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MANAGING THE NEW NHS

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RIDE OUT THE STORM

HOW TO NAVIGATE THROUGH A TEMPESTUOUS TIME FOR REFORM: 2-3

MAKING PUBLIC/PRIVATE PARTNERSHIPS WORK IN THE NHS

With a budget deficit of over 8 per cent, the government wants private sector companies to compete with public sector services in a bid to increase efficiencies, drive down costs and offer greater choice. Despite the delay in NHS reform, the health service is one area in which the government has already experimented with allowing the private sector to run back-office services.

NHS Shared Business Services is jointly owned by the NHS and business services company Steria. It manages Finance & Accounting, Payroll, Fa mily Health Services and Commercial NHS Procurement for more than 40 per cent of the NHS. This shared services model has led the way in demonstrating the efficiency savings that can be achieved – more than £70m over the last five years.

However, it's not all about saving money to achieve QIPP targets and the £20bn challenge. For NHS Shared Business Services it is about working in partnership with the NHS to transform and modernise the back office, making it fit to meet the challenges of the future – state of the art technology, governance and data security, people who listen and really understand the needs of NHS clients.

Despite the changes currently proposed the emphasis remains on improving NHS procurement, improving commissioning and providing an NHS that is focused on patient care, quality and better patient outcomes.

Improving NHS Procurement

Nearly everything you see and touch within the NHS is procured. It is no wonder then that the Public Accounts Committee recently recommended Trusts set aggressive targets for savings from procurement, demonstrating to their Boards, staff and patients that they have delivered the optimum before front-line staff cuts are considered. Procurement can no longer be seen as a tactical activity undertaken by one department - it needs to be transformed into a commercial process that feeds into everyone's role in some way.

Trusts need to invest in establishing procurement best practice processes, ensuring there is quality data available on spend behaviour to support contract compliance and transform the culture of the organisation. No Trust, irrespective of size, has the purchasing power to manage the market. However, their combined scale will give Trusts the leverage to generate significant cash releasing savings and operational efficiencies for the entire NHS. By positioning procurement as an integral part of business strategy, the NHS can go a long way to plugging the gap in overspend of £500m as recently published by the National Audit Office.

NHS Commissioning Reform

From GPs and PCTs to local councils, the commissioning landscape currently looks like more of a competition than a collaborative environment, but the challenge is the same for all those involved in NHS commissioning – how to achieve the right balance between care (quality) and resources (costs). Commissioning support is integral to achieving this balance. Meeting the commissioning challenge and addressing the scale of the deficit is going to demand a fundamental change in the way acute providers go about their business; this will depend on local relationships and a culture of common purpose that demands a whole new community approach.

The key will be to have harmonious working between the clinical commissioning groups, local authorities, their Health and Wellbeing Boards and the provider units which given the conflicting priorities is going to be difficult. A good starting point will be to ensure that all of them are basing their decisions on the same "clean and consistent data sets", something which is not always happening today. It is also an ideal opportunity to deploy an effective shared service model similar to that already offered by NHS SBS.

> "MEETING THE COMMISSIONING CHALLENGE AND ADDRESSING THE SCALE OF THE DEFICIT IS GOING TO DEMAND A FUNDAMENTAL CHANGE IN THE WAY ACUTE PROVIDERS GO ABOUT THEIR BUSINESS"

Working in partnership

NHS Shared Business Services is an excellent example of successful public/private partnership working. In addition to achieving efficiency savings and service transformation, there are many value added benefits. One example is NHS SBS clients this year sharing more than £1,000,000 through the DH licence fee surplus distribution. This is in addition to operational savings of up to 40%, enabling NHS clients to share in the continued success of the joint venture – a true NHS public/private sector success story.

John Neilson, NHS Shared Business Services

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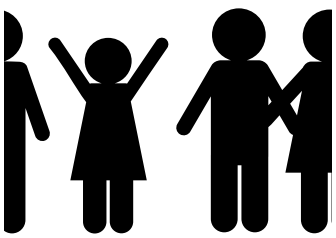

FOREWORD

MIKE FARRAR

Celebrate, don't denigrate

As the health service gathers for the NHS Confederation annual conference, it faces circumstances as challenging as anything it has had to deal with in its lifetime.

Giant efficiency savings of a size no health system in the world has ever been able to deliver are being demanded. At the same time a fundamental and politically controversial reorganisation is shifting the ground beneath managers' feet.

Sadly, when it started making its case for the reforms, the government chose to denigrate the role of NHS management in a most unhelpful way.

NHS managers and leaders continue to commit to the service and work hard, despite the uncertainty over their future jobs and personal security. Rhetoric that gives the impression that any funds spent on management and leadership in the NHS are wasted is a grievous mistake.

The importance of good management is set out by an excellent recent King's Fund report, which confirms good management is as vital to high quality care as the hands that deliver it (see page 2). Even the best surgeon in the world will get poorer outcomes if the service does not get the patient to them at the right time. I agree with the King's Fund when it says: "The role of managers should be celebrated and not undermined."

It is also right to say that we need to go beyond the simplistic view of "management bad, clinician good". It was encouraging therefore to hear the prime minister acknowledge recently that NHS leaders do "important and valuable work".

Such signs that the management debate is moving the right way are welcome but debate over other aspects of health has become infected with a similar lack of nuance.

In particular, government plans for increasing competition and the role of the independent and private sector have seen a lot of grandstanding while doing little to address how the NHS can improve to meet the challenges it faces.

The NHS Confederation has been clear all along that choice and competition are important tools to create improvement. The idea of competition to create change that avoids patients being captured by poor quality service providers can be witnessed in many parts of the NHS even as we speak.

During the government's pause, we have argued that competition should be seen as a tool and not a dogma. The frame of the political debate has changed but much remains to be worked out. What really matters now is the implementation of the reforms that really address the problems the NHS faces.

This is why the NHS Confederation needs to make its voice heard. Organisations are changing, others ceasing to exist and services are going to need to be redesigned radically if this challenging period is to be navigated safely. These are times when we need to be bold and speak, as only we can, about the NHS as a whole. ●

Mike Farrar is chief executive of the NHS Confederation

With the health bill seemingly changing by the day, planning for the future is tough. Ingrid Torjesen on priorities for managers in these uncertain times

STAY CALM AMID THE STORM

The government's decision to "pause" NHS reforms to allow time to reflect on the planned changes has created a cloud of uncertainty over the future shape of the NHS and the timetable for change.

