

Best of health

Improving lives through smarter care



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Foreword by Richard Lambert, CBI



The NHS today faces some difficult choices. The cost of healthcare is rising inexorably as new technology and drugs become available, while demand is mounting as our population ages and has ever higher expectations of what the NHS should provide. The public rightly expects high-quality NHS care, which is effective, efficient and responsive to patient needs.

Yet after a sustained period of investment, the UK public finances need a clear and robust path back to fiscal health. Following huge amounts of investment, productivity in the NHS has fallen on average over the last decade and improved only very recently. The NHS is seen as a national asset and should continue to be funded from general taxation with services free at the point of delivery. But it must develop and change to meet new needs and circumstances. In many areas, the need to demonstrate value for money could be the catalyst for long overdue reform.

The CBI believes re-engineering health services could reap savings for taxpayers, while ensuring the public benefits from high-quality health services. This report suggests there is considerable scope to reduce our dependence on hospital care and treat more patients, especially those with long-term conditions, in the community or in ways that deliver better health outcomes, increase patient satisfaction and reduce dependency on expensive hospitalisation. It is possible to make savings by re-engineering the delivery of services and addressing inefficiencies. Nowhere is this more apparent than in NHS primary and community care. All too often improved primary care feels like a runner-up to treatment in the big hospitals that dominate the public vision of what the NHS stands for.

Much good practice already exists. Many private and third-sector organisations are working in partnership with NHS organisations to deliver good outcomes at less cost, better patient care by reducing long stays in hospital, ambulance call-outs, A&E admissions while making substantial savings. Improved performance-management has also delivered higher patient satisfaction and better health outcomes.

The good practice examples in this report are not exhaustive, but illustrate the improved outcomes and savings using proven techniques, that could be more widely achieved.

We believe that if the best practice identified here in primary and community care were replicated, considerable cost savings could be delivered and health outcomes improved. Challenging the existing status quo by granting the freedom to innovate and to change will be empowering for patients and NHS staff alike. Patients will move from being passive recipients of healthcare to being actively involved in the management of their condition by measuring and reporting their own blood pressure or weight to clinicians, contributing to the formation of their own care plans. Staff should find ways to support patients in the community where patients find it best to be treated.

This report shows what has been achieved by the NHS and independent sectors working together. We know too that excellent results are being achieved by innovative practitioners in public sector NHS organisations. The results are impressive, but they exist in tiny pockets. Strong leadership is needed and we cannot afford to be precious about who delivers the service – public, private or third sector – as long as it achieves good results at the right cost. We believe more services need to face competition to drive the efficiencies most acknowledge are needed. We are not suggesting that transformation can be achieved overnight or that it will be easy or without cost, but the price of failure is high. We have an opportunity to re-engineer our health services so that they better serve the needs of today's society – and we cannot afford to delay.

A handwritten signature in blue ink that reads "Richard Lambert".

Richard Lambert
CBI director-general

Executive summary

Now more than ever, primary and community care delivery should be re-engineered to meet the increasing demands on the NHS.

Standing still is not an option for the NHS. Health needs are changing and so should health services. New treatments, better clinical practice and new drugs and technologies are changing the way care is delivered. Patients' needs are changing too as a result of demographic trends and lifestyle choices. And to top it all, twelve years of large annual increases in funding are spluttering to an end – while increased patient expectations cannot simply be deactivated or reversed.

The solution is to do more with less, finding ways to reduce the cost of healthcare without compromising on the quality of care. If it sounds impossible, there is already growing practice that is showing the way forward – through earlier diagnosis and prevention, through a replacement of unnecessary hospital admissions and treatment in the community. And while 'change management' programmes have too often stalled or produced only temporary effect, examples exist where staff have been successfully engaged in and are committed to the redesign of services to deliver more.

The challenges we face are manifold:

An ageing population: The UK's population is ageing. A third of the population – 20.7 million people – are aged over 50 in the UK and pensioners already outnumber those less than 16 years old.¹ Longer life expectancies are an outcome that owes much to the NHS, but for it to be really valuable older people need to enjoy a high quality of life. Achieving this is far from easy: more than two thirds of this age group already has at least one injury, disability or age-related disease – such as arthritis, dementia, incontinence, and reduced mobility, hearing and sight.

Impact of unhealthy lifestyles is growing: Improved standard of living and material affluence have brought health benefits, notably the near eradication of many contagious diseases. Increasingly, however, the UK's population is suffering the effects of increased affluence such as obesity, unhealthy diets and alcohol abuse. Even smoking, though declining after significant government intervention, remains stubbornly high in certain areas and among certain demographic groups.

Obesity, in particular, is rising rapidly: already almost a quarter of adults in England are currently obese, and if we carry on as we are by 2050, nine in ten adults will be overweight or obese. The cost of the overweight and obese to the NHS is estimated at £4.2bn and forecast to more than double by 2050 as it is associated with many illnesses and is directly related to increased mortality and lower life expectancy.²

Rise of long-term and chronic diseases and conditions: The early deaths of previous generations – linked to heart attacks and strokes – have thankfully fallen. Today, though, 17.5 million adults in the UK live with a long-term condition for which there is no cure: this includes patients with long-term and incurable conditions, such as diabetes, heart and lung disease, cystic fibrosis and respiratory problems, such as asthma.

Nearly nine million people report that their long-term illness severely limits their day-to-day activity³ and more than 60% of hospital bed days relate to long-term conditions – an incidence expected to double over the next 20 years.



Pressures on spending means real-term increases must stall but quality cannot slip: Over the last twelve years the record increases in NHS spending have taken the UK's annual health spend to over £100bn (**Exhibit 1**) and brought the UK close to the European-average Gross Domestic Product spending. Now standing at 7.3%, the UK's health spending is higher than Switzerland, Portugal, Belgium, Spain and Luxembourg, equal to Norway and only just behind Sweden and the Netherlands. But NHS finances will be constrained in the next five years.

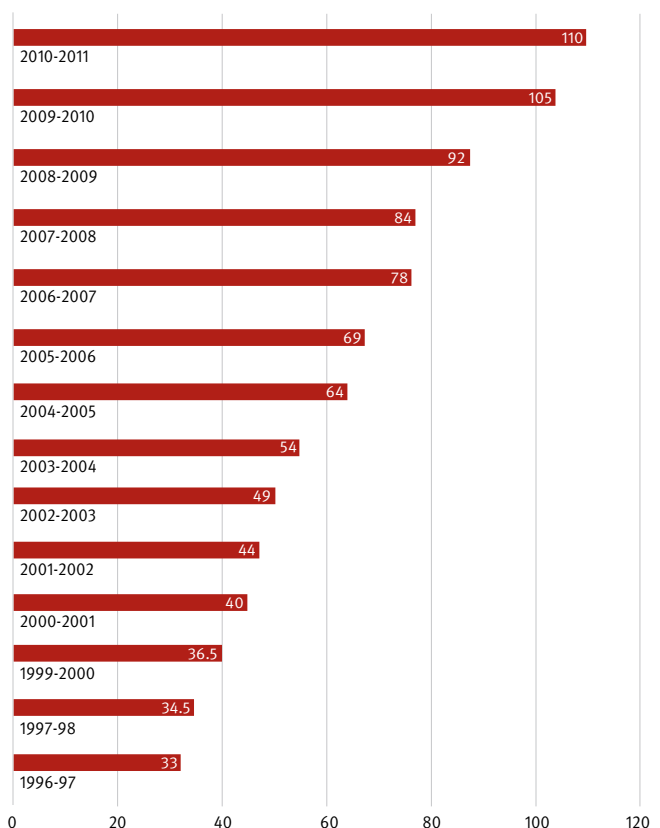
These challenges require specific action:

1. A focus on outcomes not outputs: The way we allocate resources, incentivise staff and organisations and measure success. For some, this may feel like starting again with a blank sheet of paper, but a fresh approach is needed to focus on outcomes rather than outputs. Considerable success has been achieved in reaching the government's targets on hospital admission – 18 weeks for routine elective surgery and four hours if via A&E. More patients are having their surgical procedures as day in-patient appointments, reducing the cost and increasing convenience for patients. But these output-based targets do not reduce unnecessary hospital admissions and extended stays. Too many people end up in hospital and stay there for longer than they need to: recent research for the Department of Health suggested around a third of patients did not need to be there. This has an obvious cost to the NHS and severely affects the health and life quality of millions of people with one or more long-term conditions who are disproportionately likely to end up in hospital. There is too much focus on hospitalisation as the answer to all ills. Too often, success is measured in targets based on the time a patient is kept waiting for care, rather than whether the care was necessary or whether the patient had a positive experience.

2. Measuring quantity rather than quality: similarly, the way the NHS works too often feels like a 'national sickness service' focused on cure rather than a 'national wellness service' that focuses on prevention.

At present more than 90% of all contacts with the NHS take place outside hospital – between patients and those who work in GP practices, pharmacies, dental surgeries and opticians and with the nurses, health visitors and other professionals who work in our community health services.⁴ But more than 60% of the NHS budget is spent on hospital care. Comparisons show that at £1,009 a head, the NHS spends more on hospital treatment than any other OECD member state except the US.⁵

Exhibit 1 NHS growth in real terms spending (1997-2010) £bn



We make a mistake if we assume that more spending means more success. The NHS today has an excessive reliance on hospital inpatient care and A&E department use. Instead of paying for activity in hospitals we should be paying for treatment that produces the right health outcomes – improvements to a patient's condition or health.

3. Too much focus on reactive and emergency treatment: there has been little thought about where and how patients should be treated, with most still treated in district general hospitals in the same way they have been for years. Productivity in the NHS has fallen steadily and at the same time hospital activity has grown considerably. The biggest danger is that as we have created new hospital care to bring down waiting lists, we have simply increased demand for it. Strategically, we should view ambulances and hospitals as recovery trucks and garages – necessary in urgent cases, but we should prioritise prevention. Only 24% of A&E attendances are admitted to hospital,⁶ suggesting many people are visiting A&E with minor symptoms such as headaches, diarrhoea and vomiting, which could be treated out of hospital.⁷

4. Resources in the wrong place: at present too many people who end up in hospital do so due to lack of suitable alternatives for them to be treated at home or in the community. This is not surprising since the pattern of community health service provision has changed little since the inception of the NHS in 1948. Specialists work in hospitals, GPs work in their surgeries, and community health service staff are largely peripatetic – frequently detached from primary and secondary care.⁸

Large hospitals, which are paid on a patient feed-through basis, are not best placed, for example, to reach out into the local communities and tackle the underlying causes of health inequalities or provide wraparound care for people with diabetes or depression.

Building on solutions that already work

There are already good examples of commissioners working with providers to tackle some of the stubborn challenges in healthcare and where new approaches to service delivery are improving the lives of patients.

1. Widening access for the many and not the few: Hard-to-reach groups of citizens with busy and highly-mobile lifestyles need healthcare provided conveniently. Walk-in centres on the high street and near places of work mean more people access NHS care, raising their health concerns earlier so that undiagnosed conditions are not left to worsen, leading to costly emergency treatment. Out-of-hours primary care backed by integrated patient information software already prevents thousands of A&E admissions, but could do to a greater extent if used more widely.

2. Real independence and control for patients: Providing care closer to patients' homes or in their home is not about asking vulnerable people to fend for themselves. Outreach teams, technological devices and individual care plans can ensure the right help is on hand when it is needed, avoiding hospitalisation. Planned this way, healthcare can be offered in ways that allow people to live independently in their own homes with improved control over their health.

3. Returning people to work early, preventing absence and improving workforce health: A more personalised NHS accessed easily and diagnosing illness earlier could also have an impact on absence from work and the number of people on incapacity benefit, which increase the cost of welfare payments and damages UK productivity. Half the 600,000 people who open a claim for incapacity benefits each year have a job and begin by getting a sick note, while sick leave costs an estimated £100bn a year.⁹ The new 'fit note' initiative is a step in the right direction, but working with business to support employees who might otherwise become long-term unemployed, combined with earlier support from the NHS could prevent illness and disease from undermining people's ability to return to work.

