

Humana
White Paper
0607

Effective
commissioning.
Transforming PCTs
into champions
of health and
healthcare.

Commissioning in healthcare

As their organisations take shape, PCTs across the country are getting to grips with their new roles, and creating the framework for their future strategies. The most important challenge they now face is commissioning, a critical element in the NHS programme of reform, and potentially the most powerful tool for change.

In this White Paper, one of a series of discussion documents by Humana, we explore the opportunities created by commissioning to champion a more responsive, patient-centred healthcare system.

Over half way through the Government's ten year plan for NHS reform, the last three or four years have been especially demanding for PCTs. It will come as no surprise that in a recent poll by the HSJ, 100% of PCT chief executives surveyed admitted feeling 'battered and bruised' by constant reorganisation. They have had many pressing issues to deal with, including ensuring financial balance and meeting national targets such as the 18-week maximum wait.

Now they are charged with developing a comprehensive commissioning strategy that will secure the best healthcare outcomes for the communities they serve. This makes PCTs the central architects of health service delivery and gives them the opportunity to become champions of health in the community. Commissioning will be the principle vehicle for PCTs to achieve local control, local accountability and locally desired results in terms of effectiveness, efficiency and patient experience (Figure 1).

New roles demand new skills

Commissioning in the NHS is not new. Throughout the nineties it was tested in a variety of models, beginning with GP fundholding and health authority purchase and continuing through total purchasing projects and the work of primary care groups and trusts. Although active for only a relatively short period of time, these earlier pilots highlighted a few key lessons. First, effective commissioning requires some scale, now possible through the

"Commissioning is not new, and there is already much good practice in the NHS and local government. But we now have an opportunity to build on achievements and to ensure that first-rate commissioning becomes the norm everywhere."

HEALTH REFORM IN ENGLAND: UPDATE AND COMMISSIONING FRAMEWORK, (DH, 2006)

reconfiguration of the PCTs. Second, effective commissioning needs a strong organisational structure to manage the core analytical, contracting, and administrative functions. And third, commissioning requires the development of a new set of capabilities that are not currently well developed.

Thankfully, many tools and techniques that can help PCTs manage the commissioning process already exist either outside the health service or in other health systems. Tried and tested in business and used in insurance-led healthcare systems throughout the world, techniques such as data capture and analysis, system automation and

"Everybody complains about reorganisation but the last three or four years have been especially wasteful of talent, commitment and focus."

CHIEF EXECUTIVE OF PCT
BASED IN SOUTH

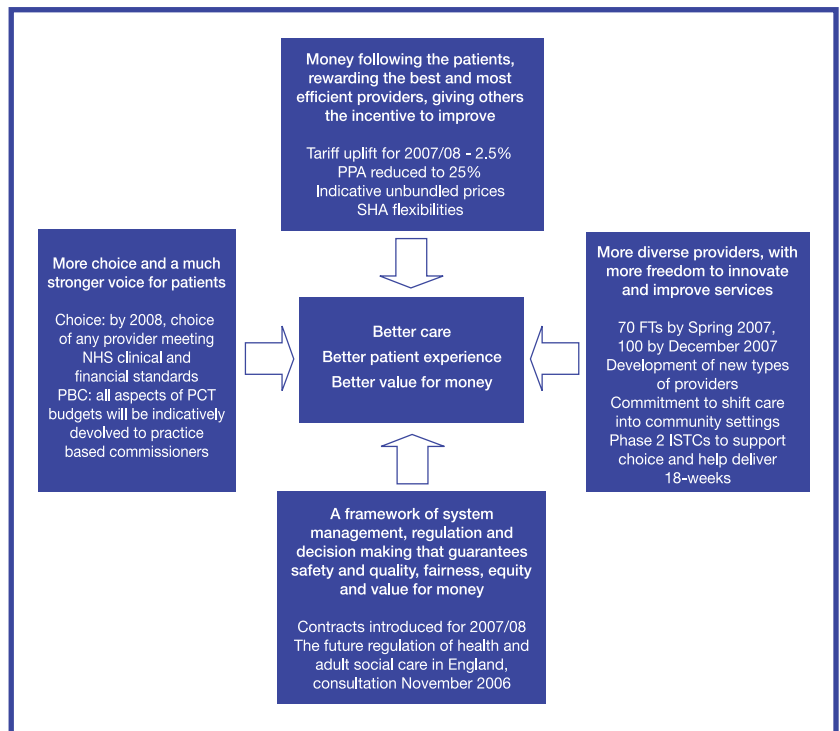


Figure 1. The NHS in England: the operating framework for 2007/08. DH, December 2006.

communication strategies can enable PCTs to grasp the commissioning nettle and start realising the benefits for their communities.