But while the direction and pace of change are uncertain, the NHS has already entered a transition phase. Hundreds of managers have left, as strategic health authorities and PCTs prepare for abolition. PCTs are handing over their functions – to fledgling commissioning consortia and local authorities – and have formed into clusters, with a lifespan of just two years, to manage the transition.

Difficult transition

Managers will have a difficult time during this transition. In March, the Nuffield Trust published a report *NHS reforms in England: managing the transition* warning that 2011-2014 is likely to be the most challenging period ever faced by the NHS. And the pause in reform has brought uncertainty which has made the situation even worse.

But Nuffield Trust head of policy Judith Smith, one of the report's authors, still expects managers to rise to the challenge: "Health service managers are very pragmatic. They have implemented lots of change in the past and they know how to do that."

The 2011-12 operating framework set out two priorities for the NHS, irrespective of the reforms: to maintain and improve quality of services; and to retain financial control and meet the Nicholson challenge of making up to £20bn in efficiency savings by 2015 though the QIPP agenda.

Managers have got to meet those two big challenges amid the transition, having to implement some new arrangements as the government plans to cut administration costs by a third and management posts by 45 per cent.

Dr Smith says: "We know from research evidence that organisational transition makes it difficult to achieve your objectives. It typically takes organisations at least three years to recover from the process of transition and regain the level of performance they had before."

NHS chief executive David Nicholson has highlighted the dangers of reorganisation: reorganisations in the past have prompted tragic events such as Mid Staffs. King's Fund chief executive Professor Chris Ham says managers must heed those warnings. "When you're changing the structure of the health service, managers at all levels tend to be distracted from what should be the core business, which is improving quality of patient care, improving performance and making sure finances are under control. Because there is so much noise in the system it is understandable... that they may not... focus on the issues that really matter."

But the right balance has to be struck between focusing on operational performance and quality of care and thinking about the future, he adds. While an organisation's management needs to look internally at strengthening their performance, they also need to look externally to ensure they understand and continue to meet the needs of commissioners and other stakeholders.

Time for a redesign

The King's Fund set up a commission last year to look at the future of NHS leadership and management. Its findings, published last month, argue that rather than being overmanaged, there is "a good deal of evidence that it may be undermanaged".

The report says the growth of regulation through Monitor, the CQC, targets and performance management has forced the English NHS to employ more managers than other UK countries to deal with pressures that are essentially politically imposed.

Professor Ham warns: "If there is no change in that regulatory performance management environment and the government persists in pursuing the cuts in management numbers and management costs, it is going to be very difficult for us to continue to deliver good performance in the health service and at the same time implement one of the biggest changes... in the history of the health service."

Rather than simply "salami slicing" 5 per cent here and there to make efficiency savings, trusts need to take a fundamental look at how they do things and redesign services, says David Bennett, chair and interim chief executive of Monitor.

Hospital trusts will have to exert influence outside their natural boundaries to do this and cope with the continuing split tariff on emergency care and the new rules around readmissions, he says.

This will be easier for trusts which took advantage of Transforming Community Services to take over community services. Other trusts will have to work hard at

Stormy Monday: the day-to-day business of improving care and cutting costs goes on as debate rages over the future of the NHS

developing collaborative relationships.

Commons health select committee chair Stephen Dorrell believes that recognising how care delivery has to change is the biggest challenge. "The only way that you can deliver the Nicholson challenge, and indeed even if you didn't have the Nicholson challenge, the only way you can deliver high quality, efficient care... is by understanding the change in the clinical model that is necessary and then manage the process of getting from where we are to where we need to be." He sees the new clinical model involving more integration and collaboration between organisations that perform similar jobs – such as community healthcare, social care, primary care and walk in centres – to provide care led from the community rather than the acute hospital.

Take clinicians with you

Management must involve clinicians, Mr Dorrell emphasises. "It is a general rule of management that you have to take your staff with you, so in the health service that means the clinicians... and given the political sensitivity of the health service, you also have to ensure that you take the wider community with you as well."

Understanding patient and commissioner needs is vital, Mr Bennett says, and this means getting close to GPs, regardless of whether they become the commissioners. "We can safely say that, whatever comes out of reforms process, a good trust will be working hard to maintain good relationships with their commissioners, whoever they are. The best trusts were talking to GPs even before it was proposed that they should be the commissioners. GPs, even in today's world, are important in understanding what patients need and helping patients decide what they want to do."

'Understanding patient and commissioner needs is vital, Mr Bennett says, and this means getting close to GPs, regardless of whether they become the commissioners'

It is also essential that trusts ensure that the decisions they make are based on good information and that they understand the costs of individual services, Mr Bennett says. "They might conclude they need to change the way that they are delivering [some services] to make sure they are financially viable. There may be other services that they simply don't need to provide any more."

In particular, trusts need to be wary of taking on risks that they can't manage themselves, such as agreeing contracts that presume commissioners manage demand. For example, a trust might take a cut in payments they get for emergency services on the assumption that there will be effective management of demand through general practice and out of hours services.

Mr Bennett warns: "The trust needs to avoid... the position where they are still getting the patients but they have agreed that they won't get paid for them."

The health bill proposes that all non foundation trusts achieve foundation status by 2014 and this is one area where non foundation trusts should absolutely not let the pause in the progress of the bill distract them, Mr Bennett says. "This is not the first government, nor the first time a government has said, that all trusts should become foundation trusts, so to proceed on the assumption that sooner or later they will have to become foundation trusts is a pretty safe bet.

"The fundamental test that we apply to determine whether a trust should become an FT is whether they are financially strong and well led. There shouldn't be a trust in the country that shouldn't be aiming to be financially strong and well led, so there is no argument for taking their eye off the ball just because of what's happening with the specifics of this bill." ●

FOTOLIA

PHYSICIAN, HEAL THY COSTS

Can patient level information costing systems encourage clinicians to help keep spending under control? The jury is still out, reports Daloni Carlisle

Some words just go together. Love and marriage, say. But finance managers and clinicians? It's hardly love's young dream.

Yet this is precisely the alliance that many trusts are trying to forge through the use of patient level costing.

The idea is that by allocating costs to individual patients, not only will trusts be able to control their finances more closely and develop an understanding of where they may be losing or gaining against their fixed income, but they will also be able to engage clinicians in resource management.

It is an approach the DH has encouraged, recommending that acute trusts adopt patient level information costing systems that marry clinical and financial activity. Monitor recommends service line reporting supported by patient level costing.