4. Empowering patients is crucial for success: Health education can empower patients to be involved in the management of their own conditions. Some are already feeling the benefit of greater involvement as they are actively supported to monitor and manage their conditions – with expert support on hand to give them independence and confidence. Keeping people active and mobile at home is crucial in preventing a downward spiral to loss of independence and ill health.



Analysis: What type of care could be delivered closer to home?

Condition	Number of patients/clinical sessions	Care at home
Diabetes	2.5 million people in the UK have diabetes and more than half a million people with diabetes who have the condition are not aware they have it. ¹⁰ There are 46,214 emergency admissions to hospital caused each year by diabetes, costing nearly £100m ¹¹	Pharmacists, dieticians, GPs and practice nurses need to be involved in the management of diabetes. Good control aids speedy recovery and early discharge from hospital. Patients can self-manage and seek help when they have minor ailments like chest infection, flu or diarrhoea and vomiting. ¹²
Stroke rehabilitation	More than 250,000 people in the UK live with disabilities caused by stroke ¹³	Regular blood tests in the community for at-risk people can prevent strokes. Smart discharge plans can manage a person's post-stroke recovery at home and in community settings. ¹⁴
Minor surgery/extended minor surgery	895,000 procedures in 2007/8 but the number is falling ¹⁵	Minor surgery in the community can improve patient access, ensure patients are seen and treated in an appropriate environment, utilise the skills of clinicians and maximise value for money. ¹⁶
Congestive Heart Failure (CHF)	60,224 emergency admissions a year at a cost of £207m ¹⁷	Community-based heart failure nurses can promote self-care and a bridge to acute care. Referral of moderate to severe patients reduces hospital admissions. ¹⁸
Chronic Obstructive Pulmonary Disease (COPD) – a lung disease caused primarily by smoking	1.5 million. 900,000 people diagnosed, approx 450,000 undiagnosed. ¹⁹ 110,748 emergency admissions to hospital a year ²⁰	Some COPD patients would be better cared for at home than in hospital. Experienced nurses assess patients' conditions in their homes, plan and deliver care, including prescribing drugs. A care bureau can provide 24-hour telephone support. ²¹
Dermatology	70,000 clinical sessions ²²	Community dermatology services already provide local clinical assessment, treatment, minor surgery and advice for a variety of non-urgent skin conditions. ²³
Palliative/end-of-life care	Around 350,000 people over 75 die in England each year ²⁴	The National End of Life Care Programme is designed to enable more patients to live, be cared for and die in the place of their choice, including their own homes. ²⁵

5. Empowering health staff to provide support to patients in their homes and communities: The culture change required and possible in NHS primary and community care cannot be achieved without the support and contribution of NHS staff. Care professionals want to buy-in to system change: for them it should mean less time wasted with the worried well and more time seeing patients who really need their attention. Nurses, midwives and other health professionals can move from hospitals to be better deployed in communities to better deliver better support for long-term conditions.

6. Spreading existing good practice: Existing practice, utilising the best of independent sector innovation, investment and incentivised performance is showing how services can be re-engineered in this way. While the results from innovative practice are impressive, too often they exist in pockets. Extending competition and patient choice in primary and community healthcare will deliver better outcomes. Policies to ensure the best provider should be implemented across NHS primary and community care. Above all, the way the NHS commissions and pays for services must be examined to ensure it is outcomes that matter which are measured, rather than what gets done. Competition and choice have been used to drive up quality and access by firing up the innovation of providers – no one sector should have the monopoly of provision – the best provider should be chosen at a price that can be afforded.

There is good practice to be found in the NHS today. Some commissioners are eagerly finding the levers that can change the NHS and using them to the maximum. They are setting themselves bold ambitions to improve health outcomes for their patients to ensure equity of access and excellence in service quality and at a price that is affordable.

7. Improving partnerships: Independent sector providers – from private and third sectors – bring new skills and working approaches to providing high quality public services. They will work strategically with public sector commissioning bodies to create efficiencies of scale and more productive ways of working. Competition among different providers to deliver health services can improve service outcomes and overall efficiency. When services are provided by government or public bodies as a monopoly, there is no stimulus to innovate and improve performance.

There are many benefits to having the independent sector working in collaboration with the NHS to help achieve the shared goal of improved health. Creating sustainable NHS markets with private and third sector providers competing increases the choice available to patients and makes all providers – public and independent

– more responsive to patient demands. Competition also has a galvanising effect on other parts of the NHS, stimulating productivity and improving health outcomes. The savings will make the headlines, but longer-term, the improved health of millions of patients will be what really count.

CBI recommendations for achieving reform

The following recommendations show the way for practical implementation of the solutions that can help the NHS maintain and improve even where significant savings need to be found and in a tight time scale. They have been developed through discussion with a wide range of independent sector providers of healthcare to the NHS and through roundtable seminars and other dialogue with NHS commissioners from across the UK.

The CBI recommends the Department of Health takes action to prioritise the following reform objectives:

Real and fair competition to drive improvements

Fair competition is needed to deliver the highest outcomes for patients at an affordable cost to the NHS. Present plans to divest the 152 PCT provider arms is an opportunity to create real competition, but re-badged ‘community health foundations’ and monolithic ‘super trusts’ formed through mergers with local Foundation Trusts will not achieve this. Instead, care provided by PCT ‘provider arms’ could be grouped by condition or patient pathway and awarded by competitive tendering to a plurality of providers from the public, private and third sectors. This would specialise community care and bring efficiencies as providers would compete on cost and quality.

Spreading best practice

There are pockets of best practice but frequently best practice is not adopted and spread. The Department of Health and SHAs need to increase the pressure to identify and spread best practice, ensuring that the right management and financial incentives are used to improve adoption of new ideas.



To ensure these aims are achieved, NHS commissioners should:

Challenge under-performance and decommission where appropriate

Commissioners should forensically examine the effectiveness of services they are responsible for. They should draw on high-quality performance data, which should focus on patient experience and patient outcomes, thorough appraisal is essential to maintain high-quality contracts. Where effectiveness, efficiency or patient satisfaction are low, steps to improve performance should be considered alongside assessment of whether the services have become unnecessary or obsolete. Payment should stop and services decommissioned should they fail to deliver or justify their continued existence alongside alternatives.

Ensure real choice and diversity in primary care

Patients need the same meaningful choice of primary and community care services as they now do in hospital care. Local commissioners should look for alternative venues, opening hours, staff composition, providers and service mixtures, to ensure all sections of the population can make full use of the services they pay for. To achieve this, they need to speed up their market stimulation efforts and ensure that all GPs and practice staff are properly informed of all the choices available and pass all of this knowledge on to all of their patients.

Collaborate to cut costs and increase democratic control

More local authorities and PCTs should identify areas of mutual interest and overlapping services to see where collaboration could deliver better outcomes and cost savings. They should conduct regular and explicit assessments to show that this engagement is occurring and is meaningful – for instance convening joint work to consider and decide policy and spending priorities for the common ground agreed. They should also involve each other in the development of their strategic plans and seek to jointly commission services where appropriate. This will enable them to explore opportunities to re-engineer services, interest new providers or challenge existing ones.

Achieve efficiency through innovative service redesign

Current small-scale tendering of existing primary and community care services has failed to radically re-engineer services or find large savings because the scope for innovation is too limited. If procurement processes set health outcomes expected instead of prescribing service design, providers would be incentivised to invest in and develop more innovative ways of delivering care. Flexibility over service design must be in the contract.

Have the faith to delegate

Effective delegation of power from the local commissioning board to an appropriate responsible manager can help overcome the slow pace of reform that can lead to inertia in the NHS. Involving the procurement staff with the relevant responsibilities right from the start at the design stage can also prevent costly reworking at later stages.

Develop new care pathways

In the future, armed with a wealth of information and on the basis of the views of patients and citizens, commissioners of all size should assess health services on the basis of clinical effectiveness and patient satisfaction. Those that consistently do not make the grade should see their funding removed.

We recommend that commissioners and providers should work together to prioritise the following objectives:

Ideas generated through strategic procurement

Commissioner engagement with independent sector providers needs to become more strategic and not restricted to single procurement processes or contract management meetings after a service has been awarded. Independent sector involvement in commissioners' development of strategic commissioning plans would generate more options for PCTs and drive greater collaborative working. PCT provider arm divestment offers a prime opportunity to do this. PCTs and SHAs that use 'meet the market' or 'provider engagement' days are making progress in this direction.

Information brings transparency and improvement

All primary care contracts should be based on data collection on outcomes, value for money and patient satisfaction. At present the majority of NHS primary and community care services do not do this, meaning commissioners cannot get an accurate picture of what the services deliver and how much they cost to run – and patients cannot find out how clinically effective they are.

Staff engagement reassures and enhances service redesign

Employee satisfaction is crucial to achieving patient-centric services that improve health outcomes. Staff engagement helps ensure that morale is high, so providers should use a range of direct and indirect methods to communicate with employees and should seek to build good relations with trade unions so that staff can contribute ideas on how to develop the service.

Harnessing professional expertise and skills

Traditional ways of working and inflexible professional boundaries can mean rigid team structures and restricted job responsibilities among health care professionals working in the NHS. Patient treatment and care are often grouped separately with poor communication and co-ordination between doctors and consultants and nurses and care assistants, even though they have been aiming for the same thing: returning the patient to good health.

Some clinicians have themselves felt excluded or alienated by service redesigns and have gone on to become opponents of change. Providing opportunities to stretch and motivate staff members by expanding and developing roles should be at the centre of service redesign: nurses, care assistants and pharmacists, for example, have already taken expanded roles in service provision, while multi-disciplinary teams have allowed staff to develop new skills in a safe, supervised environment.

Contract-management focused on outcomes

We need to move from a payment system that reimburses hospital activity but does not assess results. Contracts should specify long-term outcomes, rewarding interventions that improve and preserve quality of life for sufferers. They should include patient-reported satisfaction. Clear, outcomes-based key performance indicators should be set in contracts and payment and contract extensions should be based on results. Procurement through competitive tender and contract lengths of between three-to-five years would ensure providers were focused on the importance of these outcomes.

Cultural change requires effective leadership

The scale of the change that is required and possible in NHS primary and community care is likely to cause concern among staff and patient groups. These concerns are likely to add to existing differences of opinion between clinical staff and managers. Strong leadership has delivered support for change – and has been critical to making things happen at pace. Conversely reluctance to risk upsetting existing providers or a suspicion of national private sector providers has stifled further development.

Effective management and leadership is required at all levels so that improved patient satisfaction and health outcomes are delivered and to avoid political and ideological pressure to preserve the status quo and protect the NHS from apparent cuts. New and existing managers need training and support to equip them to secure staff buy-in to necessary re-engineering.

Tailored training satisfies staff and creates services that are quality and flexible

Giving employees appropriate training enables them to do their jobs properly and to use new technology to improve the way services work. The cost of training should be recognised during the commissioning process. Raising individual employability through helping employees to become multi-skilled increases the flexibility and quality of the service.

If all parts of the NHS can work together to implement these recommendations, we believe the NHS will make a more stable transition from steep growth in funding to austerity. But it will also produce a once-in-a-generation shift in the way NHS care is made, reaching new groups of patients, enhancing earlier diagnosis and allowing millions of people to integrate their healthcare into their everyday lives.



1

Improved accessibility and early diagnosis by providing healthcare in the high street, community and at home

A successful health service is one that delivers the type of care that patients want, when and where they want it. Increasingly, patients want greater control over their own health and the confidence to stay in their homes, knowing who to go to for help when something goes wrong.

Primary and community health services provide poor value for money where they are distant and fragmented, confusing patients who are unsure what to do when they have concerns. Patients with long-term conditions in particular have felt like passive users of healthcare rather than involved in the management of their health. Currently around 60% of hospital bed days are accounted for by people with long-term conditions. Many of these are unplanned because there was no alternative available, pushing up the cost to the NHS and discomfort and inconvenience for the patient.

Other citizens, for a variety of reasons, do not access healthcare: busy people and the young sometimes disregard health issues because they don't feel comfortable visiting a GP, leaving unseen problems, such as sexual disease, mental illness and high blood pressure to worsen. Those living unhealthy lifestyles with poor diets and heavy drinking or smoking avoid visiting their GP because they fear what they will be told and naively ignore the symptoms that follow, unsupported by health staff who could help them.

