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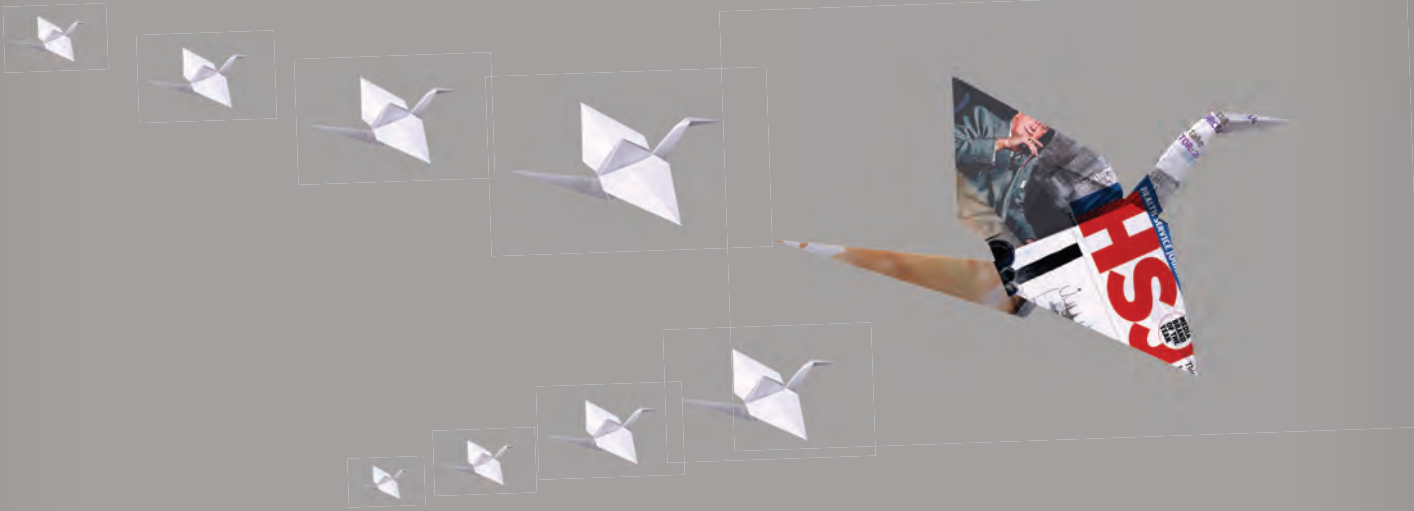
COMMISSIONING

AN HSJ SUPPLEMENT/20 SEPTEMBER 2012



GOOD DIRECTIONS

THE DATA WE NEED TO STEER THE NHS 12



MANAGERS DOCTORS SUPPLIERS GPs PROFESSIONALS
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Supplement editor
Alison Moore

SERVICE REDESIGN



As trusts' finances are squeezed they are finding it increasingly hard to spare the staff needed to drive redesign of services. Now pharmaceutical company Pfizer is offering to lend trusts a manager to kickstart such projects. Page 2

SERVICE IMPROVEMENT

Many patients whose death could be anticipated are missing out on the targeted care that could radically improve the end of their lives. The Gold Standards Framework Centre is helping trusts to target and respond to such patients as it seeks to transform end of life care. Page 6



COMMISSIONING INFORMATION

Clinical commissioning groups will need a wide range of data to do their jobs properly, including evidence of the best treatments or service models and data about the quality of care offered by GP practices. Information and intelligence systems that support commissioning decisions – and guide GPs in their clinical work – look set to play a big role in the future of the health service. Page 10





“As a company we’ve always recognised the value of working in partnership with the NHS and for a number of years we’ve been trying to create a mechanism for doing this in a way that works well for both parties.

During this time we have come to realise that such an aspiration goes beyond our already massive investment in developing new products and bringing them to market. It also includes working with the NHS to bring about a positive impact upon the whole patient pathway.