Switching to PLICS

The latest evidence is that around two thirds of acute trusts already have PLICS. A survey by the DH, carried out in 2010 and published in April 2011, received answers from 145 of the 169 acute providers, of which 95 (65 per cent) had either implemented a PLICS or were in the process of doing so. Another 20 had plans to do so in the next few years. Outside the acute sector, appetite was strongest among mental health trusts.

This agreed with research from the Chartered Institute of Management Accountants and Imperial College London's Business School, published in 2010, showing that 70 per cent of acute trusts used PLICS.

But while there are regulatory requirements for trusts to implement patient level costing, CIMA's research highlighted how it was crucial to engage clinicians too. It noted: "Engagement is crucial for going beyond a box ticking exercise and assuring the effectiveness of [PLICS]." It suggests a shift is needed from "allocating costs in ever greater detail" to analysis of activity and resource consumption "actively supporting the management of cost" and warns: "If this shift... is not achieved then PLICS... may become a more expensive top down cost exercise, with little added value in comparison to traditional costing tools."

'Most trusts are using PLICS data to tell the DH what it costs them to deliver care. But as to using PLICS data to deliver any real savings – we just don't know'

The notion is that by showing doctors differing lengths of stay or use of different prosthetics, consumables or diagnostics, they can compare practice and costs and address them. CIMA and others cite many trusts attempting to do this.

The evidence as to whether this is influencing resource use or improving practice is, thus far, anecdotal. The DH survey showed that most trusts are using PLICS data to inform their reference cost return – in other words to tell the DH what it costs them to deliver care so that the DH can set the tariff more accurately. But as to using PLICS data to deliver any real savings – we just don't know. "There are lots of anecdotes and clearly trusts are getting benefits from their PLICS," says Martin Bardsley, head of research at the Nuffield Trust. "But it is difficult to pin down formal studies to demonstrate them."

Better deal for acute trusts

The Nuffield Trust is due to publish some new work showing that the most commonly cited benefit for acute trusts of PLICS is in their negotiations with commissioners. "It provides providers with a much greater depth in terms of their arguments with commissioners about pricing and costs," Mr Bardsley says. "But it also implies an asymmetry of information in which the providers have much more than the commissioners."

The classic example is of breast surgery in which surgeons looks at the cost and clinical outcomes of doing a mastectomy in one operation and the reconstructive surgery in another compared to doing both at the same time. Clinically the combined operation makes sense for some patients but allows the trust to claim only one payment from the commissioner. Using PLICS data, trusts can demonstrate their costs and negotiate a better pricing structure.

Developing an evidence base does involve first engaging clinicians and Anja Kern, a research associate at Imperial College who leads research on PLICS for the DH, says

that this depends on moving from top down accounting – taking the total cost of an activity and dividing it to find an average – to activity based costing revealing the true costs of activities. She says: "Sometimes people think clinicians do not use financial data for professional reasons. In fact, they do not use it when the data are not good or when they do not trust the data. They are not interested in averages."

Peter Simons, a technical specialist at CIMA, adds: "The challenge is to provide information that's meaningful."

But Andy McKeon, managing director for health at the Audit Commission, is less clear about the benefits of PLICS. For a start, a pilot project by the Audit Commission uncovered some evidence that putting an emphasis on patient level costing interfered with some trusts' ability to provide the DH with reference costs. "We found reference costs had little relevance to these trusts because they were concentrating on patient level costs," he says. This has implications for setting the tariff.

But he also questions whether patient level costing tells us anything we don't already know. "It tells you about variation," he says. "And some of the things it tells you might already know or be able to identify from other sources. For example, variance in length of stay is very expensive. One of the messages for those that do not have PLICS is there are things they could do anyway."

The expensive option?

Implementing PLICS is expensive, Mr McKeon notes. It requires a decent business intelligence solution integrated with the finance solution, including a data warehouse, multi-dimensional databases and web-based tools to access data. None of this is cheap.

Then there is the time and expertise required to transform financial and activity data into something meaningful for clinicians. "It is a challenge," admits Mr Simons. "To be cruel to my own profession, and I am an accountant, most accountants are engaged in the business of providing traditional financial information and there are relatively few who understand the clinician view."

This is compounded by the fact that few trusts allocate many people to the task. In a small survey, CIMA found that trusts with an average finance department 55 strong allocated just 1.5 staff to patient level costing; even the largest trusts, with 100 finance staff, allocated just two people.

It's a false economy, warns Mr Simons. "The danger is that if you try to keep costs down, the easiest people to cut are those not doing the direct financial information. But these are the very people providing you with the insights needed to keep costs down."

With so many trusts using PLICS and an increasing number taking a more sophisticated approach, the next move is to cost patient pathways. Recent work by the Audit Commission highlighted the limitations of community data in costing whole system pathways but Tom Mulhern, founder of IT suppliers Ardentia, says trusts are now looking to use referral to treatment engines to cost pathways within the hospital.

Such a model would bring together information right from the referral and include outpatient appointments, diagnostics and treatments, hospital stay and procedures, follow up and readmission.

Mr Mulhern says: "When you start to compare pathway level costing you begin to pick up the outliers that you have never seen before." A clinician who operates quicker than his colleagues may look efficient – until pathway data highlights the cost of readmission.

The push for PLICS is certainly on. The Healthcare Financial Management Association has taken over maintenance and development of the Acute Clinical Costing Standards, which aim to support a consistent approach, and IT suppliers are developing tools such as profit and loss accounts for individual patients. The notion that accountants and doctors will forever inhabit different and opposing territories may one day be a thing of the past. ●

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FOTOLIA

THE £500m QUESTION

Vast savings can potentially be made by consolidating pathology departments but concerns remain about the quality of the restructured services. By Daloni Carlisle

Pathology does not often hit the headlines, which is perhaps as it should be. But with the service earmarked to deliver huge efficiency savings and nascent commissioning consortia turning their mind to a service that eats up around 4 per cent of their budget, it is an area that requires some thought.

The envisaged saving comes from two sources: the quality, innovation, productivity and prevention agenda and a massive service reconfiguration driven by a national review which suggested that somewhere between £250m and £500m could be released by consolidating pathology services.

Strategic health authorities are now driving through this reconfiguration, while at national level the DH and others are tackling other recommendations about efficiency, quality and accreditation.

Meanwhile, forward thinking GP consortia are looking at pathology services and asking: how can we improve commissioning so we get results when we want them, in the form we want them and at the price we want them (see box, right)?

Quite right too, says Dr Ian Barnes, national clinical lead for pathology. "We need to eradicate the myth that pathology is a 'back office' service. Pathology forms a vital part of virtually all patient care and therefore the more closely pathology is integrated into patient pathways, the more effective it becomes.