Managing health and financial risk

As champions of healthcare for their communities, PCTs are charged with ensuring that patients receive the best possible service while also arranging for efficient delivery within the constraints of NHS resources. These objectives, which appear to be in conflict, have to be managed. The essential tension between these two goals defines the path to effective commissioning and is a focal point for creative use of its power.

“GPs are sending fewer patients to hospital for unnecessary appointments following government reforms, giving practices a greater say in how the NHS provides and buys services for patients. Reports from the NHS, published for the first time today, show that GP practices in some parts of the country are cutting the number of patients they refer to consultants by a quarter by taking direct control of commissioning decisions.”

On the patient side, the PCT is responsible for identifying the needs and demands of its population, so assessment and planning are key to their role. And, as PCTs are accountable to the patients they serve, positive public engagement and feedback are critical.

On the supply side, the PCT is responsible for shaping the market, through effective methods of contracting and procurement. PCTs are also required to hold providers to account, so disciplined performance management processes need to be put in place.

At the nexus of supply and demand, where healthcare services are used, the PCT has the opportunity to use commissioning to co-ordinate and integrate care, to ensure that patients are getting appropriate care in the appropriate setting, that their transitions are efficiently managed and their experience optimised.

Managing change

The redesign of any health economy is a huge undertaking. In the mature system of the present day NHS, the many well-established routes to care now have to be re-shaped for a completely different market environment. One of the key precepts of commissioning is contestability, and now that challenge is being built into the system, commissioning is turning everything on its head. As services are re-engineered, care pathways re-drawn and new financial incentives developed, old conventions are being broken down. So how can PCTs effectively manage what is such a complex and challenging transformation? ■

“A 25% reduction in the number of GP referrals, if matched across the entire NHS, could see around 2.5 million patients receiving care in more convenient locations, such as community-based health centres and GP surgeries, rather than traditional large hospitals every year.”

GP REFORMS IMPROVE NHS REFERRALS - DH PRESS
RELEASE, JANUARY 2007

GP REFORMS IMPROVE NHS
REFERRALS - DH PRESS
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The commissioning delivery cycle

There are four key functions within the commissioning delivery cycle. Although each requires different skill sets, they are inextricably linked.

1. Assessment and planning

Assessment and planning are the critical first steps of commissioning. They establish the foundation for reform and enable the execution of a range of strategic initiatives. Collecting and analysing data are key to the process. As we describe in our White Paper 'How the use of data will affect NHS primary care performance', PCTs will have to develop new knowledge management skills and rigorously enforce data standards across all provider activities.

Health needs and demands

This is first about understanding the population – their health needs, their care seeking behaviours

and their experience in the delivery system. As PCTs begin to address the underlying causes of preventable chronic disease, they will have to learn more about health attitudes and behaviours with a view to engaging their population to embrace healthier lifestyles. The goal of the commissioners is to understand their population intimately so that services can be designed around their needs and targeted to maximise their effectiveness, keeping the trio of goals always in mind – better experience, better results, delivered more efficiently.

