



HEART OF THE NEW NHS

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**HOW ELITE
COMMISSIONING
SUPPORT UNITS
CAN SHAPE
TRANSFORMATION**

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Winter pressures risk pushing NHS hospital trusts into crisis. Now some are looking at partnering with the independent sector, commissioning outside providers to take some of the strain in the busiest times. Page 8

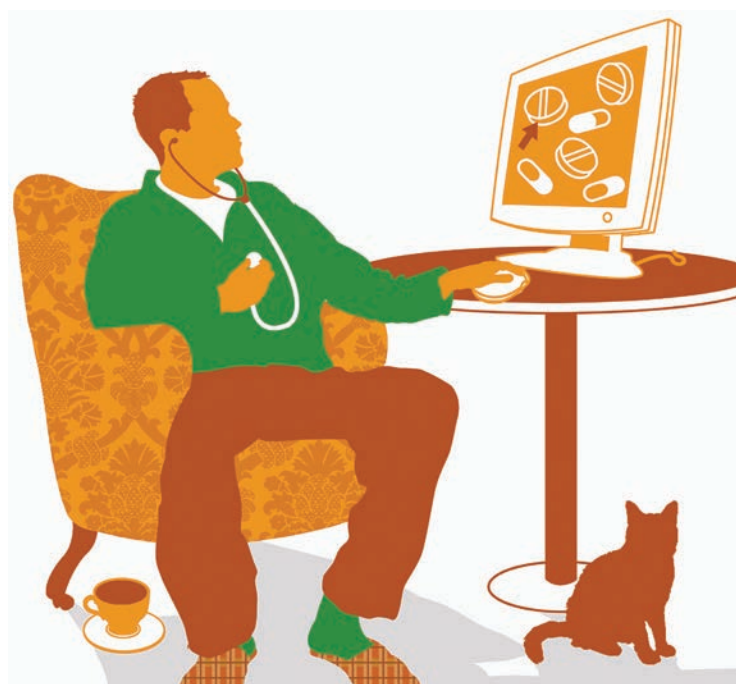
TRANSFORMATION

Commissioning support units are going through big changes. Just six CSUs have been placed on the new commissioning support regime marked out – along with various independent sector bidders – for their ability to deliver the best services. Leading CSUs believe they must play a vital role in developing new commissioning models and in helping to foster relationships across their local health economies. Page 2

HEALTH INEQUALITIES



New data analysis offers the opportunity to uncover groups under served or neglected by the NHS. A recent piece of work has highlighted increasing inequality in hepatitis C, with deprived groups having the highest levels of prevalence but lowest levels of access to treatment. Such insights may encourage commissioners to go out into local communities to identify patients proactively and push for more equitable access to the best treatments. Page 6





“ Over the past few years, commissioning support units in England have been on a journey which has seen them evolve into market leaders. They've implemented many changes, developing skills along the way. Now they are in a very strong position to deliver specialist services, not just for clinical commissioning groups but also for other clients in both the public and private sector. They are adding value on a national level, delivering services at scale, and the nature of their work is very diverse. Their journey has been considerable and there have been many changes along the way. In 2013, there were 23 CSUs and, once the current planned mergers are in place, there will be six on the lead provider framework (LPF). The process for inclusion on the LPF has seen some CSUs fall and some merge to create stronger and more efficient organisations. Those which are now on the LPF can be seen as a “best in class” standard. Independent evaluation has shown these CSUs are on a par with the best that industry and the NHS have to offer.

