FOR HEALTHCARE LEADERS

HSJ COMMISSIONING

AN HSJ SUPPLEMENT/13 SEPTEMBER 2013

CASH ADVANCE

WHAT THE PRIVATE SECTOR CAN DO BEYOND SIMPLY CUTTING COSTS 20

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Alison Moore

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Despite compelling evidence, 'enhanced recovery' measures to help patients after surgery are under used in the NHS and private sector. One independent provider has shown how they can be successfully implemented – by involving all staff and considering every aspect of the patient pathway. Page 6

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Huge numbers of people suffer incontinence each year, yet it has historically been a low priority for the NHS. Now a series of pilot projects are showing how patient pathways can be improved and more people treated in primary or community care. Page 12

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Too often the elderly end up in hospital beds when they could be supported at home. The British Red Cross now has a portfolio of services that can help, including escorting patients home after discharge, checking on them, ensuring they have meals, and helping them achieve personal goals. Page 24

JAMES CLARKE ON SUPER INCENTIVES

IN ASSOCIATION WITH CAPSTICKS

Capsticks

Achieving integration targets presents a new type of challenge to all commissioners of health and social care services. From a contracting perspective, in some cases the law prohibits the commissioning of certain service lines in a single service provision contract. So having different classes of provider being party to a single contract (and possibly with more than one commissioner), apart from being horribly unwieldy and complex, is in any event prohibited by law for some combinations of services. So how can joint working best be contracted for in practice?

Joint working is often approached purely through good will, effective communication and a shared philosophy of putting the patient first. With local authorities, clinical commissioning groups and NHS England all having distinct commissioning responsibilities, the concept of integration might seem at odds with procurement and contracting practices required by law to put the services in place.

One approach with potential is already up and running in respect of prison healthcare services. Now the commissioning responsibility of NHS England, it shows how to commission integrated healthcare services for a population on a small scale.

This is achieved first by procuring all of the services in the traditional way. For example, there may be an alternative provider of medical services (APMS) contract for primary care services, and in a primary care-led model, the APMS provider would be the co-ordinating provider for the purposes of managing the overall healthcare function. A dentist might be retained on a personal dental services contract, and separate contracts for pharmacy and mental health services would be entered into with their respective providers.

Next, the commissioners must consider how they want the services to operate in terms of integration, which might include for example making all payments through the co-ordinating provider, receiving one set of monitoring and reporting information, and requiring providers to work up a proper integrated service delivery plan. This requires a unique "super contract" that sits above all of the commissioned services contracts, to which all providers and the commissioner are party.

New providers coming onto the patch are required to join the super contract model and, in one design, providers' income is top-sliced and made subject to super contract key performance indicators to encourage proper delivery of the commissioners' integration requirements. The added advantage of this approach is that it allows standard contract forms to be used without any special amendments in respect of integration.

In a world where commissioners are obliged to consider integration, we can expect greater application of super contracts to give integrated services a robust legal foundation.

James Clarke is a partner at Capsticks
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INTEGRATION

CAN SUPER CONTRACTS SAVE THE DAY?

Agreeing incentives to integrate care might just deliver the seamless services everyone wants. By Alison Moore

Integrated services which feel seamless to the people who use them are the great white hope of the NHS.

Such services hold out the prospect of providing better care to the growing number of very elderly and frail people who so often end up inappropriately in hospital beds. And there is the enticing prospect that they could reduce the cost of care for the NHS – although it is far from certain that integrated care is a money saver in every situation.

So why isn't every health community pushing ahead with integrated care as quickly as possible? The answer is that the road to a successful collaboration can be long and hard – and is uncharted territory for some organisations.

The first concern for many NHS organisations may be around contracting: does a clinical commissioning group working with a local community health trust and local council to develop integrated care risk falling foul of procurement rules? The answer is it need not: there is provision in the 2012 Health and Social Care Act which allows them to run a single provider procurement.

But NHS organisations are likely to be cautious about this and, at the very least, need to be open about the process and ensure there is an audit trail of actions taken.

Tracey Lucas, a partner in healthcare law firm Capsticks, says that the new regulations do leave wide potential for challenge. "Procurement has to be considered but it is not insurmountable."

Another point is the impact on competition for service provision locally – something which is rising up the agenda in the health service with the Competition Commission's interest in foundation trust mergers. Many integrated care projects will be with a single provider of a service, potentially cutting out other providers.

Monitor – whose remit covers both support for integration and competition – recently issued guidance on its approach with cases that may impact on competition. "They have attempted to set out and explain in more detail what the objections are on integration," Ms Lucas says.

Jo Newton, who was involved in integration of district general hospital and other services in Herefordshire, says that this may be a step forward: at the time of the Herefordshire integration, Monitor was much less used to dealing with such issues. Now the path ahead may be clearer to all parties. Integration is often seen as an organisational solution, but there are steps commissioners can take to promote a service which feels integrated to the patient while organisational boundaries remain unchanged. It does not matter who provides the service as long as all providers work together to give the patient seamless care.

One way to do this is through a "super contract", which all service providers sign up to in addition to normal contracts. This can incentivise all providers to act in an integrated way – for example, by ensuring that the majority of the profit in a contract is concentrated in areas that require organisations to work together to improve outcomes.

Capsticks partner James Clarke says this can drive desirable behaviours such as information sharing and moving away from silos. Crucially, providers will need to commit to delivering data to the commissioner who can then use a dashboard to oversee all the contracts.

"What you need to do is incentivise the sort of behaviour you want. Money talks," he says. An example might be around infection control: if everyone is committed to a contract that penalises healthcare acquired infections, then all will try to prevent them,

CASE STUDIES OVERLEAF ▶

Joined up thinking: the elderly are a key group who could benefit from better integration of health, social and other services

rather than passing the blame around if one occurs.

If some of the contracts are tendered, then the requirement to sign up to the overlaying super contract can be written into the tender requirements.

Such a super contract approach has been used for health services for Belmarsh Prison in south east London and may now be used by more prison settings.

Integrated care does not have to involve the creation of a separate provider organisation to bridge the health and social gap divide – but it can sometimes. Local authorities are sometimes interested in the "halfway house" of a trading company, which does not have to go through a full procurement process. Ms Lucas suggests this may reflect nervousness on the authority's part – which can sometimes lead to a staged process that ends up leading to a new organisation.

But all organisations will need to bring their staff with them. While that can slow down the process, it is likely to be important for the later success of the project. Staff need to begin to think outside silos. But management can run too far ahead of staff – and service users – and not put enough time into explaining and promoting the project among them.

Any CCG looking at integrated care is likely to find it necessary to work with additional partners such as housing associations and care home operators to adopt a truly holistic approach to people's health and social care needs. And some providers of community healthcare – likely to be a crucial partner – may be social enterprises, working under three or five year contracts.

'A "cupid" may be needed to bring partners together, especially if they have a history of not trusting each other or working well together. Health and wellbeing boards could take this role'

But, once the legal difficulties are overcome, it is often factors such as the commitment of the partners which determine whether plans for integration are successfully implemented. Capsticks partner Chris Brophy highlights how there was a shared vision of better care for patients in their own homes in Kingston, for example (see case study) which has driven the development of a more integrated system.

And Ms Newton says that in Herefordshire there was a "deep partnership" with the council which helped. But all integrations involve time and commitment from all partners. An element of goodwill has been important – for example, with partners being flexible over waiving contractual rights. But Mr Clarke says commissioners now seem keen to act in a more consistent and rigorous way.

Health and wellbeing boards, although very new, may be where the drive for integration comes from. Mr Brophy points out the commissioning pathways are more fragmented than under PCTs and there can be differences between CCGs and local area teams, which are more likely to be driven by central priorities. Could health and wellbeing boards offer a way forward if this does happen?

He says that integrations often need a "cupid" to bring the partners together, especially as they may have a history of not trusting each other or working well together before. HWBs could take on this role.

But there are often a lot of bumps along the road with integration projects: issues which risk holding the project up and need to be sorted out before it can proceed. Mr Brophy says that one of the useful learning points from Kingston was the document trail, which could almost act as a road map of things to resolve for other projects.

The integration pilots announced by Norman Lamb could offer an opportunity to spread this sort of learning to other areas by producing a standard suite of documents or tools which could avoid duplication.

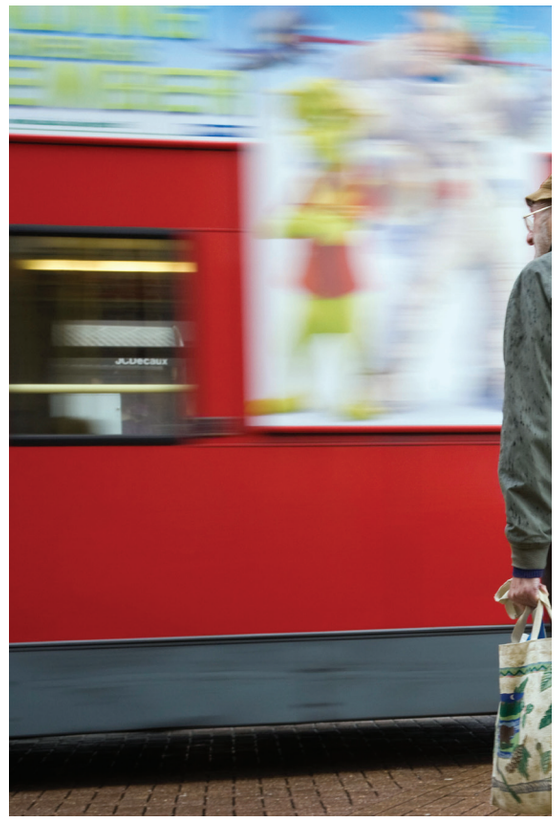
Producing care which feels seamless to the patient on the receiving end will present enormous challenges to most organisations. But these can be overcome, and the benefits for both the individuals and the NHS are likely to make the process worthwhile. ●

ALAMY

INTEGRATION: CASE STUDIES

A NEW ROUTE HOME

How joint working has enabled more older people in Kingston to stay out of hospitals and care homes – and transformed services for prisoners in south London



KINGSTON

Ask elderly people whether they want to live in a residential setting or at home and the answer is nearly always at home. But keeping them there involves multiple agencies and sometimes it is simply too difficult to do – meaning they end up in hospital or a care home.

But Kingston Council, the local clinical commissioning group and social enterprise Your Healthcare (spun off from the PCT's provider side) decided to do things differently. By enhancing reablement support at home – but also reducing duplication – more people could stay where they wanted, with residential care reserved for those who really needed it.

Given that residential homes are expensive, the scheme could pay for itself by reducing the numbers of beds needed.

This vision of an integrated service to support people at home – generally elderly but not exclusively – has taken root.

David Smith – who is both the chief officer for the CCG and director of adult social services for Kingston Council – says the council had particular cost pressures as it operates several care homes itself rather than just commissioning places in privately run homes as many councils do now. Running its own homes is more expensive than purchasing independent sector beds, putting additional pressure on budgets.

But to change the model of reablement care required organisations to be prepared to pool budgets and transfer staff to make it happen.

Staff from the council have transferred to Your Healthcare, and a section 75 agreement has provided the mechanism for council money to pass to the CCG to commission services from Our Healthcare. As these services are "part B" services they did not need to go through a full European Union tender and could be commissioned without a drawn out procurement process. Your Healthcare was already providing community healthcare services under a contract which has about two and a half years to run. A wider procurement exercise could be a possibility in the longer term.

Siobhan Clarke, managing director of Your Healthcare, says that as a social enterprise it was able to move quickly and have the freedom of action to set up the new system.

So what is different for the users? There is now a single point of access for users into the service with a single assessment, rather than multiple assessments for the different elements provided by health and social care.