But where new services, in the high street, in the community and at home, have been developed, the results have been impressive. Easier access means a broader range of people can be helped and health inequalities can be tackled. Patients with long-term conditions can take more responsibility for their own health and enjoy a higher quality of life; while older people have been supported independently in their own homes for longer, taking the strain off hospital services.



Services should be designed to improve patient outcome by being responsive to personal and changing needs, by effectively identifying and supporting health needs and doing so efficiently and providing value for money.

Healthcare in the high street – early diagnosis and healthier lifestyles

Lifestyles in the UK have changed for many and today time is precious. More and more people are leading mobile and transient lives, moving house and locality regularly to find work, study far from where they grew up, live with their partner or to progress their careers. Commuting long distances daily to and from work is the norm for millions, as is travelling further afield to go shopping or visit dispersed family members and friends. Many employees in Britain also work long hours and cannot access healthcare easily without causing disruption to the working day and inconvenience to their employers.

Yet all this change has passed much NHS primary care by. Patients are still expected to register with one GP, often housed in converted residential properties away from main transport hubs and town centres. They are expected to predict their health needs in advance, make appointments, take time off work and visit GPs during strict office hours, Monday-to-Friday.

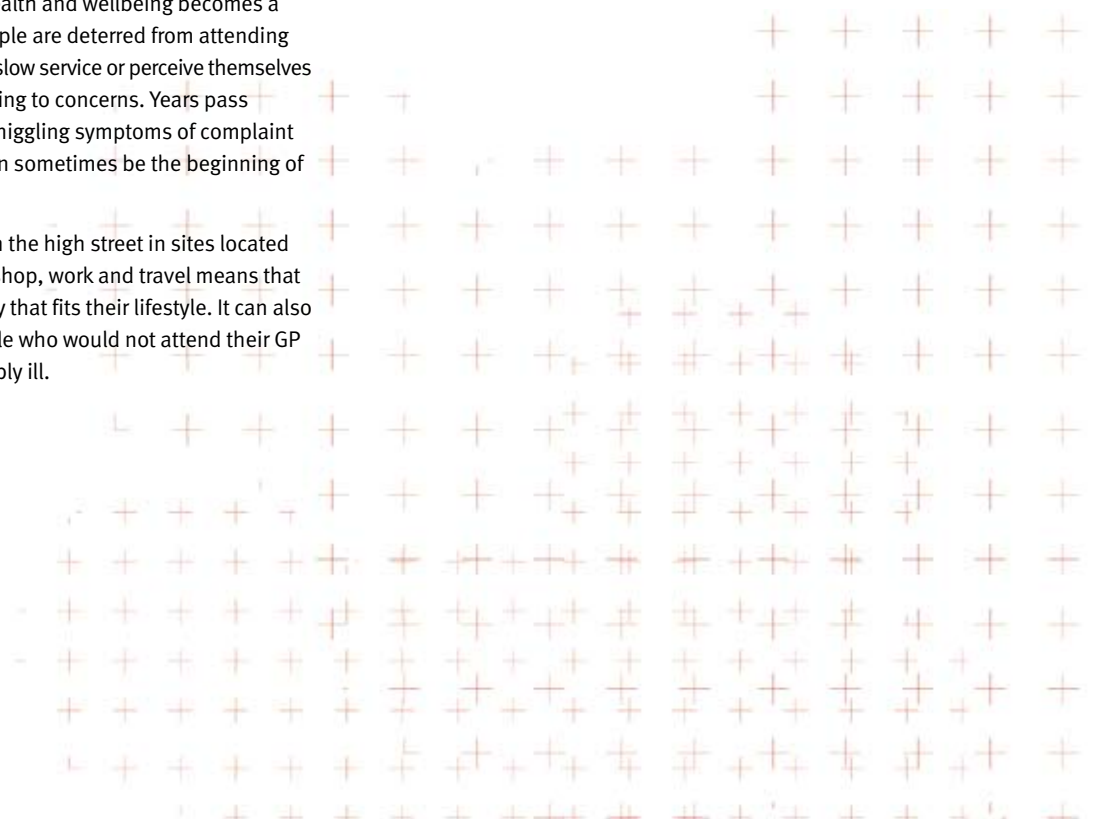
The result is that for too many, health and wellbeing becomes a second order concern. Some people are deterred from attending their surgery because they expect slow service or perceive themselves as being ‘worried well’ over-reacting to concerns. Years pass between visits to the doctor and niggling symptoms of complaint are ignored, even though they can sometimes be the beginning of something serious.

Providing access to healthcare on the high street in sites located in the places where people live, shop, work and travel means that they can use the services in a way that fits their lifestyle. It can also widen access to the kind of people who would not attend their GP surgery unless they were noticeably ill.

Recommendation: real choice and diversity in primary care

Patients need the same meaningful choice of primary and community care services as they now do in hospital care. Local commissioners should look for alternative venues, opening hours, staff composition, providers and service mixtures, to ensure all sections of the population can make full use of the services they pay for. To achieve this, they need to speed up their market stimulation efforts and ensure all GPs and practice staff are properly informed of all the choices available and pass this knowledge on to all of their patients.

For example, private providers such as Atos Origin successfully took part in the government’s walk-in centre programme to design new surgeries accessible for people ill-served by traditional general practice offerings – in particular, commuters. Half a dozen of the centres were eventually opened across the UK’s largest cities. The sites have been carefully chosen to maximise visibility and convenience, while the design and operation of the centres have been tailored with their patient demographic in mind.



Case study: Atos Origin and commuter walk-in centres for busy people

Atos Origin runs and operates the Canary Wharf NHS walk-in centre. Since the 1980s the area has grown to become a large business and shopping development, home to major banks, law firms, news media and service firms. In 2007, the number of people employed on the estate was 93,000, while an estimated 500,000 people each week shop at Canary Wharf. Nearby London City Airport and a plethora of hotels bring even more people to the area.

By all measures, the population is predominantly busy and transient, so the centre aims to ensure NHS care is accessible and convenient. It is open for 12 hours a day from 7am-7pm and is available to anyone who walks in. Patients are guaranteed a wait of no more than 20 minutes (and most wait less than this) and receptionists are given additional training to triage (prioritise) patients and, where necessary, direct them to other parts of the NHS to prevent time being wasted.

Monday is always the busiest day, when people working locally bring in health complaints that have developed over the weekend, but when their own GP surgeries are firmly closed. Atos responds to demand flexibly in its staff rota, matching the size and make-up of the doctor and nurse team to requirements – full strength to meet patient waiting time indicators but trimming down to just three members to avoid wasted capacity.

The centre sees far more than just ‘coughs and colds’ and of the 100 or so patients who drop in on a typical day, as many of six could be admitted to hospital via ambulance. Many others however are steered away from A&E when there is no clinical need. Minor injuries, for instance for broken ankles, can be dealt with quicker and more cheaply at the walk-in centre.

Although the centre does not have a list of registered patients, the fact that some have visited the centre a dozen or more times suggests they are satisfied with the service.

The Atos Origin centre was initially put under the microscope by sceptics but the local PCT has praised the provider and centre for its strong performance against key performance indicators (KPIs) covering quality, patient satisfaction and complaint handling, clinical governance and data collection. Strict guidelines ensure that a sufficient number of patient views have been collected for accuracy. The approach here has come to be viewed locally as the gold standard of data collection and replicated elsewhere.

The NHS needs high-quality information to ensure it is delivering the best care to the right people in the right place. Commissioners and providers need national and local benchmarking information of comparative data to enable them to investigate aspects of local activity, costs and outcomes and make decisions on when and how to make improvements or commission alternatives that will produce improved results. Historically, the NHS has been seen as data rich but information poor, failing to make best use of the vast amounts of data it collects. It often collects volumes on inputs such as referrals made and outputs such as procedures performed and in what time but not enough on outcomes, such as patient recovery and satisfaction.

Poor quality data and patchy collection has a subsequent effect on contract management, which in primary and community care has had a particularly bad reputation. At present, PCT provider arms are responsible for a combined spend of £11bn and employ a quarter of the clinical workforce, yet too many commissioners currently have too weak a grasp on the primary and community care services they pay for – the productivity of the workforce and clinical effectiveness of the outcomes.²⁶

There is a need to improve the quality of data submissions, but also the timeliness of submission. This is the responsibility of the organisations and people who provide the data. But for this to happen, commissioners need to make sure they stipulate in contracts with providers the necessity to provide high-quality, timely data. They also need to ensure that all the data they collect is comparable and reliable over a long enough period to ensure a clear picture on the relative performance of each provider and each service.

“The NHS has been data rich but information poor. This needs to be addressed”

Recommendation: information brings transparency and improvement All primary care contracts should be based on data collection on outcomes, value for money and patient satisfaction. At present the majority of NHS primary and community care services do not do this, meaning commissioners cannot get an accurate picture of what the services deliver and how much they cost to run – and patients cannot find out how clinically effective they are.

Appropriate KPIs matter directly to patients too. Achieving the right outcomes keeps the provider incentivised – for example Atos Origin has utilised its existing marketing skills to raise awareness of the centre through advertising on the Docklands Light Railway used by most of the area’s visitors, and through leaflet drops. Other GPs in the area have been forced to improve as a result of the centre. When large numbers of parents and children were presenting themselves to the centre at 8am during the week saying they could not get appointments with their GP, word reached the PCT. Shortly afterwards, nearby practices changed their appointments to satisfy demand.

Unnecessary or inappropriate use of A&E departments by patients who do not know where else to go remains a significant problem. Less than a quarter of A&E attendances are actually admitted to hospital,²⁷ often because the symptoms and conditions do not require hospital care and could be better treated in the community. Tower Hamlets PCT is working with the private firm Experian to use the company’s Mosaic Origins Classification to identify patient groups most likely to report minor symptoms at A&E, such as headaches, diarrhoea, vomiting and fainting, and then communicated the alternatives to them. In just four months it had reduced A&E attendance to the Royal London Hospital by more than 6% and seen a corresponding rise in appointments at local GP surgeries.²⁸

Walk-in centres can divert patients with minor injuries away from more costly attendance at A&E departments. On average, a walk-in centre visit costs around £44 whereas a visit to A&E costs around £69.²⁹ Only 24% of A&E attendances are admitted to hospital, meaning that over £250m a year could be saved if non-essential cases were seen in a walk-in centre rather than in A&E.³⁰ Co-locating NHS primary care services alongside high street retail stores is pushing the principle of accessible healthcare even further by tapping into household brands. Visibly grouping a range of services – such as healthy living advice, minor wound treatment, emergency contraception and advice – under one roof has risen patient awareness of the help available to those who want to improve their health but don’t know how.

Community pharmacies are highly accessible for patients of the NHS and those seeking to maintain good health. Around a billion prescription items are now dispensed annually by community pharmacists across the UK in over 12,000 sites.³¹ As well as being trusted by many patients, retail pharmacies make an obvious venue for the delivery of NHS primary care services. The informality and accessibility of the pharmacy encourages patients to feel comfortable raising difficult or embarrassing problems that they may not want to see their GP about, such as sexual health advice. It also means that when patients present themselves with one problem, other aspects of their health can be assessed and responded to.



Case study: NHS GP-led surgery and healthcare centre in a high street setting

NHS Somerset commissioned an NHS GP-led surgery in a Boots store that opened in September 2009. The NHS practice in Yeovil is the tenth GP surgery to be located in a Boots UK store in the last two years.

As part of the Equitable Access programme, the practice provides primary care GP services to registered patients and also provides a walk-in service to non registered patients – from 8am to 8pm, 365 days of the year.

The initiative follows other successful NHS schemes opened in Boots stores, a further nine independent NHS GP surgeries (including Halifax, Brighton, Peterborough, Chatham, Southampton and Bristol), a walk-in sexual health facility in Birmingham, an outpatients NHS dental facility also in Birmingham, an NHS phlebotomy blood donor clinic in Poole and an ophthalmic referral clinic in Watford.