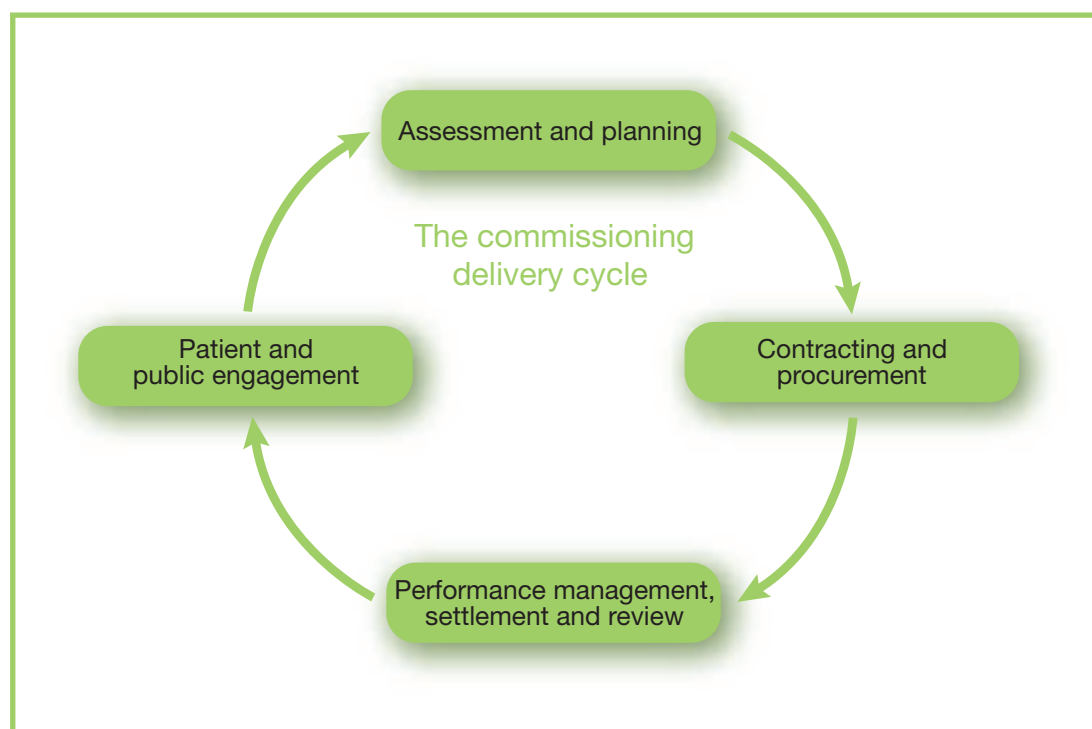
Data management

Doing this requires data. It will start with understanding what care people are getting today, where they are going, for what conditions, under what circumstances. Commissioners need to be able to map the care paths of every person in the patch.

Integrated data is the key to integrated care. Data drives all other downstream commissioning functions, including health needs and equity audits, patient needs and current demand profiles, forecasted demand, cost prioritisations and the balancing of demand and supply. These functions cannot be achieved without access to, collection and use of individualised clinical data. Each PCT should focus in the early stages on acquiring and

“Increasingly PCTs need to be outward-facing organisations, accounting to their local communities for the outcomes they achieve, and reflecting local needs and feedback in the way they commission services for their communities. They will need to anticipate and develop responses to future challenges, not be the passive recipients of the next set of instructions.”

THE NHS IN ENGLAND:
OPERATING FRAMEWORK FOR
2007/08, (DH 2006)



The commissioning delivery cycle.

using the data to help them make improvements in all aspects of commissioning and care delivery.

With good diagnostic coding, data can begin to inform the PCTs' understanding of the healthcare needs of the population, where that care is being delivered and whether there might be opportunities for more efficient solutions. Later, data mining and modelling techniques will enable the PCT to assess the individual risk of patients so that services can be targeted to at-risk individuals to mitigate their health risks and alter their health trajectories.

Tackling inequalities

Many people who are at risk do not enter the system – a likely driver of persistent health inequalities. For this population, other data collection will be necessary. PCTs will need to deliver health risk surveys – risk appraisals like “LifeCheck” (promised by the White Paper ‘Our Health, Our Care, Our Say’) that can be used to identify people with incipient conditions to whom targeted secondary prevention services can be offered.

Some high risk individuals who have been identified by data analysis or health risk appraisal will need to be further stratified. This may be done with additional interviews or surveys that will draw out mental health needs or functional limitations that can be addressed through better co-ordination of health and social care.

Techniques such as advanced analytics, data visualisation and predictive modelling can all be used to reveal otherwise hidden information. They can also identify opportunities to influence individual behaviours through targeted interventions.