Services are strongly focused on helping people to live as independent a life as possible and supporting them to recover independence after illness or injury. Previously, these services were split between the council and healthcare – now, says Mr Smith, there is a single reablement service which responds to the needs of the clients.

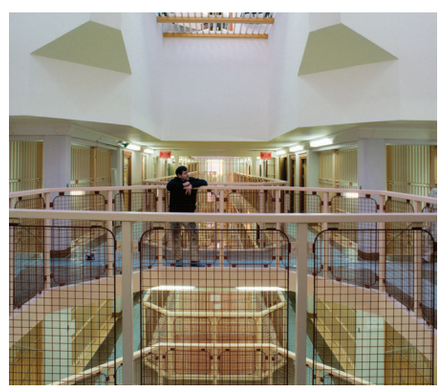
With this focus comes a shift from residential care to care in the home. Some home places will always be needed but the philosophy has changed: people discharged from hospital, for example, will be a lot less likely to be put into a care home bed long term in the future.

Mr Smith says this is already evident if individuals are tracked through the system: people who six months ago would have gone into residential care are now being supported at home. There will also be more done on prevention and telehealth/telecare to support people at home.

Ms Clarke says there is a commitment not to move people already in council residential care. But the changes – which have only come in this spring – have already allowed one home to close.

All this is better for patients, but will also yield savings for the partners. Mr Smith suggests that the difficult economic climate and the need to make savings have meant the scheme has advanced quickly. He is already wondering whether dementia care in the community could be enhanced to support some patients at home rather than in more expensive settings.

Challenges are around dealing with the different approaches to charging – social care is means tested, NHS is not – and potentially personal health budgets. The council is also reprocuring its home social care service, which is likely to reduce the number of private providers significantly.



Better care: all Belmarsh prisoners are screened

Road to integration: different care organisations in Kingston pooled budgets and transferred staff to help local elderly people

In the future, Mr Smith believes that the focus could be on more integrated approaches to commissioning health and social care, as well as on the end point – the services that are delivered.

GREENWICH

Providing healthcare to prisoners carries many challenges. While they might be a captive market – literally – many will have an uncertain length of stay, especially remand prisoners, as well as untreated health problems. In addition, information on their past history can be hard to obtain.

Getting prisoners access to the normal range of health services they could expect on the outside can be tough. High security prisoners who need hospital treatment may need escorts and special arrangements, access to primary care can be limited and sometimes mental health issues are not detected early enough.

Could better contracting of prison health services help achieve better services and outcomes for prisoners? The experience of Greenwich PCT in commissioning services at the Belmarsh group of prisons in south east London suggests that contracts could be a useful lever in delivering desirable outcomes such as better integrated care.

As well as developing individual contracts for particular health services within the prisons, Greenwich adopted an overarching super contract with a prime contractor with a number of other contracts for services around it. In this case the prime contractor was Harmoni for Health, which also provided primary care services. There were separate contracts for dentistry and mental health services – the latter from South London and Maudsley Foundation Trust.

'The difficult economic climate and the need to make savings have meant the scheme has advanced quickly'

All the contractors come together to share information to fit into a dashboard which covers both qualitative and quantitative elements of the overall service. And the construction of the contract means that when they work together they make more out of it, with a number of key performance indicators which cross over services. Regular clinical forums allow discussion of patient safety and risks.

Langley Gifford, previously assistant director at Greenwich PCT and now assistant director of integrated commissioning at Greenwich CCG, says that one of the aims from the outset was to try to create a model which encouraged integrated care in this challenging environment.

"They have to ensure that every prisoner who comes through the doors is screened to identify health needs including mental health needs and any risks," he says. Such prisoners might then need to have specialist input, and it was felt that it was unlikely that a single provider would be able to provide all of these individual services.

Employing individual providers for parts of the service meant they would be subject to different regulatory regimes. The aim was to devise a situation where, if any problems occurred in one part of the service that were severe enough to require a change of provider, this could be done without impacting on other providers and the overall provision.

In a prison setting there was also a need to ensure good relations with the prison governors and staff and the HMI Prisons regulatory regime. Before agreeing the contract and appointing providers, the PCT talked to patients, commissioners, providers and also the independent monitoring board.

The idea of a contract within a contract – a super contract – seemed to tick all the boxes. "It used something very new yet did not feel too risky," says Mr Gifford. "It felt the right thing to do."

But the PCT was careful not to make the reporting requirements too onerous: the focus was on outcomes, through shared key performance indicators, rather than collecting paper for the sake of it.

The three institutions covered at Belmarsh allowed for there to be economies of scale in some areas of provision while also ensuring continuity of staffing in others. This is something Mr Gifford also identifies as very important in prisons, where building up relationships with prison management and staff is crucial to the smooth running of services. "The basic aim is to deliver services that are of an equivalent standard that you can find in the community."

IT has been vital in ensuring that all providers can share information such as past history (as far as it is known), identified risks and medications. Prison can also provide the spur to get people to seek treatment for problems which may have existed for some time but have been ignored: not all prisoners will have registered with a GP in the outside world, for example. Teleconferencing and inreach services from consultants minimise the trips outside which are needed – important with high secure prisoners, who can need extensive escort to a hospital appointment.

The duty of commissioning prison healthcare has now passed to NHS England. But Mr Gifford feels the model used at Belmarsh has potential to be further developed to enhance incentives and drive quality improvements. ●

ALAMY

MARK FERREIRA ON EVIDENCE

Evidence-based initiatives that optimise the patient journey and clinical outcome will be of great interest to commissioners in future.

Enhanced recovery programmes (ERPs) have been at the forefront of the healthcare landscape since at least 2000.

Patients are assessed and "optimised" before surgery so that their recovery period post-surgery is faster, meaning they can often leave hospital quicker. ERP-type initiatives have been adopted by the NHS and most healthcare providers in the UK, but to differing degrees and standards.

ERPs, great infection control rates, exceptional standards when delivering government led initiatives and other programmes such as venous thromboembolism exemplar status, should be seen as important kitemarks for CCGs when commissioning patient services. They are proof of providing evidence-based exceptional patient care while demonstrating economic value.

ERP is an evolving initiative, from implementation in joint surgery to newly developed programmes in other treatment areas including colorectal surgery. Healthcare providers in the public and private sector are constantly looking for ways to improve and develop these programmes, while keeping the patient at the core. Historically obstacles have included trying to retain consistent levels of quality patient pathways across large networks of hospitals.

BMI Healthcare's 69 hospitals and clinics have implemented ERP schemes throughout the network, resulting in improved efficiencies, improved patient satisfaction and significant reductions in length of stay. A poster presented by BMI Healthcare on the ERP programmes at the recent European Care Pathways Conference was awarded first prize.

BMI Healthcare has developed the programme to include carbohydrate loading of patients, where it prepares the body with energy for quick recovery post-surgery, and is continuing its development with optimisation of haemoglobin levels prior to surgery. We offer CCGs a high quality care pathway for patients requiring elective surgery, and provide reassurance that patients are going into surgery in the ideal condition.

ERP integrates all aspects of the patient journey and allows the patient and their carers to feel a part of the whole care process, from physiotherapy training before their operation, to ensuring they have the required level of support at home post-surgery.

The patient remains at the centre of the process and patient satisfaction and empowerment are vital to its success. This approach to patient care allows CCGs to make decisions based on quality of care and patient need.

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SERVICE IMPROVEMENT

GET WELL SOONER

'Enhanced recovery' benefits both commissioner and patient but implementing its use throughout an organisation can be a challenge. Jennifer Trueland reports on how one healthcare provider did it

There's strong encouragement for commissioners to improve outcomes – and efficiency – by implementing enhanced recovery. According to NHS Improvement, the practice has "a compelling clinical evidence base and should be the norm for best practice elective care pathways".

Enhanced recovery programmes (ERPs) aim to optimise pathways to ensure that patients recover more quickly from surgery, treatment or illness and leave hospital sooner with fewer complications.

Yet despite some pretty compelling evidence, enhanced recovery is still far from universal either in the NHS or the private sector. BMI Healthcare decided to take on the challenge of embedding the approach in its 65 private hospitals and four treatment centres across the UK.

Along the way, it was able to add components to enhanced recovery – including "carb loading" so patients have the strength they need to recover quickly from operations and testing iron levels in patients' blood and treating them before surgery if they were too low.

"About 18 months ago we realised we needed to look at the care that we were delivering," says BMI Healthcare integrated care manager Ellie Cornelius. "We knew it was high quality, but we wanted to make it even better – we wanted to be sure we were doing the very best for our patients. We have a lot of NHS customers and know that commissioners are focusing on value for money – enhanced recovery seemed the way to go, bringing benefits to all our patients, NHS and private."

The organisation decided to focus on hip and knee replacement surgery, and set up a multi-disciplinary group to consider every aspect of the patient pathway. It found length of stay varied between five and 15 days.

"One hospital did a pilot of enhanced recovery and reduced length of stay considerably. So we realised that if one hospital could do it, we could do it across the group," says Ms Cornelius.

Not all hospitals had adopted standardised pathways and that there was a high degree of variability in compliance where they had been adopted. Outcomes varied, and that there were other inconsistencies, such as a lack of standardised documentation.

"We decided to work together to design a pathway which would be consistently applied and which would be better for patients," she adds. "We involved everyone, including nursing, finance, physiotherapy, medical and housekeeping – everyone had their part to play if we were going to do it.

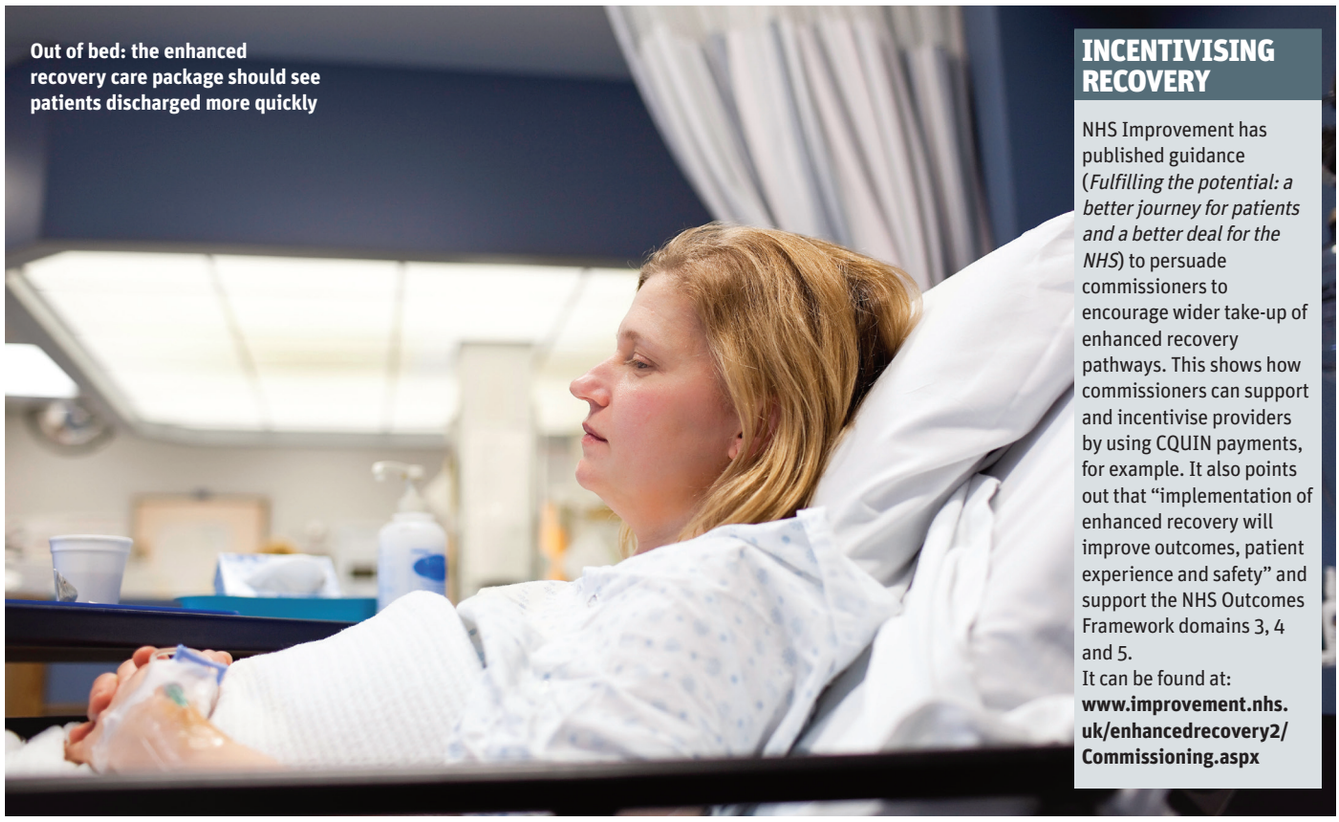
"It was a big culture change and we knew we needed to educate our staff. We did roadshows for all the hospitals, and set up ERP steering groups in each."

