Non Medical Prescribing

Dr Harald Braun

25th April 2017
OUR MISSION

Provide a data based report on the economic effects

in Primary and Secondary Care of NMP.
Overview

Changes in Service Provision per CCG in England

56% Community
21% Acute
16% GP Practice
3% Mental Health
4% Others

NMP to support GPs will reduce A&E Attendance

£271.5m Annual reduction in Acute cost

£1m

Non-Medical Prescribing

Overview

Economic Impact

£777.2m

44,629 Practitioners

Impact on Long Term Conditions

HEALTH ECONOMY

Changes in Service Provision per CCG in England
“More and better research into NMP is needed...”

“Available literature is too scarce and too unreliable to make an impact within health services...”

“Evidence base for NMP needs to increase...”

From April 2013, up to 20,000 nurses and midwives who are qualified as independent prescribers will be able to prescribe controlled drugs where it is clinically appropriate and within their professional competence. Changes to the Misuse of Drugs Regulations 2001 Act means that appropriately qualified nurses will be able to prescribe controlled drugs, such as morphine, diamorphine and prescription strength codeine.

This means that nurses will also be able to mix a controlled drug with another medicine for patients who need the drugs to be administered intravenously. The Government has introduced these changes because it hopes that this will improve care treatment, especially for those who need urgent pain relief in Acute and palliative care settings.

Nurses will also be able to supply or administer morphine and diamorphine under patient group directions for urgent treatment of very sick or critically ill groups of patients.

These changes have been long awaited by nurses, who feel that once nurse prescribing was introduced, and despite objections from the medical profession, it has been demonstrated that nurse-led prescribing can be safe and cost-effective.

Chief Nursing Officer, Professor Donna Chris Bradley said: “These changes will help deliver faster and more effective care, making it easier for patients to get the medicines they need, without compromising safety. Enabling appropriately qualified nurses and midwives to prescribe and mix controlled drugs they are competent to use, for example, in palliative care, completes the changes made over recent years to ensure we make the best use of these highly trained professionals’ skills, for the benefit of patients,” she added.

Only nurses, pharmacists and midwives who have the correct experience, and who have successfully completed additional post-registration training will be able to prescribe controlled drugs. This means that prescribing will only be carried out by appropriately trained health professionals working within their professional competence.

Most prescriptions for controlled drugs will be in the context and on the instruction of a patient’s doctor or the health professional prescriber. Those patients...
ENABLERS

✓ FASTER ACCESS
✓ APPOINTMENT PREVENTION
✓ REDUCE NUMBER OF CLINICIANS INVOLVED
✓ REDUCE LENGTH OF STAY
✓ REDUCE EMERGENCY ADMISSIONS
✓ IMPROVE SERVICE EFFICIENCY
✓ IMPROVE PATIENT SAFETY
✓ AVOID COMPLICATIONS
✓ IMPROVE DRUG ADHERENCE
✓ REDUCE DRUG WASTAGE
✓ REDUCE SIDE EFFECTS
✓ REDUCE ABSENTEEISM
BARRIERS