So, with those two principles in mind, a couple of years ago we began to appraise how we, in Pfizer Oncology, could achieve this. By listening to colleagues in the NHS, we were able to identify some areas – such as project leadership, analytical support and change management – where our expertise would be both complementary and welcome.

With so much change occurring in the NHS and with current financial pressures causing problems in many areas, not just within the NHS, this seemed to be a positive, solution-based approach to working with the cancer community and the NHS.

Working with Pfizer Health Solutions, an internal company resource with many years of innovative thinking behind it, Pfizer Oncology began to develop a plan – a plan to share the organisation’s wealth of experience and skills

‘Our expertise is used to help the NHS and help us learn more about our biggest partner’

with the NHS in a way that could bring joint benefits. Balancing capacity and demand is a major challenge in some parts of the NHS, in the same way that it is for the pharmaceutical industry. We wanted to work with the NHS to build real partnerships that would enable us to help each other.

Open discussions with colleagues in several NHS sites soon identified leaders willing to engage with us on these issues. Local implementation of the QIPP agenda proved to be key in our discussions. Following those initial discussions, the expertise of Pfizer Health Solutions in managing service redesign projects and developing innovative answers was brought into play.

Four projects have now been completed, three more in oncology are just beginning while another four in other therapeutic areas are being explored.

This is real partnership working, with our experience and expertise being utilised to help the NHS and to help us learn more about our biggest partner.

Jonathan Wright is national account director for oncology, Pfizer UK
www.pfizer.co.uk

SERVICE REDESIGN

OUTSIDE CHANCE

Need external help with that redesign project? One firm is lending some trusts a manager. By Alison Moore

NHS organisers – both commissioners and providers – have a challenging task ahead if they are to control costs and improve quality. For many, the QIPP agenda and the requirement to save £20bn can appear daunting, even insurmountable. It will require organisations to look at almost every aspect of how they operate, from management costs to care pathways.

NHS chief executive David Nicholson told the NHS Confederation conference earlier this year that financial constraints would be there for as long as many people worked in the NHS. “The issue we are not delivering on is service change,” he said.

But such demands to improve care are difficult in a system where management numbers have been cut and the capacity to tackle redesign projects may be limited.

So it is not surprising if organisations sometimes need external assistance. Traditionally they may have approached management consultants but tight budget controls can make that difficult.

A number of NHS organisations have found help from an unexpected source: Pfizer, better known for its pharmaceutical products. Pfizer calls this approach Together Works Better and it is aimed at benefiting the patient, NHS and, indirectly, the company – but it is swift to point out that this sort of collaborative project is not about selling more drugs.

The company and NHS organisation agree the scope and aim of a project, define what each side will contribute and then work together for an agreed period. In some cases, this can be as long as a year.

Typically Pfizer might contribute the time and skills of a project manager for one or more days a week, plus support from their colleagues, while the host NHS organisation will provide work space, access to relevant data and resources, and high level support.

Pfizer will not always charge for its contribution – meaning that the host organisation may get project management free of charge. This can allow them to tackle

projects that would have struggled to get funding or which they might not have had the capacity to staff.

But can an outside organisation really offer meaningful support to the NHS in areas such as redesigning pathways or understanding cost structures?

The answer has to be that, although the NHS is great at doing what it does, sometimes someone who is slightly distant from the everyday problems and pressures can spot a solution.

“In the NHS you are immersed in it, living and breathing it every day,” says Mark Bray, from Pfizer’s oncology team. “Having external eyes looking at it does help.

“The NHS is under huge financial pressure at the moment. We understand that. We know it is not all about the medicine and we are trying to alleviate the pressure in other ways by bringing our commercial expertise to the table.”

While looking outside for expertise is always a bit of a leap of faith, feedback has been very positive, he says.

Dedicated manager

“Simple things like project management – having one person dedicated to the project – make a huge difference. I think if it is another piece of work that is tacked on to all the other things an NHS manager is having to do it can get lost.”

