Expert Panel Feedback on Business Proposals

This document was created in 2012 as part of PD094 'Making the Business Case' by The Chartered Society of Physiotherapy. Although it is a historical document, it is felt to continue to be useful as expert panel feedback on business proposals. It is important to take this in context and review other more up to date and local examples alongside this.

This section gives examples of four highly effective and innovative physiotherapy services, and asks a panel of experts to comment on how such services might further develop the evidence they are already collecting into full business proposals.

Building the evidence

All over the UK, physiotherapy providers are hard at work leading highly effective and often innovative services for their patients, and routinely assessing their impact as part of standard good practice.

How might they need to build on their current approach to collecting, collating, analysing and presenting information?

Our examples

Responding successfully to commissioners' specifications will require new approaches to collecting information and using this evidence to prove effectiveness.

We asked our members to come forward with some examples of excellent services that are already changing both patient outcomes and how work is done, and some of the kind of information they're currently collecting. In seeking current examples of good physiotherapy practice that might be persuasive to commissioners, we looked first and foremost for practice that, as well as being innovative, has a supporting evidence base that has been clearly documented.

By 'evidence base' we mean clinical effectiveness, demonstrated by credible published research – but also, critically, value for money, showing a measurable economic 'payback' for investment in the service.

We sought initiatives that addressed current NHS priorities, including the perennial priority of improving overall systems efficiency. We were also keen to look beyond musculoskeletal physiotherapy, as physiotherapy extends into numerous other areas of healthcare practice. The four examples we have chosen give a small flavour of this diversity, as well as the scale of the impact that good physiotherapy can achieve.

The examples show clearly that many physiotherapists are already approaching measurement and assessment with value for money and the contribution of their service to the wider health economy in mind – two key areas commissioners will want to see reflected in a full business case.

Our panel

We then asked a panel of experts – the director of a modernisation initiative, a head of therapy services and a financial consultant – to suggest, on the basis of their areas of expertise, how they would approach further development of the examples provided into full business proposals. What kinds of evidence would they find persuasive if they were holding the local purse strings?

Our aim was to capture the kinds of processes that might be involved in developing business information that is ‘fit for purpose’ in a rapidly evolving and often competitive commissioning environment.

1. Promoting independence of patients

Name of service
Incontinence service for men and women

Location
The Somerset Nuffield Hospital, Taunton and the North Devon District NHST Hospital, Barnstaple

Lead contact
Professor Grace Dorey, Professor of Physiotherapy, University of the West of England

Overview

This service is focused on returning or renewing the independence of patients. It uses pelvic floor exercises, coupled with advice, to treat men and women with incontinence. The evidence suggests physiotherapy is significantly effective for between 70 and 80 per cent of women and men with incontinence. Projected financial savings are based on the cost of the service compared with the cost of surgery and the long-term use of incontinence pads.

Service summary
The service is provided by a specialist to men and women with urinary and faecal incontinence, women with prolapse, women with sexual dysfunction and men with erectile dysfunction in two hospitals in Somerset and Devon. Within North Devon, there are 10,000 adults with urinary incontinence and 1,500 with faecal incontinence. It is a conservative treatment approach, retraining the muscular function of the pelvic floor of patients.

Evidence of effectiveness

Quality of service/patient experience
There is a case for viewing this kind of conservative service as a first-line treatment before considering the expense of surgery. It contributes to reducing the number of patients who require secondary care medical or surgical consultant appointments. It is more cost effective than a lifetime of provision of incontinence pads, and patients benefit from a life without pads. The exercises and advice are effective in treating both men and women.

Policy targets
The service can contribute to the government's 18-week target by shortening the patient pathway for many patients whose needs can be addressed within their physiotherapy episode of care, and by making the pathway more manageable for the smaller number of selected patients who need further intervention.

Projected savings
Data collected in North Devon showed that, in 2000, the cost of drugs, appliances and containment products was £466,540, while surgery for incontinence cost £41,219 – a total cost of £507,759. Employing a continence specialist physiotherapist for three hours a fortnight cost £1,500 per year. Even if physiotherapy were only successful in 50 per cent of cases, this would represent an annual saving of £253,879.

If the success rate reached 70 per cent, as the research indicates is possible, and only 30 per cent of patients were to require further support or treatment, then the savings achieved would be as much as £355,431 a year.

Our panel's suggestions

The moderniser
'This is an excellent example of a physiotherapy service offering a cost-effective treatment based on robust clinical evidence.

'It identifies a key policy target – the 18-week waiting target, now a requirement for all clinical specialities and NHS organisations. This kind of link to relevant, topical targets for commissioners is crucial. In making a full business case, I'd advise Grace to state exactly how her service is meeting this target more effectively or efficiently than other services, building on her comparison with the cost of surgery.