✓ CONFIDENCE
✓ CONCERN OVER SAFETY
✓ EDUCATION
✓ COLLABORATION
✓ DOCTORS AND MANAGERS
3 ROUTES TO THE REPORT

ROUTE 1:
WORK OF OTHERS

ROUTE 2:
PERSONAL AND
GROUP INTERVIEWS

ROUTE 3:
DATA ANALYSIS
MODELLING
1.1 Summary of Key Points

- Between 2% and 3% of both the nursing and pharmacist workforce is independent.
- 95% of nurse prescribers and 80% of pharmacist prescriber qualifications are relevant. 86% of the nurses and 71% of the pharmacists are nurses and pharmacists prescribers predominantly in secondary care settings.
- Study results indicate that overall, nurse and pharmacist prescribers would agree.
- The study findings indicate that current educational programs for prescribers are operating largely satisfactorily, and provide evidence that non-steroidal inflammatory prescribing has been largely independent, and
- has been used to increase the quality of existing services.
- Only about half of the trusts reported a strategy or written plan for prescribing.
- Key clinical governance and risk management strategies for the majority of trusts.
- Acceptability of independent prescribing to patients is high reporting that they were very satisfied with their visit to the pharmacist.
- When comparing care provided by their nurse or pharmacist, 70% of patients in this study did not report a shared care strategy for independent prescribing.
- Results indicate that non-steroidal inflammatory prescribing was generally acceptable and that nurse practitioners were engaged in the implementation of prescribing after training has taken place (Brown et al., 2005). A key aim of this study is to examine the barriers to prescribing, and to suggest potential ways to overcome them.

Abstract

There are many obstacles in implementing nurse prescribing for nurses who undergo the initial training required in order to prescribe. This article outlines some of these obstacles and suggests ways around them so they are not unreasonable.

Method

Until 1994, nurses were explicitly prohibited from prescribing. As part of the implementation of the Nursing and Midwifery Order, a new prescription, the nurse practitioner, was introduced in 1996, allowing independent prescribing in England. A number of independent nurse practitioners have been independent from 2001, and more recently, the number of independent nurse practitioners in England has continued to increase.

Discussion

Barriers to nurse prescribing

The impediments to undertaking training to become a nurse practitioner can be examined under two main headings: those that are internal to the potential prescriber and those associated with external factors. Internal factors

Methodology

Route 1 - Work of Others

Evaluation of nurse and pharmacist independent prescribing

Breaking down the barriers to nurse prescribing

James Blanchflower, Leah Greene, and Christine

The next step for independent nurse prescribers

From April 2012, up to 20,000 nurses and midwives who are qualified as independent prescribers will be able to prescribe controlled drugs, where it is clinically appropriate and within their professional competence.

Changes to the Misuse of Drugs Act 2001 mean that appropriately qualified nurses will be able to prescribe controlled drugs, such as morphine, diazepam, and prescription strength of codeine.

This means that nurses will also be able to access a controlled drug with another medicine for patients who need the drug to be administered intravenously.

The Government has introduced these changes because it hopes that this will ensure safer treatment, especially for those who need urgent pain relief in A&E and palliative care settings.

Nurses will also be able to supply or administer morphine and diazepam under patient group directions for urgent treatment of very sick or critically ill patients.

This will make it easier for patients to receive the medicines they need, without compromising safety.

Training appropriately qualified nurses and pharmacists to prescribe new controlled drugs will be delayed until April 2015.

The Government has introduced these changes because it hopes that this will ensure safer treatment, especially for those who need urgent pain relief in A&E and palliative care settings.

Nurses will also be able to supply or administer morphine and diazepam under patient group directions for urgent treatment of very sick or critically ill patients.

This will make it easier for patients to receive the medicines they need, without compromising safety.

Chief Nursing Officer, Professor Dame Donna Baverstock, said: “These changes will help, deliver faster and more effective care, making it easier for patients to get the medicines they need, without compromising safety.”
ROUTE 2 - PERSONAL AND GROUP INTERVIEWS

KEY QUESTIONS (1)
- What is the cost of NMP?
- How many GP visits did NMP prevent?
- How many hospital bed days did NMP save?
- How many consultant visits did NMP save?
- Does NMP show faster access to care?
- Does NMP...?
- Do NMPs...?
- Do care eg profession...?
- Do NMP...?
- Do NMPs...?
- Do NMPs help...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?
- Do NMPs...?

KEY QUESTIONS (2)
- What level of NMPs are prescribing after qualification?
- Do NMP medication reviews improve medication regimes?
- Do NMP medication reviews improve concordance/adherence?
- Do NMP medication reviews identify side effects?
- Do NMPs follow recommended prescribing patterns?
- Do NMPs follow recommended consultation procedures?
- Do NMPs...?
- Do NMPs...?