Health, wellness, and chronic disease prevention

As PCTs come to terms with the underlying preventable health risks that drive so much of our health costs, they will want to understand more about what is influencing the relevant health behaviours and direct services to address them. To do this, the effective commissioner will want to understand more than simple health risk – it will want to grasp the likelihood that individuals will engage with a programme as well as the likelihood that they will be activated to do something different and make a change in health behaviour. By knowing people intimately, and by capturing data on what people do – what services they use, how they use them and how effective those services are – the

Case study – Darlington PCT

Darlington PCT is clear about the potential benefits of practice-based commissioning (PBC) especially the opportunities it brings to build commissioning decisions on sound clinical data and on the detailed knowledge GPs have about the needs of their own patient populations.

Collaboration is key for Darlington's 11 practices, with the focus on starting small, moving forward together and using PBC to make tangible and sustainable improvements in the patient pathway right across primary and secondary care.

Carole Harder, Darlington PCT's Director of Primary Care, explains: “In Darlington some practices have had experience of fundholding, but this needs to be different. Typically under fundholding the emphasis was on reducing waiting times and moving contracts between different acute providers. However, with the introduction of the 18-week target from referral to treatment, practice-based commissioning can focus more on redesigning patient pathways.”

“It will encourage us to develop a detailed picture of which services GPs are referring to and what's happening to the patient at each stage of the pathway,” says Carole. “But for all this to happen, we need to open up a much closer commissioning dialogue between the practices and the PCT.”

As a key strand of this closer dialogue, a new Commissioning Forum is under discussion. This would bring together a clinical lead from each practice, Carole herself, the PCT's commissioning directorate, and acute trust representation.

effective commissioner can learn to maximise the effectiveness of its targeting.

Identification, stratification, and targeting are the key features of the assessment process that will enable the PCT to develop efficient systems to achieve its goals.

Shaping the structure of supply

There is an equal need to assess the delivery system so the commissioner can determine whether sufficient capacity of the right kind exists, to ensure that health needs can efficiently be met.

Commissioners will want to identify gaps, misallocations, and service inadequacies in order to begin to address those problems. This can be achieved by encouraging current commissioned services to improve performance, by creating a market for new services to meet new patient needs, and by influencing the delivery system to reallocate resources to increase access and efficiency. Examples might include increasing the availability of occupational and physical therapy services, increasing screening and access to community-based treatment for depression, and encouraging more direct access to specialty care through new forms of organisation that bring specialty care and primary care into greater proximity.

In the end these have to come together in an assessment of the value being obtained by current health spending and an identification of options for the redistribution of resources to provide the best value for money.

A process of discovery

Understanding how patients move through the care system – identifying where they get their care, and the parts of the process that provide value, or could be improved upon – will help the PCT to guide people more efficiently and to develop mechanisms that will ensure people receive care that is relevant to their individual needs, and is delivered at the most appropriate level.

The following services seek to improve delivery at three levels:

Demand management – pre-authorisation of medical admissions and select procedures, referral management, and discharge planning with ongoing monitoring to assure that people move efficiently through the system, avoiding needless care and delivering short-term system savings.

Care management services – including pre-admission and post-discharge counselling, decision support for preference-sensitive conditions, and chronic disease management to assure that patients are well managed through the care pathway and their treatment adheres to clinical guidelines.

Health and wellness services – ultimately to get ahead of the coming wave of preventable vascular disease and its complications, and to influence the health and wellbeing of individuals now and in the future, it will be necessary to invest in targeted services that encourage people to adopt healthier lifestyles.

2. Contracting and procurement

Contracting and procurement is a fundamental skill set for any commissioner of healthcare. It requires systems and experience that can build on existing relationships and manage new providers, including:

- Expert negotiations with all types of providers
- Innovative use of incentives to influence provider behaviour
- Data management including tariffs, Service Level Agreements (SLAs) and incentives for enhanced services, payment approval and provider audits
- Real-time data analysis to support rigorous (automated) performance and contract monitoring
- Standardised monitoring and audit processes to identify opportunities for recontracting and automate bill approvals
- Identification of process improvement and best practice across SLAs.