"Commissioners therefore need to work with pathology staff, to better understand what contribution pathology can make to improving clinical pathways and patient outcomes."

But the Royal College of Pathologists is not convinced that the NHS reforms as envisaged will support consortia to commission a quality service – or indeed the NHS to deliver one.

Lab experiment: pathologists worry they will end up competing solely on price

Understanding quality

College president Professor Peter Furness is profoundly depressed by what he sees. "From our perspective the fundamental problem underlying commissioning is that the whole model underlying the reforms presupposes people buy services understanding quality," he says. And when it comes to pathology, he says, they don't. "We risk people making decisions about commissioning diagnostic services on price, period."

"There are intelligent commissioners out there," adds Dr Rachael Liebmann, assistant registrar at the college and clinical director of the Kent and Medway pathology network. "But it's a long learning curve. Every conversation I have had with a new commissioner starts with them saying with a big smile that they know nothing about pathology."

'Every conversation I have had with a new commissioner starts with them saying with a big smile that they know nothing about pathology'

It's not just lack of knowledge. The quality outcomes framework contains nothing about pathology, says Professor Furness. "Outcomes start by defining a group of patients with a diagnosis but our work comes before the diagnosis. So the whole issue of measuring quality misses the point when it comes to quality in diagnostic services."

Dr Barnes counters that it will be up to the NHS Commissioning Board to decide how best to deliver improvements in pathology that contribute to outcome measures.

Then there is the current mandatory lab accreditation scheme, which the college regards as inadequate for measuring clinical quality. It is trying to remedy the developing key performance indicators (KPIs) that are due to be published in July. They won't be mandatory but could be used to benchmark quality services, says Professor Furness.

Dr Liebmann is leading this work. She explains: "It is very possible for a lab to get a good result on its accreditation when it is on its knees in terms of quality but is very good at getting its paperwork in order."

The element that is lacking currently is any measure of what pathologists do with results of tests. "It is reasonable to point out that you can commission a pathology service that just sends results and does not add any clinical context or interpretation," she says. But would that be a quality service?

Emphatically not, says Dr Liebmann. "The KPIs are very much about the need to get the right diagnosis in a timely way, not a fast diagnosis that you then have to turn around because it's wrong."

The DH has invested in improving pathology services, notably through encouraging them to adopt the lean programme. Dr Barnes says: "In histopathology, for example, we supported projects across 12 labs to implement the lean programme. As a result of this work, over 157,000 patients have benefited from improvement in turnaround times, quality and safety, which has addressed mechanisms to reduce errors in specimen labelling and requests, achieving a "right first time" approach, improving safety for patients and reducing the need for additional staff time to correct errors."

What the GPs want

NHS East of England is one of three SHAs that has worked with the DH to develop approaches to the reconfiguration. It is now at the stage of having concrete plans to consolidate 18 pathology departments into a smaller number of hubs serving the region and has asked for bids from existing NHS providers against service criteria. Final proposals are expected by January 2012.

Part of the preparatory work involved asking GPs what they wanted from a pathology service and their list is rather different from the list of issues outlined by the Royal College of Pathologists.

Top of the GP list is guaranteed sample collection times throughout the day, followed closely by access to all results electronically, then guaranteed rapid turnaround. Expert advice about patient pathways and results was important – but some way behind these process issues, alongside reducing unit costs.

Dr Hemal Desai, a GP and lead for NHS East of England transforming pathology service project, says these priorities reflect GPs' experience of pathology as a service that collects samples at its convenience rather than the patient's, delivers results in a haphazard way and does not let GPs see results of tests carried out in hospital at their request.

'GPs' experience of pathology is a service that collects samples at its convenience rather than the patient's'

"Quality is different from a user perspective than from a provider perspective," he says. "GPs know what is important to them and ask whether they really need to worry about the technical aspects. As long as providers are competent and there is a good way of assessing whether what they commission is safe, then the answer is no."

The consistent message coming across from all sides is this: that commissioners, whether in consortia or clusters, need expert advice when it comes to commissioning pathology.

Dr Desai says: "We think it is critical that commissioners get independent advice and that's difficult because it usually comes from your local provider." He is currently looking at whether the Royal College of Pathologists, other representative bodies, or indeed people who have attended the DH pathology leaders course could provide this.

Ultimately, though, Dr Barnes, Dr Desai, Dr Liebmann and Professor Furness all want the same thing: a high quality service delivered efficiently that meets the needs of users. And for that, significant transformation is needed at all levels. ●

'IT HAS REDUCED THE TENDENCY TO TICK LOTS OF BOXES JUST IN CASE'

Reducing the amount spent on unnecessary tests is a priority for the South Reading GP commissioning consortia. Last year, the consortium underspent on its annual pathology budget of £1.7m by over £152,000.

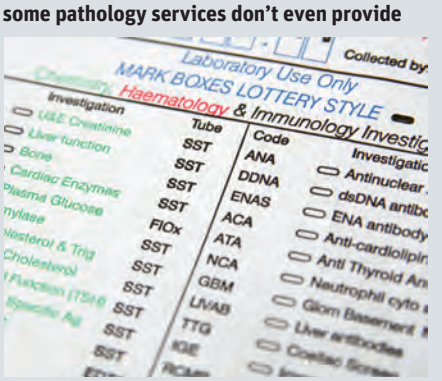
It did so by giving practices in the 20-strong consortia regular information about their spend against budget and median spends across the consortia, printing forms with "top tips" from the local biochemist about ordering tests and a traffic light spreadsheet showing which tests were above median.

Elizabeth Johnston, chair of the consortia, says these measures have produced cost savings by ensuring that GPs request the right test for the right patient in the right conditions.

She adds: "The ability to email the lab to request a further test on saved serum if an initial result comes back abnormal has been invaluable as it has reduced the tendency to tick lots of boxes 'just in case', at the outset."

None of this would have been achieved without the support of NHS Berkshire West and Geoff Lester, the biochemist at Royal Berkshire Foundation Trust, she says. By working together they have been able to deliver the data and the expert advice that goes with it.

Dr Johnston believes such collaboration is vital – but it may be unusual. "It's only recently, through talking to consortia in other parts of the country, that I've realised that some pathology services don't even provide commissioners with any activity data, so I think the way we are working together locally may be unusual."



Box clever: a form GPs use to order blood tests

She argues that clinician-to-clinician contact is vital to delivering quality and will be a crucial consideration in commissioning in future. She expects to commission jointly with neighbouring consortia to deliver economies of scale but would be wary about changing provider and destabilising the excellent local service provided by the Royal Berks.