‘In 2013, there were 23 CSUs. There will be six on the lead provider framework’

They sit alongside private organisations which have also made it onto the framework. All have challenges ahead. They are now in a competitive market, and they need to strive to make their services best value. They will need to develop further skills. But we are confident they can continue to provide a breadth of innovative commissioning support services which not only deliver value for money but have a real impact on improving health and health outcomes. CSUs have helped clinical commissioning groups achieve substantial savings and improve services, as the examples on the following pages show. They've worked with patients to ensure services are tailored to local need, have delivered innovative IT solutions, and have made a real difference to the quality of services being delivered. They are contributing to the future of the NHS and to the NHS England vision. The future is bright for CSUs and their clients. The LPF provides real opportunities for innovation and fruitful partnerships. CSUs will continue to draw upon their unique skill sets from the public sector, private sector and NHS. They are marketing strong portfolios of which they should be rightly proud. Andrew Kenworthy is director of CSU transition programme, NHS England. www.england.nhs.uk

TRANSFORMATION

SUPPORTING CHANCE

Those picked to lead the new era of commissioning support have a golden opportunity to move beyond backroom work and show how they can facilitate new models of care. By Jennifer Trueland

Early in 2014 when Somerset Clinical Commissioning Group was exploring plans to centralise stroke services, closure of one unit was very much on the table. A service review had assumed that stopping stroke services at Yeovil Hospital would offer clinical benefits, and provide the best service possible within available resources. But when the CCG turned to the Geographical Information System team at South West Commissioning Support Unit, these assumptions were turned on their head. Following a sophisticated mapping process looking at time and travel implications, it was discovered that the clinical benefits of closing Yeovil were smaller than had been expected and that added travel times could have an impact on stroke treatment. The evidence was clear, and the CCG decided to retain the unit. According to Trevor Foster, GIS and primary care manager with South West CSU, the specialist mapping service is beginning to attract attention across the NHS and beyond. “The good thing about being part of the CSU is that people are becoming more aware of the service we can offer. This technology can make a real difference to patients and add value for commissioners.” South West CSU (which will merge on 1 April with South CSU and Central Southern CSU) was among the commissioning support units to win a place on NHS England’s commissioning support lead provider framework. Following a rigorous procurement process and a number of mergers, six CSUs and various independent sector bidders were selected for their ability to deliver the best support services to CCGs and other commissioners. It’s been quite a journey for CSUs since they started two years ago, says Andrew Kenworthy, director of CSU transition

programme at NHS England. “They’ve been through many changes and many new skills have been learned along the way. The lead provider framework is ensuring that CCGs have real choice over quality assured providers.” The changing landscape around CSUs – not least the rationalisation – means that they have a great deal to offer, in terms of specialisation (such as the mapping example above) and in providing services at scale, says Mr Kenworthy. He points to the value that CSUs are adding at a national level, for example, by looking at waiting lists and waiting times – and “cleaning” them up so that only those who should be on the lists are there. Another national project has involved work to ensure that when a patient gets a diagnosis of dementia in one part of the health service, that information is shared across all parts of the system, which should ensure that the patient gets better co-ordinated care. **Rise to the challenge** He acknowledges that the challenges are far from over for CSUs, which like the rest of the commissioning world are having to up their game by developing new skills and expertise in areas such as outcomes-based commissioning. But he believes the framework will help. “The framework is about making sure that CCGs have a choice over quality accredited providers,” he says. “Yes, CSUs will have to compete for business, but those on the framework can show that they are ‘best in class’ standard.” Nick Relph, managing director of South East CSU, says the launch of the framework is an exciting time and brings real opportunities. “It’s as if we have a licence to operate,” he says. “It shows we can provide excellent support. I would hope that CCGs



Team builders: CSUs can foster collaboration between organisations on their patch

would see we have a deep passion for the NHS, and the knowledge and commitment to work towards realising the vision in the Five Year Forward View.”

He believes that CSUs have an important role to play in supporting CCGs in developing new commissioning models, but also in helping to foster relationships across the local health economy. His own background – former roles include chief executive at a primary care trust and strategic health authority – has given him a good overview of the challenges faced by different parts of the system, and he believes that CSUs are ideally placed to foster the “disruptive innovation” that is part of improvement.

Beyond boundaries

Across the country, each CSU can point to examples of where they are adding value, with some initiatives reaching well beyond what might be seen as their natural geographical boundaries.

For example, North of England CSU is aiming to grow sales of its innovative

business intelligence tool RAIDR.