These are important functions because after all, it is through contracting and procurement that the effective commissioner will seek to shape the delivery system to meet the needs of its populations and to encourage the development of innovative solutions to emerging health problems.

Commissioning for quality

As they begin to secure and hold contracts on behalf of GP practices, tendering and contracting will become important core competencies for the PCT. Cost is not the only issue. Building on national frameworks and guidelines, PCTs will have to achieve a balance between best quality and value-for-money for their stakeholders – patients and tax-payers.

This will have to be achieved within a non-adversarial environment. There are healthy traditions of networking and collaboration within the NHS and these have to be protected in the new era of commissioning. How should they be managed to achieve the PCT's health and efficiency goals?

- They should be mutually beneficial
- They should be understood as relationships and therefore incorporated as long-term commitments
- They should be performance managed – with clear expectations on both sides, and a discipline about measurement and accountability for delivery

“Contracts will be the key accountability mechanism between PCTs and an increasingly diverse range of providers. This has serious implications for PCTs in 2007/08. They need to ensure that expectations, planning assumptions, and the balance of risks and controls are all clearly defined in the contracts they put in place.”

THE NHS IN ENGLAND:
OPERATING FRAMEWORK
FOR 2007/08 (DH, 2006)

“Strong accountability for performance will continue throughout the system. But the nature of accountability relationships and behaviours will evolve in 2007/08. The quid pro quo of less central prescription and intervention is that local boards take greater ownership for continuous service improvement and act in the public interest. We expect this to be an underlying principle of local approaches to performance management across the NHS.”

THE NHS IN ENGLAND:
OPERATING FRAMEWORK
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Commissioning for improved integration and care co-ordination

The new healthcare reforms advocate greater co-operation and joint working partnerships between PCTs and local government to produce Local Area Agreements. Working together creates a more holistic view of a population's health and social care needs, leading to better integration of services.

Jointly commissioned services will then extend to public health, children's services, mental health, and adult services. Joint commissioning arrangements with local authorities will vary across England, but they need to be formalised and transparent, with clear definition of which body has lead accountability.

3. Performance management, settlement and review

Establishing key metrics to measure, monitor and report will improve contracting, reduce costs and centralise administrative and clinical management functions. Developing an enhanced management information system populated from primary, secondary, pharmacy, dental and mental health data which generates real-time, reliable information will allow PCTs to establish key performance metrics and benchmarks to monitor performance.

Performance management, settlement and review covers five separate areas.

PbR transactions – these require robust performance metrics based on population need, ability to improve provision, and to track results at the patient/provider level. Critical to this is the ability to monitor the accuracy of coding (diagnosis, procedure, length of stay, admission route, outcome, care setting etc).

Case study – Lambeth PCT Community Diabetes Services Practice

South Lambeth Road practice has developed a community diabetes service using Primary Medical Services (PMS) as a contracting tool.

The practice has a GP who is a long time clinical assistant in diabetes at the local NHS Trust.

Through PMS the practice has contracted with Lambeth PCT to deliver a community diabetes service to serve its own population and those of neighbouring practices in Stockwell. The practice has negotiated a baseline figure with the PCT for the number of patients for whom it can provide a community diabetes service. The service is less expensive than hospital provision and provides continuity of care. If negotiated and promoted well with local practices and their populations, it could be extended across the whole of the PCT through PBC, resulting in early efficiency gains across the health economy.

Key performance metrics may include measures of:

- Cost and utilisation – including length of stay, emergency visits, use of high-technology procedures
- Outcome – including mortality, readmissions, complications
- Process – including adherence to evidence-based practices
- Structure – including patient safety
- Patient experience – including follow-up care, waiting times, and communications

Many Foundation Trusts are now getting real value from their investment in new reporting systems developed in conjunction with Monitor (see panel). These enable FTs to assess the strengths and weaknesses of their service lines and make the necessary adjustments.

Once the same range and quality of data is available to PCTs, we can expect to see the introduction of similar assessment methodologies leading to real benefits in tracking patient activity, the care provided and the associated costs.