Anne Iveson, group chief pharmacist, adds: "Some nurses said they thought that earlier discharge was unsafe – but we showed them the international evidence which showed it was not only safe, but actually better for patients.

"A lot of it was about helping people to feel confident in themselves about what they were doing."

Even physiotherapists who were sceptical about ERP at the start are changing their minds when they see patients going home looking better than when they stayed for longer, says Sarah Tribe, national lead for physiotherapy.

Eighteen months after the process was introduced, length of stay across the group has fallen and all hospitals have reduced average length of stay. Other patient benefits include greater use of local anaesthesia and changing medicines to reduce side effects.



Out of bed: the enhanced recovery care package should see patients discharged more quickly

INCENTIVISING RECOVERY

NHS Improvement has published guidance (*Fulfilling the potential: a better journey for patients and a better deal for the NHS*) to persuade commissioners to encourage wider take-up of enhanced recovery pathways. This shows how commissioners can support and incentivise providers by using CQUIN payments, for example. It also points out that "implementation of enhanced recovery will improve outcomes, patient experience and safety" and support the NHS Outcomes Framework domains 3, 4 and 5.

It can be found at: **www.improvement.nhs.uk/enhancedrecovery2/Commissioning.aspx**

'BMI was able to add components to enhanced recovery – including carb loading so patients have the strength they need to recover quickly'

BMI Healthcare is now looking at standardised enhanced recovery pathways in other areas such as gynaecology and spinal surgery, as well as continuously improving the new hip and knee pathways.

It has also introduced blood testing several weeks before surgery, allowing time for treatment with iron to ensure levels are optimal to cope with surgery.

And, rather than being starved before surgery, some patients are being given drinks. "It's like carb loading but we don't give them a Mars bar," says colorectal surgeon Ian Jenkins. "It's a sugary drink which is a clear fluid so they can have it even two hours before surgery. It helps them deal with thirst and gives them energy."

"We believe in enhanced recovery and want to embed it in our business model," Ms Cornelius adds. "It's good for patients and it's also good for us."

CASE STUDY: THE SANDRINGHAM HOSPITAL, NORFOLK

Three years ago, the average length of stay for joint replacement patients at BMI The Sandringham Hospital was five days. Today it is two to three days, with ambitions to cut that still further.

"My last four patients – two hips and two knees – were home in two days," smiles Hilary Tudor, senior physiotherapy manager at the hospital in King's Lynn. "But it's not so much about fast discharge – although nobody wants to stay in hospital longer than they have to: it's about confident discharge. We want people to feel confident that they are ready to go home."

Reducing length of stay involved everyone in the wider healthcare team, including surgeons, nurses, domestic staff and porters, she says. "It's important that everyone is positive about early discharge – if just one person says something negative then it has a real impact on how people feel about it.

"It starts with the pre-admission assessment," says Ms Tudor. "Right from the very beginning we're talking to patients about our expectation that they will be able to go home early so that they are prepared."

This involves advising patients that they should, if possible, arrange to have someone to stay with them when they are first discharged, and also giving them an early heads-up if they will need any supportive equipment or other help, so that it is in place before the patient is admitted.

Patients and their families like this approach, she says. "Evidence suggests that people recover better in their own homes. It's not about rushing people: it's about setting their expectations so that they know what is going to happen."

A safe and confident discharge has many elements, she says. Pain control has to be good, any nausea and vomiting has to be treated, and early mobility encouraged.

The need to do prescribed exercises is stressed throughout, from the pre-admission assessment. Patients are encouraged to get up – and dressed – as soon as they can. Wearing day, not night, clothes is psychologically important to persuade patients they are ready to be up and about.

The hospital's physiotherapists work out an individual programme for each patient, and this doesn't stop when they are discharged. Patients are invited back for further hospital physiotherapy sessions, either in small groups or one to one.

Post-op contact and continuity is also assured by giving patients a number they can ring if they have any questions or concerns after they have gone home.

"The important thing for us is that we are providing a high quality outcome and a great patient experience," she adds. In the latest analysis of the nationally produced Patient Reported Outcome Measures, The Sandringham Hospital was rated as 12th in the country for hip replacements. ●

ALAMY

ANDREW ROBERTS ON PARTNERSHIP

When the NHS reforms came into effect in April, commissioning was heralded as a new opportunity for partnership between the NHS and pharmaceutical industry. Being asked to collaborate and work more closely with the new NHS makes a great deal of sense, but what does that look like in reality?

Our starting point at Napp was to ask a simple question. How can we best support the common, shared values that bind both the NHS and the pharmaceutical industry? Our overriding motivation is to secure the best possible outcomes for patients, who are after all our families and friends. This means doing our best to support commissioners, healthcare professionals and other stakeholders. It's about adding value beyond medicines.

In the respiratory field, we're helping the NHS capture best practice. We're working with CCGs to create inhaler technique programmes that address the specific training needs of healthcare professionals around improving inhaler use and adherence.

Our Napp Academy provides NHS workers with business management skills needed to negotiate the new commissioning environment, in addition to providing respiratory training for nurses and clinicians.

With a focus on outcomes, we're aware that the pharmaceutical industry needs to demonstrate measurable results for our products in the real world. Napp is piloting a web-based tool to allow professionals to record outcomes in patients prescribed one of our pain products. We're launching a similar system to allow GPs and nurses to record how patients are performing after prescribing our newly launched Fixed Dose Combination inhaler. This is particularly valid given the importance of gathering data on new products in patients needing a critical level of control to avoid life threatening and hugely costly exacerbations.

This is how we are capturing real world evidence that NICE and NHS England need to guide commissioning decisions and improve outcomes. We are proud to have supported this supplement and a debate at this year's Commissioning Show on these important issues that will affect the industry and NHS frontline.

We hope that an increased focus on collaboration and innovation will apply to the way the NHS deals with pharmaceutical companies too. If companies are going to be able to bring the medicines to market we need our products to be fairly assessed and, where appropriate, added to formularies. All we ask for is a level playing field and that the data we are gathering is used as part of this process.

We're optimistic that commissioning will provide opportunities to enable the NHS and Napp to work together to deliver improved patient outcomes – which is ultimately what we're all aiming for, after all.

Andrew Roberts is director of market access and communications at Napp Pharmaceuticals Limited

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IN ASSOCIATION WITH NAPP

NAPP

DEBATE: ASTHMA

RUN THE RISK ANALYSIS

Stratifying patients by risk, self care and better use of drugs were priorities for a recent expert panel debating the commissioning of asthma care. By Alison Moore

Asthma affects around 10 per cent of the population and, while it is often well controlled, some sufferers will have frequent trips to hospital and the risk of premature death.

But does the new commissioning environment offer an opportunity to improve care for these patients, reduce unnecessary costs for the NHS and make better use of medications? That was the question posed at a debate organised by Napp Pharmaceuticals at the recent Commissioning Show in London.

HSJ editor Alastair McLellan, chairing the debate, said a discussion on the "micro challenges" of commissioning could bring out the challenges and opportunities in the system.

Kevin Holton, transition lead, diagnostics, science and early diagnosis for NHS England, set the scene by describing the broad picture of asthma prevalence and impact in the UK – with a £1bn cost but a two fold variation in reported prevalence, a five fold variation in asthma-related hospital admissions for children and a six fold variation in adult emergency admissions.

Not every patient was getting the best treatment, based on the available evidence, and commissioning of services was often not "end to end" including both primary and secondary care, he said. And a small proportion – 5 per cent – of those with asthma accounted for 80 per cent of spend on the condition.

There was a need to use data to benchmark how different areas were doing, to use evidence based pathways and to use the levers already in the system such as CQUIN (Commissioning for Quality and Innovation). And finally there was a need to engage with patients.

Dr Michael Dixon, chair of the NHS Alliance, agreed on the importance of data in understanding what was already being done and where the inequalities lie. Then there was a need to look at where clinical commissioning groups could get "the biggest bangs for our bucks".

Clinical commissioning groups could bring together primary and secondary care clinicians to make sure patients did not fall between the gaps in services, and also look at aspects such as education and housing. But self management for those with asthma – and ensuring they knew what to do if their condition changed – would be key. Practices should have a register of "at risk" asthmatics who were most likely to need emergency care and admissions to hospital should be classed as a significant event, as 75 per cent were preventable.

But there is much best practice in the NHS, pointed out Andrew Roberts, director of market access and communications at Napp. The issue was spreading it.

He said Napp's focus was improving outcomes for patients: medicines would only be valued and used if there were robust outcomes that could be measured.

There were opportunities for companies such as Napp to become involved in patient education to improve the benefits from the medicines which were prescribed: in the Isle of Wight a project to improve inhaler technique had reduced hospitals admissions by 75 per cent (see overleaf). New medicines reviews – at a point where care of the patient was being transferred – could also help patients use their medicines better.

"We are acutely aware of the importance of understanding the importance of outcomes from medicines. There is a lot of talk about real world capture," he added.

CASE STUDIES OVERLEAF ▶

Profit motive: hospitals do not always tell parents many asthmatic children do not need admission

‘GPs are chasing up patients who are perfectly well, just to qualify for payments’

Napp was now tracking patients on its newer medicines to find out what happened to them.

But what was needed to help CCGs bring about improvements in asthma care, asked Mr McLellan. Dr Dixon was emphatic that “headroom” was crucial – but primary care could play a part in improving care, if resources were improved.

He said the Quality and Outcomes Framework (QOF) was becoming a “tick box affair”, which led to GPs chasing up patients who were perfectly well, just to qualify for payments, while there was a need for a system which supported working across the primary-secondary care divide.

Mr Holton added that the QOF tended to support silo based care but needed to look at how GPs were incentivised to deal with complex patients with co-morbidities. But while he supported reviewing payment issues in some areas improvements had been made despite them, he said.

But what priority should CCGs give asthma, among all the other challenges and priorities they face? Dr Dixon suggested the answer to that would vary according to local circumstances: data would help CCGs judge how they were doing and whether they needed to concentrate on this area.

Mr Roberts highlighted some of the help available to CCGs from the pharmaceutical industry. This could include education and training, and helping make better use of data to identify asthma patients at risk of deteriorating, for example. And he said he was hopeful that the recent changes to the NHS could drive improvement.