RAIDR (Reporting Analysis and Intelligence Delivering Results) has been praised for turning data into usable information, and has been taken up by more than a fifth of GP practices across the country.

Similarly, Arden and Greater East Midlands CSU has been attracting national interest in its new integrated model of care, Discharge to Assess, which aims to improve planned discharges for older people unable to return home unsupported.

The successful CSUs can also highlight where they are adding value in bringing together the various players across a local

‘CSUs can highlight where they add value in bringing together various players across a local health economy’

health economy. For example, Midlands and Lancashire CSU has delivered collaborative modelling exercises to help commissioners and providers reach a shared view about likely future acute sector capacity requirements.

Keith Douglas, managing director of South CSU, believes that CSUs are evolving, as are relationships with commissioners. “At the start I think the relationship was more transactional – CSUs were there to provide backroom services at scale. But over the last year we’ve been involved in more transformation and project work.

“At first, it was CCGs asking us to provide a service, but now they are seeking our advice.”

The unique position of the CSU as an “insider-outsider” NHS organisation brings huge insight and benefits, says Mr Douglas, a former radiographer and NHS manager. “I’ve always spoken of my personal need to understand the benefits that our work brings to patients,” he says. “I’m proud of what we’ve achieved so far and excited about what’s to come.” ●

TRANSFORMATION: CASE STUDIES

POINT AND CLICK

How CSUs are adding value – including an app that points people to the right service for their needs

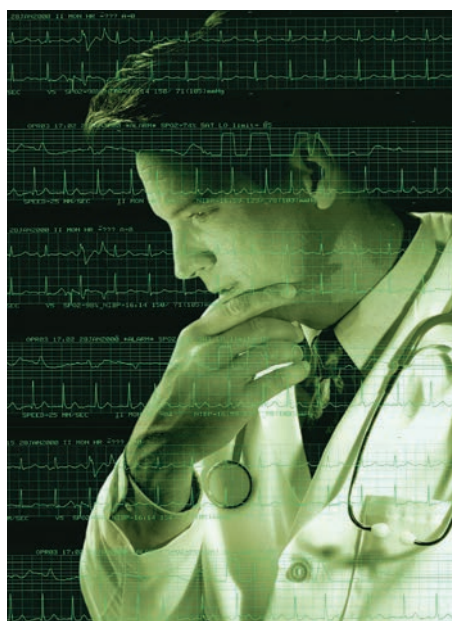
HEALTH HELP NOW

It's estimated that between 15 and 25 per cent of people who present at A&E just shouldn't be there, but go because they simply don't know where to turn.

Lack of awareness of local services, including practical things like when they are open, is contributing to the well documented problems facing our emergency departments, with a knock-on impact throughout healthcare systems.

Step in Health Help Now. An app and website, specifically designed for a local health economy in Kent, it helps people find the right services to meet their needs, particularly when they aren't sure what to do or who to contact.

Health Help Now was developed by South



Health Help Now eased pressure on A&E medics

East Commissioning Support Unit in partnership with local clinicians in Kent and Medway, explains Emma Burns, principal associate – communications with the CSU.

"I attend local urgent care boards and the problems facing A&E would come up time and time again," she says. "There had been various attempts to provide information to people on where they should go when they were looking for help, but they hadn't worked. For example, when a leaflet was produced, it was found to be too complicated.

"So we decided to develop a digital solution – something that would be easy to use but which would have a lot of information."

Despite being a self-confessed "non-techie", Ms Burns helped to drive the creation of the app and website, which launched in December 2013.

In a sense, she says, the solution unites bits of the old NHS Direct app, which many found too complex, and local Choose Well apps, which contain information about local health services.

What makes Health Help Now stand out is that people can choose from a list of common symptoms and will then be signposted to appropriate local services. Advice is tailored to different age groups (ie baby, child, young adult, adult and older adult) and it gives detailed information on the nearest services across Kent and Medway, including whether they are open or closed, directions and a map.