Budget and activity management – the capturing, tracking and reporting on all financial aspects, providing support to GPs and oversight of regulatory and statutory requirements is critical

How Monitor is helping FTs develop their management systems

Monitor has set up a business and financial framework to help Foundation Trusts identify a service line reporting toolkit to determine which specialties and procedures will give their hospitals the best yields.

PCTs can look at the supply sides of their health economy and determine the adequacy and completeness of its systems to identify what needs changing or modifying. Every PCT will need to develop their own very specific business toolkits to identify the needs of their practitioners and patients.

Case study – North Bradford PCT

PBC was introduced into North Bradford four years ago. All secondary care has been included in the scheme, allowing North Bradford to accelerate the development of extensive locality services for a wide range of care.

The number of patients attending casualty has not risen. The understanding of elective referral patterns between GPs has allowed the widespread development of alternative care pathways across primary and secondary care, with consultants from many specialties now working in primary care with GPs. Waiting times have fallen well below 6/12 and the majority of patients are at 3/12.

PBC has generated maximum practice and clinical engagement – essential ingredients in the process. Practices have been in the driving seat, taking ownership of the problems, while the PCT's role has been to facilitate and co-ordinate this process.

for budget and activity management. A range of standard financial and activity measures can be used, depending upon the nature of the organisation and reflecting the different accounting principles used. The generation of real-time data and use of standard monitoring techniques (trends, variances, risk-based approach) would detect any problems at an early stage.

Performance management – involves the use of information to identify opportunities, improve access and create forums in which PCTs can plan and prioritise and communicate changes. More robust measures and benchmarking will enable results-based rewards and incentives, more frequent and accurate reporting, quality and best-practice improvement, and better informed and engaged patients.

Using a set of measures developed along NSF and NICE guidelines, available data could be used to determine the initial 'starter set'. High achievers would receive reward payments and public recognition. Lower performing hospitals might be penalised through procurement, public notification and economic withholds.

PBC operating processes – PCTs will need to develop a performance management framework to oversee GP practices operating under PBC. PCTs could

create a 'dashboard' to evaluate service levels and service delivery performance. The dashboard would be structured into key domains to capture relevant measures for cost-effective, quality healthcare. A standardised tool that tracks patient safety, service delivery and financial performance on a PCT specific and comparative basis might include:

- Patient experience metrics including consumer engagement, patient satisfaction, GP intelligence
- Quality of service statistics, including clinical outcomes, health status, patient safety
- Operating statistics, including staffing, key activity, productivity, process measures
- Financial activity and cost statistics, including cost, utilisation, comparison to targets.

Patient choice and GP intelligence

PCTs must hold themselves accountable to the highest of standards and principles. This involves developing forums for communication with all stakeholders, allowing input into decisions and strategies based on performance and progress against key goals. Provider awareness and public recognition are strong influencers of increased market competition and continual improvement.

Under commissioning, patients are now expected to play an important role in the redesign of local health systems. John Appleby of the King's Fund says: "The government's intention is to create a financial system that will allow patients to choose their hospitals. If some hospitals are able to expand services and attract patients from other areas, then others will be put under pressure to reduce costs and find other ways of maintaining their income. Most hospital costs are fixed. Hence, in the short term, revenue losses more or less convert straight into financial deficits. The extent to which patients will exercise choice in practice will therefore be critical."

4. Patient and public engagement

The overall goal of patient and public engagement is to achieve a fundamental shift in peoples' behaviour and attitudes towards their own health and wellbeing, thereby maximising opportunities for healthy lifestyle decisions that will lead to increased disease prevention and therefore a reduction in the burden of illness.

Patient communication and public engagement in the NHS are still in their infancy and public

"It is the responsibility of the NHS community leadership to fully engage with clinicians, staff, patients and the wider public to communicate and explain the need for change and the potential of the reforms locally to improve services and people's lives."

THE NHS IN ENGLAND:
OPERATING FRAMEWORK
FOR 2007/08 (DH, 2006)

awareness of PCTs is very low at present. From the public's viewpoint, the role of PCTs has never been clear. Unfortunately, PCTs often only come into public focus during debates about changes to local services. This can make them appear to be insensitive bureaucracies, divorced from the feelings and wishes of local people.