Geoff Rollason, programme director for Pfizer Health Solutions which advises the NHS on service redesign, says: “We are trying to work with NHS organisations to realise efficiency savings.” Among the NHS clients have been several cancer networks, looking to improve pathways and ensure they meet the standards around treating patients, and understand the cost of components of the pathway.

While it might sound surprising that the NHS does not understand what it is spending on components of cancer care, this was flagged up in a National Audit Office report as a barrier to improving care.

Tough challenge: David Nicholson says trusts must deliver service change despite the financial squeeze



With the requirements to start treatment within 31 days of diagnosis and to see urgent referrals within 14 days, cancer networks face a big challenge to co-ordinate the necessary tests and consultations. An ageing population is also likely to lead to more pressure on capacity and costs as more patients are referred and need treatment.

Problems can also seem overwhelming in their scope and complexity. The Pfizer approach is to break them down into smaller parts. For example, redesigning an oncology pathway might be implemented for one tumour site first and then spread out to other sites. "It's helping them to define the project and breaking it down into smaller doable chunks and succeeding within a timeframe. Then rolling that out to other areas using the learning from this," says Mr Rollason.

"Part of the work has been to help the NHS so that people are not completely boggled by the scope of what they are trying to achieve."

But what does Pfizer get out of this? Part of the answer has to be a better understanding of how the NHS – its main UK healthcare customer – works and some of the pressures and challenges different parts of it are facing. Victoria Lawrence, senior oncology and haematology account manager at Pfizer, says: "The projects have really helped us gain a deeper insight into the challenges the NHS faces. As a result, they will help to shape the way we work with the NHS on future collaborative projects. As a company, we are keen to apply a solutions-based approach to help the NHS realise efficiencies."

Projects such as these can also enhance the skills and expertise of Pfizer staff, and benefit its reputation through being engaged in credible joint working with the NHS. And, in the longer term, a more cost-efficient NHS is likely to benefit pharmaceutical companies and other suppliers: a financially struggling organisation will balk at buying new products.

One issue for NHS organisations is always going to be sustainability. Having made changes, what happens when the team involved moves on? Mr Rollason says the aim is to ensure that the work can continue: a detailed report is always prepared for the host organisation, and can help guide further work.

And ultimately implementation of changes, which will often affect multiple organisations and may be controversial with some, is a task for the NHS.

"We want to help the NHS to develop its own capabilities. In the past, industry has been accused of doing joint work and then sailing off into the sunset," says Mr Bray. "We know sustainability is the key. Understanding of how some of this work can be replicated is key." ●



SERVICE REDESIGN: CASE STUDIES

THE COST OF IGNORANCE

Tackling lack of knowledge about costs and waiting times has been key to projects to improve cancer care

CENTRAL SOUTH COAST CANCER NETWORK

Understanding the costs of cancer care pathways is crucial for commissioners as they seek to ensure patients receive the best care within available funding.

Cancer services have traditionally been commissioned through a variety of methods, including block contracts and payment by results. This approach to cancer commissioning restricts the ability to optimise the care pathway due to a lack of knowledge of the totality of costs.

In 2010 a National Audit Office report said that the lack of high quality information on costs of cancer services inhibits substantial further improvements in services and patient outcomes. Former cancer czar Professor Sir Mike Richards agreed that there needs to be better information and full clarity about costs for different cancer services, and the right incentives to reward quality and efficiency.

Last year the Central South Coast Cancer Network instigated a project to estimate the cost of the lung cancer care pathway within the network, as a core priority agreed with local commissioners.

Patients with lung cancer typically have poorer outcomes when compared with most other tumour sites, with survival rates at one year at 29 per cent within CSCCN. It was clear that understanding the total cost of treating lung cancer patients would contribute to the commissioning of the most appropriate care for this patient group. Due to the scope of this project, the network decided to focus on the chemotherapy element of the lung cancer care pathway in the first instance.

Pfizer and the CSCCN had been exploring the opportunity to undertake joint work beneficial to both organizations. Pfizer agreed to provide a project manager for two

days a week to support producing a lung cancer chemotherapy cost modelling tool which could potentially be used to calculate costs for other tumour sites.