KEY QUESTIONS (3)
- Where NMP is in use could it be extended, eg increasing referrals, and what results would that achieve (cost, time, satisfaction)?
- How many NMPs currently active and localities?
- Level of NMP activity for NMPs?
- Do GPs report an improvement in their practice from use of NMPs?
- Do NMPs improve access to care for groups that have trouble/are not accessing healthcare?
- Does access to NMP training improve skill levels of health professionals?
- NMPs reduce the number of GP home visits required?
- Can efficiency of NMP be increased?
ROUTE 3 - DATA ANALYSIS AND MODELLING

**Methodology**

**Evaluate Local Impact**
- Calculate reporting levels in NW Clinicians Audit
- Allow for reporting bias
- Calculate savings achieved locally

**Evaluate National Impact**
- Based on National Population Statistics
- Based on Regional NMP numbers

**Potential at current staff levels**
- Potential levels of NMP saving
- Based on activity levels moving to those of the top quartile
- NMP in GP Practice

**Activity and Cost Prevention**
- Prevention using NW Clinicians Audit
- Prevention using National Figures

**Current Impact**

**Further Opportunities**
**Introduction to the Commissioning Suite**

**CLINICIANS AUDIT**

- **AUDIT**

**MEDICATION REVIEWS**

- Excess dose of a drug identified
- Appropriate medicines regimen identified
- Inappropriate regimen identified
- Decreased risk of drug interaction
- Patient was not taking some or all of their prescribed medicines
- Inappropriate repeat prescriptions
- Sub therapeutic dose of a drug identified
- Identified delayed access to medicine

**PRESCRIBER TYPE**

- Independent/Supplementary
  - 22%
  - 4%
  - 74%

- Community Practitioner Nurse Prescriber
  - 9%
  - 3%
  - 88%

- Supplementary
NHS DATABASES

Evaluate National Impact

Introduction to the Commissioning Suite

NHS DATABASES

- PROMS
- OOH
- NHS Patient Safety
- ODS/ONS Demographics
- CIUPP/RUP initiatives
- HES
- SUS
- QOF
- ePACT.net
- NMP
- Monthly Workforce Statistics

Key Features:
- Organization Location and Codes
- Patient Scoring
- Registered clinicians
- NMP Impact on QIPP targets
- TMD
- Podiatry
- Oncology
- Nurse led services
- Community
- A&E and NMP Impact on Outpatient NMB
- Near Real Time
- Reduced prescribing cost by GP
- BNF
- Nurse Codes and Location
- Number of items prescribed
- NMP Registration CCG/GP
- Diploma Formulary
- Correlate to Hospital Stay
- Non Prescribing Nurses
- High/Low Secondary Care Provider
- Time of Qualification
- Nurse to Consultant Ratio

Data Analysis:
- Disease Groups
- List Size
- Links to Primary Care
- Medicine Review points
- Clinically used
- Slots freed for GP
- Up to date Prescribing
- Community Prescribing
- LOS by Speciality
- Lost Delayed Discharge
- QC/CTE variables by procedure/most frequent

Healthcare Insights:
- Delayed Discharge
- LOS by Speciality
- Clinical Effectiveness
- Nurse-led initiatives
- QIPP targets

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Economic Impact Results

1,566 NMPs in secondary care the NW delivered over £32.8m of efficiencies in a year

Assuming the same activity profile, 44,629 NMPs in England deliver £777m in a year

### Economic Impact Results

<table>
<thead>
<tr>
<th>NMP Type</th>
<th>Count</th>
<th>Month’s Value</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacists</td>
<td>58</td>
<td>£ 63,713</td>
<td>£ 1,099</td>
</tr>
<tr>
<td>Nursing</td>
<td>1,491</td>
<td>£ 2,531,725</td>
<td>£ 1,698</td>
</tr>
<tr>
<td>Health Visitor/ School Nurse</td>
<td>196</td>
<td>£ 40,072</td>
<td>£ 204</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>34</td>
<td>£ 35,964</td>
<td>£ 1,058</td>
</tr>
<tr>
<td>Podiatry</td>
<td>41</td>
<td>£ 34,899</td>
<td>£ 851</td>
</tr>
<tr>
<td>Midwifery</td>
<td>7</td>
<td>£ 8,289</td>
<td>£ 1,184</td>
</tr>
<tr>
<td>Radiography</td>
<td>3</td>
<td>£ 18,258</td>
<td>£ 6,086</td>
</tr>
<tr>
<td>1 Month Cost Prevention</td>
<td>1,830</td>
<td>£ 2,732,920</td>
<td>£ 1,493</td>
</tr>
<tr>
<td>12 Month Cost Prevention</td>
<td>1,830</td>
<td>£ 32,795,044</td>
<td>£ 17,921</td>
</tr>
</tbody>
</table>