'Other ways to build this evidence of service effectiveness into a full business case might be:

- analyse local demographics and prevalence of incontinence compared with national averages or comparators, and highlight resource needs if local rates are higher
- pinpoint any reductions in outpatient referral rates or the need for other professionals' input
- if the service is able to see new patients immediately, show how this reduces delays
- compare costs per patient and total annual savings with no treatment, physiotherapy intervention and surgery, including predicted activity levels
- add patient experience and voice (including quotes if possible) to show service value from the customer's perspective.'

The service manager
'This is a fine example of a cost-effective service. In presenting it to commissioners I'd highlight cost–benefit and financial ratios, including:

- the total cost of the service
- how many patients it reaches

- its predicted success rate
- how much money it could save in terms of patients seen.

‘I would also link this information to the national continence guidelines and to a total pathway – primary care in the screening process and secondary care if the physiotherapist assesses that they will not be able to achieve an acceptable outcome for the patient.’

The financial consultant
‘In building a full business case I’d draw out actual as well as predicted impacts – there is often a material difference between the outcomes we hope for and those we actually achieve. I’d also include two key pieces of information:

- the cost of the service itself
- the capacity of the service – how many physiotherapists are needed to treat the number of patients with incontinence quoted?

‘I’d look realistically at success rates – once patients have followed the exercise regime, do they never need incontinence pads or surgery? I suspect the reality is that for some patients there is total success, others experience some improvement and for a number their dependence on incontinence pads (and possible recourse to surgery) will continue.

‘What I find impressive here is the potential scale of the financial savings, coupled with a huge potential improvement in patients’ quality of life, in an area of practice that is not often at the forefront either of commissioners’ attention or indeed that of the profession.’

2. Reducing mortality rates

Name of service
Home-based cardiac rehabilitation

Location
Guy's and St Thomas' NHS Foundation Trust

Lead contact
Helen Alexander, Senior Physiotherapist in Cardiac Rehabilitation

Overview

This is a home-based cardiac rehabilitation service for patients with coronary heart disease or who have had a recent heart event or procedure. The evidence suggests that cardiac rehabilitation can reduce all-cause mortality by 27 per cent and cardiac death by 31 per cent.

Financial savings are derived through the avoidance of return to hospital with further coronary events.

Service summary
A key challenge for cardiac rehabilitation services today is to reach as many patients as possible. This service had achieved a 68 per cent uptake in 2005, but wanted to understand and address the needs of those patients who did not attend the hospital-based programme. Evidence shows that home-based services can be as effective as institution-based programmes.

Research indicates that the patients least likely to join a group or institutional setting need to be offered an alternative. This home cardiac rehabilitation programme was developed as the treatment of choice for patients not appropriate for or not able to access the hospital-based programme. A cardiac rehabilitation physiotherapist provides the service, conducting two home visits and six telephone calls.

Evidence of effectiveness

Quality of service/patient experience
The physiotherapist's knowledge of exercise, and the modification of these exercises for any co-morbidity (for example, osteoarthritis, peripheral vascular disease), worked just as well in a home situation as in an institutional one, and programmes could be tailored for the most appropriate type and level of exercise regime for patients.

Policy targets
The National Service Framework for Coronary Heart Disease (CHD) (Department of Health, 2000) set a target of offering 85 per cent of heart patients' cardiac rehabilitation. The programme has increased the rate of access to rehabilitation by three per cent.

Projected savings
The programme is low cost, requiring only one whole time equivalent (WTE) post to run the home-based programme alongside hospital based rehabilitation (attended by 293 patients in 2005). The reduction in health service utilisation as a result of cardiac rehabilitation is approximately £100 per patient per year. In two years, this makes the provision of cardiac rehabilitation cost neutral. Trials have shown a significant reduction in the cost of readmission to hospital and treatment coupled with savings resulting from an earlier return to work.

Our panel's suggestions

The moderniser
'This is an excellent example of a physiotherapy service based on robust clinical evidence offering an innovative way of meeting a national target – in this example the National Service Framework for CHD and the national drive for attendance at cardiac rehabilitation it identifies.

'Other ways to build this evidence of service effectiveness into a full business case might be:

- highlight demographics and prevalence of CHD and cardiac events locally compared with national averages or comparators – remind commissioners if there is a local higher rate or prevalence or standard rates, and whether resources are needed to address this
- put more detail in the project savings section, including where information and data comes from and its validity
- add activity and/or number of patients seen each year, plus projected reduction in health service utilisation (such as reduction in outpatient follow-ups, GP attendance or A&E attendances)
- while trials are excellent evidence, they need to be applied to the local population or client group, with clear indications of any gains in terms of increased activity and/or access, reduction in demand and waits, and so on
- add the patient experience and voice.'

The manager
'This service demonstrates excellently how to spot an opportunity, meet specific needs

and hit a target. I think most commissioners would be interested in this service, which appears to deliver benefits for the patients and prevent further expenditure on other services.