The audience’s questions showed that asthma care was an issue for many of them. The links between out of hours services – which often deal with “brittle” asthmatics – and primary care were highlighted as important, with Dr Dixon suggesting that every asthmatic’s contact with OOH services be treated as a significant event.

And there was a call for improved self management of asthmatics with support for self care based around pharmacies. Pharmacists had more time to see patients, and now have the infrastructure to see patients confidentially, Mr Roberts pointed out.

Sharing of information – sometimes made more difficult by NHS regulations on confidentiality and competition – was pinpointed as important in much of this. Mr Roberts suggested there were opportunities for rapid transformational change once these issues were overcome: in Cambridge (see overleaf) some patients who were regularly seen for asthma problems were being given smartcards with relevant information which could be easily accessed by healthcare professionals.

Dr Dixon said that offering motivational interventions to patients identified as “at risk” helped: this could be one to one or group work but needed to be tailored to the patient.

And Mr Holton summed up the opportunities to improve care for asthmatics: through proactive management, self care plans and using the tools available to improve services. ●

THE WRONG INCENTIVES?

CCGs do offer the opportunity to improve asthma care. One of the barriers, however, is the current tariff system, which incentivises admitting patients to hospital while inadequately rewarding good primary care.

Dr Charles Alessi, interim chair of NHS Clinical Commissioners, says that makes it harder to send the message to parents that many asthmatic children don’t need admission and can be managed in primary care. At the moment much asthma treatment is profitable for hospitals – even if rising A&E numbers mean an attendance is only paid for at 30 per cent. An overnight stay – normal for an asthmatic child – will bump the cost up for the CCG. This can mean there is little incentive for hospitals to join CCGs and give parents a consistent message about the best place for care. “There are some really mixed messages for the population,” he says. “A lot of secondary care clinics reinforce that there is the right place to be.”

He would also like to see more emphasis on prevention – such as stopping smoking – and working with schools on appropriate access to medication. In primary care, there is a need to improve skills in dealing with child asthmatics and to ensure that practice reflects evidence based guidelines.

BUILDING RELATIONSHIPS

Relationships between the pharmaceutical industry and NHS are changing as both sides see an interest in getting the best value out of the money the NHS spends.

And that means making sure that certain medicines are prescribed and used effectively. Andrew Roberts, director of market access and communications at Napp Pharmaceuticals, says pharmaceutical companies can have a role to play in enabling this. “Our ethos is around bringing value. Our philosophy is not that we are into selling anything other than medicines but there are services that we offer which can make sure the medicines are being used effectively,” he said.

Sometimes this can be around the use of medicines by patients: such as improving inhaler techniques. Offering specialist training to health professionals so they are better equipped to assist patients can improve outcomes. This has been demonstrated in a well known scheme on the Isle of Wight, but the company is keen to look at other sites and see if different approaches work in different areas (see overleaf).

Another way it can offer support is in helping CCGs use their data better. This can enable risk stratification to identify patients at risk of deterioration and hospital care and target them for interventions to prevent. This can reduce costs for the NHS and save lives: 1,000 people a year die of asthma. Companies such as Napp are keen to offer training to use data more effectively and to inform developments in services.

ALAMY

ASTHMA: CASE STUDIES

BREATH OF FRESH AIR

How commissioners and trusts are forging new partnerships with companies to develop services

CAMBRIDGE

Getting the most out of medicines is crucial to both improving patient care and ensuring NHS money is spent effectively.

And the point where a patient's care transfers between hospital and the community is often a good opportunity to intervene as the patient is likely to have been prescribed new medications. The new medicines service is designed to address this, allowing patients' medicines to be assessed by a community pharmacist.

But targeting patients and encouraging them to undergo a review can be a challenge – and often NHS staff are too hard pressed to set up schemes to assist this.

However, in Cambridge that is about to change. Pharmacists in the city's main hospital, Addenbrooke's, and their colleagues in the community are coming together on a steering group to discuss how to identify patients with respiratory conditions who have been seen in hospital. Respiratory conditions are a relatively common cause of hospital admissions.

Allison Siddorns, who works for Napp, has been seconded to the NHS PrescQIPP programme to work on this project three days a week. In a short time, she has managed to set up the steering group and organise initial meetings.

The next challenge will be to work on ways of identifying respiratory patients who have been at Addenbrooke's and encourage them to contact their local community pharmacist for a review. At the moment community pharmacists are unlikely to know that a patient has been in hospital and that their medication may have changed, so some sharing of information – with patient consent – will be important.

Ms Siddorns says: "My role is to engage with local stakeholders. What we are trying to do is develop the service to fit in with the local environment.

"The main objective is to increase the uptake and effectiveness of the new medicines services and also the targeted medicines use reviews to benefit patients who have recently left hospital."

These can include better use of inhalers to improve asthma control and ensuring that patients are taking only the medicines they need and not, for example, taking duplicate medications prescribed by both GPs and consultants.

From the NHS point of view, it has the potential to avoid waste and ensure effective use of medications: although each new medicines review costs £25, the estimated benefits are £95 so there is the potential for savings.

The aim is to build up a service which is sustainable: Ms Siddorns is project managing the development of it but will withdraw next February and says it is important the service can then continue.

The major challenge so far has been around the time pressures on many pharmacists and NHS staff, especially at a time of great change in the NHS. That makes embedding the scheme into existing services even more important if it is to run itself in the future.

At the end of the project, she hopes to develop a transfer of care toolkit which could help other areas improve uptake of medication reviews, across all clinical areas. Respiratory medicine was chosen as a good place to start because it is a relatively high cost area and patients are often admitted to hospital – but that does not mean the system can't be replicated for other long term conditions.

The project was originally part of NHS Midlands and East's PrescQIPP programme, which had the overriding objective of delivering prescribing efficiencies without reducing quality. PrescQIPP has now been taken up by the Eastern Academic Health Science Network, which is keen to work with healthcare industries on initiatives.

PrescQIPP programme manager Liam Cahill says there is good evidence that reviews like this can save significant amounts of money but it can sometimes be difficult to set them up and demonstrate a return on investment – especially when organisations have not been used to working together. "Having someone from a private sector organisation with skills such as creating task and finish plans to work with local stakeholders is useful," he says. "Having someone from outside who can look at this from a different perspective from the people sat round the table means we have the opportunity to take people out from their individual perspectives."

Ultimately, the learning from the Cambridge project could be shared over a much wider area through a best practice toolkit.

ISLE OF WIGHT

Equipping patients with the knowledge to use inhalers correctly is important if outcomes are to be improved and

Dispensing wisdom: pharmacists can help patients use inhalers better and review medications to avoid duplication

ALAMY

‘Research has shown that only a small percentage of healthcare professionals are able to demonstrate use of inhalers correctly’

unnecessary costs avoided. Half of all patients are thought to use inhalers ineffectively, often leading them to abandon using them or to use ever higher doses without the beneficial effects they need.

But it’s not the patients’ fault: research has shown that only a small percentage of healthcare professionals are able to demonstrate use of inhalers correctly. That means to improve patients’ use of inhalers doctors, nurses and pharmacists will need additional training so they can show patients how to use them well.

A project in the Isle of Wight has shown that this can be successfully done: after health professionals were offered training, the number of deaths from asthma attacks on the island fell by 75 per cent and hospital admissions for this group dropped by 50 per cent. The project has been highlighted by NICE as an example of best practice.

Even so, the project has not yet influenced practice across the country. One of the reasons may be that it is not clear that the scheme will have the same benefits if it is replicated in the same form elsewhere. The Isle of Wight is a relatively enclosed community with strong relationships between those working in health which may have helped uptake of the training.

Napp, which was not involved in the original project, is now working with a group of CCGs in different situations to try to draw out lessons from it that could guide other areas in delivering some of the benefits. The aim is to find out which components of these models work best for different CCGs, allowing them to introduce changes which have the best chance of success.

Joe diCapite, project manager at Napp, says the Isle of Wight project was fantastically successful but it might make sense to adjust the project for other areas to reflect local circumstances – for example, targeting practice nurses in areas where they are the main point of contact for asthma patients. “The message we are getting is that the IOW experience is incredibly helpful but we need to speak to the CCGs to see how we can relate that program to their own locality,” he says.

He is now talking to CCGs covering different types of communities and hopes to hold the first training sessions – which Napp will fund – in September. Hopefully, the experience of the first few CCGs which implement this will generate some outcomes data that will enable some broader lessons to be drawn out. This could help guide implementation of similar schemes across the country.

“People are very aware that inhaler technique is an issue that needs to be addressed and they are looking for support,” he says. “We are pushing at an open door.” ●

ELIZABETH RICHES AND ANDY LEE ON UNDERSTANDING

The rationale for partnership working between NHS commissioners and the pharmaceutical industry is widely recognised as being based on mutual benefits, including the common goals of improving access and the quality of care for patients, a need to increase and share expertise, and a commitment to secure full implementation.

But in practice, partnership working often fails to deliver for both parties.

Although a common goal may be identified, in reality each partner often focuses on its own objectives while mistrusting those of the other party. This creates a lack of shared understanding and commitment – a partnership of necessity – and a failure to establish essential honesty, respect, accountability and trust. Too often, questions are raised on what actually gets delivered with no focus on measurable outcomes. This, as a consequence, leads to frustration on both sides.

Astellas Pharma has put together an innovative partnership model to work with NHS commissioners. The model is based on delivering demonstrable outcomes by focusing on what patients need, with an explicit understanding of how actually delivering this will benefit all partners.

Astellas commissioned WG Consulting, a company that has significant experience in commissioning and partnership working in the NHS, to support the successful implementation of this important initiative.

The model allows the identification of issues within existing care pathways via a unique combination of data analysis – in the form of a "resource footprint" – and subsequent qualitative research with clinical and provider stakeholders.

Together these create a genuine shared understanding of what needs to be done, and full engagement in developing the solution and demonstrating outcomes.

With such solid foundations for partnership in place, emphasis then shifts to shared delivery with a real focus on implementation. NHS commissioners are freed to provide leadership and vision and ensure clinical engagement. Astellas is able to optimise its relationships with clinicians and providers, and supply specialist disease-area knowledge while collaborating with WG Consulting to support the project management and the delivery of specialist commissioning tasks, ensuring all parties are able to meet their commitments.

The Astellas/NHS partnership pilots have identified opportunities which enable high quality clinical practice to be delivered with clear measurable outcomes. Astellas aims to be seen as a partner of choice in joint working projects in urology and urogynaecology.

Elizabeth Riches is health outcomes manager at Astellas Pharma and Andy Lee is partnerships and commissioning director at WG Consulting

www.astellas.eu
www.wg-group.com

UROLOGY

TIME TO PUT CONTINENCE ON THE MAP

Services to treat urinary and faecal incontinence have been a low priority for the NHS. Helen Mooney reports on groundbreaking efforts to redesign pathways

Two in three adults are likely to suffer from some form of lower urinary symptoms (LUTs) in their lifetime, often with the embarrassment and impact on daily living of incontinence.

But there is comparatively little known about the way in which NHS services for these patients are planned and delivered around the country, the extent to which these services improve their lives, and whether the services that do exist represent good value for money.

The costs are not insignificant: the NHS spends around £500m a year treating urinary and faecal incontinence but, despite the prevalence of these conditions, continence provision has never been a priority for NHS. The system and services available are fragmented and inadequate for people with continence problems.

The most recent National Audit of Continence Care, led by the Royal College of Physicians and published in 2010, describes in detail the care given to people with continence problems in a variety of NHS settings. It found that only four services in England met the requirements set out in the Department of Health's 2000 *Good practice in continence services* guidance and in the subsequent 2001 National Service Framework for Older People.

