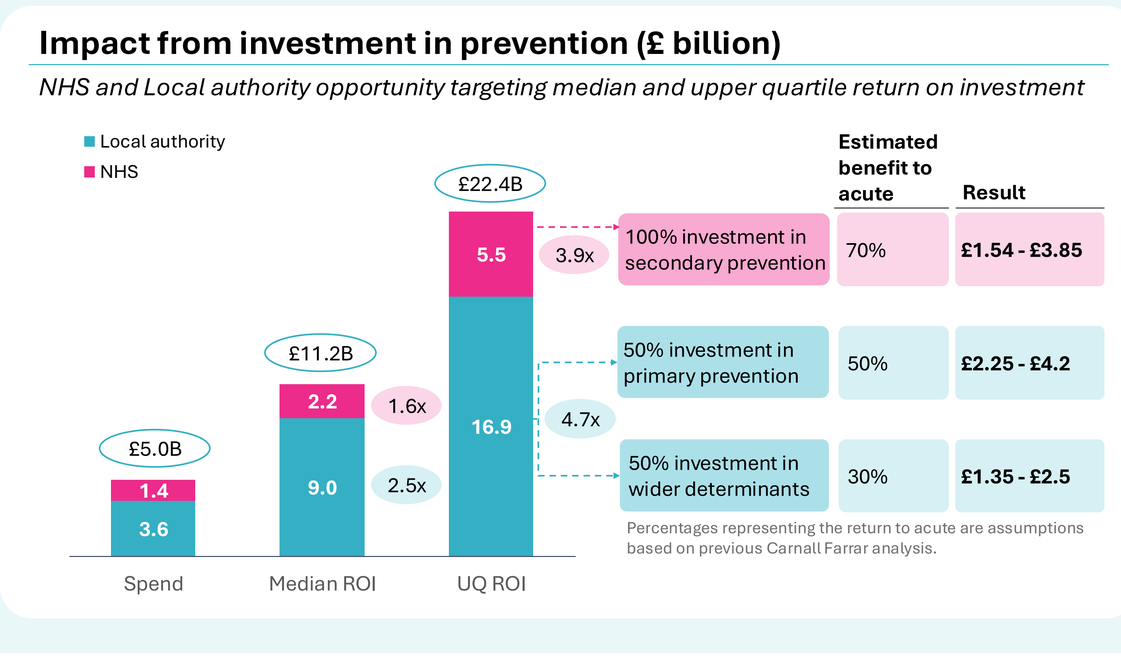


Figure 3. Prevention return on investment (ROI)[4]



***Abbreviations**: CKD, chronic kidney disease; CVD, cardiovascular disease, FTE, full-time equivalent; UQ, uncertainty quantification; WAU, weekly activity unit; WTE, whole-time equivalent*

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Experts in health

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4) CF Analysis; DHSC; NHS Confederation; King's Fund