‘Costs per patient are clear, but in working up a full business case I’d advise Helen also to identify how outcomes and cost savings would be evaluated. Also, I’d clarify whether it would be possible to get the same patient outcomes from completely different inputs – cover the issue of cause and effect.’

The financial consultant
‘This is a very imaginative way of approaching cardiac rehabilitation and links well with the broader spectrum of long-term illness management, especially in its use of exercise and its recognition that hospital-based care does not work for everyone. In making a business case, I’d give more details about the supporting research base: for instance, what is the evidence that home-based care can be as effective as institution-based care, and how is ‘effective’ defined?

‘I think commissioners would wish to know:

- how the cost of this service compares with the hospital-based service – for example, whether the costs of travel and therapist time lost while travelling are matched by an improvement in outcomes
- the absolute cost of the service and whether the home-based service is offered as well as the hospital service, rather than instead of it
- the anticipated savings, for example, from avoiding returns to hospital – it may be possible to extrapolate this from the outcomes of research elsewhere, along the lines of “If the experience of x were applied to this community, we would anticipate a reduction of y in the number of subsequent myocardial infarctions saving commissioners £z per year at current tariff rates”.’

3. Streamlining access to physiotherapy services

Name of service
Patient self-referral in primary care

Location
Twenty-six general practices in Scotland

Lead contact
Lesley Holdsworth, Clinical Effectiveness Co-ordinator, NHS Forth Valley and Glasgow Caledonian University

Overview

This project undertaken in 2003/05 piloted patient self-referral to physiotherapy in a range of physiotherapy settings throughout Scotland, and assessed acceptability, impact and outcomes. Projected savings are based on comparing the average costs of self-referral and GP-referral episodes, and extrapolating these at both general practice and nationwide levels.

Service summary
This innovative service allowed patients to refer themselves for physiotherapy – that is, without first consulting their GP. Any patient could use the self-referral system, and there were no exclusions.

Data relating to 3,010 patients was analysed.

Evidence of effectiveness

Quality of service / patient experience
Over a twelve-month period, 22 per cent of patients opted for self-referral – all others were referrals suggested by a GP or actual GP referrals. Self-referrers were better attendees at appointments, got better quicker; and were absent from work in lower numbers and for fewer days.

Self-referrers also generally waited less time in referring themselves when compared with GP-referred patients.

Policy targets
The self-referred patients were lower-cost patients than those using the traditional GP-

referred route, using fewer GP appointments and less medication, and had fewer diagnostic interventions including onward referral to secondary services.

Projected savings
The average cost for a self-referred episode of care was 25 per cent less than those referred by a GP. Total average cost per self-referring patient was £66.31 compared with £88.99 for a GP referral – a saving of £22.68. It should be noted that these figures relate to 2004 and pre-date the changes to general medical service and consultant contracts.

The work identified that if self-referral were extended across all of Scotland, and based on a self-referring rate of 22 per cent, NHS Scotland could save approximately £2 million per year.

Our panel's suggestions

The moderniser
'This innovative and cost-effective service is based on the current policy of self-referral, which is in turn driven by the need to reduce delays in access to services. The premise is that if you see people earlier, they get better faster and so cost less. In putting together a full business case, I'd show clearly how it meets all these drivers.

'In making a robust business case for commissioners, I'd add the following:

- any demographic and prevalence data locally compared to national averages / comparators
- activity data per practice and collectively – this allows the commissioner to get a feel for the quantity elements
- how cost savings from self-referral link to activity data – showing this in a staged way – per patient, per physiotherapist, per practice, a per cent of GP practices, all GP practices
- any hidden potential additional cost savings – such as reduction on outpatient referral rates to services such as orthopaedics or rheumatology – plus reduction in need for other professionals' input, reduction in A&E attendances and so on
- projected cost savings to local economy – for example, did people go back to work quicker or manage to return to work after a prolonged absence?
- add the patient experience and voice'

The service manager
'This all makes such sense, but in putting together a convincing business case for commissioners, I'd go into more detail about the case mix of self-referrals and GP referrals. If the patients who self-referred would not have gone to the GP in the first place

or accessed private physiotherapy, this might be an additional service and cost the health economy more.

‘It would be useful to look at the variation of presenting conditions from GP referrals and capture resultant GP and physiotherapy activity – perhaps the number of patients going to GPs with musculoskeletal injuries and the average number of physiotherapy treatments – before and after the project.’

The financial consultant
‘I suspect what NHS commissioners fear most about self-referral is an explosion of demand that they will be obliged to fund. This fear comes partly from a belief that, were it not for the GP gatekeeper, a flood of demand for physiotherapy would swamp NHS services; and partly from years of physiotherapy referrals being subject to tighter and tighter criteria, in the hope that many would-be patients, especially in more affluent areas, will switch voluntarily to private physiotherapy.