Dr Johnston says: "The consortium uses pathology to answer clinical questions; therefore we wish to commission a service that delivers robust clinical answers. Cheap tests on the wrong patients are useless, especially if this leads to further tests or inappropriate referrals. The current local, clinically led pathology services provide a supportive clinical service for GPs. This is the model we wish to commission, as I believe it offers a quality, safe service for patients and locally has demonstrated value for money."

ALAMY

Evidence for Quality and Productivity

The NHS is facing a significant challenge to improve quality of care while delivering substantial efficiency savings.

The Quality, Innovation, Productivity and Prevention (QIPP) collection on NHS Evidence includes over a hundred quality-assured, real life examples showing how colleagues locally and nationally are rising to the challenge of saving money without compromising quality. If the examples were adopted by 50% of eligible organisations, they would save the NHS over £700 million.

Southend Hospital NHS Trust reduced the cost of transporting patients to hospital for their dialysis treatment by 60%. This was achieved by mapping the postcodes of patients to coordinate treatment days and times accordingly and reassessing mobility status for people using ambulance transport.

Rampton Hospital in Nottinghamshire halved shift handover times by introducing The Productive Mental Health Ward initiative from the Institute for Innovation and Improvement. Reducing handover times by 15-20 minutes per shift created an additional six hours a week to spend on patient care.

The QIPP collection also includes monthly reports on potential disinvestment topics which are derived from reviews conducted by the UK Cochrane Centre and a searchable database of 'do not do' recommendations drawn from NICE guidance.

Get involved

The QIPP collection clearly illustrates that there is no shortage of innovative ideas in the NHS. However, NHS Evidence is always looking for more examples.

To find out more or to submit your own example, visit the QIPP collection at **www.evidence.nhs.uk/QIPP.**

NHS Evidence: provided by NICE

DOCTOR CARROT WON'T SEE YOU NOW

The days of mass media, single-issue health campaigns look numbered. Future marketing will be much more local. By Helen Mooney

Ever since the Ministry of Food designated Doctor Carrot "the children's best friend" and promoted the idea that carrots improve our eyesight, we have become used to government funded public health campaigns.

But the government's vision for the future of public health in England could see such campaigns if not consigned to the history books with Dr Carrot, then certainly much reduced from their current level.

The government's focus is now very much on future marketing that is local and tailored to individuals. The Department of Health's new social marketing strategy for public health *Changing behaviour, improving outcomes* published in April says that, with the exception of smoking and some health protection campaigns such as a flu pandemic, central single-issue campaigns will be scrapped.

It also says there will be a "shift away from traditional mass media channels, towards those channels government already owns, such as government websites and poster sites in government buildings".

National Social Marketing Centre director John Bromley warns that the government must ensure that funding is earmarked for supporting the development of local social marketing capacity and skills.

'Professor Davies questions whether public health messages tailored to local populations can really deliver the mass behaviour change needed'

"This is particularly acute given the major structural changes that local health services are experiencing," he says.

He is worried axing single-issue mass media campaigns before new multifaceted campaigns get off the ground mean that the progress that has already been made risks being undone. "Meanwhile, the marketing power of the commercial sector – with its infinitely greater resources – will continue to be exercised," he says.

The move towards localism and away from national, government funded public health campaigns also worries some public health specialists.

Dr Frank Atherton, president of the Association of Directors of Public Health, says: "Although there is a lot of work going on at a local level on behaviour change, wider mass media campaigns also play a role and any withdrawal of central funding needs to be planned and not just dropped on people."

In his view, public health campaigns work best when national messages are funded by the Department of Health and combined with regional and local campaigns. "It's about getting the right message to the right people at the right time," he says.

Professor Lindsey Davies, president of the Faculty of Public Health, questions whether public health messages tailored to local populations can really deliver the mass behaviour change needed to bring down smoking rates, obesity levels or alcohol consumption. "Successful public health campaigns are about a holistic approach," she says. "You have to get information to people about what they can do to improve their health and then inspire them to make those changes."

According to a DH spokeswoman, the only single-issue campaign the government will continue to deliver is the Smoke Free programme which had been shown to affect "successful behaviour change and improved public health, as well as long term savings to the NHS".

The government intended to "take a life course, holistic approach so our activity will target every stage of life with a trusted brand providing all the information, support and advice on all topics relevant to that stage in a person's life."

It remains to be seen whether in future national public health campaigns dry up completely but, for now, it seems that they are ill-fated. ●

NATIONAL EYE HEALTH WEEK: THE SHAPE OF THINGS TO COME?

Now in its second year, National Eye Health week aims to bring together eye care charities, health professionals, representative organisations and the private sector to promote the importance of eye health and regular sight tests for all.

The idea is to get all those involved in promoting eye health to do it together in the same week. David Scott-Ralphs, chair of the National Eye Health week steering group and chief executive of eye health charity SeeAbility, says this mass mobilisation is key to its success. To find out whether the week has had an impact on public awareness the organisers will carry out a public survey to measure whether the public has "got the message". Mr Scott-Ralphs says that each year the organisers will try to build on this baseline.

"A number of different individual organisations have tried to run awareness weeks in the past with varying degrees of success," he explains. "The vision sector has previously been quite disparate, but this strategy means that different bodies and organisations can come together, and there is both the appetite and ability to work together."

Mr Scott-Ralphs says the campaign is "very, very cross sector" with everyone from RNIB to the Royal College of Ophthalmologists, Tesco and Specsavers getting involved.

INNOVATION, NOW

BT helps the NHS cut costs while improving patient care

NHS organisations across the country face similar challenges: how can they deliver efficiencies and increase productivity while still ensuring that patients receive the best possible care and how do they increase quality and clinical outcomes when there is so much pressure on resources?

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Telehealth services can help patients manage their conditions better from home.

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POWER OF GOOD

We should applaud moves to give communities more say in commissioning, says Hilary Samson-Barry

Joined together: GPs will be urged to collaborate with community groups

Andrew Lansley has a favourite catchphrase: "No decision about me without me." This mantra is at the heart of the Health and Social Care Bill, which seeks to give patients a voice.

Of course this catchphrase is not new but patient centred care is key to the coalition's ambitious reform of the NHS, offering us more choice and control and services designed around our needs.