It was publicised initially in north Kent and in its first six months, the local Darent Valley Hospital noted a significant drop in numbers of people attending A&E who did not go on to have investigations or significant treatment.

The website can be accessed from smartphones, tablets, desktop computers and laptops and in its first 14 months, had more than 42,000 hits from more than 28,000 users. Each session involved looking at an



average of five pages and lasted two and a half minutes.

Although the bulk of users fell in the age category of 25-44, some 12 per cent of users were aged 65 and over.

In December 2014, an app was launched and in its first two months, there were almost 1,400 sessions, and around 700 users.

"Feedback has been really positive and we've had interest from CCGs in other areas," she says. "It's a great example where the CSU, working with local clinicians, is really adding value for patients, and for the health service."

OUTCOMES-BASED COMMISSIONING IN NORTH AND EAST LONDON

Redesigning mental health services for children and young people in London's East End was always going to be complex, not least because of historical fragmentation.

Tower Hamlets CCG realised that a new approach was needed, and approached North



Home help: Health Help Now had more than 28,000 users in its first 14 months

and East London (NEL) CSU for support.

“It was a really exciting project because it involved values-based and outcomes-based commissioning,” explains Laura Churchill, associate director of delivery improvement with the CSU. “We hadn’t done it before, but nobody else had done it either, so we were learning alongside our client, which was a great and really positive experience.”

Getting to the heart of what service users wanted and needed from services was key, and the CSU engaged service users to help define the outcomes and values which would be at the heart of the commissioning process.

“We worked with the charity Young Minds which helped us find out what was important to children, young people and their families,” she says. “I feel that really added value to the project.”

Over three months, the project team held six listening events with more than 50 children, young people and their parents. It also held several workshops with

stakeholders, to co-produce draft outcomes. This will form the basis of a new contract, delivering a more patient-centred service based on what children and young people have said is important to them.

Richard Fradgley, director of mental health and joint commissioning with Tower Hamlets CCG, is very positive about involvement with the CSU.

“We chose to work with NEL CSU’s delivery improvement and transformational change (DITC) team for the delivery of this project because they know us and our organisation really well, and are familiar with our current contractual arrangements,” he says. “They have provided a structured approach to the development of outcomes relating to this important service that builds on well-known theories and methodologies.

“Also, they have learned alongside us how to innovatively build outcomes into contractual agreements with our providers. The DITC have supported us in engaging with a really broad range of stakeholders, including patients and their families, and have provided an independent and impartial view in facilitating these discussions.”

The CSU is also supporting development of a new values-based commissioning framework. This will form the basis of future

‘We have developed a proven methodology for outcome-based commissioning that encourages innovation’

pathways for older people with frailty and people living with psychosis or diabetes.

Having a basic framework to build on will save commissioners time and money, but the real benefit of outcomes-based commissioning is the ability to commission services that patients really need and that will help them lead healthier lives.

Tony Hoolaghan, NEL CSU director of DITC, comments: “Our services are bespoke for each organisation and their specific needs, but because we have developed a proven methodology for outcome-based commissioning that encourages innovation, our customers benefit from significant savings in budget and time.”

The size of the CSU means that clients can benefit from learning from elsewhere across the region, says Ms Churchill. “Often we are part of the glue that binds a project together,” she says. “CCGs are small, so not only can we offer capacity and expertise in things like contracting, but working with several CCGs on different projects means we can share knowledge and understanding of problems and good practice.”

REHABILITATION SERVICES IN THE SOUTH WEST

Commissioners in the south west of England drew on expertise from the local CSU to improve rehabilitation services across three CCG and local authority areas.

The aim was to review current services in Bristol, North Somerset and South Gloucestershire and agree new models of care to make more effective use of therapy time and achieve a more joined-up approach to services.

Bringing in extra capacity and expertise at different stages of the project was crucial, as was providing support to ensure that everyone was signed up to a common goal.

And that’s where South West CSU came in. According to project manager Elizabeth Williams, the CSU was able to add value in a number of ways, not least in terms of flexibility.