Patient and public engagement goes far beyond the conventions of stakeholder relations. It must seek to engage everyone and everything that can influence the health of a community, including all providers and clinical stakeholders. And it must ensure that everyone is pulling in the same direction.

Engagement with patients is essential, because it is proven that engaged patients become activated to support their own health and trained to interact productively with their care givers. This results in better self-care, improved compliance to clinical regimens, and better outcomes.

A key objective is to make NHS initiatives such as 'patient choice' and 'public voice' programmes more effective in what is set to become an increasingly consumer-led NHS – something we examine in our White Paper *'When patients become consumers: the next challenge for the NHS'*.

With the right skills on board, PCTs can work to:

- Employ metrics for monitoring patient satisfaction and patient experience and introduce a mechanism for soliciting regular feedback at the point of service delivery.
- Foster a spirit of collaboration, partnership and co-ownership between key stakeholders including PBCs, PEC Groups, GP groups, SHAs, local authorities, LINks, and other patient, public and professional bodies by creating a forum for regular meetings and discussions, beyond statutory board meetings and AGMs.
- Develop an annual engagement plan which builds on the existing process for formal public consultations and introduce new strategies to engage the whole community, addressing socio-demographics as well as literacy and language issues.
- Develop a Patient and Public Service Bureau to receive, handle and report complaints and questions. This service can be used as an early interceptor of issues within the health service, built around the existing PALS unit, and will identify problems for ongoing learning.

- Work with clinicians to improve their communication skills, encouraging them to consult collaboratively with their patients in order to achieve shared decisions in health and healthcare.
- Foster pro-active relationships with the media and keep the public regularly informed about service delivery levels and new initiatives via a mix of public relations, local press, TV and online channels. Publish the results of findings to enable patients to make informed choices and motivate providers to continually improve the quality of their offer.
- Develop an annual communications plan for each of the key stakeholders so that the PCT is informed of and listens to what stakeholders are saying.

Delivering decision support

There is a range in the type of information PCTs can provide, from keeping people informed about new medical breakthroughs and scientific developments, to more targeted, personalised information relevant to an individual's life stage, health state and circumstances. This is especially important when reaching out to sections of the community who are not normally assertive, engaged or committed to public programmes. Tackling inequalities means engaging with people who thus far have been under-represented and under-served by the healthcare system.

Communicating empathetically

People are understandably nervous about healthcare issues, especially when operations and hospital stays are part of their treatment. By communicating in a style that conveys a feeling of empathy and demonstrates an understanding that healthcare can at times be intimidating, people will be reassured that the PCT is 'on their side'. At the same time, delivering the knowledge people need and request, and providing guidance to help them make decisions, will confirm that the PCT runs an expert and capable support system.

Effective and efficient commissioning for improved patient experience

Commissioning can become a powerful tool that will enable the Primary Care Trusts to deliver on the NHS promise of better care, better value, and a better patient experience.

Effective commissioning requires having both vision

"Buying in commissioning skills should also be considered. As there is currently a lack of in-house skills, the NHS could benefit from overseas expertise in the form of either companies or specific individuals."

DEVELOPING EFFECTIVE COMMISSIONING IN THE NHS (MONITOR, 2005)

and ability to manage the delivery of a detailed plan. It depends critically on involving all practitioners and constituencies in the local community. A system which can align these objectives will deliver the best healthcare experience for its local population with the best possible health outcomes.

The ultimate objective is to create a better healthcare system, responsive to the needs and character of local communities. Collaboration between hospitals, doctors, and other healthcare providers, as well as community organisations, employers, and other community leaders, are key to achieving this goal.

Five rules for effective commissioning

Innovate – PCTs are in the driving seat of NHS reform. They have a real opportunity to take healthcare to a new and exciting level that not only addresses the needs of their populations, but is able to inform and empower individuals to make positive lifestyle decisions that will pave the way to health for generations to come. Commissioning gives PCTs the best available lever for change.