The provision of these clinics and surgeries affords opportunities for more integrated health care solutions and improved outcomes. In Poole, for example, services such as dietetics, an acute back pain clinic, physiotherapy, podiatry and a GP branch surgery are all based together under one roof alongside Boots pharmacists and opticians, offering patients more health services closer to home.

Most Boots stores are located on the high street so working in conjunction with local health providers offers patients more convenient access to a wider range of healthcare services.

Boots is the largest community pharmacy provider in the UK, encompassing some 2,600 local and larger urban centre and allied pharmacies and is committed to working with PCTs and GPs to open more centres, similar to Birmingham. But progress is slow and schemes can take up to 1/3 more time than required to implement due to repeated and duplicated local PCT procedures that are not shared as best practice.

It is estimated that some 57 million GP consultations a year involve minor ailments such as acne, athlete's foot, backache, constipation and diarrhoea, which could be dealt with at a pharmacy. The average GP surgery consultation lasts 11.7 minutes and costs £32. The same 11.7 minute consultation in a pharmacy would cost £17.75. Moving just half these patients to a pharmacy could save over £400m a year.³²

High street pharmacies and walk-in centres are ideally placed to offer healthy lifestyle advice, preventing illness later in life, but also spot the early symptoms of costly conditions. Peripheral arterial disease (PAD), for example, affects at least 720,000 people in the UK³³ and over 102,000 people are newly diagnosed each year.³⁴ PAD is in the same family of conditions as heart attacks or stroke, but unlike them, it develops gradually and can remain unnoticed for long periods suffering lower rates of diagnosis and treatment. The heart disease organisation Target PAD has estimated that £48m could be saved by the NHS if identification is made earlier and more effectively.³⁵ Greater use of these types of informal and convenient settings could help achieve these savings and more for other conditions, such as hypertension, early stage osteoporosis and pre-diabetes, allowing them to be treated before they worsen.

Recommendation: spreading best practice There are pockets of best practice but frequently best practice is not adopted and spread. The Department of Health and SHAs need to increase the pressure to identify and spread best practice, ensuring that the right incentives are used to improve adoption of new ideas.

High street and walk-in centres are the logical venues for health MOTs

The Department of Health launched its NHS Health Checks scheme in April 2009 and aims to reach everyone aged between 40-74. It estimated that the scheme could prevent 1,600 heart attacks and strokes and help save 650 lives a year. This would be done through screening more people for high blood pressure and then proposing lifestyle changes and treatment with statins before they have a heart attack or stroke.

Community pharmacy is ideally placed to offer NHS Health Checks in convenient and accessible settings in the high street. This kind of scheme, emulating private health insurance by providing 'health MOTs' for the public, could be the logical next step for the kind of high street services described here. Their success in seeing patients

“Community pharmacy is ideally placed to offer convenient and accessible services in the high street”

earlier through their accessibility, convenience and informality has already meant conditions can be effectively diagnosed and treated earlier before complications have developed that require more intrusive and expensive interventions.

Larger independent sector providers, like Atos Origin and Boots, can and will invest in services to enhance patient access and care if they are given larger contracts that give them space to invest. For example, Atos’s Canary Wharf site offers standards of environment far higher than usual typical GP surgeries and being purpose-built, it is fully wheelchair accessible and includes specific design features –for example, to enable quick transfer to ambulance and collect urine samples in a discreet manner. The company’s other walk-in centre is on the concourse of Manchester’s Piccadilly Station, while a similar centre in Leeds is based inside the prestigious ‘The Light’ shopping centre.

Negotiations to achieve this were not easy and there was clearly a higher lease charge, but the significantly higher footfalls show patients appreciate it. The very limited expansion of existing schemes – barely a dozen NHS walk-in centres and co-located retail stores in almost ten years – means that commissioning lessons must be learnt to realise the benefits of innovation. Central co-ordination, through a national framework, for instance, would assist the implementation of the walk-in centre programme and ensure the momentum is sustained. But many independent sector providers, even those with a well-established presence in a local area, still report that this dialogue with commissioners is not happening.

Recommendation: ideas generated through strategic procurement Commissioner engagement with independent sector providers needs to become more strategic and not restricted to single procurement processes or contract management meetings after a service has been awarded. Independent sector involvement in commissioners’ development of strategic commissioning plans would generate more options for PCTs and drive greater collaborative working. PCT provider arm divestment offers a prime opportunity to do this. PCTs and SHAs that use ‘meet the market’ or ‘provider engagement’ days are making progress in this direction.

Convenient treatment in the community **Dealing with long-term conditions**

Patients with long-term and incurable conditions, such as diabetes, heart and lung disease, cystic fibrosis and respiratory problems, such as asthma, frequently find having a normal life a real struggle.

Many patients have to make regular and repeated visits to distant hospitals for planned courses of treatment, check-ups and tests, taking hours or days and weeks – incurring considerable travel time and costs. A lack of support between scheduled appointments over time can mean that when problems develop out of hours problems, patients have little option but to call 999 and face an emergency admission to A&E departments. In both cases, regular and long, unnecessary and sometimes unplanned stays in hospital, far from home, makes continuing or returning to work unlikely and isolates sufferers from their family and social lives. Where treatment for long-term conditions is disjointed or poorly-coordinated, it can have a big impact on lives of the relatives of a sufferer too.

Patients with long-term health conditions make heavy demands on the NHS. Recent estimates suggest that 52% of all GP consultations, 65% of all outpatient appointments and 72% of all inpatient bed days are associated with long-term conditions. This type of chronic disease management is not cost-effective. Regular hospital stays – especially unplanned ones which require ambulances and paramedics to bring patients in – tie up expensive and limited resources such as beds, staff and wards that are not best designed for managing long-term conditions.

To give one example, one common long-term condition is chronic obstructive pulmonary disease (COPD), a lung disease where people have difficulty breathing because of long-term damage to their lungs. The biggest single cause of COPD is cigarette smoking. It is one of the most common respiratory diseases in the UK and its fifth biggest killer, causing 30,000 deaths a year in England and Wales alone. More than 900,000 people have a diagnosis of COPD although this figure is thought to be much higher with as few as 1 in 4 patients actually having their condition recognised.³⁶

Like other long-term conditions, COPD can affect every aspect of someone's life, requiring very intensive and health regular monitoring through repeated visits to their GP and district nurse and an intense, indefinite course of medication. One million hospital bed days are required per year for people suffering with COPD.³⁷ If the treatment is poorly-managed or the medication incorrectly-taken an emergency worsening of health can develop. Today the annual cost to the NHS of treating COPD is over £800m and the cost to the NHS looks set to rise. But there is an alternative which can improve quality of life and reduce costs.

This is because, as with many long-term conditions, most care needs are predictable and can be delivered in the community, where it is cheaper, more convenient and improves the quality of life and health of sufferers. Instead of constant GP and hospital appointments planned throughout the week and 999 calls at evenings and weekends, patients can be educated and involved in the management of their own health. They can communicate with expert staff based remotely to ensure medication is taken and confirm their condition is stable. New multi-disciplinary teams can effectively be deployed to prioritise face-to-face visits to patients that need them most, offering faster access to services than was previously available.

Patients using these services report improved confidence and greater satisfaction levels because they know their condition is being closely monitored. They became more aware of their own symptoms and are able to self-manage them, safe in the knowledge that a rapid response is available if a change is detected or reported in their condition. Replacing visits to hospital with monitoring at home is much more convenient and improves quality of life for sufferers and their families.

Case study: Sheffield PCT COPD management through telehealthcare

- More people in Sheffield suffered from COPD than most other parts of the UK
- Patients with COPD were frequently being admitted to hospital, creating strain even though there was little need for most patients to be there.
- Telehealth monitors installed in the homes of COPD sufferers has meant that many can receive their care at home and be connected to health experts if there are any concerns.

Sheffield has a high prevalence of COPD. In some areas of the city, up to 8% of the 550,000 patients within the PCT have the condition, and in the city centre the figure is three times higher than the national average. This is due to regional factors and the area's history of occupational exposure from the steel industry.

With around 2,000 COPD-related hospital admissions a year, the condition placed a heavy burden on healthcare resources in Sheffield. The PCT decided that a fresh approach was needed to help minimise avoidable COPD admissions.

Monitors were installed in the homes of high-risk patients who had been discharged from hospital. These measure vital signs including heart rate, weight, blood pressure and oxygen levels. The monitor also asked a series of clinical questions to further determine the patient's current condition.

Once measured, the data is transmitted to central monitors in secondary care and to the public health development respiratory nurses office. The COPD nurse triages her 'virtual ward' against agreed criteria and can prioritise the visitation schedule.

As a result of the pilot telehealth study, COPD hospital admissions dramatically decreased by 50%. This saved the PCT between £30,000 to £40,000, allowing them to purchase 15 more monitors. During the pilot, home visits were reduced by 80%, cutting travel costs and allowing healthcare staff to prioritise their workload, which ensured the most effective use of their time. It has been calculated that based on a cost of £2,000 per hospital admission, saving 50 admissions a month, could potentially save the PCT £1.2m a year and across all PCTs up to £189m.

“Many patients reported feeling that their recovery had been better in their home than in hospital”

Where patients have become confident using their alternative services, big savings have been achieved. Medium and long-term efficiency savings have been found through steep reductions of ambulance call-outs, emergency admissions and unplanned hospital interventions, together with a fall in the number of inpatient bed days for those admitted. But too often overall the costs and savings are not assessed, with money spent in the community not offset against the greater cost of hospitalisation and A&E.

Early discharge from hospital into the community

Unnecessary costs and reduced patient satisfaction arises from the failure of hospitals to return patients home as quickly as possible once they are ready to do so. Bupa is taking part in a pilot study to correct this, working with a number of hospitals to ensure earlier discharge of patients into the community. Patients are still under the care of their consultant but have their treatment provided by Bupa in their home environment. The NHS Audit office took a sample group of 42 patients, estimating that 312 bed nights had been saved, freeing up capacity to be reused to improve productivity or potentially to be closed. Based on their independent figures the savings showed that care in the community was in excess of 55% cheaper than hospital care for the same patients.

Crucially, patient feedback reported very high rates of satisfaction: many patients reported feeling that their recovery had also been better in their home than in hospital, and while this was subjective, patient views matter. In some of these pilot sites, Bupa is being asked to employ a nurse to work with the matrons locally to identify suitable patients to be released into a community setting to develop the pilot further, so that more patients can benefit and more unnecessary hospital stays can be avoided.

The same principle could be applied to more patients and conditions, with potential for much larger savings. The Department of Health’s cancer reform strategy has calculated that £270m a year could be saved by reducing the number of unnecessary days cancer patients spend as inpatients.³⁸

Tailoring the care of these conditions around each patient can mean a more personalised service can be offered. Strong relationships between case-management staff and their patients allow both sides to build a shared knowledge of a person’s condition. This can then inform referrals to new types of treatment that can alleviate pain and discomfort and reduce unpredictable deteriorations in health.

Even when unplanned care is needed, out-of-hours concerns can be handled by primary care teams available to patients via specialised phonelines between planned visits. Proper signposting of this kind of help can mean that where emergencies do occur patients know where to turn, providing peace of mind instead of panic and distress.

Case study: Somerset PCT with Bupa Home Healthcare and Avanaula – COPD partnership providing patient-centric care for long-term condition management

- Somerset PCT has commissioned its new services for patients with long-term lung disease in a way that maximises innovation and emphasises outcome and integration over structures.
- It intends to diagnose chronic illness earlier, better support it in the community and avoid expensive acute care.
- The way it interacts and engages with its chosen provider encourages constant self-improvement to the service.

Somerset PCT has developed a new community-based county-wide COPD service. The service represents a successful outcome-based commissioning proposal because it was built around patient needs, informed by a questionnaire completed by over 100 COPD patients.

Prior to the commencement of the new COPD service in February 2008, support for patients and access to pulmonary rehabilitation was fragmented. Patients frequently found that if their health suddenly deteriorated they were being admitted to hospital because there was insufficient support in the community. Once admitted to hospital patients could spend days before arrangements were made for their discharge. This was expensive for the commissioner and uncomfortable for the patient, and fail to deal with the cause.

Patients are provided with a thorough evidence-based assessment (with the results documented) and all patients are assessed and have a personalised care management plan.