“What we have within the CSU is specialist skills, for example in project management,” she says. “So we can provide that capacity. With a dedicated project manager, you have someone who has the time, and the energy, to work across stakeholders.

“But we also have contracting expertise, which means that when projects reach the stage of having to draw up contracts we can provide that capacity too.

“With access to the CSU, [customers] can bring in different people at different stages, which is a really flexible way to building capacity.”

In addition, she says, as an organisation which is not aligned to any one of the commissioners, providers or other stakeholders, the CSU team has the ability to act as an honest broker.

“In this project we weren’t looking for a one size fits all solution, because we realised that different areas would have different needs,” she says. “But we did work very hard to align the services as closely as possible. There was a very strong feeling, particularly from providers, that it was a big help that they only had to go to one set of meetings, and we tried to come up with systems and models that would work across all three CCG areas.”

Contracting experts

Contracting expertise was crucial, she adds. “It was important that more money was invested in services in the community, but this had to be done without destabilising secondary care,” she says.

Key to the whole process was getting good buy-in, right at the start, and keeping all stakeholders, including patients and the public, informed at all stages.

“Time invested at the beginning saves much more time later,” she says. “Establishing shared purpose helps drive the process and sustain momentum.” ●



“ NHS reforms have made addressing health inequalities a statutory requirement for all health and social care commissioners and providers. In 2010, the Marmot review into health inequalities in England found more deprived people have a higher chance of premature mortality. Yet socio-economic factors are still overlooked when assessing access to diagnosis and treatment.

Hepatitis C disproportionately affects disadvantaged people. A recent study that we conducted of diagnosis and treatment of the condition in England identified a clear bias against deprived patients.

With more effective treatment available and greater public awareness, Public Health England, local authorities, NHS England and clinical commissioning groups have a tremendous opportunity to work together to tackle hepatitis C. Increasing early diagnosis is the key. The UK health system is sitting on a wealth of data that, with the right analytical skill and modelling, can uncover opportunities to dramatically improve early diagnosis rates. Predictive analytics can fuel the transformation from a focus on the volume of procedures to the

‘The UK health system is sitting on a wealth of data that can improve early diagnosis rates’

value of outcomes. Predictive tools are helping providers assess patients’ risk of contracting a condition – this type of modelling could be significantly beneficial in tackling hepatitis C.

Hepatitis C does not present symptoms in its early stages, so people can remain unaware they are infected for years. Collecting, integrating and analysing data from multiple sources could effectively identify those at risk, who could then be tested.

The NHS is spending nearly £83m a year tackling complications associated with the disease, and this is projected to rise to £115m. The annual cost of care for a person with decompensated cirrhosis is £12,432; for someone with hepatocellular carcinoma it is £11,078; and every liver transplant costs in excess of £50,000. The cost of a basic antibody dried bloodspot hepatitis C test is £15. Whilst this is a very simplistic presentation of savings potential, it highlights how earlier diagnosis could significantly impact not just the patient, but the related spend for hepatitis C.

One answer to the question of how to create a real step change in hepatitis C prevalence in England is to enable providers to unlock the knowledge within the information they already hold, turning data into actionable insight that can be readily applied on the frontline.

Tim Sheppard is general manager at IMS Health.

www.imshealth.com



HEALTH INEQUALITIES

A TALE OF NEGLECT

Good data analysis can reveal uncomfortable truths – such as the reality that the poorest hepatitis C sufferers get least help from services. By Catherine Blackledge

In the classic fairytale, Cinderella is barred from going to the ball. Accustomed to an unequal existence at the hands of her step-family, she accepts this latest inequality as her fate and does not complain.

There are striking parallels between Cinderella’s situation and the most deprived patients with hepatitis C in England. Data from IMS Health highlights the increasing inequality, in terms of socio-economic status, in access to diagnosis and treatment of hepatitis C in England.