Let data drive decision making – The number one priority of all commissioners must be to develop a flexible system for collecting and using data, and the scientific tools to use it effectively. The starting point is the linking of encounter data, individualised to the patient and as detailed as possible. These data will enable commissioners to map the clinical trajectories of people in the system, and to risk stratify the population. More effort must be devoted to capturing information through surveys, risk screens, and other means. Because the more information available, the better the PCT will be able to understand the attitudes, behaviours and contexts of healthcare decision making.

Commissioning for outcomes – This requires a systematic approach, using evidence-based care standards as a mechanism for reducing variation, encouraging efficient clinical practice and engaging with patients.

Invest in long-term change – Becoming a data-driven organisation tomorrow requires investment in information systems today. Getting ahead of long-developing chronic diseases that could cripple the health system in ten years time requires investing the time, effort and creativity to alter today's self-destructive health behaviours.

Involve the whole community – Data does not substitute for values. Commissioners need to have mechanisms for engaging their communities to provide directional guidance about what specifically they want the local health system to accomplish. The communities must help commissioners determine what to do. The data will then tell them how to do it.

Summary: the challenges facing PCTs

The key outcomes of good commissioning can be summarised as:

- Improved health and wellbeing and reduced health inequalities and social exclusion
- Secure access to a comprehensive range of services
- Improved quality, effectiveness and efficiency of services
- Increased choice for patients and a better experience of care
- Best value achieved within available resources

The effects of good commissioning should be easy to recognise:

- Practices will be engaged with PBC
- The PCT will be running a small financial surplus
- Overall health status will be improving
- Inequalities in health status across the PCT area will be narrowing
- Patient experience will improve ■

About Humana

- Headquartered in London, Humana Europe offers commissioning support to the NHS. We are a subsidiary of Humana Inc, one of the largest health benefits companies in the US with over 11 million members and 20,000 employees. Around two thirds of our members receive government-funded healthcare.
- Humana integrates expertise in data analysis, health service design, contracting and procurement, performance management and consumer engagement. As a result, we are one of only a handful of organisations in the UK able to offer an integrated healthcare commissioning service.
- We are a company run by experts in health and healthcare with frontline NHS, international and multidisciplinary experience ranging from consumer engagement and behaviour change to clinical excellence.
- Working in partnership with you, we will provide tried and tested strategies for health and healthcare organisations to improve the patient experience and reduce health inequalities.
- Our approach is recognised by doctors and healthcare professionals as supporting their interactions with patients and removing obstacles to the frontline delivery of care.
- We have achieved demonstrable health improvements through innovative programmes including case management, care co-ordination, health and wellbeing intervention and disease management.
- We have a proven track record in slowing the trend of rising healthcare costs.
- We have a history of adapting, innovating and implementing best-of-breed solutions across the spectrum of healthcare delivery.
- Through our unique consumer-driven approach, we understand how people interact and engage with the healthcare system and how to configure services around the needs of the individual.
- Through constant innovation, we are focused on achieving a fundamental shift in individual attitudes and behaviour, leading to healthier lifestyles and a consequent reduction in the burden of illness.

Contact us

We welcome your views. This white paper can be reviewed on our website at humana.co.uk. Send us an email to add to the debate: info@humana.co.uk Tel: 020 3004 3200 Fax: 020 7495 6190

Awards

2006 American Business Awards

June 2006

Humana won a Stevie Award for its SmartSummary Rx benefits statement in the Best New Product category at the 2006 American Business Awards.

2004 American Business Awards

April 2004

Finalist in 3 categories: Most Innovative Company, Best Customer Service Organization, Best Engineering Executive.

CDHCC Awards

April 2004

Best example of technology facilitating consumer-directed health plan, 2004 Consumer Directed Health Care Conference.

Computerworld Premier 100

January 2004

For exceptional technology leadership, innovative approaches to business challenges and effective execution of technology strategy.

eHealthcare Leadership Awards

October 2003

4 consecutive years / 2003 Results Gold Awards in Best e-Business, Best Health / Healthcare Content, Best Overall Internet site.

CIO 100

August 2003

For demonstrating resourceful use of technology and excelling in generating greater value from limited resources.

Forrester Research CDHP Survey

July 2003

"A leader in the deployment of self-service technology, Humana's consumer-directed offerings feature the broadest access to customer service and content among the leading plans."