‘At one level, Lesley’s work fuels these fears. One of the reasons that self-referrers in Scotland were better attendees at appointments, got better quicker, and were absent from work in lower numbers and for fewer days is that many come from the younger working male population that tends to make less use of GP-led healthcare provision.

‘While in this project, no increase in referral rates was found in areas where there were historically good levels of physiotherapy provision, some would say that this points to just the kind of explosion of demand that NHS commissioners fear. But in fact self-referral saves money. The key to the business case is not the relative cost-efficiency of self-referral, but the projected national savings of £2 million per year.

In making the business case, I’d give more detail of how this is calculated. I suspect it depends heavily on time saved in GP surgeries, though the harder-to-quantify long-term savings from addressing problems like lower back pain early must also be considerable.’

4. Reducing hospital length of stay

Name of service
Acute medical wards service redesign – seven-day / extended-day working

Location
Cardiff and Vale NHS Trust

Lead contact
Sue Rees, Deputy Head of Physiotherapy

Overview

This remodelling of acute care uses physiotherapy to reduce delays in transfer of care and reduce hospital length of stay. Projected savings are based on marginal bed-day cost, which is for beds and lodgings plus some overheads estimated at £29–£51 per day as opposed to actual bed day cost which would have been in excess of £200. The intention is that additional temporary capacity would not be required to accommodate these patients as a result of improved bed utilisation.

Service summary
A new seven-day-a-week service was piloted in place of the traditional five-day service in order to create more contact time with inpatients, and offer a faster response time to emergency patients and those who needed immediate input from physiotherapists in order to avoid admission. Reducing lengths of stay was a key target.

Staff had also been unhappy with the inadequate staffing levels in the old five-day service which was stressful for everyone. The five-day service had 11.6 WTE staff covering 248 beds; a shortfall of 6.4 WTE was identified.

The new extended day service employed six additional staff over a seven-day rota, with four of the team providing the seven-day / extended-day model. A team of two staff in each of these teams worked three shifts of 10-hour days on Monday to Friday and one six-hour working day on Saturday or Sunday. The weekend days were shorter, as some discharges of patients could not take place at weekends because some elements of the community services, including therapies, do not offer a reciprocal seven-day service.

Despite this, a high number of discharges were facilitated on the weekend, which would not have been the case previously.

Evidence of effectiveness

Quality of service/patient experience
This seven-day service has proved cost effective. It reduced the number of beds occupied by medical patients and was especially effective in reducing the number of outlying patients. It reduced the need to transfer patients from the emergency medical admissions unit short stay ward to another medical ward by 43 per cent. This in turn freed up surgical beds for surgery patients, allowing the trust more scope to achieve its surgery access targets.

The pilot revealed a 53 per cent average reduction in length of stay, from 15 to seven days, for medical emergency admission patients receiving physiotherapy. This would result in a potential reduction of 36,440 bed days per year or the equivalent of 100 hospital beds. This projection would not be sustainable, but if only 25 per cent of this were achieved the projected benefits would be a reduction of 9,110 bed days a year, broadly equivalent to a 25-bedded hospital ward, through the employment of 6.0 WTE physiotherapists.

The service increased therapists' contact time with relatives and patients, facilitating accelerated discharges and contributing to the reduced length of stay.

Policy targets
Response times from referral to intervention reduced from approximately 24 hours to 2.3 hours.

Projected savings
The service redesign freed up a total of 9,110 bed days (a conservative estimate), the equivalent of 25 hospital beds. The medical bed requirement was reduced by approximately one ward, based on an achievable reduction in length of stay of two days per patient. At the time of the project the cost of bed-day savings based on a marginal bed day cost only would be £268,836 for a two-day reduction in length of stay and £403,254 for a three-day reduction in length of stay (equates to 37-bed equivalent). The cost for staff was £261,559 including approximately £10,000 for administrative support and non-staff recurrent costs.

Our panel's suggestions

The moderniser
'This is a superb example of how to remodel innovatively a physiotherapy service to offer a more cost-effective service, focused on creating savings by reducing length of stay and hospital re-admission rates. Delivering these benefits has significant attractions for hospitals, but also potentially allows the freed up bed days to be used by other specialities.

Wales does not yet have a tariff regime, but if it did, that might make profits for a hospital. This example is clearly linked to current key policy directives of reducing length of stay and the reduction of use of hospital beds.