Another report – *Commissioning for incontinence, lower urinary tract and bowel symptoms*, published last year by health policy consultancy MHP Mandate and funded by pharmaceutical firm Astellas – also found that primary care trusts were neglecting to assess need and implement national guidance when it came to continence services.

A freedom of information audit of PCTs in England found the overwhelming majority – 95 per cent – could not give an estimate of the number of people with continence problems in their area.

It also found 45 per cent were unable to give details of the performance of local NHS services and 38 per cent could not provide a breakdown of spending on continence services. Meanwhile, only 5 per cent of PCTs included continence in their joint strategic needs assessment. About two thirds said they had not taken action to implement guidance on continence issued by the National Institute for Health and Clinical Excellence.

The report also found "worrying inequalities" in spending. Of those PCTs that did hold data on planned expenditure, the majority – 68 per cent – predicted the same or lower spending on continence services for the next financial year compared to 2010-11.

Paul Abrams, director of the Bristol Urological Institute and chair of the expert group that carried out the audit, says that it is a "sad fact that continence provision has never been a priority for NHS improvement or investment".

However, a series of pilots involving a number of clinical commissioning groups and Astellas Pharma, supported by WG Consulting, have shown that patient pathways can be improved and more patients can be treated in a primary or community care setting.

Clinical focus groups held at each of the Astellas and NHS pilot sites revealed some common problems. Andy Lee, WG Consulting's partnerships and commissioning director, explains that LUTs patients are often referred to secondary care because GPs frequently do not have the time to assess patients following the NICE

CASE STUDIES OVERLEAF ▶

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guidelines, or because they are unaware of where else to refer them.

"There are a lot of Cinderella systems that are not focused on outcomes. GPs refer to secondary care or patients are prescribed containment products such as pads which they use for life. Either way the cash register starts ringing. The whole pathway is wrong and ultimately it is affecting the quality of life of these patients."

He says that many patients are referred to secondary care when they could more effectively and efficiently be treated in a community setting.

But in a number of pilot sites, partnership working between commissioners, providers and Astellas, has led to the development of new pathways.

Elizabeth Riches, health outcomes manager at Astellas, explains that the company has expertise in over-active bladder conditions and produces a commonly prescribed drug, Solifenacin, for the treatment of such conditions. It therefore

has an interest in improving the care pathway for LUTs patients.

"By doing joint working to actively improve the patient pathway we think the most clinically appropriate treatment will be prescribed," she says.

The company commissioned WG Consulting last year to analyse the state of LUTs services in the pilot sites, and to support Astellas and the NHS organisations to come up with better solutions for those services and for the patients using them.

"Although we are specialists in over-active bladder conditions, we had to broaden out the scope of this work to LUTs in order to talk in a language that the NHS would be interested in," Ms Riches explains.

She says that Astellas were not keen on the approach often taken by industry when working with the NHS, which is to provide finance but not measure outcomes in the long term.

"We were keen to work in partnership with NHS organisations and we wanted to work with WG Consulting as they are a Department of Health Framework for Procuring External Support for Commissioners company and know how the NHS works and have a level of recognition within the NHS."

The pilots set about gathering both qualitative and quantitative data which Mr Lee says has been vital in persuading all parties involved of the need to change the way services were run.

He says that clinicians, in particular, can be influenced by data – and that the solutions tend to be around collaboration and collective improvement rather than going out to competitive tender.

Astellas with support from WG has completed work across three NHS pilot sites, and has delivered a LUTs commissioning pathway toolkit from which CCGs can pick and choose to help them best develop their own community and primary care led service pathways for patients with LUTs.

"Commissioners can use the toolkit and we will supply an account manager at a local level or we will match the funding a commissioner puts in either with money, or time and expertise, in order to help analyse and then develop better services," Ms Riches adds.

She says that project is ultimately about commissioners and industry working together to develop long term partnership solutions that benefit patients in terms of the services they receive.

Results from the pilot sites have included new services being set up so that patients are seen by nurses in a community hospital rather than having to go to an acute hospital, and CCGs gaining a deeper understanding of where patients are being referred and treated – and where there might be cost savings and service improvements.

UROLOGY: CASE STUDIES

HOW TO TURN AROUND REFERRALS

CCGs are starting to tackle problems with costly hospital referrals by collecting and analysing more data, setting up new services and redesigning pathways

DURHAM DALES, EASINGTON AND SEDGEFIELD CCG

Durham Dales, Easington and Sedgefield clinical commissioning group entered into a partnership with Astellas last September to try and improve its urology service for patients across the Dales.

Astellas helped to fund an analysis (undertaken by WG Consulting) of the services that were already in place for LUTs and urology patients across the patch. The CCG matched this by employing a project lead to manage the pilot.

Clair White, the CCG project lead, explains that Astellas originally approached the organisation with figures which showed the referral rate for urology patients between secondary care consultants at one of their service providers – City Hospitals Sunderland Foundation Trust – was 400 per cent above the national average.

"One of the CCG commissioning intentions was already centred around the urology service, but when we saw the figures we realised that this was massive and a much bigger challenge than we previously thought."

She explains that the project team carried out a full service review of urology provision at the three providers – City Hospitals Sunderland Foundation Trust, County Durham and Darlington Foundation Trust, and South Tees Hospitals Foundation Trust.

"We analysed all the data across the patient pathways... and found that people were getting lost in the handover between services."

As a result of the pilot, the CCG has now set up a one day a week nurse-led urology assessment clinic at Bishop Auckland Hospital, part of City Hospitals Sunderland, with a further half day a week being provided at the Richardson Community Hospital, part of County Durham and Darlington.

"The aim is that GPs refer patients to these clinics and there is minimal need for onward secondary care referral... There were 750 patients referred to secondary care urology services that were discharged on their first appointment last year and this was the target group for referrals to the clinic," she says.

In total, the project team identified 1,000 extra referrals which were costing the CCG £480,000 a year, with GP urology referrals alone 20 per cent above the national average.

CCG chief clinical lead Dr Stewart Findlay says that the level of data the process created really helped to engage clinicians and patients in the pilot and make it successful.

"The extra funding and expertise from the partnership really helped to speed up the project," he says.

"In a way it was a type of free commissioning support. If we are really going to improve services in primary care in the future we have to make it possible for GPs and CCGs to do this kind of thing. If we don't invest in this kind of working we are going to run out of money," he adds.

Ms White agrees: "We needed project support from Astellas and WG Consulting or we would not have taken it to the nth degree and from identifying the problem to the pilot's launch in five months."

She says that engaging clinicians was crucial in developing the new service and that this was made much easier because they felt that for the first time patients had been put "at the heart" of developing the new and improved service.

"There was the worry that it would end up shifting referrals from one provider to

another but we worked closely with them and brought all the providers together to discuss what was happening."

The new service, which offered patients who are referred to the service by their GP an appointment within five days, has been running since May and the CCG has already seen a 40 per cent reduction in secondary care referrals.

MILTON KEYNES CCG

In Milton Keynes the partnership between the CCG and Astellas supported by WG Consulting started off in June last year after Dr Omotayo Kufeji, GP lead for maternity and children's services at the CCG, heard a presentation on the findings for urology referrals in other areas of the country.

"One of the primary drivers for us in deciding to work with Astellas was the publication of the recent NICE guidelines on urinary incontinence which has at the crux of it that these services can and should be managed and provided in the community," Dr Kufeji explains.

"When we looked at the figures we saw that some patients were being referred to hospital but were being redirected back to the community. We wanted to get the flow of patients to go through community services."

He says that the CCG wanted to make sure that only patients with the most complex urological conditions were being referred to secondary care.

As in Durham Dales, Milton Keynes CCG got project management support from Astellas and also employed its own project manager. Tim Jones, Milton Keynes CCG project manager, explains that the CCG had three providers all providing slightly different urology services.

"We found that actually all three services were needed, but what we did do was analyse the data on how practices referred to secondary care and the rates of referral to community services," he adds.

He says that all three service providers were asked to record a minimum dataset about each referral which recorded diagnosis, treatment and outcome.

The project team also got the three providers to agree a standard care pathway which aligned to the NICE guidelines.

"At the start of the project we thought that we had three providers providing the same services and the ambition was to develop a standard contract and care pathway and set up an any willing provider market that we had evolved. However, we found out that this was not the case and that the three providers were all providing slightly different services. We found that we were comfortable with having all three services."

'By having really good information about the services, we could benchmark the price and challenge it'

The three providers – NHS North West London, Milton Keynes Hospital Foundation Trust, and GP practice Newport Pagnell Medical Centre – held three different contracts for urology service provision with the CCG, but the data revealed that 90 per cent of referrals and activity were going through the medical centre.

"Nearly all GPs referrals go to Newport Pagnell," Mr Jones explains. "This fact brought our attention to the pricing and we have managed to renegotiate the pricing and saved £15,000 a year off the tariff price with Newport Pagnell.

"We were able to make the saving by having really good information about the services so we could benchmark the price and challenge it."

He says that, although the CCG may not have made huge savings, it has made some, as well as recovering the costs of the project. But in addition it has established a minimum dataset for urology patients across the region, which he adds in the NHS is "quite a big deal". And it now has greater understanding of referral patterns.

"We have established much better relationships with the three providers and have got a clinical reference panel where we know we can get together. From a clinical engagement point of view the project has been excellent.

"The services know much more about each other now and they are independently engaging with each other now, as well as the fact that they are all working to the NICE guidelines."

Dr Kufeji agrees: "There is a more standardised flow and pathway for patients now. Working with Astellas and WG Consulting has been hitch free and they have been very supportive.

"There are definitely benefits to CCGs working with industry and we would definitely not shy away from working with industry again in the future if what they are offering fits with what we want to achieve."

Mr Jones admits that the NHS in Milton Keynes has traditionally been a difficult area for industry to get into but that the partnership working and relationships between clinical leads and project management made the difference to this pilot. ●

ALAMY

SMOKING

DON'T LET SERVICES BURN OUT

Smoking cessation services must fight their corner in the new NHS and adjust to include new 'harm reduction' approaches. By Jennifer Trueland

It's the stories from taxi drivers that make a big impression on smoking cessation expert Linda Bauld.

Professor of health policy at the University of Stirling and the UK Centre for Tobacco Control Studies, she enthuses about the impact that quitting smoking has on individuals.

"You only have to sit in the same room with someone who has given up smoking to see what a phenomenal, life-changing effect it has had," she says.

"I've had the most amazing conversations with taxi drivers. I travel a lot and, of course, they ask what I do, and when I tell them I get their stories about how they quit, and what worked for them, whether it was using a product or going to a local group. Every story is important – one doesn't stand out more than another."

Smoking costs lives and it costs money, to individuals and the economy as well as to the NHS. It's well documented that smoking cessation services are among the most effective health interventions we have, potentially saving the NHS far more than the investment it puts in. But despite historical successes, the landscape of smoking cessation is changing, forcing services to adapt, and to make their case for funding to continue their work.

Structural change in the way that health services are commissioned and delivered was always going to be a challenge for the smoking cessation world. With responsibility for public health shifting to local authorities, those delivering services have to get used to a new way of working, new ways of commissioning, and new people to impress with their arguments for continued funding.

In a way, says Andy McEwen, director of the National Centre for Smoking Cessation Training, services now have to redo what they did 14 years ago when they were first being set up.

"Smoking cessation services really need to fight their corner and make sure they are seen as a priority for the local authority. It's still a very new field [in terms of health services] but they have to continue to make their case in the same way as they did in 1999."

A major challenge is a lack of understanding among some managers and commissioners about what smoking cessation involves. "There is some ignorance about the specialty – some people think that you just tell people to stop smoking, but obviously it's not that easy," says Dr McEwen.