* 1,830 includes double counting where participants hold multiple roles; 1,566 unique participants

### NMP Setting

<table>
<thead>
<tr>
<th>NMP Setting</th>
<th>Count</th>
<th>Month’s Value</th>
<th>Monthly Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>9,674</td>
<td>£29,288,818</td>
<td>£3,028</td>
</tr>
<tr>
<td>GP Practice</td>
<td>7,184</td>
<td>£6,812,286</td>
<td>£948</td>
</tr>
<tr>
<td>Community</td>
<td>25,394</td>
<td>£27,348,272</td>
<td>£1,077</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1,347</td>
<td>£1,077,637</td>
<td>£800</td>
</tr>
<tr>
<td>Social Care</td>
<td>449</td>
<td>£103,280</td>
<td>£230</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>380</td>
<td>£118,251</td>
<td>£311</td>
</tr>
<tr>
<td>Voluntary Sector</td>
<td>201</td>
<td>£19,787</td>
<td>£98</td>
</tr>
<tr>
<td>1 Month Cost Prevention</td>
<td>44,629</td>
<td>£64,768,331</td>
<td>£1,451</td>
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<tr>
<td>12 Month Cost Prevention</td>
<td>44,629</td>
<td>£777,219,972</td>
<td>£17,415</td>
</tr>
</tbody>
</table>

* 1,830 includes double counting where participants hold multiple roles; 1,566 unique participants
Economic Impact Results

NMP in Primary Care

Impact on Secondary Care £298m

Impact on Primary Care £114m

NMP in Secondary Care

Impact on Primary Care £59m

Impact on Secondary Care £306m

Secondary Care

Primary Care
Further Opportunities

- Opportunities in Primary Care – Changes in Workforce
- Opportunities in the Health Economy e.g. further utilisation of NMP
Reduction of Secondary Care Use - Diabetes

- The worst performing practices with no NMP have higher A&E, NEL and readmission rates than practices with NMPs.
- If practices in the upper quartile (25%) with no NMP could achieve activity rates of well performing practices with 1 NMP, efficiencies of over £15m could be achieved.

<table>
<thead>
<tr>
<th>Diabetes LTC</th>
<th>A&amp;E</th>
<th>NEL</th>
<th>Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity avoidance per 1,000 patients (2.15 - 1.13), (0.92 - 0.48), (0.51 - 0.32)</td>
<td>1.69</td>
<td>1.01</td>
<td>0.4</td>
</tr>
<tr>
<td>Patients in Upper quartile (25% of 0 NMP 1,026 practices)</td>
<td>8,655,375</td>
<td>5,284,389</td>
<td>5,284,389</td>
</tr>
<tr>
<td>Annualised number of patients activities avoided</td>
<td>14,628</td>
<td>5,337</td>
<td>2,114</td>
</tr>
<tr>
<td>Average cost of activity</td>
<td>£118.23</td>
<td>£1,710.26</td>
<td>£2,060.72</td>
</tr>
<tr>
<td>Annualised reduction in Cost</td>
<td>£1,729,395</td>
<td>£9,128,038</td>
<td>£4,355,865</td>
</tr>
</tbody>
</table>
Reduction of Secondary Care Use – All Major LTCs