'Most of the information needed to build a solid business case is given, but I'd add more hard data to demonstrate the actual impact thus savings potential. For example:

- any demographic and prevalence data locally compared to national averages or comparators
- actual activity data
- the data assumptions needed to give the projected reduction in bed days and the predicted cost saving
- actual reduction in length of stay and bed days saved across key specialities and the resultant cost saving
- actual impact on re-admission rates across the organisation and the resultant cost savings
- any hidden potential additional cost savings – such as equipment and drugs
- if the service is able to see new patients immediately – impact on reduction in delays, which may have an impact on the 18-weeks wait and other policy priorities; this is a major benefit of the project in that better bed utilisation will reduce impact on elective admissions as a result of the severe emergency pressures creating an overflow into elective beds
- impact on staff turnover and saving on the costs of recruitment and agency cover
- the patient experience and voice – have things got better?'

The service manager
'This is really interesting because the evidence to date about the efficiency of seven-day services is mixed.

'This is probably a provider business case rather than a commissioning one because it appears to have had significant benefits for patients, their relatives, hospital capacity, and expenditure on inpatients and staff morale. The savings are quite difficult to calculate because it depends on what happens to the bed days saved. If a ward closes then those savings are realised.

'If this service is as good as it looks, it needs to be developed so it can be used nationally across inpatient services.'

The financial consultant
'This is an impressive example of lateral thinking about hospital staffing and trying to make genuine seven-day working a reality.

‘It is interesting that the trust’s attempts to work in this way were ultimately constrained by the inability of community services to cope with weekend discharge from hospital. One wonders whether in this context the underlying constraint is the availability of NHS community nursing or the working practices of other agencies.

‘Success has been achieved by introducing new physiotherapist posts, combined with a change in working practice. It would be useful to know what consideration was given to skill mix in the expanded physiotherapy team.’

Key learning points

These four examples suggest that making the core business case for physiotherapy can be used to:

- Avoid other healthcare costs, either temporarily or permanently

The continence service in North Devon is an excellent example: it reduces the need for surgery and for supplies of incontinence pads. Many well-documented musculoskeletal services work in the same way, by reducing the need for orthopaedic surgery or diagnostics. A single intervention, if it leads to patient adoption of exercise routines, can avoid a continuing, and sometimes life-long, expense.

- Avoid potential healthcare episodes that would inevitably lead to future costs

The Guy's and St Thomas' Hospital cardiac rehabilitation is a fine example. Business cases of this type are harder to prepare because they require estimates of a hypothetical future cost. We all like to believe that physiotherapy helps patients avoid future problems, but a business case requires a sound evidence base to justify that belief.

- Avoid costs in other parts of the healthcare system or in the wider economy

This is the core of the impressive Scottish self-referral project. Sometimes this type of business case is harder to persuade commissioners to accept as they do not necessarily gain directly in the short term. There may also be a conflict of interests: GPs involved in commissioning may be reluctant to agree proposals built around savings in GP time. So the business case needs to draw heavily on the wider responsibilities of the commissioning body to promote healthy communities.

- Release capacity in the healthcare system, enabling either cost savings or the generation of extra income

The Cardiff and Vale Trust's far-sighted investment in physiotherapy, besides improving the quality of patient care, has freed up the equivalent of a hospital ward. The NHS can either save costs or use the capacity for income-providing services: which option is more attractive will depend on local circumstances, and the business case will need to be framed accordingly.

- Substitute for more expensive health professionals

There are elements of this in some of these examples – physiotherapy time, for instance, tends to cost less than the time of a GP – but it is also possible to construct whole business cases around such substitution, or around the skill mix within a multidisciplinary team. Clearly such changes would need to be safe and clinically appropriate. The GMS contract nevertheless makes this type of business case potentially attractive in primary care settings by rewarding activity rather than the individual undertaking it. The payment by results regime in secondary care still mainly rewards the activity of medical consultants.

It should be noted that none of our examples includes the cost of the change process itself. In practice this can often be an obstacle at local level. Commissioners may be wary of potential redundancy or restructuring costs, or the costs of running two services in parallel for a period. They will also be conscious that it is sometimes easier to identify surplus capacity than to release the savings in hard cash.

These concerns are understandable and business cases should be sensitive to them. But if the potential gain is material, and the business case is robust, it is for the commissioner to smooth the path for implementation. All good commissioners will value sustainable efficiency and effectiveness more highly than short-term expediency.

This section has demonstrated the importance of evidence – both clinical and financial – in supporting a business case for a physiotherapy service. The next section also highlights the value of evidence, but puts this within a context of what commissioners are looking for and what providers have learned when preparing bids or unsolicited proposals for a service.

Learning from commissioners and providers

Effective commissioning is a complex process. Ensuring it works on the ground to build high-quality, fit-for-purpose services that meet patient needs will require strong skills on all sides.

But commissioners have valuable tips to offer about what they are looking for, and many providers already have good experience of presenting their service as delivering both quality and cost-effectiveness. This section interviews some of them and distils the key learning points.

Whether you are preparing a formal tender in response to a commissioner’s specification, or putting together an unsolicited bid to show commissioners and planners how you can

provide new solutions to service problems and improve patient care, the good news is that others have been there before, and have valuable insights to share.