Lansley's vision is to democratise, empower and streamline the NHS through commissioning consortia and the slimming down of bureaucratic structures. Changes to the General Medical Services contract will also boost this spirit of people power with the introduction of a new incentive payment to encourage GPs to improve patient participation and make practices more responsive to patient needs and wishes.

The big question is how should this £1.10 payment per registered patient be used, and how should patients and communities be involved in the design and delivery of health services?

A key concern is that patient participation may become a box-ticking exercise for GPs. There's a danger they'll fail to understand the broad and varied needs of the communities they serve if they over-rely on self selected patient representatives.

But used effectively, the £55m funding earmarked for patient participation could make a real difference to care people receive, particularly in deprived areas where more patients have long term, complex and multiple needs. Research by Turning Point shows that, even in such communities, people are keen and able to get involved in design and delivery of services.

Turning Point Connected Care involves training local people to research the health, housing and social care needs of their local community. Projects such as this are proving that community engagement can effectively narrow the gap between the priorities of commissioners and the needs of local communities, designing and delivering cost effective services while still improving health and social care outcomes.

Our work in Hartlepool is a good example of community led commissioning. The Turning Point Connected Care pilot, which involved primary care from the start, developed more responsive, joined-up, accessible local services in the deprived Owton ward. The aim was to involve the community in the commissioning process in a way that would fundamentally shift the balance of power in favour of local people.

The process began with an audit of need led by community members, which found that:

- people felt alienated by the complexities of the care system when they passed through different services;
- lack of choice had led to low aspirations and acceptance of poor quality services; and
- there was a lack of adequate information which could enable them to take more responsibility for their health and wellbeing.

At the core of the resulting Connected Care service is an outreach team of care navigators who work to improve access, promote early interventions and support choice.

In the 12 months to June 2010 a team of three navigators dealt with 1,388 cases, secured £750,000 in benefits for individuals and established a number of extra services. These include an independent living service for vulnerable older people, benefits advice, a supported housing complex, a handyman service and a time bank, in which people deposit their time and skills and can call on others when they need help. All of these services are managed through a social enterprise overseen by residents and local community organisations. This kind of community led commissioning has proved really successful.

There is another benefit from building community engagement into GP commissioning in that it leads to greater partnership working. This is important as commissioning has to date struggled to join up in a way that is "co-produced" between partners and communities. The result of better engagement is better outcomes.

The co-operation of partners and communities is not only needed for an adequate service. It's also essential if the economic challenges of the coming years are to be met.

An NHS which provides "better for less" can be the result of the economic climate or the ideal of patient led provision. One thing is sure though: GPs and consortia now have a real opportunity to make the "no decision about me without me" mantra a reality. It is my hope that they will be given the right tools to seize this opportunity. ●

Hilary Samson-Barry is director of statutory relations at Turning Point

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IS IT TIME TO GET PERSONAL?

Personal health budgets are the latest tactic to boost wellbeing but the DH has a long way to go to convince professionals of their worth, reports Emma Dent

Personal health budgets that let people buy their own services have been promoted as an important move towards expanding personalisation and, through that, personal wellbeing.

Detailed evaluation of 20 of over 60 personal health budget pilots, including a handful centred on mental health care, should be available by October 2012.

But there is now evidence that those who are not involved have their doubts about PHBs. A report published in March by the NHS Confederation's Mental Health Network examining the views of mental health professionals found that, although clinicians surveyed were theoretically in favour of anything that increases a service user's wellbeing, several obstacles remained to them backing the scheme.

First, they were reluctant to concede control and accept they did not offer service users sufficient choice of care and treatment. Second there was concern about lack of empirical evidence supporting PHBs. Overriding this is "low awareness and understanding" in general of PHBs.

None of which surprises DH personal health budgets team lead Alison Austin. "They [PHBs] require a culture shift for professionals and service users."

She argues that "PHBs recognise the importance of the individual service user's own experience and knowledge. The relationship becomes a more equal partnership".

But allowing users to take control will take getting used to, says Royal College of Nursing mental health advisor Ian Hulatt. Mental health staff may not be "deliberately paternalistic" towards service users but are accustomed to working in a risk averse, accountable, environment.

He says: "For example, there is concern about what will happen if a service user, say, gets into debt. Well, it would be the same as if you or I did."

Work by mental health charity Mind has found mental health service users were the most likely to benefit from personal budgets, but the least likely to be offered them. "There is a lot of misunderstanding around how personal budgets work; clear guidelines are needed," says its head of policy and campaigns Vicki Nash.

Consumer power: patients may choose to buy non-NHS services

ALAMY

'What is clear is that professionals need to be persuaded by the evidence'

The Confederation's report highlights how mental health workers are worried that, if PHBs are used to purchase non-NHS care, this could lead to the closure of statutory services.

Research has found that direct payments in mental health – a forerunner to PHBs used in social care – were typically used to pay for non standard services. This was anything from paying for a personal assistant to help with filling in forms, shopping, cooking or cleaning, to paying for respite care, transport or education costs, a broadband connection or gym membership.

Mr Hulatt points out that if users are looking outside statutory services to improve wellbeing, there may be lessons for the NHS in what it should provide.

Ms Nash, meanwhile, points out that the whole point of choice is that service users can choose not to have PHBs. Older people, for instance, are more likely to stick to a standard care model. However, she agrees that if users pursue care outside the NHS this could challenge the way services are currently purchased on block contracts.

Mental Health Network director Steve Shrubb urges putting PHBs in context. "This is not an all or nothing debate, there is a middle road," he says. "Nobody is saying, for instance, that a service user cannot be admitted to an inpatient unit because they have spent all their personal budget.

"But what is clear is that professionals need to be persuaded by the evidence and service users and professionals need to be brought together to understand how the system works. The NHS is littered with good ideas that were implemented too early; personal budgets should not be rolled out until evaluation of the pilots has taken place." ●

FIND OUT MORE

The NHS Confederation report can be found at
➔**www.nhsconfed.org/Publications/Documents/Facing_up_to_the_challenge_of_personal_health_budgets.pdf**
DH information on personal health budgets
➔**www.personalhealthbudgets.dh.gov.uk/About**
More on the Mind work on PHBs at
➔**www.mind.org.uk/campaigns_and_issues/policy_and_issues/putting_us_first**

SPECIAL REPORT

HAND IN HAND

Partnerships between the NHS and the private care home sector are evolving and organisations such as Barchester are demonstrating how care of older people benefits from a joined up approach

The NHS has long regarded the private care home sector with at best detachment and at worst suspicion. This is beginning to change as more and more commissioners and providers begin to explore the possibilities offered by partnerships with their local homes.