'NICE became the first in the world to recommend a harm reduction approach for people who have been unable to quit in one step'

Smoking cessation services have a good case, he says, in that what they are providing is highly cost effective, but they have to guard against the specialty being "dumbed down".

This year saw the launch of a new practical tool known as VISION to help commissioners assess and model the smoking cessation needs of their populations (see box, overleaf) which, it is hoped, will help.

Viral Doshi, pharmacist specialist in the London Borough of Hillingdon, which offers a pharmacy-led smoking cessation service involving behavioural support and medications, is excited by the opportunities

CASE STUDY OVERLEAF ▶

brought by the commissioning changes.

"Smoking cessation remains the single biggest cause of preventable death and disability in the country and there is still a lot of work to do before we can reach our objective of being smoke free," he says.

"The [Hillingdon Smoking Cessation] service is excited by the opportunity to work with Hillingdon Council; the move allows us to contribute to a huge range of linked issues, such as the chance to show the wider societal impact of smoking, including littering and loss of productivity. We look forward to being able to be involved in further public health areas such as the pharmacy needs assessment, and are able to link in to the council's wide network of facilities and contacts, including its communications facilities."

The challenge for commissioning takes place amid a major shift in smoking cessation guidance.

In June, NICE published what has been described as "landmark" guidance on smoking cessation. Following a lengthy and exhaustive review of the evidence, the body became the first in the world to recommend a harm reduction approach to stopping smoking, for people who have been unable to quit in one step.

The guidance is the first to recommend that licensed, nicotine-containing products can be used to help people reduce the amount they smoke, especially those who are highly addicted to nicotine. This sets a challenge to smoking cessation services that have traditionally recommended and supported the "abrupt quit" approach.

Professor Bauld, who chaired the NICE guidance development group, defends the change. "I think there is good evidence now that we didn't have 10 years ago," she says. "I

think that services need to find a way of integrating harm reduction – it's something that services should be embracing."

Although there is no clear evidence that cutting down on tobacco consumption improves health, there is evidence that people who reduce the amount they smoke are more likely to quit eventually, with concomitant health benefits. Around two thirds of smokers in England say they are trying to cut down, compared to 40 per cent who say they will set a quit date. The two thirds who have said they want to cut down are more likely to quit in the future, says Professor Bauld.

On the ground, Mr Doshi accepts that there is a need to support smokers who are harder to reach and more resistant to quitting. "The NICE guidance is a useful intervention," he says. "However Hillingdon Smoking Cessation Services support those who wish to stop completely, and this will remain the main objective of our service."

The new kids in town in the harm reduction world are e-cigarettes. Not being licensed products (yet) these are not covered by the latest NICE guidance on recommending licensed nicotine-containing products. But the body does appear to give a qualified endorsement, saying: "Advisers should tell people who smoke that some nicotine-containing products (for example electronic cigarettes and topical gels) are not currently regulated by the Medicines and Healthcare Products Regulatory Agency and so their effectiveness, safety and quality can't be assured. Also advise them that these products are likely to be less harmful than cigarettes."

The MHRA has said all nicotine-containing products will have to be regulated as medicines by 2016. It is a move welcomed by most in smoking cessation, although it doesn't come quickly enough for some, who are concerned that products which don't have to demonstrate their efficacy, safety and quality will remain on the market until then.

Meanwhile, one of the main issues facing cessation services is getting people through their doors. There has been a rapid decline in demand in England, with around 500,000 fewer people (12 per cent) setting a quit date in 2012, compared to 2011. Does this mean that services will have to market themselves better to consumers, as well as commissioners?

Ben Carrick, director of global consumer policy with Johnson & Johnson, which owns the Nicorette brand of nicotine replacement therapies, accepts that services have to change. "The key thing is about helping someone to be tobacco and nicotine free," he says. "The low-hanging fruit has been picked, if you like, and services are now having to engage with people who are harder to reach and harder to motivate."

He believes that harm reduction has the potential to engage a wider group of people – not the "happy smokers" who want to continue smoking, but those who want to cut down, and who want, eventually, to be smoke free.

But Dr McEwen says that although numbers using NHS smoking services declined last year, previously there had been a steady increase for 14 years. "Smoking cessation services have a duty to provide an effective clinical service for people addicted to tobacco – in a way it's not up to them to get people through the doors," he says.

'There is evidence that people who reduce the amount they smoke are more likely to quit'

Professor Bauld agrees. "Since 2010 we haven't had any mass media campaigns in England because of the coalition government's freeze on public health advertising. We know that campaigns trigger quit attempts, so without the campaigns, we lost one of the most effective triggers."

Having said that, she believes that services themselves can do a lot to attract more people, including being more imaginative about how, and where, they work. She points out that numbers of people setting quit dates in Scotland increased following the new community pharmacy contract, which has a distinct public health element, and incentivises pharmacy-based services. Although the more generalist service offered in pharmacies is less effective in individuals than help from a smoking cessation specialist, the sheer numbers taking up the pharmacy-based services meant that, overall, more people quit.

Services can also help by keeping in touch with their clients, adds Dr McEwen. "We know the majority of people will go back to smoking, it's a serious addiction," he says. "But looking after your customers is basic social marketing; it's about keeping in touch and letting people know they can come back."

No smoke: e-cigarettes are taking off although they are neither regulated by the MHRA nor covered by NICE guidance

NEW TOOL FOR COMMISSIONERS

VISION (Value of Investing in Smoking Cessation Impact, Outcomes and Numbers) is a new tool developed to help commissioners assess and model the smoking cessation needs of their populations.

McNeil Products Ltd, the makers of Nicorette and owned by Johnson & Johnson, created VISION in collaboration with a group of public health and smoking cessation experts, and other stakeholders.

It is intended to help facilitate quantifiable decision making in the changing public health and NHS commissioning landscapes, and allows users to calculate the value of smoking cessation interventions.

According to senior public health manager Russ Moody, who introduced the model at the Public Health 2013 conference in March, VISION is evidence-based with an outcomes-based orientation, and is driven by publicly available data that can be fully referenced.

The tool has three main sections: the first gives an overview of the current situation for a given local area, the second allows you to start to calculate the cost burden of smoking by age group, and the third allows you to contrast and compare the value of smoking cessation interventions by building up a number of different scenarios.

For example, you might compare the benefits of giving nicotine replacement therapy over the counter to having a full smoking cessation service which includes all evidence-based interventions.

The cost burden of smoking can be calculated for all smokers, or broken down by age group, giving commissioners an idea of where the "hot spots" are, and allowing them to make decisions about where to focus their efforts in order to get the best value results.

According to Mr Moody, the unique selling point of the tool is its functionality and flexibility. Although it is based on the most recent figures for England, it can be adapted for other regional data, and is "pragmatic and practical", he says, giving information about the medium and long term cost savings of smoking cessation interventions.

SMOKING: CASE STUDY

SMOKE GETS IN TO THE COUNCIL CHAMBER

How public health managers in one city aim to develop smoking cessation in the new commissioning landscape – and ensure it keeps a high political profile

PLYMOUTH

For Russ Moody, investing in smoking cessation services is a no-brainer. The real question is how you make the best use of the resources you have.

"There's a vast evidence base – we know it saves lives," he says. "It reduces health inequalities, and is good value for money. But at a time when everything is being squeezed, we really have to look at what we're doing to make sure we are getting the most from our investment."

Mr Moody is a senior public health manager with Plymouth City Council, having moved to the local authority as part of the shift of public health responsibilities in April. As a result, he is responsible for guiding smoking cessation services into a new era, which he accepts brings challenge as well as opportunity.

On the plus side, he says, Plymouth has long been at the forefront of smoking cessation, which means there is a positive and successful base to build on. "We have a strong policy framework and we have well established local expertise, with very strong leadership from a core team," he says.

Back in the late 1990s, Plymouth was designated a health action zone, which came with specific funding to tackle health inequalities. This gave smoking cessation services in the city a flying start.

"We've been lucky in that we've had good, consistent support from executive levels, and good, consistent funding," he says.

Traditionally, he explains, smoking cessation services in Plymouth were run with a core team of experts, with no commissioner/provider split.

Now Plymouth City Council has outsourced the operational side, while keeping the core team. Rather than being stand-alone, as in the past, they form part of the wider health improvement team.

Good legacy: a pub in Plymouth, a city that has been at the forefront of efforts to cut smoking

There are risks in the changes, he concedes. "Historical relationships and referral pathways have been disrupted. There's a new interface, and Plymouth City Council has to establish relationships with GPs and pharmacists – and has to have individual contracts with each of them. There are over 100 providers, and we've got to manage those."

There are opportunities too, however. Because smoking cessation – and health improvement as a whole – now sits with the council, there is potential for synergistic action to help tackle the multifactorial issues which affect health and wellbeing, including smoking.

One of the ways in which Mr Moody believes smoking cessation services should adapt and develop is in listening more to the service users' agenda, and in trying to organise services and support accordingly.

"Our future plan is to become even better about finding out what people want," he says.

These could include improving access to services, and making sure they are available at times and places to suit those who already want to engage, as well as reaching those who currently do not.

He believes that the new NICE guidance on integrating a harm reduction approach will help engage more people, and will provide an opportunity for services to support more people to an eventual quit.

"I think we'd like to develop even better access, and to be a lot more client-focused, and much more involved in the kind of interventions they want," he says. "We could be a bit more holistic in looking at lifestyle issues – without losing our specialism."

One of the service's major strengths has been its proven track record of meeting challenging targets. Being able to demonstrate a return on investment has been crucial for ensuring that senior managers and commissioners take smoking cessation seriously.

"It's all part of the jigsaw," he says. "We're in the political arena with a real focus on resources."

He estimates that smoking costs Plymouth more than £100m per year, while smoking cessation costs around £1.1m – a worthwhile investment, he believes, as it has led to thousands of people quitting over the past 14 years.

Making that case strongly to commissioners is vital, however, which is why he was keen to be involved with the VISION tool developed by McNeil Products, the makers of Nicorette, in collaboration with a panel of public health and smoking cessation experts (see box, left).

"I'm excited about the opportunities of working with the local authority, and having the extra levers to make a difference to people's lives. It's good to have an extra tool to help drive strategic decision making and resource allocation." ●

ALAMY

BRUCE MELIZAN ON PRESERVING SERVICES

Delivery of healthcare services and the role of the private sector is an emotive issue. The reality now, with a budget shortfall of £30bn, is that both the public and private sectors need to be jointly focused on delivering the best outcomes to society, particularly when it comes to the commissioning of services.

In a recent survey on the future of public service delivery, undertaken by Interserve and YouGov, 82 per cent of healthcare respondents facing cuts expected them to lead to the outright removal or reduced availability of frontline services.

If we are to preserve service levels and improve the quality of the patient experience within budget, we need to redesign public healthcare service delivery. This requires the creation of patient-centred care that is coordinated across the patient's pathway in and out of hospital. We have observed that joining estate redesign, facilities management and a more patient-centric model of care can deliver enhanced utilisation of facilities and reduce the cost of delivering healthcare services.

To meet the fiscal constraints and the growing demand for services, the private, public and third sectors need to work together to redesign service delivery. We have been developing this approach through our work with University College London Hospitals and UCLH Charity to run the first UK patient hotel. The synergy between the partners is paramount to creating a smooth patient experience and saves the hospital a significant sum, as a traditional hotel is three times more expensive than the patient hotel.

'Healthcare staff facing cuts expected removed or reduced services'

Added to this, our ability to deliver complex care at home services, through Advantage Healthcare, means we can reduce hospital occupancy rates, inpatient numbers, hospital operating costs and enable better clinical care. Again, this sees health, social services, private and third sectors working together to help improve the commissioning process.

Both these concepts help highlight how important it is to consider the whole patient pathway. Looking past individual budgets, there is an opportunity to bring together the commissioning process and the care service to reduce costs and improve care.