Richard Harris, senior programme lead at the network, says the resources that Pfizer contributed enabled the project to move forward. “Within the Cancer Network we have a number of work programmes to deliver, and it is sometimes difficult for a cancer network to resource absolutely everything,” he adds.

The methodology involved two key elements. The first was to utilise national reference costs and chemotherapy healthcare resource groups to estimate the cost of the procurement and delivery for each lung cancer chemotherapy regime used within the network. The second was to identify chemotherapy clinical activity from the oncology electronic prescribing system.

These two elements were then combined to estimate the overall cost of lung cancer chemotherapy within the network – approximately £2.8m a year.

The outcomes of this project were shared by Pfizer and CSCCN at the Cancer Network National Development programme in March 2012. Both project partners have also begun transferring the learning from the chemotherapy cost modelling tool to the colorectal cancer pathway.

And the acceptance of the methodology and the approximate figures which have come out of it is opening the way for discussions with clinicians and commissioners about cancer costs and pathways.

In the future, it may help to highlight variations in care which need to be understood to ensure patients get the best care. For commissioners, the challenge may be to ensure this is delivered within a tight financial envelope so that best value is achieved from spending.

“What we are now starting to look at and



build on with our CCGs [clinical commissioning groups] is what defines quality chemotherapy services and how we can measure it,” says Mr Harris.

“It does have the potential to lead to change. Commissioners are looking at what they pay for chemotherapy and asking do they get the best outcomes for that money?”

ANGLIA CANCER NETWORK

For patients undergoing worrying tests and diagnosis of cancer, the NHS needs to ensure that the time that they wait for a diagnosis is as short as possible.

From an NHS perspective, a shorter pathway to diagnosis also helps organisations meet targets around cancer care. Cancer patients should be treated within two months of referral by a GP: getting a diagnosis quickly will enable many to be treated well within that time and help organisations meet the target.

And different pathways have differing costs; the “sweet spot” is to find the ones



Role models: Richard Harris, Jonathan Smith, Loretta Kinsella, Michael Browne and Wendy Keating of the Central South Coast Cancer Network team, which has done cost modelling of cancer care

region with median time to first invasive test ranging from 14 to 29 days.

The cost of the diagnostic part of the lung cancer pathway also varied enormously – from £472 per patient to £5,356, with patients at different sites having a varied number of tests.

Analysis by the Pfizer project manager drilled down to find out what was happening at different trusts by tracing the pathway of patients from each referring trust. Perhaps most importantly, it highlighted a striking difference in the decision to treat times for patients having two tests: for those with an endobronchial ultrasound, the decision to treat time averaged 27 days; for those with a mediastinoscopy, it was 44 days.

It seemed switching all patients to an endobronchial ultrasound would both speed up the process of diagnosis and treatment for them – and save the network up to £84,000 a year.

Other recommendations included the need to anticipate diagnostics as early as possible in the pathway, to improve data collection and to carry out further work to understand variations in cost.

Gareth Jones, director of the Anglia Cancer Network, says: “What Pfizer bought to the table was the project resource to apply to it. The sort of resource that they brought we could probably have developed ourselves but it was not immediately available to us.

“They offered a very good young project manager who got alongside our site-specific group clinicians. Her work focused on the diagnostic pathway rather than the treatment pathway. The issue is to get a quick accurate diagnosis as soon as possible.

“What they gave us was the luxury of having a good project manager working on a fairly discrete area which might otherwise have fallen off our work programme as we concentrated on the big ticket stuff”

The project manager was also supported by her Pfizer colleagues with visits from senior managers.

“What she left was a really good piece of analysis showing where there was scope for further work. We have now used our own resources to continue it,” says Mr Jones.

The network is now bringing in changes to the patient pathway and diagnostic tests are being changed. Mr Jones says it is possible that some of this would have happened anyway but the work of the Pfizer project manager sharpened the case for it.

He adds that, although there was initially some suspicion about Pfizer’s involvement, the work had come to be seen as “ethical sponsorship”.