Driven largely by the pressure to prevent unnecessary acute admissions and prevent delayed discharges, the NHS is working with the sector in a wide variety of ways. GPs now run sessions within nursing homes, for example, while acute trusts and mental health trusts are starting to use their expertise in nursing care for the elderly and for people with dementia (see case studies) to free up acute beds and provide a better experience for patients.

Co-operating is the key when it comes to care of older people

Good value

Barchester Healthcare began exploring the ways in which it could cooperate with the NHS about three years ago with the aim of raising both quality and productivity while delivering good value for the public purse. With more than 200 care homes providing services for more than 10,000 people and a reputation for excellence, the company felt it had something to offer.

Steph Palmerone, director of strategic initiatives and by profession an occupational therapist, says: "We wanted to be part of the solution and not part of the problem."

Over three years Barchester has developed a series of innovative partnerships with the NHS to a point where this work now accounts for 25 per cent of the company's turnover.

Ms Palmerone is adamant this is about much more than transactional services: yes, Barchester can offer award winning care for people with dementia; yes, it has been prepared to adapt homes to meet new needs that arise from these new contracts with the NHS; yes it is probably cheaper to place someone in a nursing home while making funding assessments for long term care than keep them in an acute bed.

But the real value of partnership comes when the two sectors start to work at a strategic level, she says.

Joint work with NHS East Midlands is a good example. Since 2009 Barchester has been a key player alongside health and social care services in developing the regional vision for dementia services as well as the locally agreed Dementia Charter and new care pathways.

'We wanted to be part of the solution and not part of the problem' Steph Palmerone

Jill Guild, strategic relationships and programme manager at NHS East Midlands until spring 2011, says: "Barchester really helped us to understand the tipping point between diagnosis and needing support and how people can end up in a care home too soon and what that means for them."

Local commissioners and homes are piloting new pathways that will improve patient care by smoothing the care sector transition and reducing antipsychotic drug use.

Ms Guild says: "At the beginning of the whole process,

we were not that keen on bringing the independent care home sector in as a partner. With hindsight, I would say that it is crucial. We needed to understand each other's roles and responsibilities."

Innovative learning

One of Barchester's earliest partnerships was with Nottinghamshire Healthcare, the county's mental health and learning disability service provider. In 2008, the two organisations signed a formal agreement to work together to share good practice to create an innovative environment.

They began to lay the ground by bringing managers together to explore what a partnership might mean and then by seconding staff between them.

Nottinghamshire Healthcare executive director for local services Simon Smith says: "When you work in partnership like this, you find you have a lot of shared values. It starts to break down the myths."

Only now, as trust has built up, are the two embarking on real service changes. A new care pathway designed jointly by the trust and Barchester for younger people with dementing illnesses will be implemented this year.

Mr Smith says: "When you are supporting people who are very vulnerable you have a responsibility to find the best ways to support them and that means being flexible and providing a personalised service. That's what we have been able to explore. In my view, we should be finding ways to develop the support and care of people who have both health and social care needs and we need to find ways to work in partnership with a range of organisations that actively contribute to care. That is the principle at play here."

Barchester Healthcare chief executive Mike Parsons (left) with Nottinghamshire Healthcare chief executive Professor Mike Cooke

Reablement aims

It is a principle that many in the NHS are still uncomfortable with and many would see an ulterior motive from the care home sector – to drum up business. None of the people interviewed for this piece agree.

Tony Warnes is demand and

Homes such as Woodside in Norwich are embarking on innovative schemes

CASE STUDY 1: REABLEMENT BEDS IN HAMPSHIRE

An acute bed is no place for convalescence, yet a period of time recuperating after a spell in hospital is just what many people need, especially if they are older and have lost their confidence about living independently.

In Hampshire, the county council and primary care trust have worked closely to commission 43 "reablement" beds in independent care homes where people who no longer have a medical need but are not ready to return home can spend up to six weeks receiving nursing care and support that will help them decide their future.

Barchester Healthcare is one of the contracted providers of what has become known locally as "time to think" beds.

Hampshire County Council demand and capacity director Tony Warnes says: "All the evidence shows us that an acute bed is not the right time or the right place for an older person to make decisions about their future care, whether that is a supported return home or to long term care.

"This is about actively supporting a period of recovery and final decision making."

During a fully funded reablement period, individuals undergo full social and occupational therapy and healthcare assessments as well as support in regaining the skills they will need for daily life. There are weekly reviews to gauge progress gained and to ensure families are closely involved.

"We have found two very significant benefits," says Mr Warnes. "The first is that staff morale is lifted as staff feel that they are making a positive contribution to individual's recovery.

"We also find that the time and input into helping people regain confidence really pays off. As a minimum average, 65 per cent of the people using the time to think beds who had initially decided to opt for long term care decide to make a supported return to home at the end of their six weeks."

In addition to being an intensely "person centred" service, it also has whole system benefits, says Mr Warnes.

It reduces length of stay in the acute ward by a conservative estimate of 14 days when compared with long term placements being made directly from a hospital. It is a three-way partnership that draws on the strength of each player, he adds.

The county council has long experience of contracting with the private care home sector, while the NHS and social services share expertise and resources in reablement. The private care home sector, meanwhile, has the physical beds and expert 24-hour nursing care on hand.

Commercial confidentiality makes it difficult to discuss the cost/benefit of these beds, says Mr Warnes. The sums do however show that the cost of a full six week spell in reablement is cost neutral compared with the average cost of using an acute bed for 14 days while a long term care placement is organised.

"This is really about providing a quality service," adds Mr Warnes. "The feedback is that this is a service that enables people to make a decision about which they are better informed and more knowledgeable."

'We find that the time and input into helping people regain confidence really pays off'

‘By working in the nursing home I can see patients regularly, meet families and staff ’

CASE STUDY 2: GP SESSIONS IN EXETER

In June 2009, Exeter GP Leo Clarke started to run twice weekly sessions for 60 dementia patients living at the local Barchester Healthcare home, Lucerne House. So far, he has saved the NHS £10,000 in medicine costs and reduced emergency admissions by 42 per cent.

Dr Clarke says: “This is all about providing continuity of care. By working in the nursing home I can see patients regularly and meet with families and support staff.”

While nurses can always call a doctor in an emergency, he says his regular presence every Monday and Friday means fewer emergencies arise. An audit of out of hours admissions in the 15 months before and 15 months after he started showed that they were reduced from 12 to seven.

This level of involvement is rare. It is possible partly because all the dementia patients at Lucerne House are registered with Dr Clarke. But it is also down to the willingness by everyone involved to raise standards.