There are still significant challenges ahead for commissioners but we hope these articles highlight some of the ideas and concepts that can help bring the system together, as well as how we can work together to improve patient care – whatever the environment.

Bruce Melizan is executive director at Interserve

www.interserve.com

EXTERNAL PROVIDERS

OUTSIDE EDGE

Private sector organisations argue that they can help commissioners tackle problems of cost and capacity, redesign pathways and join up services. Jennifer Trueland reports

If there is a consensus around any aspect of healthcare right now it's that commissioners are facing major challenges. Squeezed budgets, changing demographics, rising expectations plus the opportunities – and costs – of expensive new technologies all add up to a pretty powerful cocktail.

"Add to that the changes to the commissioning landscape and, wow, it's busy," says Bruce Melizan. As executive director with Interserve, a construction and support services provider with very close links to the NHS, he sees commissioners as the glue that brings cohesion to the different elements of the patient journey – but he says they cannot do it alone.

"If you fast forward five or 10 years, I know the public is going to have even greater expectations of the National Health Service. That drives the need for everybody to be open-minded about what services look like in the future. We need to make sure that everybody understands the capabilities of the health service, and make sure that everyone is focused on patient outcomes rather than on a more emotional – and less evidenced – emphasis on the source of provision. For me, great patient outcomes are rather more important than who provides the care."

Ian Targett, director with Westminster Advisers, a public affairs agency with a specialism in health, agrees that fresh thinking is needed. "There's been a fundamental change in the commissioning landscape since April and obviously that brings challenges," he says. "But in the medium to longer term we're really looking at more integration across the piece, and that includes local authorities as well as health services, and developing pathways that will bring things together. It's a massive challenge – if it had been easy it would have been done before."

He believes that local authority health and wellbeing boards are well placed to influence a more joined up approach, but says that they cannot do it alone. "What we need to see are partnerships between commissioners and providers to develop fresh ideas, not just around hospital care, but afterwards too.

"Care has got to be safe and appropriate, but alternative pathways need to be explored. We need to prepare for the healthcare challenges of the future, not just around the quality of care and the patient experience, but also about the sustainability of funding."

According to Tim Smith, strategic support director with Interserve, there's a real danger that commissioners are focusing on cost rather than on value for money – although he can understand the temptation.

"There are some real challenges for commissioners. It's a tough world out there for them, and I think that there is a danger that the pressure they are under means there is less of a focus on the patient, and more on cost. I think that commissioners, providers and the private sector need to come together and focus on the patient and look at value for money, rather than commissioning just on the basis of cost."

He says that increasingly Interserve is being approached after the tendering process is finished and asked to pick up a contract – often one which they hadn't gone for in the first place.

"There are times when we're either not winning contracts on the basis of cost, or not even tendering for them because we knew they could not be fulfilled at the contract price – only to be approached and asked to take over some weeks or months down the line.

"What I'm hearing more and more is that commissioners are working to a fixed tariff and we wouldn't even want to compete on

CASE STUDIES OVERLEAF ▶

Good value? Commissioners are being urged not simply to opt for the lowest price

‘Private sector organisations can sometimes be among the only constants in a transforming world’

that – then the contract fails and they come and talk to us,” he reports.

“I’d like commissioners to consider the consequences of looking at cost at the expense of value for money.”

Cost-based commissioning can actually lead to increased costs to the health service, if, for example, a patient needs to be readmitted to an expensive hospital bed. But there are also quality issues, he says. “The patient might be at home, but have had a bad experience. That’s important too.”

He believes that the private sector brings value in several ways, particularly as health services and local authorities bed in to the restructured public sector environment.

“There’s a lot of media-driven animosity towards the private sector, but we’ve been here for a while now and we’re not going away. There is a lot of capacity challenge in the public sector, and the private sector can work across boundaries and join the dots.”

In a sense, as public sector bodies change and develop, the “corporate memory” is actually held by private sector organisations, which can sometimes be among the only constants in a transforming world.

“We can help parts of the public sector to join up,” says Mr Smith.

He is an advocate for what he calls “whole place accounting”, that is, looking across public sector budgets as a whole, rather than in discrete – potentially competing – parts.

He gives an example from a local authority senior manager who lamented money spent unnecessarily on keeping a child in care. The grandparents were keen to take care of the youngster, but were in social housing and told they could not qualify for the necessary extra bedroom. The council therefore spent £1,000 a week to keep the child in care.

“The extra bedroom would have cost £100 per week – and would have saved the council £900,” he says.

New ways of thinking and commissioning across boundaries need to be considered, says Mr Smith, who suggests the private sector should be intimately involved in this.

He points to the patient hotel at University College London Hospitals, which is run by Interserve, and which offers patients much greater choice, as well as saving money (see overleaf) as an example where private and public sectors can work together successfully.

Mr Melizan agrees, and says that changes to the NHS work two ways: “There’s a lack of clarity, and that brings frustrations, but it also brings opportunities. We very much want to be part of the solution, working with commissioners to find the best way forward, and letting them know how we can help, particularly when it comes to looking after people with complex needs in their own homes.

“Where we do work together locally, it’s amazing how people’s imaginations can be unlocked and they can begin to see the art of the possible.” ●

EXTERNAL PROVIDERS: CASE STUDIES

FOUR STARS FOR YOUR NHS ROOM

UCLH's 35-bed patient hotel is just one notable example of private and public sector working together to cut costs and improve services

ADVANTAGE HEALTHCARE

In the quest for integration it's sometimes forgotten that community services are often ahead of the game.

Health, social services, and the private and third sectors are already working together to care for a diverse range of people in their own homes, and have been for many years.

According to some in the field, however, the full benefits to the health and social care system of care at home have yet to be realised, bringing challenges – and opportunities – for commissioners.

"I think that care at home has the potential to solve many of the problems currently being faced by the health service, and to smooth the patient journey from hospital to home," says Phil Burrows, managing director of the Advantage Healthcare Group, and a leading provider of care at home.

"One of the main challenges in today's NHS is managing the patient flow: you don't want patients to be stuck in hospital for longer than they need to be there. That leads to so-called bed-blocking, and has a knock-on effect throughout the system, including problems in emergency departments.

"But if you can get people home, in a timely manner, with a bespoke package of care, then you are managing that flow better and everyone, including the patient, benefits."

If anything, the new commissioning landscape – including the advent of health and wellbeing boards – should help drive that agenda. But in Mr Burrows' experience, the situation is patchy across the country.

Commissioning might be going more smoothly in areas where there is a commissioning support unit, he says, but even in these the new systems are taking time to bed in. A major block is building personal relationships, he says.

"The problem that we have, even as a provider with a proven track record, is wading through layers of people to get to the person who is actually making the commissioning decisions," he says.

"I'd like to see more direct engagement, so that commissioners actually have a better idea of what it is that we can offer."

Sometimes there can be a lack of understanding among commissioners at a local level of the range of services that are out there, he says. "There's a complex landscape, and a lack of engagement makes it even more challenging."

Private sector companies such as Advantage (which was acquired by Interserve last year) say they are offering an increasingly high level of care for everyone from the youngest to oldest in society, yet few commissioners will get them round the table at an early enough stage.

"What we're saying is that we can contribute at the planning stage – we'd like to be involved as early as possible," Mr Burrows says.

According to Bruce Melizan, executive director of Interserve, smoothing the patient journey from hospital to home is a key challenge for commissioners. "If you or I are seriously ill we want to be in hospital, being treated by the best people there are," he says. "But at a certain point in our recovery, if we're given the opportunity to be cared for at home, then I know what I'd prefer."

He believes that the current commissioning orthodoxy can actually provide disincentives for hospitals to get patients home more quickly, and says this doesn't need to be the case. "It's not that the systems aren't flexible; it's more that some ways of doing things have become hard-wired into local systems. I think that the solution is just getting the different parts of the system to work together and to communicate." Naturally he would like private companies like Interserve to be involved in this process, although he stresses that the private sector is only one part of the system – and doesn't have all the answers.

Ian Targett, director with Westminster Advisers – a public affairs agency with a specialism in health – agrees. He believes the private and public sectors have a lot to learn from each other, and that there is great benefit in bringing them together.

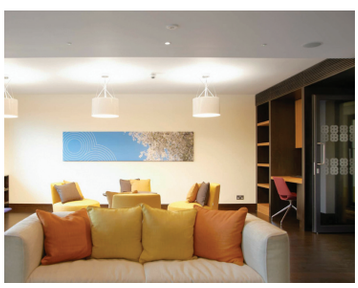
"I think it's a two-way street: it's about sharing ideas and pooling experience," he says. "But it's important – we're talking about working for patients and the long term sustainability of UK healthcare."

UCLH PATIENT HOTEL

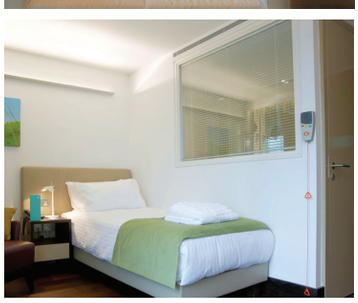
Last year, on the eve of the Olympics, a very special four star hotel opened in a discreet location above a building society in central London. Its stylish decor, comfortable furnishings and the friendly smiles of reception staff all suggest that this is an establishment where the wellbeing of guests is assured.

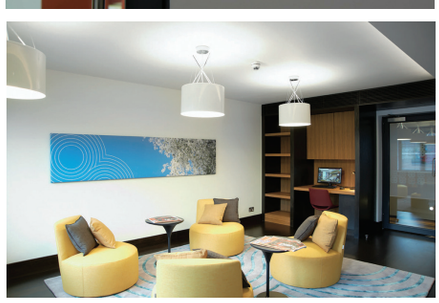
Only a few touches – chargers by the beds for drug packs, for example, and bathroom fittings designed for maximum infection control – suggest that the clientele might not be your typical London hotel visitors.

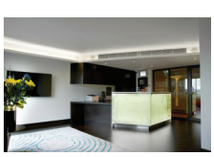
The Cotton Rooms is the first hotel of its kind in England. Developed for patients of the nearby University College London Hospital, and funded by UCLH Charity, the 35-bed hotel is run by Interserve, and is an example of private and public sector working together to benefit patients. It's also a striking instance of an initiative where private and public can learn from each other, working synergistically to create a smooth pathway where the patient experience is paramount. It welcomes 200 patients and



Hotel NHS: The Cotton Rooms have been enthusiastically received by patients and carers, who can stay there while being treated at UCLH







‘The problem we have, even as a provider with a track record, is wading through layers of people to get to the person actually making the commissioning decision’

carers a month, who would otherwise have had to travel daily for treatment, be put up in a commercial hotel, or have taken up an expensive hospital bed although there was no clinical necessity for them to do so.

“As a national referral centre we have patients who travel a long way for treatment,” says Alison Clements, head of operations and performance for the UCLH Medical Clinical Board. “Sometimes they have to come into hospital every day – for chemotherapy, for example, which is obviously very tiring. We were using hotels but realised it would be so much better if we had our own hotel.”

All the patients – or guests – are actually fit to be at home but they have the reassurance that they are close to the hospital if need be.

“It looks like a four star hotel, but it’s been designed with patients in mind,” Ms Clements says.

“I think it’s given more choice. The referral criteria mean that you have to be fit enough to be at home, but it’s true to say that some of these patients previously would have been staying in a hospital bed when they didn’t need it. It’s an added benefit that we’re freeing up hospital beds for people who actually need them.”

Patients are given choices over the sort of room they want, and can have a family member or carer to stay with them. Breakfast is provided and there is an airy common room where guests can gather if they wish, or they can relax in their rooms.