<table>
<thead>
<tr>
<th>LTC</th>
<th>AE Potential Saving</th>
<th>NEL Potential Saving</th>
<th>Readmission Potential Saving</th>
<th>Total Potential Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>£2,760,723</td>
<td>£19,692,569</td>
<td>£9,435,724</td>
<td>£31,889,016</td>
</tr>
<tr>
<td>Cancer</td>
<td>£2,993,974</td>
<td>£21,493,133</td>
<td>£5,161,619</td>
<td>£29,648,726</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>£2,988,553</td>
<td>£14,752,637</td>
<td>£7,605,387</td>
<td>£25,346,577</td>
</tr>
<tr>
<td>Hypertension</td>
<td>£4,076,113</td>
<td>£14,151,351</td>
<td>£5,470,538</td>
<td>£23,698,002</td>
</tr>
<tr>
<td>Asthma</td>
<td>£4,762,567</td>
<td>£12,237,207</td>
<td>£4,043,122</td>
<td>£21,042,896</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>£2,366,762</td>
<td>£13,728,745</td>
<td>£4,771,906</td>
<td>£20,867,413</td>
</tr>
<tr>
<td>Stroke</td>
<td>£2,838,558</td>
<td>£11,952,897</td>
<td>£3,794,615</td>
<td>£18,586,070</td>
</tr>
<tr>
<td>Diabetes</td>
<td>£1,729,395</td>
<td>£9,128,038</td>
<td>£4,355,865</td>
<td>£15,213,298</td>
</tr>
<tr>
<td>Back Pain</td>
<td>£1,453,877</td>
<td>£7,373,126</td>
<td>£4,880,646</td>
<td>£13,707,649</td>
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<tr>
<td>Parkinson</td>
<td>£483,029</td>
<td>£10,644,046</td>
<td>£2,448,371</td>
<td>£13,575,446</td>
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<tr>
<td>Heart Failure</td>
<td>£1,248,018</td>
<td>£7,399,085</td>
<td>£4,250,785</td>
<td>£12,897,888</td>
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<tr>
<td>Dementia</td>
<td>£979,028</td>
<td>£7,668,429</td>
<td>£3,165,244</td>
<td>£11,812,701</td>
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<tr>
<td>Epilepsy</td>
<td>£1,468,083</td>
<td>£6,214,055</td>
<td>£2,441,180</td>
<td>£10,123,318</td>
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<tr>
<td>COPD</td>
<td>£1,546,221</td>
<td>£4,672,278</td>
<td>£2,348,616</td>
<td>£8,567,115</td>
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<tr>
<td>Rheumatoid Arthritis</td>
<td>£931,633</td>
<td>£6,022,665</td>
<td>£1,331,591</td>
<td>£8,285,889</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>£425,557</td>
<td>£3,767,697</td>
<td>£2,103,178</td>
<td>£6,296,432</td>
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<tr>
<td>Total</td>
<td>£33,052,091</td>
<td>£170,897,958</td>
<td>£67,608,387</td>
<td>£274,558,436</td>
</tr>
</tbody>
</table>

- The model assumes that all practices with the highest attendance and admission rates with no NMP are moved into the upper quartile (25%) of the best preforming practices.
- If this “best case scenario” can be achieved, primary care could see a saving of over £270m by upskilling approx. 3,000 nurses out of the 23,066 GP practice nurses (13%)
- More senior nurses may move from band 7 to band 8A at an extra monthly cost of £10k, totalling to £10m extra cost + £7m training
- The maximum annual net saving is approximately £233m per year not taking into account additional prescribing costs
Introduction to the Commissioning Suite

- NMP Potential to meet the needs of patient groups
- NMP Potential to manage long-term conditions
- NMP Potential to manage co-morbidities / complex medication regimes
# Opportunities in the Health Economy