Dr Clarke says: “When you work somewhere regularly you have a chance to think about how care can be improved.”

With the support of Ide Lane Surgery and NHS Devon, he has installed PCs and networks that allow doctors access to records online at Lucerne House.

“I can look up allergies and lab results and it means that records are available to out of hours doctors too,” he says.

He is now using digital photography to help nurses track wound healing and working to implement the Liverpool Gold Standard for end of life care. Another initiative supported by NHS Devon involved working with a local pharmacist to review medication and implement best prescribing practice. This saw the drugs bill drop by £10,000.

“We are now using batch dispensing,” says Dr Clarke.

Medication is prescribed for six months and released monthly from the pharmacy.

“There is less administration for nurses and patients’ regular medication is reviewed at least every six months,” he says.

“My philosophy has always been to practice proactive medicine, maintain traditional values and also incorporate 21st century medicine and technology in medical care of all. Patients in a nursing home deserve that too.”

Representatives from the Alzheimer’s Society drop in to Lucerne House

CASE STUDY 3: AVOIDING ACUTE HOSPITAL ADMISSION IN NORWICH

There is a lot to be said for having good relations with your neighbours, as clinicians at Thorpewood Medical Group and Barchester Healthcare’s Woodside nursing home in Norwich will testify.

Woodside lies on one side of the GP practice’s car park, making it the ideal location for a “step up” bed to which GPs and nurses can refer patients who need acute care but not admission to an acute hospital with all the disruption, expense and risk involved.

“We already had good relations with the nursing home and were happy their standards of nursing care were excellent,” says commissioning manager for Thorpewood Medical Group, Amanda Carver. “Their location means our specialist nurses have very easy access and it is easy for partners and carers to visit.”

With money from NHS Norfolk’s innovation fund, clinicians at the nursing home and GP practice designed and adapted a room at the home, bringing it up to hospital standard and installing a telehealth “pod” to monitor and record relevant biomedical signs such as pulse and blood oxygen.

Ms Carver explains: “We can determine what is measured and the parameters that are acceptable for each patient. It is linked to a computer so we can monitor the patient remotely.”

They also worked closely with colleagues in the local acute trust, community services, ambulance trust, social services and the out of hours medical providers. Patients who meet strict criteria and have an acute medical need can be admitted to the bed where they receive expert nursing care under the care of a GP for up to five days.

“Typically these are elderly people with pneumonia, a urinary tract infection or have had a fall,” says Ms Carver.

Patients have access to hospital diagnostics, such as x-ray, exactly as if they were in an acute hospital bed. While they are in the bed, they receive clinical assessments to deal with any outstanding medical needs and social care assessments to ensure a smooth transfer home again.

With 18 months’ experience of using the step up bed, patient satisfaction is very high.

“Patients love it,” says Ms Carver. “They say the food is fantastic.”

Not one patient has been admitted to hospital out of hours.

Costing is difficult, but Ms Carver has compared the cost of the step up bed to that of acute care for matched patients.

“The yearly cost of an acute bed is £94,000. We are paying £64,000 a year for the step up bed – and this doesn’t take into account all the intangibles and added benefits.”

She admits the bed is not fully used as the admission criteria are strict. The practice hopes to enrol another local GP to make better use of it and also hopes to develop step down beds at Woodside to facilitate discharge from hospital.

capacity director for Hampshire County Council, where Barchester now provides reablement beds (see case study 1, page 15).

Mr Warner says: "I refute this absolutely. It is just not what we are finding. We are clear in our contracts what we are contracting for and if we found a significant number of people using the reablement beds stayed on in the home longer term, then we would not renew the contracts.

"If anything, you could argue that they are shooting themselves in the foot – this is all about reducing demand for long term care."

Mike Parsons, chief executive of Barchester, hopes more commissioners and providers will look at the sector with fresh eyes to address long term care challenges, demand management in the acute sector and improving end of life care.

"The partnerships we are developing are not short term," he says. "Barchester may be unique in investing in such long term relationships; our size means we can. By following our history of employing and investing in local people, with access to apprentices, NVQs, nurse preceptorships and our own business school, we can work with local partners with a genuine understanding of the local culture and community." ●

All smiles: partnerships can lead to a better standard of care

CASE STUDY 4: AVOIDING DELAYED DISCHARGE IN BLACKPOOL

When patients are hospitalised and it becomes clear their next move will be to 24-hour care provision, moving them on can be a time consuming process.

It takes approximately 14 to 21 days just to complete the complex assessments and get a decision about funding; an acute hospital bed is neither the safest nor the most cost effective place to be while this takes place.

Now Blackpool Teaching Hospitals Foundation Trust has developed partnerships with local nursing homes to transfer patients to a care home bed while the relevant assessments take place.

One of these is with Barchester Healthcare to provide five beds in their Memory Lane community at its Glenroyd care home in Blackpool. The contract has been running since November 2010 and is about to be increased to eight beds.

These beds are specifically for patients with dementia and it works "exceptionally well", says Emma Montgomery, acting team manager of Blackpool Teaching Hospitals Discharge Team.

Glenroyd care home in Blackpool is working to ease patient assessment

Patients receive the expert nursing care they need from the home's nursing team while the discharge team carry out the nursing and social care assessments and liaise with the families and relevant authorities.

"We do all the assessments at the care home," says Ms Montgomery. "In addition to it being a more appropriate place for medically fit patients and cheaper than a hospital bed, we find it gives patients and families some breathing space while they decide what to do next."

For many families and patients, this will be the first experience of a nursing home.

"Quite a lot of people have never been in a care home before and it is a huge transition," says Ms Montgomery. "They get a chance to see what it can be like and some time to look around for a more permanent placement.

"We also find that some people who we thought needed 24-hour care in fact recover and make a supported move back home."

Agreeing the partnership itself involved a huge amount of work, with the discharge team visiting homes to observe how nursing staff work with patients, liaising with the Care Quality Commission, checking staffing levels and so on. The feedback from patients has been extremely positive, with a vast majority saying the experience was excellent.

"I would say this works exceptionally well," says Ms Montgomery. "It is taking pressure off the acute hospital, helping patients to be discharged to a more appropriate environment and the communication between the discharge team and the care home's nursing team is excellent."

A sceptic might argue that this is just another way for a care home to drum up business. Ms Montgomery does not agree, pointing out that less than 10 per cent of the patients using the contracted beds permanently stay in the home.

"This is a genuine partnership that works in the best interests of patients," she says.

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