“It’s a cost-effective method for us,” says Ms Clements. “And it’s proving very popular with patients.”

It’s also proving to be a new challenge for the hotel manager. Interserve’s Eros Trevisan has enjoyed a varied career in hotel management, ranging from five star resort hotels abroad to country house establishments in the UK. Recently he worked on the rebranding of a Marco Pierre White hotel.

So how does the patient hotel differ from a “normal” hotel? “It’s very different. If you’re working in a commercial environment the emphasis is on profit; you’re always thinking of the bottom line. This environment, which is half public, half private, feels very different and what you’re aiming to provide is a bit different. Here, it’s not about profit, it’s all about customer satisfaction.”

If you look at the journey of a customer of a commercial hotel it’s “all about upselling”, he adds. “At every stage you’re looking for financial benefit. But here we’ve cleared all that and our aim is customer service. That’s reflected in our recruitment – we’re not looking for sales people, but for customer service.”

So successful has this approach been that Ms Clements – who calls the reception staff “exceptional” – is hoping to learn from their training and transfer it to NHS reception staff.

It’s also the first time that Mr Trevisan has been involved in setting up a hotel with input from clinicians and patients, but he sees the value in this approach. “We all look at things from a different viewpoint: designers want it to look good, but the clinicians wanted to make sure that patients had things that they would need.”

Feedback from guests has been hugely positive, he says. “They’ve been really enthusiastic about it. Sometimes people haven’t known what to expect – all they know is that it’s an ‘NHS hotel’ so they don’t know what that’s going to be like, or maybe they have some idea. But then they get here and, as one guest said to me, it’s actually a bit like a boutique hotel but with all the things you’d need.” ●

BritishRedCross

SERVICE REDESIGN

I WANT TO WALK TO THE END OF THE ROAD

Third sector support can help patients live independently at home – and achieve personal goals unlikely to be a part of any care package. Alison Moore reports

SUE COLLINS ON INDEPENDENCE

Every year the British Red Cross helps hundreds of thousands of people live independently in their own homes for as long as possible. The charity's dedicated staff and volunteers help people to rebuild their confidence, their resilience, and their health.

Its home from hospital schemes support patients who no longer require acute care but who need extra support to be able to cope at home, particularly when simply tackling the cooking and cleaning feels like a daunting challenge.

Its support at home packages help people connect with their communities, make sure they take the right medication to improve their wellbeing and, crucially, signpost people on to other support from the local diabetic nurse to British Legion clubs or exercise or knitting clubs.

These schemes not only make a huge difference to vulnerable people and their families across the country but are increasingly being shown to make a big impact to commissioners and the health and social care sector in general.

Independent research has revealed that British Red Cross services can save the NHS up to £10,000 per person supported, while another study highlighted a return on investment of £1.50 for every £1 spent by commissioners.

By reducing unnecessary hospital admissions, supporting hospital patients to be discharged as soon as they are medically well and preventing delayed transfers of care, taking the strain off GPs, and enabling people to stay in their own homes rather than care homes, the British Red Cross preventative care services can potentially save millions of pounds each year.

Sue Collins is head of independent living at the British Red Cross
www.redcross.org.uk

As the population ages and more of us suffer with chronic conditions, hospital beds are becoming scarce resources – ideally only used by those who really need specialist input, and with stays as short as possible.

But the dilemma for the health service is that it is not only health needs which determine hospital bed use. Very often people end up there because they can't cope at home or can't be discharged promptly because there is no support at home.

So it is no surprise that clinical commissioning groups and other commissioners are beginning to look at the broader picture of a patient's needs. While health input may be relatively easy to arrange, other elements of an individual's life may be harder to address. Social care can support people in their own homes but cuts in council budgets and time-pressured staff mean it is often an inadequate solution. And families may live too far away to fill that gap.

Many CCGs have found the solution lies in the third sector. The British Red Cross (BRC) believes it is unique in occupying the ground between home and health, offering a portfolio of services aimed at supporting patients to become or remain independent. Head of independent living Sue Collins says the services are very person-centred – supporting the person's individual goals and what they identify as important to them.

For example, one man the BRC helped had had a stroke that affected his communication and also his ability to use IT for services such as online banking. He is now getting targeted IT support and is regaining his independence through it. This has not only helped him but also his wife, who had relied on him to do these things and was starting to lose her independence.

"Everything we do is about promoting the service users' wellbeing," says Ms Collins. "We believe that if we promote the wellbeing of the individual, that promotes community resilience. We support people at home either post-hospital admission or when they could be at risk of admission. Many of our services support people through a crisis but the key thing is that we refer people on and we signpost other services."

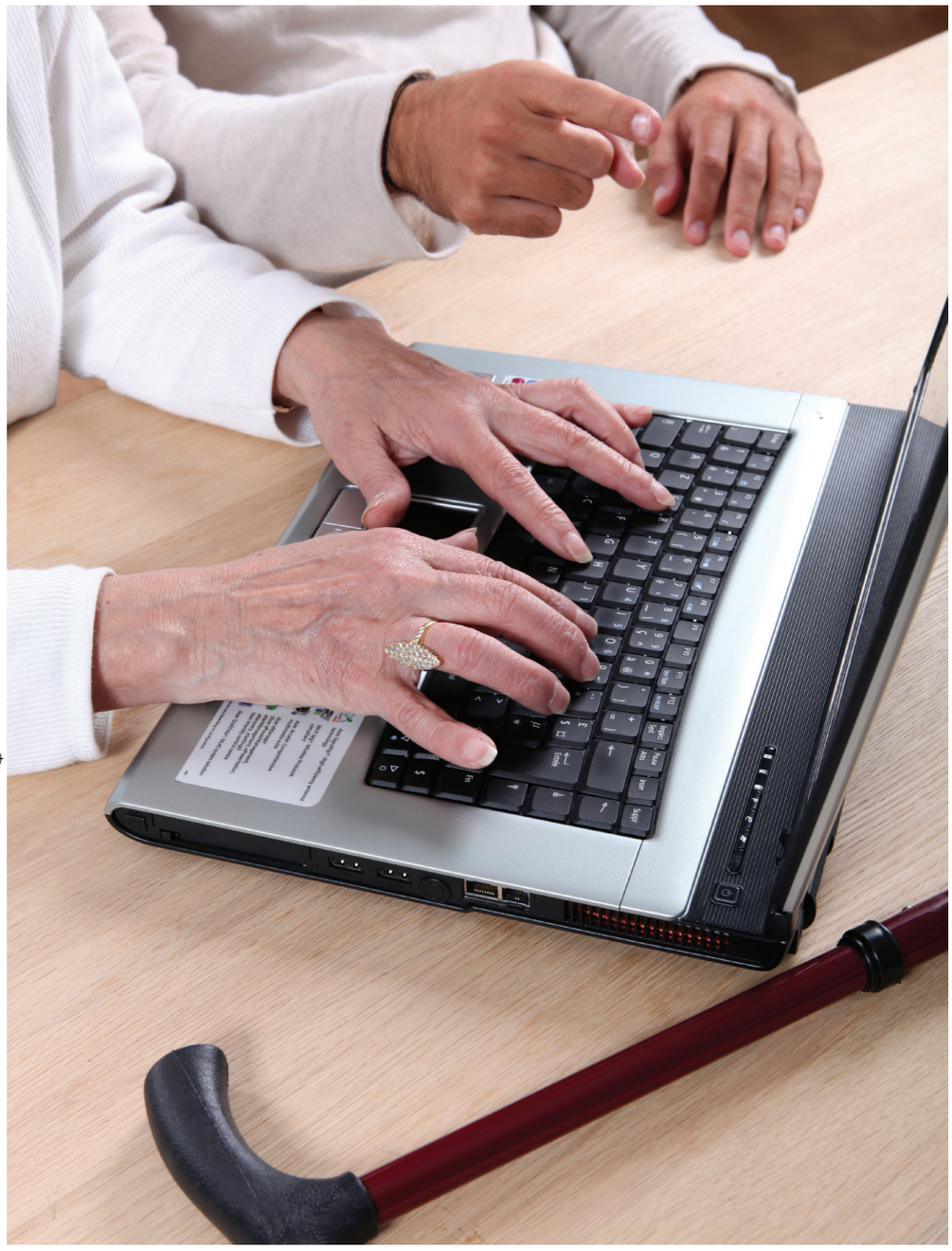
In many cases, this support will be short term, such as assisted discharge which has been piloted in Blackpool (see case study) and is now being rolled out in five acute hospitals in Glasgow. With trusts facing fines for readmissions, there is a new impetus for trusts to ensure people can be supported at home.

But in other cases support can be ongoing: the organisation works with dementia sufferers in South Wales, for example. Tasks can include ensuring dementia sufferers take their medications – but also staying to chat and to ensure there is a meal ready for them, and they are reminded to eat it. This support is not time limited and can be vital in keeping people out of institutional care or hospital.

'Tasks can include ensuring dementia sufferers take their medications – but also staying to chat'

"We have got a growing number of services directly commissioned by CCGs in England, and health boards in Wales, Scotland and Northern Ireland," says Ms Collins. Part of the attraction is the range of service on offer – from care in the home linked to admission prevention, through to equipment loans and transport and to what she calls added value services such as neck, back and shoulder massages for patients and their carers. "We have a compelling package of services which are focused on what the individual wants to remain living independently," she says. Ideally the BRC would like to deliver a consistent package of services across the UK, but that depends on support from local commissioners.

Many of these services are provided by a mix of paid staff and volunteers. But Ms Collins is keen that using volunteers is not



Keys to independence: the BRC has offered targeted support to help stroke patients use IT

seen as a cheap option – they require supervision, training and support. What they can offer in return is time – often far more time than would be available through paid social care, which tends to be task oriented and measured in slots of 15 minutes.

For example, one lady had Parkinson's and struggled to walk. With the help of a BRC volunteer she achieved her personal goal of walking to the end of the road. That took an hour – and would be unlikely to have been included in any care package.

Not every elderly or unwell patient will be able to remain independent: but keeping those who are able to live at home out of hospital is good for both them and the NHS.

CASE STUDY: BLACKPOOL

Every A&E staff member is likely to come across patients whose medical needs have been met but who are difficult to discharge because of their social situation.

They may have no one waiting at home, relatives who are some distance away and concerns about going home and spending the night alone. Many such patients will end up spending a night or more in hospital without a pressing medical need – putting pressure on beds and making it harder for trusts to meet the four hour A&E target.

But in the Blackpool area, such patients can be taken home by the British Red Cross, whose staff will settle them in, provide immediate support, and contact family, friends and care agencies if the patient wants them to.

It's a simple service but one which has been shown to save £280 per patient and help put them back on the path to independence.

Nalini Patel, who runs the 2pm to 10pm service out of Blackpool Victoria Hospital, says staff in A&E, the medical assessment unit and the discharge team will refer patients to the BRC. Often they can be seen within 10 minutes, assessed as suitable and can then be escorted home.

Once home, the BRC staff member will settle the patient, might make a hot drink and light meal, pick up any essential shopping, check the house for hazards – many patients have come into hospital because they have had a fall or a trip – and check they have taken any medications. This all helps to reassure the patient and means they can then manage overnight. They are also given an information pack about available services.

'Often patients can be seen at the hospital within 10 minutes, assessed as suitable and then escorted home'

A couple of days later the BRC will get back in touch to check on the patient. This is an opportunity to signpost them to other services – such as home care or meals on wheels – and arrange referrals which can help them going forward.

The Fylde Coast enhanced hospital to home discharge service has been running for over a year and has been funded by CCGs in the area. Last year it saw 780 people with an average age of 73, and the possibility of extending the service to cover weekends is being considered. ●