Figures for the period 2010-2012 reveal that treatment rates for hepatitis C patients are higher in those socio-economic groups that are less deprived, while treatment rates are actually falling in the most deprived 10 per cent of hepatitis C patients. The IMS Health data also indicates that, of newly diagnosed patients, 80 per cent are in the most deprived 50 per cent of the population.

Charles Gore, chief executive of the Hepatitis Trust, welcomes this information: “It is useful because it backs up other data we have about the deprived status of these patients in England and in Scotland. This is clearly a disease that is most prevalent in disadvantaged groups.”

Commenting on the IMS Health insight, he adds: “The other key thing that is interesting is that it shows, given this disproportionate effect, that this group of patients gets the least access to treatment. It widens an existing inequality.”

The question exists: are these low and falling treatment rates related to the socio-economic status of hepatitis C patients and the prejudice that this is a disease associated with a poor lifestyle and drug abuse? “The expectation of this patient group is very low,” says Mr Gore, “they tend to be used to being ignored. They have the opposite of the sense

of entitlement and may believe that it is fine for everyone to ignore them.”

That is why, he notes, research like this – highlighting the situation of a group who do not speak up for themselves – is vital. Without it, those commissioning services and providing care may continue to overlook these people. “Data like this will hopefully put pressure on local authorities to make sure testing is commissioned and put pressure on the NHS for effective treatments to be available.”

IMS Health’s data provides novel insight because it is drawn from two information streams: it integrates proprietary IMS Hospital Pharmacy Audit information with hospital episode statistics outcome data at a patient level. Known as Hospital Treatment Insights, the dataset can provide information on the whole patient journey, from GP through to specialist treatment.

“It gives for the first time an indication of not only what a patient is being diagnosed with but also what they are being prescribed. For the first time, they are being linked together at the individual patient level,” says David Franks, director, offering development and marketing at IMS Health, who has worked on the hepatitis C project.

There is a great deal that can be done with the information, says Mr Franks. “You can look at patient treatment pathways; look at what drugs the patients get, whether those medications change, or slice into the information across the pathway to see, for example, what the market share of a particular drug is or what particular indication it is being used for.”

The dataset was set up in January 2010 and incorporates HPA data from 42 trusts (about 25 per cent of the total). Anything that is dispensed through the hospital



Sharp insight: thousands who need treatment for hepatitis C are not getting it

pharmacy is recorded (ward stocks, such as analgesics, and medicines used in an acute/emergency setting, such as thrombolytics, are generally poorly covered).

Under data privacy laws, the information can only be looked at on a national aggregated level. However, individual trusts working with IMS Health do then have the ability to look at their own activity in comparison to the national picture.

This kind of data, says Mr Franks, enables commissioners or others “to see, not just whether drugs are being prescribed, but also which type of patients they are being prescribed for, so they can assess the

‘Data like this will hopefully put pressure on the NHS for effective treatments to be available’

appropriateness of the intervention”.

Looking at the hepatitis C dataset, he says it highlighted the difference in treatment rates between the deprived and the less deprived.

Dr Deepak Joshi, consultant hepatologist at King’s College Hospital Foundation Trust, hopes the IMS Health insight can help direct commissioners to go out into their local communities and see what is really needed.

It is positive, he says, because “it highlights an area that in the past has often been overlooked; it highlights the need to identify patients and enable access to the newer drugs that are becoming available”.

Up until four or five years ago, he notes, with no new effective treatments in sight, there was little optimism. In contrast, today, with a raft of new drugs approaching launch (see box, right) there is a real enthusiasm about what can be done.

“It is a real opportunity to highlight the disease and what services we do have, and build on that,” he says. “There is an opportunity to tackle this disease head on. The landscape has changed dramatically.”

It is hoped that, with data revealing the inequity of the situation to those commissioning services and the promise of drugs that do work, far fewer hepatitis C patients will be ignored. ●

HEPATITIS C FACTS

According to Public Health England, around 160,000 individuals are chronically infected with hepatitis C in England. Between 2006 and 2011, just 28,000 people (3 per cent of the infected population) received treatment. The Hepatitis C Trust estimates that between 100,000 and 150,000 patients in the UK remain undiagnosed with hepatitis C.