Overall, he argues, the project has made a useful contribution to the QIPP agenda in the area. “There is no silver bullet project which will deliver it all – it is lots of little things like this one.” ●

which are cheaper while also offering patients optimal care. Pathways which are more expensive but don’t offer additional benefits for patients eat up money which could be used to improve care elsewhere.

Anglia Cancer Network was aware that suspected lung cancer patients on its patch faced considerable variation in care, including time to diagnose. Ultimately quicker diagnosis might offer the hope of better outcomes for patients through earlier treatment but in the short term it could reduce their anxiety and help achieve referral-to-treatment times.

The network decided to work with Pfizer to understand exactly what was happening, pinpoint some of the factors leading to these variations and highlight what could be improved.

Pfizer provided a project manager to work with the network. The work she was able to carry out has helped to guide the networks’ thinking about the way ahead.

An initial analysis showed patients were facing widely differing waits across the

‘Analysis showed patients were facing widely differing waits across the region’



KERI THOMAS ON DYING WELL



“ Think of the recent death of someone you knew. How was it? Too often such stories include crisis-driven over-hospitalised care, struggling over-stretched staff and gaps in communication at this most crucial time. With an ageing population, the stark reality of end of life care is hitting us, yet in this area we can simultaneously improve care while improving cost effectiveness.

Putting patients at the heart of care, improving long term planning and preventing unproductive hospitalisation, especially for the elderly, are matters close to the heart of clinicians and are nowhere more important than in end of life care. There are both humanitarian and financial reasons for change – this “economic no-brainer”, though complex to implement, can become reality if we make the right commissioning choices now.

This is where GSF can help. The National GSF Centre for End of Life Care is the leading provider of end of life care generalist training and expert support. GSF focuses on system change, helping to give the right care for the right person in the right place at the right time – every time. The centre also provides local audit reviews, reports and bespoke support for struggling organisations needing.

GSF helps put policy into practice at grassroots level in line with the government’s end of life care strategy, and helps you attain

‘This is not only about dying well but living well to the end’

QIPP and NICE targets, ensuring you provide better care while saving money. Backed by a strong evidence base and track record over 12 years and supported by national policy, GSF enables generalist frontline staff to provide a “gold standard of care” for all people nearing the end of life in any setting.

Only GSF training programmes for specific settings lead to accreditation and the quality hallmark award, recognised by the Care Quality Commission and others as markers of best practice. The London Procurement Programme for example, awards continuing care funding only to GSF-accredited care homes. Using a few GSF principles is insufficient – only supported GSF programmes will deliver. New integrated cross-boundary care projects are developing, with “Gold/GSF” patients at their heart.

This is not only about people dying well but about living well to the end. Now is the time to get it right – GSF can be part of the solution for your area.

Professor Keri Thomas is national clinical lead at the GSF Centre CIC for End of Life Care; honorary professor of end of life care at the University of Birmingham; and clinical expert – end of life care at the Royal College of General Practitioners
www.goldstandardsframework.org.uk

IN ASSOCIATION WITH GSF



SERVICE IMPROVEMENT

SEARCH FOR DIGNITY

Better identification of people in the last year of life could transform end of life care, reports Alison Moore

The government’s end of life care strategy – launched in 2008 – has led to a new focus in the NHS on providing high quality care for those approaching the end of life and offering them choice wherever possible.

Many NHS organisations have taken this on board and improved both services and staff skills. But more can be done to ensure that people in the last year of life receive the best care, in the most appropriate setting, enabling them to live and die well in the place of their choice.

The onus will now fall on clinical commissioning groups to improve care and reduce costs associated with unnecessary hospital admissions.

Professor Keri Thomas, national clinical lead at the Gold Standards Framework Centre for End of Life Care, believes the key in end of life care is to be more proactive. “We should anticipate earlier and move towards a whole system approach to ensure that, wherever a patient, is they will receive gold standard VIP care towards the end of life. This means providing appropriate support and training for everyone involved in their care and improving coordination.”