Following assessment, patients can access a wider-range of services in the community, such as, pulmonary rehabilitation, oxygen assessment, and nebuliser assessment as appropriate, in nurse-led clinics in a variety of community settings, enabling care closer to home. Patients are able to access 24/7 acute exacerbation support. Patients receiving long-term oxygen therapy (LTOT) can be reviewed at least annually, in accordance with NICE guidelines.

Rolling out best practice and cost savings

Successful community-based and outcomes-focused services are not easy to set up and operate. They require clear and strong local NHS leadership, patient and public engagement in the design, innovation on the part of providers and collaboration with clinicians and healthcare staff.

Since there is no medical cure for most long-term conditions, the services that treat them need to be built around the patient and their needs, such as convenience and improved quality of life. These should be the indicators that the contracts should be measured against and which payment should follow. Contracts that use such KPIs to regularly evaluate and report on outcomes such as patient satisfaction and complaints give a clearer picture on the effectiveness of care. The question that should be asked of all long-term care should be: ‘how can care best help patients feel healthier and happier and how can it be delivered in the most cost-effective way?’

At the moment, all but a handful of existing primary and community care services operate through a ‘rolling’ or indefinite arrangement whereby commissioners pay providers for health ‘activity’ undertaken – for example, hospital appointments for check-ups, ambulance call-outs, hospital admissions and in-patient bed stays – with no holistic appraisal conducted to measure their efficiency or effectiveness. This system ignores the patient because it pays for services and care that actually can have detrimental effect on a person’s health – for example, paying for each night in hospital, regardless of whether the stay was necessary and despite the discomfort and disruption caused to the patient and their family.

Contract length matters here. The current practice of indefinite rolling-contracts awarded to NHS providers that offer no incentives for sustained performance need to be ended, but many existing contracts with the private sector of less than five years and sometimes as short as one or two years do not provide sufficient time to encourage investment and provider commitment.

Recommendation: contract-management focused on outcomes

We need to move away from a payment system that reimburses hospital activity but does not assess a health outcome. Contracts should specify the long-term outcomes, rewarding interventions that improve and preserve the quality of life for sufferers. They should include patient-reported satisfaction. Clear, outcomes-based key performance indicators should be set in contracts and payment and contract extensions should be based on results. Procurement through competitive tender and contract lengths of between three and five years would ensure providers were focused on the importance of these outcomes.

Home support can help older people live independently

Increased longevity is a triumph for public health, but the UK’s population is ageing fast: a third of the population, 20.7 million people, are aged over 50 in the UK and pensioners already outnumber those under 16 years old.³⁹ By 2025 the number of people aged 85 or older in England is set to increase by 70% to nearly two million. In this group more than a third of men (37%) and more than half of women (55%) live alone⁴⁰ and more than two thirds of this age group already has at least one injury or disability.

There are a number of age-related illnesses such as arthritis, dementia, incontinence and, reduced mobility, hearing and sight. Almost half of over 75 year-olds will have age-related macular degeneration,⁴¹ damaging their vision and up to 700,000 people are estimated to be suffering from dementia in the UK today. People aged 60 and over now consume approaching 60% of all prescription items,⁴² while treating Alzheimer’s disease costs the NHS more than any other single disorder.

Even fit and healthy people lose strength and power as they get older and slips and falls are already the biggest cause of accidental death in the UK. Becoming immobile can often be the first step in a downward spiral to loss of independence and ill health.

Dealing with the increasing burden of aging is one of the biggest challenges facing the NHS today. Increased life expectancy without improved life quality for older people is a poor outcome. For too many people, old age can mean frustration, social isolation and loneliness, low self-esteem, withdrawal and depression. But this need not be the case with the right support.

A changed relationship with the NHS

Older people don't want to feel like a burden on the system, they want the care and support that can keep them active and in control of their lives. For most it will mean finding the right mix of support to keep them living in their own homes.

This will require intervention at community level and primary care should be the principle vehicle for the delivery of healthcare services at the most local level. People aged 65 and over already visit their GP on average seven times a year.⁴³ In the future, primary and community care services must evolve to pro-actively support older people – at home, not just closer to home – while avoiding unnecessary and expensive hospitalisation.

Service redesign, personalised assessments patient needs, new ways of working for staff, using visits and the phone, and a wide range of technological devices is helping to achieve this – the pace of change now needs to speed up.

Staff are working with older people to decide which methods will be most effective – for example, ensuring they take their medication on time and in the right doses – whether that will be written instruction, education, compliance aids and reminders or direct supervision. Monitors, phonecalls and visits are being used in the right combination to prevent and respond to trips and falls or to investigate absences of patients with cognitive impairments. This replaces the need to call out ambulances for false alarms and improves patient safety.

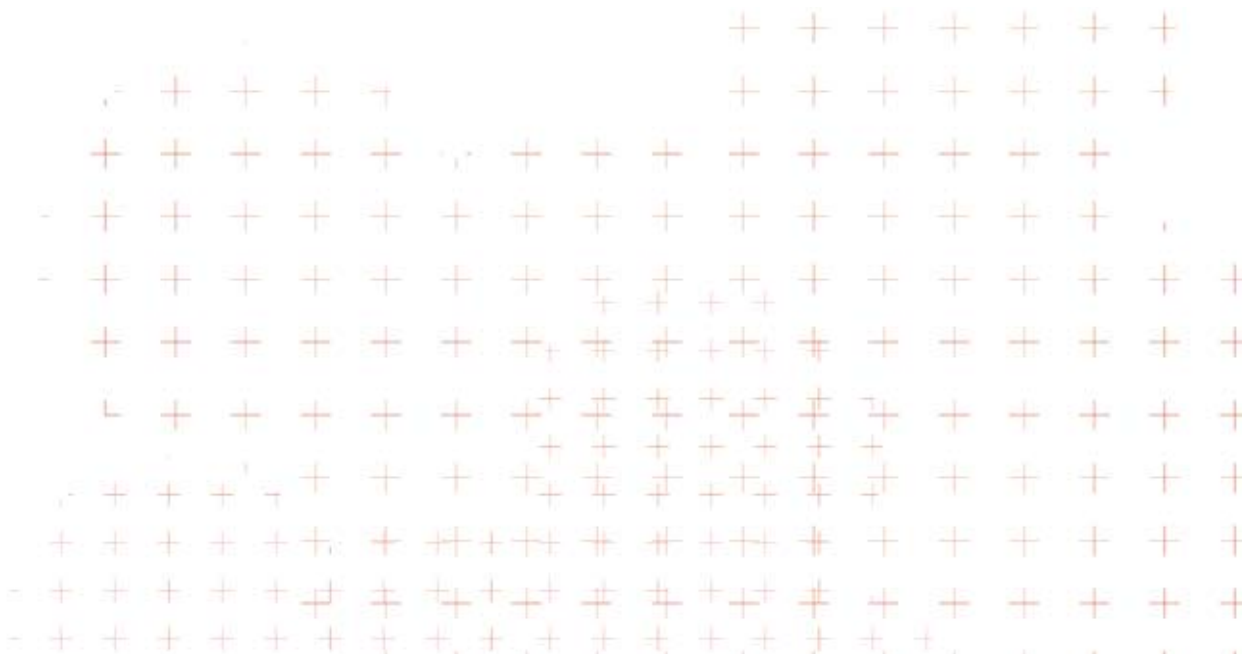
Case study: Nottingham PCT chronic condition management through telehealthcare

Nottingham City Primary Care Trust and Tunstall, a provider of telecare and telehealth solutions, have collaborated to use telehealth and telecare products to monitor around 800 people a year in their homes.

The monitors allow patients to measure their own weight, heart rate, blood oxygen levels, blood pressure and glucose levels, and also answer a series of questions to further determine their current condition. It then transmits the data to a community nurse to assess the information and provide medical intervention if needed. If necessary they will refer the patient to their GP or have them immediately transferred to hospital for emergency care.

With around 22,000 hospital admissions a year in Nottingham – 40% of all hospital activity – linked to people who could be supported at home, the telehealth project aimed to dramatically reduce hospital admissions and GP visits. This will lessen the burden on primary and acute care providers and ensure NHS resources are used effectively.

Furthermore, because Nottingham is the seventh most deprived city in the country, the PCT hopes that the initiative will also educate patients to be more aware of their own symptoms and to actively manage them – a vital step in reducing the burden on existing primary and community care services.



For telehealth devices, like those used in Nottingham, a five-fold return on investment has been proven on examples to date, reassuring sceptics of spend-to-save efficiency. Estimates show that, based on existing usage, if each of the 17.5 million people with conditions that could be managed at home were given a telehealth care monitor, hospitalisations could be reduced by 50% and nurse home visits by 80%. This has the potential for big savings, as the average hospital bed stay cost is £378 per day.

Better use of innovative service delivery like telecare technology could prevent 80,000 older people from entering residential care which would deliver cost savings of £4.5m by 2013-14 and give them the confidence to stay living independently at home.

It is not just technology that can bring these benefits either. Developing the working practices of primary care staff and personalising care through patient involvement can improve patients' wellbeing and peace of mind while taking pressure off NHS resources.

Better utilisation of primary care will lead to less need for hospital care

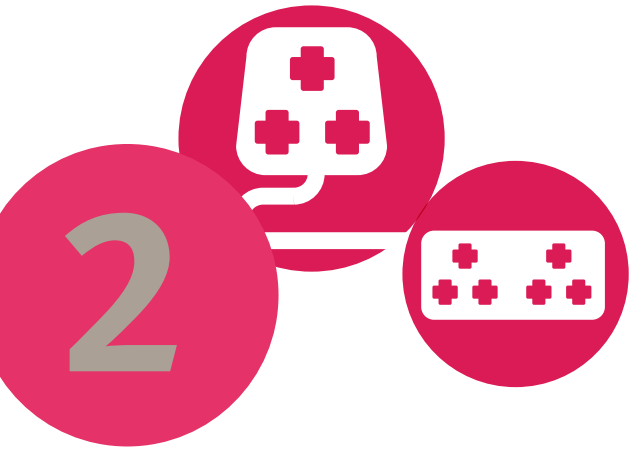
There needs to be more use of primary care services which give older people real independence in their lives by avoiding regular hospital visits and overnight stays and the associated travel and personal cost to them. With healthcare associated with their age impinging less on their daily lives, they have increased expectations of the quality of life they can enjoy. When in their homes, they have the peace of mind that expert staff are still supporting them from afar and will react swiftly to requests for help or signs that their health is at risk. For example, the Community Matrons Project in Newham, East London (a partnership between Serco and Newham PCT) works with hundreds of patients with age-related conditions, such as arthritis and heart disease and gives them the skills and confidence to self-manage their conditions more effectively at home.

This scheme is delivering measurable benefits. An evaluation conducted in July 2007 indicated a significant reduction in hospital admission among patients on the scheme, while those admitted to hospital reported shorter stays. The evaluation also found:

- Emergency hospital admissions had fallen by 26%
- A&E admission had fallen by 16%
- Non-routine contacts with primary care had fallen by 57%.

The project is on target to save the PCT about £3m over the next three years through helping people manage their conditions. Across all PCTs, this could mean up to £456m.





Integrated healthcare means convenience, efficiency and improved health outcomes

Patients using the NHS don't see professional boundaries or understand internal structures and they don't comprehend why health and social care are so separate. But they do feel the frustrations and suffer the effects of disjointed services: uncertainty of where to go, inconvenient appointments and wasted trips to hospital, endless visits to different sites, disrupting work and social life, constant retelling of their personal details and condition history, paper-chases between GP surgeries and hospitals, lost paperwork and medical records, delayed referrals, questions that cannot be answered because another department is responsible and uncertainty of 'what happens next'.

At the moment, the way the NHS commissions care too often does not take these types of patient experience factors into account and care 'pathways' are fragmented because the NHS sees primary care providers and acute care providers instead of one journey through the eyes of the patient.

If the NHS is to be a patient-centred organisation, then the way every part of it works should be designed with the patient experience in mind. Staff and pathway planners should consider how services and systems can fit together to raise awareness, fit around the patient's life rather than vice versa, and how they can keep patients informed, reassured and involved in their care. They should root out delays and money-wasting duplication.