This section explores the experiences of three commissioners and three providers – all working in NHS management roles including primary and acute care – and what they have learned from the bidding process.

The view from the commissioner

From a commissioner's perspective, there are some key points which any bid must address if it is to be considered.

Answer the brief

It might sound obvious, but check that your bid provides the information that the commissioner wants, not what you ***think*** the commissioner wants. Commissioners and planners are working within a framework of priorities and constraints, and this drives the kinds of services they commission.

The easiest way to check that you are meeting the commissioner's requirements is to structure your bid according to the information set out in the specification. If this isn't clear, then contact the commissioning agency to find out more.

Commissioner perspective 1: Going the extra mile

Paul Crooks, Service Development Manager (Redesign), Westminster PCT

What makes a successful bid?
It is the responsibility of the commissioning agency to issue a service specification or description of the work it wants organisations to bid for. This helps potential providers to understand what the commissioning agency is looking for so they can respond appropriately. If the commissioning agency hasn't issued a specification then this is an opportunity for potential providers to be proactive and arrange a meeting with the commissioner to find out what they want.

What I am interested in knowing is:

- Did the provider answer all the questions fully? The sure way for the commissioner to be satisfied that a provider has done this is if the format of the bid reflects that of the specification. If they do this then it helps me to score the application efficiently. Applicants who come up with a different format for structuring their bids are like people who decide not to complete a job application form – it doesn't always go down well.
- Is there a clear demonstration that the provider understands what our aspirations are for commissioning the work?
- Has the provider gone the extra mile? If a provider understands our aspirations, then they will also be able to identify the risks that we won't have anticipated. A good submission will propose solutions to questions in ways that add value. It should make a clear separation between the basic cost of what I've asked for and the cost of any proposed enhancements.
- Will the work be project managed appropriately?
  Submissions should give sufficient attention to developing a realistic and appropriately resourced project management structure. I'd be looking hard at the experience of the project manager in delivering projects of a similar scale.

Gather evidence

Commissioners are unlikely to be impressed by exhortations to contract you because you say that you know how to do the job. As well as the clinical and research evidence that demonstrates why the services you propose will make a difference (especially if you are submitting an unsolicited bid), commissioners will be interested in the views and recommendations of those you have worked with, especially clinicians and doctors.

This helps them to know that you come with a track record of quality practice. But it also demonstrates that you have an ability to communicate across disciplines, something which is likely to become increasingly important as the health policy agenda moves towards professional competencies, care pathways and multidisciplinary working.

'Doctors' views are very influential in the commissioning context. If you have good relationships where medical staff are supportive of your service, then use these as evidence in submissions.'
Heather Wicks, Head of Non Elective Care Commissioning, Oxfordshire PCT and Professional Advisor in Orthoptics to DH

Commissioner perspective 2: Put yourself in our shoes

Heather Wicks, Head of Non Elective Care Commissioning, Oxfordshire PCT and Professional Advisor in Orthoptics to DH

What do you look for when commissioning a service?
It depends on whether the provider is responding to a tender or not. If a provider comes knocking on my door with a proposal, I want to see that there is a demonstrated population need and that the service being proposed is tailored to meet this local need.

All providers (whether responding to a tender or not) need to show what they are intending to do, what the benefits will be for patients, GPs and other health professionals, and how it will save money. You also need to show what your key performance indicators will be; they should demonstrate how you will measure whether the proposal will do what you said it was going to do.

What tips do you have for providers who are preparing a bid?
The things I look for are:

- Objective evidence of clinical benefits – this doesn't always have to be research evidence although this is obviously preferable. It could also be softer evidence like strong professional consensus.
- Analysis of clinical and cost effectiveness – this depends on the process. In some cases a commissioner might have a tendering process and have an envelope of money and you need to show how you can deliver the service specification for this amount. In others, you set out the service you want to provide and show how much it will cost.
- Commitment to meeting wider agendas, for example, minimising clinical risk, health and safety, and patient involvement in the design of the service and evaluation.

- Clinical competence and ongoing maintenance of quality of service, for example, CPD
- Whether the bid is written within the context of the NHS modernisation or reform agenda and how that can play out at local level – a service manager needs to know the national policy agenda and be able to assess how it should work locally and, if so, how?

What are the key relationships to develop when putting a bid together?
You need to consider your internal relationships and get a provider support team in place, including the finance people. You shouldn't have to do this all yourself. You may be able to demonstrate how you can help your provider organisation meet its own targets (for example, waiting times). Try and dangle this carrot in front of clinical services – you may be patted on the back and welcomed with open arms.

You also need to show that you have considered your relationship with patients and done some market testing: 'we thought this was a good idea, we tested the idea with patients and they said it was great.'

Be realistic

Like providers, commissioners are trying to supply a quality service to patients and are looking for bids that address the service specification in a cost-effective way. Don't promise more than you can deliver.