On the horizon are effective, tolerable oral treatments that can cure the disease in over 90 per cent of patients in just 12 weeks. Sovaldi (sofosbuvir) has been approved by NICE but, amid concerns about cost, NHS England has requested the deadline for services and funding to be in place to be pushed back to August 2015. Olysio and Daklinza have also recently been approved for use.



“For most NHS commissioners, elective care capacity has been at the front of their minds for some time due to the need to comply with the 18-week waiting time target.

It is often said that the more you have the more you use, but we all know that the demands being placed on the care system are not reducing. So how do you balance capacity and demand whilst always prioritising quality?

The NHS is driven by routine and demand, agreed work plans, limited resources and the need to balance elective and urgent care. Elective care can be planned, but with the knock-on effect from cancellations due to emergencies, together we need to start developing a flex and fix process; a “campus of care” approach.

This means knowing the capacity for urgent care, for patients fit for discharge, and also system-wide theatre and bed capacity in other hospital settings.

At BMI Healthcare we have availability of both people and facilities, such as high dependency units, diagnostics and imaging services.

Evening and weekend working with a focus on effectiveness and efficiency means that we

‘By working in partnership, we are able to use our flexibility to meet the patient’s choice of clinician regardless of the environment’

can provide flexibility to support an elective care campus.

In this “campus” approach, maximising available capacity needs to be balanced with patient choice. We all understand that the relationship that a patient develops during their first encounter creates a level of trust with their clinician, sometimes meaning that patients will often choose to wait longer to continue their care with that clinician.

By working in partnership, we are able to use our flexibility to meet the patient’s choice of clinician regardless of the environment. For example, often we will work in partnership with a trust which would have cancelled patient lists but instead the NHS surgical/theatre team have used our theatre and bed capacity.

When demand is rising and capacity is tight, we need to work together across the whole system capacity to ensure patients receive the professional care they need, when they need it. Teamwork is the key.

Jan Thomas is NHS commercial director of BMI Healthcare.
www.bmihealthcare.co.uk

EXTERNAL PROVIDERS

LEND A HAND OPERATION

South Tees and other NHS hospitals are turning to the independent sector to plug the gaps when services are overstretched. Catherine Blackledge reports

At the end of a bitterly cold January 2015, South Tees Hospitals Foundation Trust found that severe winter bed pressures and a technical breakdown in theatre had resulted in the cancellation of 100 elective operations.

The trust put in a call to the independent BMI Woodlands Hospital to ask if it could help with its capacity problem and prevent orthopaedic elective surgeries from being cancelled. The answer – via “spot purchase”, an arrangement that enables procurement of services as needed – was yes, and the first patients were seen days later.

This scenario is not unusual, says Debbie Dobbs, executive director of BMI Healthcare’s Woodlands Hospital in Darlington, County Durham. Over the last eight years bar one, which was a very mild winter, spot purchase of BMI Woodlands’s services has helped ease local NHS capacity pressures. It doesn’t always mean opening up theatres on a Sunday – as they did for South Tees – but as the 38-bed hospital is typically running at full capacity (70 per cent of which is NHS activity), it often does.

Spot purchase also operates in a more planned manner. Knowing her local NHS management team is beginning its gap analysis for 2015-16, Ms Dobbs will be involved early in the planning phase. “We are in constant contact with trusts at the divisional level,” she says. “We sit down with the director of operations and chief financial officer and discuss where gaps are and what we can do to help.”

If that means opening every Sunday and running dual lists, that is what they do. At the moment, they deliver around 500 orthopaedic spot purchases a year and are working with County Durham and Darlington Foundation trust, as well as South Tees.

Patient satisfaction is high. “We try to keep the patients in the same pathway,

seeing the same consultant, and we have a dedicated NHS team in the hospital.” If a patient is with the same consultant and has already been assessed for surgery, BMI will do a review of that assessment, making sure it is in line with its own procedures.