There is a promising body of evidence to suggest that better integration of NHS and local authority care has the potential to deliver greater personalised care to patients and more economic care to communities.⁴⁴ It could also produce a shift towards health promotion and prevention through improved collaboration and involving patients in the management of their own care and health.

‘End-to-end integration’ means people can easily find one destination providing a logical home for previously dispersed services. Patients entering the service will find a smoother journey where internal communication has been strengthened by no longer being organised along segmented responsibilities, and will have a better awareness of the support on offer.

Healthcare integration has been used effectively overseas for the purpose of cost containment. This is because it can give managers a means for assessing human and equipment resources, which could lead to cutting inefficiency. But current good practice here in the UK demonstrates it can also be an effective tool for achieving quality outcomes. Integrated healthcare can be used to empower patients and staff, allowing the patient and commissioner to preview the expected care to be provided and boost collaboration between primary and secondary providers, hospitals and GPs and social care providers.

Suffolk PCT has been bold in its efforts to integrate the sexual health services it provides, successfully partnering with the independent provider, Take Care Now. The initiative involves the appointment of one ‘accountable provider’ for all sexual health services in the PCT area, seeking to join up the previously separated sexual and reproductive health services where care was split between the secondary and primary care sectors. The initiative will move sexual health services into the more informal primary and community care setting, reducing unnecessary costs and inconvenience/inaccessibility for young people and achieving the objectives of the national strategy for sexual health.

Because success will be based on specified outcomes achieved and the contract has been deliberately light on prescribing service structure, the provider has been incentivised to innovate to achieve allocative efficiency.

Case study: Suffolk PCT and Take Care Now (TCN) sexual health initiative: joining process not structures

Sexual health has more recently become a significant health improvement priority. Suffolk has rising rates of sexually transmitted infections (STIs) such as chlamydia and rising rates of termination of pregnancy. Although teenage conception rates are lower than the national average, they are high in some areas of the county.

But sexual health is more than prevention of STIs and unintended pregnancy: it has elements relating to emotional wellbeing, positive self-esteem and body image. TCN is working in partnership with NHS Suffolk and Suffolk Community Healthcare – the former PCT provider arm – to ensure high-quality and confidential services are available to everyone – young or old, male or female, with or without a partner.

The joined-up service links care and treatment that used to be separated between primary and secondary care. Activities such as prescribing the contraceptive pill, dispensing condoms, injections, implants, emergency contraception, information, counselling and confidential advice can now be referred more smoothly.

These can then connect better with services for preparation for pregnancy, pregnancy testing, abortion, breast and testicular self examination advice, blood testing, treatment for sexually transmitted infections – including chlamydia screening for under 25s, sexual difficulties and male and female sterilisation.



The freedom to innovate

Innovation and integration need to be built into the NHS and reflected in the contracts for providing services. Contracts that do not stipulate structures for how the services are to be provided and instead set metrics related solely to the health outcomes achieved are the ones that will enable the NHS to find savings and quality improvements through innovation. In the Suffolk programme, TCN has been given the freedom it needed to be truly transformational in service development; and has already reformed the role of consultants in some aspects of care. Rather than delivering treatments that did not require advanced skills, TCN's role has become a governing one with nurses now delivering the service. This has significantly reduced the costs and far from damaging care quality, it has allowed it to become more patient-focused.

By re-prioritising clinical expertise on the cases where the need is higher, resources have been moved from the highly-expensive hospital setting and into reproductive health services provided in the community, where it can be more accessible and proactive. In this case, preventative care, such as chlamydia screening, can now become more prominent and play a part in the ambition to improve public health outcomes.

Recommendation: efficiency through innovative service redesign Current small-scale tendering of existing primary and community care services has failed to radically re-engineer services or find large savings because the scope for innovation is too limited. If procurement processes set health outcomes expected instead of prescribing service design, providers would be incentivised to invest in and develop more innovative ways of delivering care. Flexibility over service design must be in the contract.

Improving commissioning and removing monopoly provision should help re-shape primary care services

Better commissioning and provider relationships offers a 'once in a generation' opportunity to refocus parts of NHS care on personalisation and outcomes – challenge the status quo in the way the Suffolk contract does, but it is clear that PCTs and SHAs are approaching the issue with differing attitudes. Some are acting as strong advocates of change in using competition and contestability to shake up service provision while others have been less confident and tentative in confronting existing provider-side interests.

Concerns have been expressed about the way some PCTs are divesting themselves of their provider arms – either in an uncertain direction or with a simple determination to separate balance sheets in time to escape criticism from the Department of Health or SHA. A focused but slower stakeholder engagement process is necessary. The outcome could still result in an arms-length 'community health trust' being created, but it would also allow proper market preparation should a market testing or tendering-out option be sought. Without this, there is a danger commissioners will feel restricted in the choices before them as very few independent or third sector providers could bid to run an entire provider arm at short notice.

Strong commissioning is an absolute necessity for the NHS and many commissioners would appreciate greater support with developing the necessary skills and competence. This could come through the creation of joint commissioning hubs like the ones being created in London, or drawing more heavily on the provisions of the Framework for procuring External Support for Commissioners (FESC). Or it could come from independent sector providers developing their own commissioning support products and taking them out to commissioners. Some SHAs are co-ordinating strategic commissioning activities for their regions by collectively establishing areas of priority where front-line clinical services have had historically weak clinical outcomes. With their commissioners they are preparing 'pipelines' of services that can be tendered to the market to attract options for serious re-engineering through new service provision.



Recommendation: real and fair competition to drive improvements Fair competition is needed to deliver the highest outcomes for patients at an affordable cost to the NHS. Present plans to divest the 152 PCT provider arms is an opportunity to create real competition, but re-badged ‘community health foundations’ and monolithic ‘super trusts’ formed through mergers with local Foundation Trusts will not achieve this. Instead, care provided by PCT ‘provider arms’ could be grouped by condition or patient pathway and awarded by competitive tendering to a plurality of providers from the public, private and third sectors. This would specialise community care and bring efficiencies as providers would compete on cost and quality.

Working across institutional boundaries can improve outcomes and cut duplication of costs

Very few of the people who most use NHS services do so in isolation – many of them also receive social care and support from their local authorities. Many local authorities and primary care trusts share co-terminus boundaries. The ‘total place’ pilot initiative looks to bring local authorities together with education, welfare, police, courts and skills bodies. The aim is to improve quality by joining up services but also to cut out duplication, reduce overheads and decide how much is really making a difference. For the NHS this is an opportunity to join together bodies responsible for promoting public health messages to cut smoking, reduce obesity and improve sexual health. This logically brings together healthy living services provided by the NHS with the leisure and sport facilities operated by local authorities.

The concept has already moved from theory to practice with some local authorities and PCTs already embracing the opportunity to collaborate. In Wales and Northern Ireland for example, successful steps have been taken to join adult health and social care services. Others have made joint appointments of senior managers. The same person fills the roles of chief executive of Knowsley PCT and executive director of health and social care at Knowsley Council, while in Herefordshire, a joint chief executive of the council and PCT manages a merged team comprising the 100 staff members from the commissioning arm of the PCT. Some 1,200 staff from the administrative functions of the county council Waltham Forest in East London are proposing to go further by recruiting a joint finance director as part of proposals that could lead to a full merger.

Knowsley credits front-line staff with beginning the processes of joint working that have spread to the higher levels of management. But this does not yet appear to be common practice in many other local authorities and PCTs who are still not co-ordinating, especially in the way they provide support for older people’s health and social care. In instances this is leading to perverse duplication and overlap, where two teams of employees are going into the same homes to make similar assessments or fit equipment in isolation of what the other is doing. This is undermining efforts to achieve the impressive savings possible when care in the home is well-planned.

But there are other reasons to integrate the working of both partners. Because by collaborating on a shared mission the two commissioners strengthen their impact. Local authorities bring a more developed local brand, lacking in the NHS where the concept of PCTs is new and unfamiliar, and also greater local accountability through direct elections. Combining their work with that of PCTs could help counter the view that local authorities lack responsibility and importance, because health services usually rank higher in importance with the public than refuse collection and road maintenance.

Moreover, with pooled budgets both sides are better able to command the attention of those providers who need a certain scale to participate. They can also have more confidence tackling and challenging embedded provider-interests in hospitals and GP surgeries, which all too often act as local monopolies resistant to change.

Strong local voices are needed – from patient groups and local government to help avert fears that the leading edge examples of service re-engineering contained in this report will clumsily translate into unquestioning support for mass-production and or crude out-sourcing. The best local authorities are well aware that communities have different needs and priorities and that the diversity and variation in the provision of services is necessary and welcome to reflect and respond to community needs.

“Bringing together primary and community services means patients can more easily access care”

Recommendation: collaborate to cut costs and increase democratic control More local authorities and PCTs should identify areas of mutual interest and overlapping services to see where collaboration could deliver better outcomes and cost savings. They should conduct regular and explicit assessments to show this engagement is occurring and is meaningful – for instance convening joint work to consider and decide policy and spending priorities for the common ground agreed. They should also involve each other in the development of their strategic plans and seek to jointly commission services where this is appropriate. This will enable them to explore opportunities to re-engineer services, interest new providers or challenge existing ones.

Helping patients to access the most suitable care

In other areas of NHS care, the use of technology and improved communication and engagement techniques can be used to integrate the patient-facing part of care to educate patients in knowing who can best help them, when they need it.

Until now, the ambulance service has been the victim of its own success – some patients with illnesses out-of-hours have instinctively dialled 999 for instance. Ambulance response costs are estimated at £158 per call, but many inappropriate calls are made, for example advice on earache or sunburn, and very often older people who have fallen but are not seriously injured.⁴⁵ A very large proportion would be better, and more cheaply, served by their GP, community services or a minor injuries unit.

Bringing together primary and community services under an umbrella has meant large numbers of patients have already been able to conveniently and easily access the care they need out-of-hours in a more appropriate setting. Delays have been reduced to make the journey more comfortable for patients and aid their return to work or home. These new services have solved the historic problem of a disjointed provision which patients struggled to navigate and which involved clinicians bureaucratically form filling to meet meaningless targets, diminishing the standard of patient care. Through better integration of out-of-hours primary care, a significant percentage of hospital admissions have been avoided and with it unplanned acute intervention which had been expensive for the PCT and inconvenient to patients.

Existing good practice must be extended more widely to build on the potential to deliver better outcomes. With the life of the existing pilots sometimes restricted to just three years, all sides will need to seize the opportunity to continue and expand good practice.

Case study: South East Health Ltd and (STAN) single telephone access number

- Three-year pilot aimed at assisting GPs in accessing alternatives to acute admission in an emergency using a single phonecall from referrer to a STAN (single telephone access number) clinician.
- Strategic approach aimed at reducing avoidable admissions to hospital, reducing delayed transfers of care and maintaining patients at, or close to, home.
- Pilot designed by GPs who acknowledged they had time for one referral phone call, not to phone round every service to see if they could meet the need .

In East Sussex and Brighton & Hove, private provider South East Health Ltd has supported GPs and other referrers to access appropriate care for 12,000 patients a year through a single telephone access point allowing a clinician to clinician discussion. The service has then taken on the entire liaison with the service provider, patient and family and ambulance service to transfer the patient on behalf of the referrer.

By developing alternative care pathways, 12% of patients (1,000 a year) have been able to access community-based services instead of acute care, getting care they needed, in the most appropriate setting while avoiding the risks of acute admission and saving the NHS the high tariff costs of acute admissions to hospital.

At the same time, gaps in community services have been identified which would have enabled a further 8% (800 patients a year) to have avoided acute admission if the services or capacity had existed at the time.

At the outset, many referring GPs and the acute hospital trusts disliked the idea of an interface of this kind but the service was a great success and is now much appreciated by referrers and receivers of patients and has been tendered as a contracted service.

Reducing hospital admissions through re-engineering of primary care will bring big savings to the NHS and improvements to the patient experience and health outcomes. In 2008/2009 1,026 patients utilised the reworked primary care pathways developed by South East Health and consequently avoided an acute admission at an estimated saving to the PCTs of between £1.3m and £2.5m. Potentially, this service could save the NHS £342m across all PCTs.