## Reduction of Secondary Care Use – Locally Delivered Initiatives

<table>
<thead>
<tr>
<th>Commissioning Opportunity</th>
<th>Initiative</th>
<th>Outcomes</th>
<th>Assumption</th>
<th>Reference</th>
<th>Fin Year</th>
<th>Age</th>
<th>Current Spend</th>
<th>Av Cost</th>
<th>Opportunity</th>
<th>Avg Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEL Admission Reduction</td>
<td>A&amp;E Stroke</td>
<td>NEL Admission reduction</td>
<td>Patients with LOS 0 and 1 can avoid being admitted</td>
<td><a href="http://tinyurl.com/nfduevy">http://tinyurl.com/nfduevy</a></td>
<td>2012/13</td>
<td>2</td>
<td>£3,155</td>
<td>£1,798</td>
<td>0</td>
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<td>2013/14</td>
<td>21,759</td>
<td>£1,159,700</td>
<td>£553</td>
<td>3,490</td>
<td>£292,539</td>
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<td>2014/15</td>
<td>8,217</td>
<td>£3,535,249</td>
<td>£79</td>
<td>1,055</td>
<td>£96,291</td>
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<td></td>
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<td></td>
<td>Total</td>
<td>52,236</td>
<td>£2,452,384</td>
<td>£640</td>
<td>8,185</td>
<td>£272,124</td>
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<td>Capacity</td>
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<td>52,236</td>
<td>£2,452,384</td>
<td>£640</td>
<td>8,185</td>
<td>£272,124</td>
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<td>GP Extended Hours</td>
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<td>Use of NMP in Care homes</td>
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<tr>
<td>ACS Ear, nose and throat infections</td>
<td>NEL Admission Reduction</td>
<td>Patients with 5 LOS can avoid being admitted</td>
<td></td>
<td><a href="http://tinyurl.com/nc3xy2">http://tinyurl.com/nc3xy2</a></td>
<td><a href="http://tinyurl.com/pcmcbf">http://tinyurl.com/pcmcbf</a></td>
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<td>360</td>
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<td>915</td>
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<td>ACS-Coronary and aortas, and aorto-iliac</td>
<td>NEL Admission Reduction</td>
<td>Patients with 5 LOS can avoid being admitted</td>
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<td><a href="http://tinyurl.com/nc3xy2">http://tinyurl.com/nc3xy2</a></td>
<td><a href="http://tinyurl.com/pcmcbf">http://tinyurl.com/pcmcbf</a></td>
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Introduction to the Commissioning Suite

Health Economy Impact Modelling

Overall, six service areas were evaluated for the economic impact of introducing additional NMP practitioners:

1) NMP in Care Homes
2) NMP Pharmacist
3) NMP in OOH Practices
4) NMP Palliative care
5) NMP Physiotherapist services
6) NMP Podiatry services

NMP in Care Homes

NMP Pharmacist

NMP in OOH Practices
Three Areas of Impact

**NATIONAL**
- £777 Million
- Currently achieved by 44k NMP Practitioners in various settings

**PRIMARY CARE**
- £271 Million
- By adding one NMP Practitioner to key GP Practices

**HEALTH ECONOMY**
- Up to £1m
- Changes in Service Provision per CCG in England

Analysis in respect of LTCs and the addition of just one NMP practitioner into certain GP surgeries indicate value contributions of circa £271m that can be obtained annually. A more focused use, encouraged by commissioners, of the NMP initiative in a variety of health circumstances can have significant positive effects on both patients care and finances. In respect of the latter, values of up to £1m for out of hospital care per CCG in England are obtainable.

Include NMP in Services can save up to £1m per CCG

Include NMP in Practices can save up to £271m

Already, NMP contributes £777m to the NHS budget
**The Challenge**
Excellent material, results and forecasts **BUT** limited absorption by decision makers

**The Answer**
National campaign to embed NMP within multiple pathways and across wider areas of England

**Scope of Promotion**
The ultimate targets of the campaign are the decision makers/decision formers within and outside the NHS ranging from those in government, through pathway designers or managers in the NHS to practice managers

**Targets**
- National Government
- Parliament
- NHS England
- CCGs, CSUs, Acute
- Public Health England
- Interest Groups

**Media Routes**
- Journals e.g. HSJ, BMJ, SAGE
- National Press (Health Correspondents)
- Local Press
- Broadcast Media

**Conferences Route**
Core group of speakers created and each allocated to specific conferences
Introduction to the Commissioning Suite