'I'm not interested in well-written solutions that haven't got a hope in hell of being delivered within the timescale specified.'
Paul Crooks, Service Development Manager (Redesign), Westminster PCT

'Providers who are already offering a good service are well placed – why would we want to change their contract?'
Heather Wicks, Head of Non Elective Care Commissioning, Oxfordshire PCT and Professional Advisor in Orthoptics to DH

Demonstrate added value

This may sound as though it contradicts the earlier advice in this section about sticking to the supplier specification. But feedback from commissioners suggests that including ideas about how a service could be improved – even if this needs to be costed as a separate item – demonstrates a willingness to help a commissioner provide an even better service for their local population.

Commissioner perspective 3: Quality as well as quantity

Sue Blennerhassett, Lead Officer for Community Based Capacity, Gateshead PCT

What do you look for when assessing bids?
The sorts of things I'm interested in include:

- Cost effectiveness – if everything else is equal then the lower cost is preferred, but if the extra cost is because of something that a provider is offering then I would need to consider this. Sometimes a commissioner will prefer the additional value that the more expensive service will provide
- Clinical governance arrangements – a provider needs to have the ability to meet NHS standards and workforce standards
- Service philosophy – what are the aims of a provider and how do they approach the work they do?
- Complaints procedure and how will the provider report on patient satisfaction?
- Contingency arrangements – for example, how will the provider cover for staff who are sick?
- Communication with the NHS – this includes how available a provider would be in between times of service provision
- Commitment to service development
- Policy overview – I would expect a provider to know about the policies and priorities and general direction of the NHS nationally, and also what that means for the local provider.
  The more you know about the priorities for a service then the better you can fit in with them as well as influencing future priorities to benefit the local population.

What do you constitute as a convincing evidence base?
References and service reports such as patient satisfaction and outcome reports.

Is it okay to contact commissioners in advance?
It's not inappropriate to contact the commissioners to seek clarification – the tender document should make it clear who to contact. It doesn't do any harm at all to try and find out as much knowledge in advance as you can. If commissioners feel it would bias them in some way speaking to you, then they will refer you on to someone who can help you.

The view from the provider

While negotiating a way through the commissioning process is a new experience for many physiotherapy providers, some have already been through a successful tendering process and have learned valuable lessons along the way.

It takes time

Like everything, putting a bid together will probably take a lot longer the first time you do it. There are a number of steps that precede writing the actual application, which in itself is time consuming.

These are explained in more detail below and include analysing the cost of what you provide, gathering evidence and meeting with colleagues in your own organisation and with commissioners.

Demonstrate your ability to meet hard targets

A cost-effective service might be competitive financially, but it also needs to demonstrate how it can deliver quality in ways that make a difference to the other priorities and targets that commissioners are trying to meet, as the commissioners quoted above suggest.

In other words, a financially sound application needs to be accompanied by a service proposal that meets other hard targets too.

'Having worked closely with commissioners for a number of years, it is very clear that we need to know what we actually manage right down to individual unit costs.'
Suzanne Jones, Professional Lead for Therapies, Oxfordshire PCT and Direct Access Physiotherapy Manager, Oxford Radcliffe Hospitals Trust

Provider perspective 1: Feel the fear and do it anyway

Fiona Ottewell, Head of Physiotherapy, Gateshead Health NHS Foundation Trust

How was your experience of putting a bid together?
Having to put a bid together was scary, and I felt I had a lack of time, experience and confidence. My previous experience of tendering consisted of completing two sides of an A4 tick-box form 10 years ago. In contrast, the tender specification I prepared for providing a musculoskeletal physiotherapy service to two GP practices ran to almost 17 pages. So this was much more complex and the timescales were really tight.

There was also the nerve factor later on in the process because I had to be interviewed by the commissioners from the PCT and one of the practice managers as part of the

procedure.

In the end my bid was the successful one even though we were an NHS provider competing against providers from the independent sector.

Why did you win?
I believed that the independent sector would beat us in terms of cost. But the feedback I received indicated that we won the tender because of the quality of the bid that we submitted, as well as the added value that we offered, as well as one of our options being cheaper than the independent sector.

What tips do you have for physiotherapists who have to write a bid?

- Your most important ally is your organisation's contracts department – they are experts when it comes to writing tenders. I didn't know how I was meant to respond to such a big specification but they helped me with the process and showed me how to complete the tender. You should also work collaboratively with anyone else in your organisation who has submitted a bid.
- Build relationships with the commissioners – we took the initiative and went out to the GP practices that were tendering for the work to understand from them exactly what they wanted and to get to know them on a personal level. They were delighted that we did this, and our competitors did the same thing after they heard what we had done.
- Identify your unique selling factors. I got great support from my colleagues within the physiotherapy department who were delighted to help me draw up a description of all the services that we had to offer.
- Make sure that everything in your bid is clear – be absolutely explicit about every aspect of your document.
- Prepare for the fact that putting a bid together is extremely time-consuming, especially the first time – you can't cut corners.