Harmoni has also successfully managed the demand for acute care elsewhere in the NHS. The Urgent Care Centre it runs at the front of an A&E has achieved significantly shorter waits for diagnosis – 19 minutes down from 93, while discharge time average 29.4 minutes saving on hospital stays. There has been a 29% reduction in low-cost investigations and a 5% drop in A&E admissions.

Supporting patients recovery in the community

Integration can work successfully at the other end of patient interaction with the NHS too – ensuring that after-surgery or intervention treatment and recovery can be completed in a safe, supported way, without or with reduced hospital or GP visits. This was the thinking behind Sheffield PCT's redesign of their intermediate care pathway.

It recognised that its current intermediate care service was not providing the city with the outcomes required. Problems identified through patient and staff engagement included above average length of stay in medical and surgical specialties, large excess bed day payments from PCT to the acute trust due to delays in care, discomfort for patients and double the national average rate of care homes with nursing occupancy by frail older people. Also, services across Sheffield were not consistent, having developed differently in the four predecessor PCTs, creating a fragmented service.

Sheffield PCT used management and development consultancy Mott MacDonald to conduct a 'gateway review' of existing intermediate care in the city. This delivers a peer review in which independent practitioners from outside a particular programme or project use their experience and expertise to examine the progress and suggest organisational change to improve results.⁴⁶ The reviews listen to the voice and concerns of patients and the public when seeking to change services. In Sheffield's case, more than 300 people and dozens of community groups contributed to the consultation process.⁴⁷

The new service was required to be patient-centred and offer choice, promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. A smooth and integrated pathway joining and improving existing services was seen as the best route to achieve

this. An assessment of what type of care and outcomes patients needed ensured that its gateway review produced a detailed plan of how and when it intended to commission the new service.

The effect could lead to decommissioning of existing hospital bed capacity, with the prospect of projected savings in the cost of each bed episode and the number that will be needed.

Case study: Sheffield PCT – a new vision for integrated intermediate care

Current bed-based intermediate care services and the assessment and rehabilitation centre will be decommissioned and a completed overhaul is planned for the intermediate care currently commissioned in the community because the two needed to be connected better.

The PCT has decided to split commissioning of the services into two sizable tenders to encourage vendor interest and investment.

Acute intermediate care would be centred on just one new-build site with only around 120 beds (a very significant reduction on the number being paid for before to deliver the specialised care that could not be provided in the community, including stroke, orthogeriatric and geriatric rehabilitation. The PCT believes it can not only reduce the number of bed stays significantly, but can reduce the cost of each intermediate care bed stay from £1,000 a night to £500. The acute side of the intermediate care service has initially been developed through collaboration between the local Foundation Trust, mental health trust and Sheffield PCT provider arm services on an initial contract expected to last five years. It was key condition that any assets procured would be on a tenant basis allowing the PCT full flexibility to commission from different providers if it chose to do so in future.

The PCT is again turning to the market for the community services aspects of intermediate care, by using a competitive tender process to select a provider, who will run the whole breadth of services to ensure maximum integration. The contract, especially for community care, is heavily outcomes-based with key performance indicators written into the contract whereas details of service delivery are not.

For example, providers will need to ensure provision of a single point of access with a two-hour response time for assessment of care needs and the service must facilitate local authority efforts to achieve timely social assessment and improved access to supporting services and technology which facilitate independent living.

A proper strategic review means patients can pass through specifically-designed centres and pathways rather than through old-fashioned ad hoc arrangements where they used to, for example, spend time in hospital on wards not intended for such care.

The new service has already sparked interest from several other PCTs from across England and the PCT will be looking to replicate the system design attributes to reshape other patient pathways which offer the same scope for improvement. But this new practice needs to be adopted more widely.

Recommendation: developing new care pathways
Armed with a wealth of information and on the basis of the views of patients and citizens, commissioners of all size should in future assess health services on the basis of clinical effectiveness and patient satisfaction. Those that consistently do not make the grade should see their funding removed.

Building on best practice and delivering cost savings

New services are welcomed by most people – staff, patients, community activists and politicians alike – but there is often a reluctance to acknowledge that better services can lead to excess capacity elsewhere in the system. With restrictions on NHS spending looming, rolling out new services and laying them on top of existing ones is a financial impossibility, so existing services will need to change and evolve to increase their effectiveness. The real challenge will be decommissioning services.

As this report shows, there are already successful examples of where commissioners have been bold and significantly reduced the number of hospital bed days they were paying for. This has not led to longer waiting lists or untreated conditions – rather to better outcomes and increased patient satisfaction.

But there are some who resist any change to hospital provision arguing that it is always in the best interests of patients to be cared for in hospital and that efficiency savings are not possible because the bed will be filled with another patient. Real service re-engineering requires that where bed days and hospital admissions have been reduced, the surplus capacity should be decommissioned without delay, otherwise inefficiency will worsen.

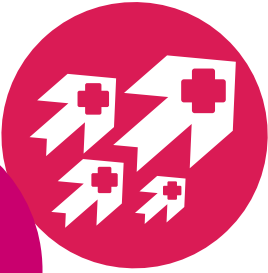
The Department of Health was right to tell commissioners to regard decommissioning of NHS services as a success because it meant that services which did not meet patient need were replaced with more suitable alternatives elsewhere. Where there is a clear, developed and credible rationale, decommissioning needs to become a more common activity for the NHS.

Recommendation: challenge under-performance and decommission where appropriate

Commissioners should forensically examine the effectiveness of services they are responsible for. They should draw on high-quality performance data, which should focus on patient experience and patient outcomes, thorough appraisal is essential to maintain high quality contracts. Where effectiveness, efficiency or patient satisfaction are low, steps to improve performance should be considered alongside assessment of whether the services have become unnecessary or obsolete. Payment should stop and services decommissioned should they fail to deliver or justify their continued existence alongside alternatives.



3



Getting employees on board is critical to re-engineering health services to achieve improved outcomes

The scale of the service change that is required – and is achievable in primary and community care – cannot be delivered without the support and contribution of the employees who provide the healthcare. There is enormous potential to improve health outcomes through better using the expertise and knowledge of staff, through changed working practices and through better use of new technology. These in turn will help improved integration of services and a new mature relationship with the general public and patients.

Healthcare professionals – whether from the public, private or third sectors – want the best for their NHS patients – but at times they can seem resistant to the change that could transform health outcomes and patient satisfaction. Wherever change is accompanied by uncertainty and concern about future job security, staff resistance can occur – too often change is viewed as an attack on jobs and medical professionalism. For example initially staff acted as a barrier to service integration and improved ways of working in the South East Health ‘single telephone access number’ until they saw for themselves the benefits on the ground.

Staff fears can be allayed through effective engagement in re-engineering services. Indeed staff involvement in re-engineering of the sort described in this report is essential as it can and should deliver benefits to patients but also for staff. Where better services are provided, staff have felt the benefit of increased job satisfaction – for example, from a new focus on the high-priority patients – where increased staff time is offered to those who most need it, rather than the worried well or those who are effectively managing their own healthcare. Healthcare professionals have been empowered to provide the support and education necessary to enable more people to live independently in their communities, secure in the



knowledge that help is there when it is required. This is in turn empowering for patients and their families, reassuring vulnerable people that they will not be asked to ‘fend for themselves’ at home.

Of course, effectively involving staff in change brings its own challenges, but shying away from these will lead to poor service outcomes. Staff engagement is an essential element in service redesign and staff must always be invited to consider how they could work differently in ways that would improve patient satisfaction and health outcome – rather than prioritising their own fears and concerns.

Effective engagement and involvement of health professionals is essential for successful re-engineering

Effective employee engagement, information and consultation are key to delivering successful services, because employee satisfaction is related to customer satisfaction and vice versa.

In the private and third sectors, healthcare employers know the importance of involving employees in decision-making matters, particularly the decisions that directly affect their working lives and the patients they serve. So they use a range of methods to involve employees, including direct communication through regular team meetings and newsletters as well as indirect communication through staff representatives. Establishing good relationships with trade unions, where they are recognised, is also important. Likewise, trade unions and employee representatives need to engage constructively with efforts to change and improve service delivery so their members can be proud of the service they offer.

This kind of engagement runs neatly alongside wider communication with the public, through elected representatives, particularly at the local authority level and also with representatives from local involvement networks and foundation trust governors and members.

Designing services with the involvement of local healthcare professionals – from doctors and nurses to practice managers and reception staff – ensures their expertise and know-how is captured in order to maximise their effectiveness and efficiency. The examples in this report show that when all or part of the local clinical workforce was not properly involved in the design or were not made fully aware of the services available, underuse of new provision has occurred – with patients that could benefit being unable to do so. For example, responding to pressure from patients and the service commissioner, as part of its COPD service in Somerset, Bupa engaged directly with the community and district nurses to identify the additional training needed to deliver the new support and to build on their knowledge of local delivery to improve service design.

Recommendation: staff engagement reassures and enhances service redesign Employee satisfaction is crucial to achieving patient-centric services that improve health outcomes. Staff engagement helps ensure that morale is high, so providers should use a range of direct and indirect methods to communicate with employees and should build good relations with trade unions so that staff can contribute ideas on how to develop the service.

Effective leadership empowers staff to deliver improved health outcomes

Re-engineering services requires cultural change and effective leadership which gives employees a line of sight between their job and the vision and aims of the organisation is essential. In the difficult financial conditions that lie ahead, it is vitally important that leaders maintain high levels of morale and motivation among their employees. Understanding an organisation’s journey is critical to keeping employees engaged.

Effective managers offer clarity on direction of travel and outcomes: they show appreciation of employees’ effort and contribution, treat their staff with respect and ensure work is organised efficiently and effectively so that employees know they are valued, and are equipped and supported to do their jobs.

Where there is a shared commitment from managers and staff to improve the patient experience and health outcomes the NHS will be able to deliver the scale of change necessary to make the savings required without compromising on service quality. Where staff feel they are able to voice their ideas and be listened to, about how they do their job and in decision-making in their own department, with joint sharing of problems and challenges, and a commitment to arrive at joint solutions, real change can be delivered.

For example Sheffield's decision to mainstream telehealth across the city followed a successful 12-month pilot in 2007, which saw a reduction in hospital admissions, GP visits and matron and community nurse home visits. The same technology enabled primary and secondary care teams in Nottingham to make the best possible use of healthcare resources. Successful pilots can help overcome the fear of change and demonstrate that teamworking and effective use of new technology can enable services to be delivered in new ways that benefit patients.

Full involvement of all team members is essential, and during the Sheffield pilot, a community matron case-managed the patients to prevent unnecessary hospital admissions. A specialist team of occupational therapists, nurses and physiotherapists from primary care is now working with secondary care respiratory nurses to manage patients with more complex needs. Supported by telehealth, this helps timely discharge from hospital, allowing valuable hospital resources to be redeployed to other key areas or to be decommissioned.

Recommendation: cultural change requires effective leadership

The scale of the change required and which is possible in NHS primary and community care is likely to cause concern among staff and patient groups. These concerns are likely to add to existing differences of opinion between clinical staff and managers. Strong leadership has delivered support for change – and has been critical to making things happen at pace. Conversely, reluctance to risk upsetting existing providers or a suspicion of national private sector providers has stifled further development.

Effective management and leadership is required at all levels so that improved patient satisfaction and health outcomes are delivered and to avoid political and ideological pressure to preserve the status quo and 'protect' the NHS from apparent 'cuts'. New and existing managers need training and support to equip them to secure staff buy-in to necessary re-engineering.

Leadership is about more than telling staff what to do or coaxing them on a journey: it is also about creating a space in which people can do and want to do what needs to be done – in other words, 'task, trust and tend'.

It is front-line staff who will often provide the most effective new ideas for ways of working that will save time or money and improve patient experience and health outcome. This is because they often understand what is going on at the 'shop floor' better than management. So involving them in the setting of an organisation's strategy and devolving discretion to them of how to meet agreed goals will not only help increase the likelihood that they will be focused but will allow required changes to be fed back up the management tree to keep the organisation on track.