The independent sector and the NHS working together in this way is highly beneficial, says Ms Dobbs. “From the patient perspective, it’s very important to be given the choice locally; from the local NHS point of view, with the pressures on them, it’s vital too.”

She adds: “We have got massive support from the NHS and we have a fantastic working relationship. They do not feel threatened by engaging with the independent sector; they see us as an extension of them.”

Difficult winters

Rakesh Marwaha, chief officer, NHS Erewash Clinical Commissioning Group, concurs. “The services of the independent sector are critical for the capacity we need to deliver the 18-week waiting time target. Working with the independent sector gives us the head room to do urgent care work. For example, this winter’s been particularly difficult: working with the independent sector we can continue to do our elective care work and patients can continue to be supported in their care.”

Mr Marwaha, who is on the board of NHS Clinical Commissioners, points to a change in recent years in the working relationship between the NHS and the independent sector. “Five or 10 years ago, there was a lot of scepticism about what the independent sector could do,” he says.

“What has become clear over time is trust that the independent sector will take on the more complex patients. We now have the understanding about what the independent



Theatre pressures:
NHS trusts are looking to the independent sector to take on some elective operations

sector can do. They are now part of the healthcare economy?”

He adds: “BMI Healthcare and others have spent time working with clinicians and ourselves to be part of the system. I know nationally the independent sector is very important as part of our overall capacity to deliver to patients. We have the same conversations with the independent sector as we do with local providers – it is all about looking at what is best for patients.”

At BMI Healthcare The Alexandra Hospital in Cheadle, Manchester, the passage of time and a developing understanding has also had an impact on the type of spot purchase work that the 140-bed hospital provides. As well as offering routine orthopaedics, it provides cardiac surgery, some cancer services, and complex urological, thoracic, spinal and gynaecological procedures as required.

“As time has gone on,” says Sarah Agnew, The Alexandra Hospital’s director of operations, “the more confident the NHS feels with us, the more complex the work has become. They see us more as a partner now than they have ever done before.”

It is the needs of the NHS organisation, she says, that determines how they work together. Ms Agnew points to the cath lab at The Alexandra Hospital, which carries out cardiac ablations, stent work, 3D mapping of

‘If you have a pressure point on your patch, if there is capacity there, why can’t we work together?’

veins and aortas and fits pacemakers. “We do have pressures but there are areas of downtime,” she says. “The cath lab was operating at a 60 per cent utilisation rate.” She has worked with local trusts on this and patients from the University Hospital of South Manchester Foundation Trust are now benefiting from this spare capacity.

In cardiology, the hospital has been working closely with University Hospital of South Manchester since 2012 to ease capacity issues; similar work is underway with Central Manchester University Hospitals Foundation Trust and has just begun outside the Greater Manchester area with Sheffield Teaching Hospitals Foundation Trust. Overall, it delivers around 350 spot purchase procedures a year.

Ms Agnew also highlights how BMI Healthcare’s The South Cheshire Hospital in Crewe found a novel way of working with its neighbour, Mid Cheshire Hospitals

Foundation Trust. A covered corridor joins the two sites, and when Mid Cheshire was experiencing a shortage of post-operative beds, a spot purchase arrangement enabled patients to be operated on in the NHS facility and transferred via the corridor to receive post-operative care from BMI’s The South Cheshire.

“The NHS is using our services more and more,” says Ms Agnew. “We can assist them. We are a commercial organisation, but we are there to deliver a service for the patient. It is an overall benefit to the health economy.”

Ms Dobbs’ advice for others working this way is to make sure communication channels are clear. “For us,” she says, “the only hurdles were around good communication between the NHS and ourselves. We just pick up the phone.”

She underlines the relationship her hospital has with the local commissioners and has a message for others. “For those areas where commissioners feel the independent sector can’t play a part, go and see. If you have a pressure point on your patch, if there is capacity there [in the independent sector], why can’t we work together? Forge the links, see what is on offer. It does not make sense for patients to be cancelled and cancelled and cancelled when local capacity is available.” ●