Get help from colleagues

No one expects physiotherapists to become accountants overnight. One of the strongest messages running through both the commissioner and provider perspectives given here is to work with other people who will be able to supply expert advice, particularly on cost and budget matters.

You should also be able to demonstrate that you have the backing of your organisation when submitting a bid, and in securing this you may be able to demonstrate how your service can help meet your organisation's overarching targets, such as waiting times.

Build relationships

One of the clearest messages from providers (and commissioners) is to make sure that you understand what the service is that you are being asked to provide, or trying to persuade a commissioner to engage.

Building relationships with the commissioner and potential users of the service is an effective way of doing this, whether you already know the commissioning staff or not. You should also draw on wider professional networks – both physiotherapists and other clinicians – to demonstrate the effectiveness of your work and your ability to collaborate in a multidisciplinary way.

Provider perspective 2: Blow your own trumpet

Sue Rees, Deputy Head of Physiotherapy Services, Cardiff and Vale NHS Trust

What tips do you have for physiotherapists who have to write a bid?

- Make sure you have answers to all those really nasty questions that you may be asked. These might include: How do you know that reduction in length of stay was due to physio input? Why can't/don't you provide the same services on the weekend as during the week? What will you be able to deliver for less than you have bid for? Can this be done by someone else? How do you know that this investment will do what you have said it will do?
- Try to look for and provide innovative solutions.
- Sing your own praises from the highest hills. Find every opportunity to sell your message, including developing a 'corridor sound bite' to help foster support from influential colleagues.
- Know who you are writing for – make sure you change the language to meet the audience.
- Quality is a given, so you need to identify other more hard-hitting objective outcomes too. In reality there are a great many demands on the same pots of money held by commissioners. Outcome measures such as increased patient contact time or increased number of patient contacts are not of real benefit unless they are linked to strategic targets such as reduction in length of stay, readmission rates and of course reducing waiting lists. You can use care pathways and so on to demonstrate improved efficiency.
- It is important to back up your evidence with data but this can be difficult to achieve. If your data is flawed then you need to say so. It is better to have lots of low-level data than one piece of excellent data that takes six months to assemble.
- Finally – don't give up!

Stay informed

For frontline workers, it can be difficult to step back and absorb the bigger picture of changing service provision, shifting priorities and emerging strategic directions. However, it will be difficult to write a bid that meets the demands of the commissioner without having regard to the broader policy context in which you are proposing to provide your service. Again, get advice on what are the likely policy areas that are relevant to your proposed service if it is not already set out clearly in the service specification.

Believe in yourself

One of the striking themes to emerge from providers' contributions is how important a sense of self-belief is. Change is often threatening, but the experiences of those who have already been through a tendering process suggest that it is possible to emerge on the other side with a well-regarded, cost-effective and influential service.

Provider perspective 3: Be a model of good business

Suzanne Jones, Professional Lead for Therapies, Oxfordshire PCT and Direct Access Physiotherapy Manager, Oxford Radcliffe Hospitals Trust

What tips do you have for physiotherapists who have to write a bid?

- Know your service down to the micro level, including what your unit costs are – you must become business minded and learn the tools and language for working with the new breed of commissioners and service redesign managers.
- Never say 'we need more', always put a case together based on evidence – when setting out any case or approaching commissioners you always need to be well informed. You need to have carried out a needs analysis, know your population base, who your clients are and where your proposal fits into national and local priorities. You should also do a cost–benefit analysis and a risk–benefit analysis.
- Show that you are cost effective and that you can change the way you utilise your services – you need to prove that your service is delivering on targets and that it is efficient and effective in its outcomes.
  'Lean' is the new management term being introduced into the health service from industry.
- Know what the priorities are within your health community – you need to be aware of the drivers and levers that commissioners are working under. However good your idea is, if it does not hit the targets or support other services to deliver them then it will not stand a chance of being considered.
- Regularly scan the horizon for what is going on – this includes having a comprehensive list of useful web pages that you refer to regularly and being an active member of iCSP.

- Make contact with your commissioners – get to know your local groups and the clinical leads and make sure that they are aware of what you do, what you can offer and the current constraints that you work under. They are important allies and drivers within the new health and social care communities.

Moving forward with confidence

The perspectives in this section demonstrate that providers can equip themselves with the service knowledge, understanding of impacts and business skills they need to competently tender or solicit their services to commissioners. This section has also highlighted that commissioners are not just interested in the bottom line: they want their patients to receive high-quality care that meets a range of their service targets, which of course will include value for money.

The challenge is to put the good advice above into practice. The next section includes a number of tools which can help you to do just that.