Sometimes, complicated and slow procurement processes have prevented the expansion and replication of re-engineered services that have been successful elsewhere – like the expansion of GP services based in high street stores or the early projects that used telehealth and telecare technology. Trusting procurement staff is key to reversing this: they should become the single point of contact for providers, empowered to lead a more proactive approach to developing innovative solutions to persistent health problems. Once the right checks and balances are in place – for instance financial caps – commissioning bodies should devolve responsibility to local procurement staff to sign-off services that replicate a successful service model from elsewhere. This would ensure decisions can be made more swiftly, allowing more pilot projects – already notorious in the NHS for stalling – to grow and spread quickly, bringing benefits to more patients.

Recommendation: having the faith to delegate

Effective delegation of power from the local commissioning board to an appropriate responsible manager can help overcome the slow pace of reform that can lead to inertia in the NHS. Involving the procurement staff with the relevant responsibilities right from the start at the design stage can also prevent costly reworking at later stages.

“Leadership is about creating a space in which staff can do and want to do what needs to be done”

Team working will lift improvements in care and staff morale

Patients value the contact they have with health professionals – doctors, nurses, practice staff and health visitors. There are many examples of new teams being formed and innovative services better utilising staff skills being set up. This should be part of a move away from meeting targets that miss the point – towards treatment and care of NHS patients that improves health outcomes. But like many large organisations, the NHS has too many teams and specialists that work in silos with little or no integration. This is bad for patients because it leads to overlaps and duplication – or gaps in provision.

Often staff working in local communities are more aware of the needs of that community than staff in large hospitals. For example many pharmacists want to develop their role from dispensing prescriptions to spotting the early signs of poor health and providing screening to diagnose it, or life-style advice to prevent it. It can also mean nurse-led units taking on the role previously filled by consultants where a reassessment of the medical requirements made it possible.

Creating multi-disciplinary teams to deliver care for complicated chronic conditions can ease communication and integration, reducing delays and also made the service more patient-focused. For healthcare staff too, there is the benefit of spending more of their time on core healthcare work as false alarms and unnecessary calls-outs are much reduced and the associated travel avoided. Staff in these teams are able to use a wide range of methods to stay in touch with their patients – this increases their effectiveness clinically and raises efficiencies by prioritising patient contact over travelling to and from the office.

Case study: A4e and Heart of Birmingham PCT assisting new mothers through a new approach to community midwifery

Aston is an area of high social deprivation: it has the second highest 'Jarman 8' score of social disadvantage within Birmingham and the area's unemployment rate is more than double than that of the whole of Birmingham. Aston has a younger population than that of Birmingham, with relatively more children and fewer persons of retirement age than the city average. The need to redesign service provision and deliver improved accessibility to core services to improve the health and social outcomes for the Aston area was obvious.

The Community Outreach Family Support Service are working with the Maternity Support Service to tackle embedded problems to ensure early detection of premature life expectancy and specifically, reduce the infant mortality rate to at least the city average and at best the city's best.

A4e has focused the service on providing activities throughout the community, including a more flexible programme of parent education and drop-in for maternity advice to facilitate choice and access. A revised education programme delivers workshops around pregnancy, birth and parenthood in a variety of formats. It also offers pre-conception care and advice to support the transition into parenthood, while antenatal care, breastfeeding and post-antenatal care continues until the child is 12 months old. Furthermore, there is a flexible drop-in clinic available to those that have missed their appointments. The ultimate objective is to catch people upstream and impact on infant mortality as well as reducing visits to A&E. It provides maternity care to an estimated 900 women a year.

High quality care, targeted on outcome improvement is the ethos of the service and initial signs are positive in terms of:

- Improved outcomes for children by reducing infant mortality and increasing life expectancy from birth
- Increased breastfeeding initiation rates
- Reduced the numbers of women smoking during pregnancy
- Ensuring all women are booked by 12 weeks of pregnancy
- Ensuring all women have a named midwife and access to a maternity support officer.

Evidence here showed that, like many deprived areas, there had been a poor uptake of core services in Aston and consequently health outcomes were considerably below the national average. Community staff were not connecting with those most at need and poor health messaging meant advice was not getting through – for example, there was low uptake of breast-feeding. Existing services were inflexible and did not meet the needs of the ethnically diverse local population. Evidence locally and nationally revealed that women and babies from deprived and ethnic minority communities have poorer pregnancy and child health outcomes.

Involving staff in the team has been key to the service redesign. Working with team members, A4e has reformed and diversified individual roles: midwives now prioritise the more clinically critical families, while the focus of the maternity support officers' work is now geared towards supporting women with high social needs. The team's management has also changed with a new manager introduced for the remainder of the programme to offer a reinvigorated push on delivery. This was necessary because front-line midwives have little free time to view the strategic performance of the service. Improved process and procedures have been implemented to ensure key data is captured accurately to enable the maternity service to work better with other services on joint cases where multiple agencies are involved. The aim is to provide a truly holistic support service to the residents of Aston.

Service transformation is not easy but it is essential, and requires using staff skills to best effect, adding new skills where there are gaps and better utilisation of advanced clinical skills so they are applied where they are most needed. New management techniques are needed to refocus staff and services on the right outcomes.

Case study: Competition of provider in dealing with underperformance: Atos Origin and the St Paul's Way medical centre

In 2008, Atos Origin beat 50 organisations and individuals to win a ten-year contract to run the St Paul's Way GP practice in Tower Hamlets, East London. The practice is in one of the most socially deprived areas of London: over two thirds of its 10,500 patient list is Bangladeshi and rates of coronary heart disease and mental health problems are almost twice the national average. Consultation rates are also 50% higher than average.

Under-performance had been rife at the practice and patient dissatisfaction was high, with repeated complaints about problems in getting to see a doctor. After years of concern the PCT used the retirement of existing GP partners to take over its management, pending a competitive tendering process. With Atos Origin matching two highly-respected local practices on clinical quality and access it clinched the bid with additional expertise of managing a multiuse building, procurement, marketing and administration, and price – 6% lower than the lowest general practice bid.

Concerns from those opposed to new providers have not materialised. Patients are unconcerned who provides the service but they have noticed improvements and enhancements: opening hours have been extended to 8am-8pm and St Paul's Way is the only practice in the local area to be open on a Saturday. Services have expanded too, with a primary care walk-in service running alongside pre-booked clinics. Registered patients who have minor illnesses or ailments can now see a clinician without making an appointment.

Other new services on the way include smoking cessation, sexual health, learning disability, chlamydia & gonorrhoea screening, enhanced minor surgery, heart attack and stroke rehabilitation, palliative care, depression, immunisation top-ups and drug misuse support. The centre has already been refurbished to provide a more modern facilities and Atos eventually aims to move into purpose-built premises nearby.

With any new project it is essential to get the right staff and build a team committed to delivering good outcomes. For example, Atos built a team of healthcare professionals to deliver its GP practice in Tower Hamlets. In meetings patients informed Atos, that an over-reliance on locum doctors was a factor in the poor quality of the service that had gone before, because staff turnover was damaging the continuity of care. Investment in staff is often a necessity to achieve change. At the St Paul's Way GP practice healthcare was previously provided by three doctors and a nurse, now there will be five GPs, two nurse practitioners, two practice nurses and a healthcare assistant as well as admin and reception staff. To maintain staff stability and commitment, the company has offered a level of clinical freedom and managerial involvement to the practice GPs that would normally only be afforded to partners.

All aspects of workforce change were explored and all staff were involved, including 'backroom' staff too often overlooked. For example, the new reception team does more than check people into the surgery, it filters phonecalls so that, where necessary, patients can speak to a GP about their condition over the telephone before deciding whether they need to visit the centre.

Recommendation: harnessing professional expertise and skills Traditional ways of working and inflexible professional boundaries can mean rigid team structures and restricted job responsibilities among healthcare professionals working in the NHS. Patient treatment and care are often grouped separately with poor communication and co-ordination between doctors and consultants and nurses and care assistants, even though they have been aiming for the same thing – returning the patient to good health.

When clinicians have felt excluded or alienated by service redesigns they have gone on to become opponents of change. Providing opportunities to stretch and motivate staff members by expanding and developing roles should be at the centre of service redesign: nurses, care assistants and pharmacists, for example, have already taken expanded roles in service provision, while multi-disciplinary teams have allowed staff to develop new skills in a safe, supervised environment.

Investing in appropriate staff training and development is essential

Sometimes, the way the public sector trains and manages its staff feels like a 'one-size-fits-all' approach, rather than being related to a needs assessment. Investing in staff skills as well as involving staff is essential to ensure lasting change. What is needed is a focus on the use of new technology, productivity improvement techniques through re-engineering processes, and a reorientation of the way systems work to make them more focused on good outcomes for patients.

Employees delivering public services from independent sector providers report training packages more focused than those offered in the public sector. Independent sector providers use training to align individuals' own interests and experience with the needs of the service. For example, employees may be trained to carry out new roles to make services more responsive.

Companies like Serco and A4e aim to enable their healthcare staff to undertake a range of positions now and in the future. To ensure employees take advantage of such opportunities for development and progression, more organisations should follow best practice and conduct a 'training needs assessment' with each staff member because training must be provided on the basis of individual need.

Case study: 'in-sourcing' skills to enable NHS staff to lead change at the local level

Tribal Group consultancy finds efficiencies for the NHS by 'in-sourcing' skills in staff members. This means its consultants do not simply descend on an organisation, impose impersonal change on existing staff and depart only for their work to be forgotten. Instead, the company involves and engages NHS staff to think about what they want to achieve and then collaboratively develop ways to succeed. It provides consultancy, support and delivery services to PCTs to improve the delivery of health services.

In October 2008, it was appointed for a three-year period to support a PCT in its development as a world class commissioner to reduce inequalities and improve health services for the local population. With their new skills, existing staff and Tribal consultants have already achieved £2.3m of independently-audited efficiency savings in six months, these are cash-releasing and not cost avoidance and the target is to achieve a minimum of £15m over three years. The improvement programme includes:

- Medicines management – using patient-level NHS data on diagnostics – identified potential changes and savings on the quantity and types of medicines prescribed. Significant savings in the management of statins and proton pump inhibitors through the deployment of consultant pharmacists has meant that £500,000 has been saved to date through medicines management. The project is on schedule to save much more throughout its life
- Forecast changes in patient demand to inform planning of service provision in the future. This has started a debate about the future size, shape, scope and style of secondary hospital services, given the likely productivity requirements on the NHS. This work is proceeding in parallel with the Transforming Community Services implementation programme to provide a strategic development programme for all healthcare in the area
- Practice-based commissioning to produce greater buy-in from local GPs as the programme had presently failed to take off. Consolidation and creation of groups of GPs and surgery managers has helped launch a pathway redesign for diabetes, breathlessness, outpatient services and muscular skeletal services.
- Health needs assessment of the PCT area to provide commissioners with detailed modelling data of the local population and health burdens.

At times external support is required to help staff develop the necessary skills. The Tribal Group is helping the NHS fill established capability gaps – for procurement and management skills – from within, helping staff develop the necessary skills which previous NHS training has left relatively undeveloped. This has enabled new skills to be embedded in the team rather than contracting with an external project team to deliver the service.

Recommendation: tailored training satisfies staff and creates quality, flexible services Giving employees appropriate training enables them to do their jobs properly and to use new technology to improve the way services work. The cost of training should be recognised during the commissioning process. Raising employability by helping employees become multi-skilled increases the flexibility and quality of the service.





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The CBI's Public Services Strategy Board – aims and principles

Private providers make a significant contribution to public services in the UK. Competition has been used to cut maximum waiting times for hospital treatment, improve results in schools, reduce re-offending, build and maintain modern public buildings, release more resources to the military front line, make streets cleaner and safer and much more.

Economic uncertainty means our public services face an unprecedented challenge. Now more than ever the government should explore innovative ways to deliver them and to measure and compare the different ways of delivering these services.

The CBI Public Services Strategy Board believes competition amongst providers is the most powerful tool the government has to improve the value and quality of our public services and generate fresh ideas. The best providers, regardless of sector, should compete on a level playing field to deliver public services.

Business needs effective public services to operate efficiently and should be part of the fabric of how they are delivered.

This is why we will continue to pursue vigorously the modernisation agenda.



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