As Royal College of General Practitioners clinical champion for end of life care, she is working with and the DH and QIPP teams to develop RCGP guidance on commissioning end of life care, due in October.

Most care will always be delivered by generalist frontline staff rather than palliative care specialists. The GSF Centre – formerly hosted within the NHS but now run as a not-for-profit social enterprise – focuses on training generalists and supporting organisations to improve end of life care. The GSF programmes cover different settings – and complement each other leading to integrated cross-boundary care developments.

Improving proactive care starts with identifying patients who are likely to die. The vast majority of GP practices keep registers of patients thought to be in the

final year of life but these are not comprehensive: a national survey found that only around a quarter of people who died were on the register, while those identified received better coordinated care. This means many whose death could be anticipated are missing out on targeted care and the opportunity to express their preferences through advance care planning. It may also mean they are more likely to be admitted to hospital as an emergency.

The GSF Centre is developing IT support to help identify people likely to be in the last year of life earlier, prompting inclusion on GP or locality registers or the electronic palliative care coordination system. The GSF domiciliary care programme helps care workers recognise deterioration early and respond accordingly.

Professor Thomas points out that most people die of long term conditions, co-morbidities, frailty, dementia and organ failure, rather than cancer. Proactively identifying people using GSF prognostic indicator guidance means their care can be planned and coordinated and unnecessary admissions prevented.

When 13 GP practices in the Lancaster area undertook the GSF Primary Care training programme Going for Gold, the number of patients on their registers increased by 70 per cent in a year. The practices have also started to see a fall in the number of patients dying in hospital, a trend mirrored by others using GSF programmes.

The GSF centre has also been working with care homes – where many of these patients will live – for nearly a decade to train staff and accredit homes meeting its standards. Homes have to demonstrate improvements against 20 quality standards including decreased hospitalisation – most GSF-accredited care homes halved their hospital death rates.

“Organisations are looking for some external evaluation and embedding of a quality standard – and that is what we



Getting older: an ageing population means the NHS must rethink end of life care

offer,” says Maggie Stobbart-Rowlands, GSF lead nurse. “End of life care is everybody’s business, and involving staff – from nurses to housekeepers – in their care is crucial. We see dramatic improvements in the confidence of staff so they better advocate for residents and provide top quality care.”

This work has been mainly funded by PCTs and local authorities as an “invest to save” or QIPP approach: better care for patients at the end of life need not be expensive but multiple unnecessary admissions to hospital always will be, so it doesn’t take long to recoup the investment. Many areas commissioned GSF training for large numbers of care homes – and bucked the national trend of hospitalisation.

Somerset PCT for example demonstrated significant decreased hospitalisation rates for GSF homes compared to non-GSF homes, and GSF nursing homes in South East London increased their home death rate from 54 per cent to 72 per cent.

Acute and community hospitals now can also apply for GSF training and accreditation, with over 60 hospitals

‘Most GSF-accredited care homes halved their hospital death rates’

currently in training. They face particularly difficult challenges but, as about 55 per cent deaths occur in hospital and about a third of hospital patients are considered to be in their final year, this is a crucially important area.

In Lancaster, following successful use of GSF in care homes and primary care, the acute hospital is now being incentivised by the CCG through CQUINs (Commissioning for Quality and Innovation framework) to undergo GSF training. Savings will be reinvested to improve palliative care provision and support for patients at home.

GP commissioner Peter Nightingale says: “The GSF in the community has made a big impact but the missing link was what was happening in hospital. It seemed to make sense to try and get us all speaking the same

language, with a unified approach to end of life care using GSF and aim for a reduction in hospital deaths of 20 per cent.”

Hospital admissions are particularly detrimental for people with dementia who are likely to become distressed and disorientated away from familiar surroundings. The GSF team suggest measures to decrease hospitalisation for people with dementia and launches its new dementia training programme this autumn.

Changing demographics mean CCGs will be coping with an increasing number of people nearing the end of life with complex conditions. Improving end of life care fulfils the QIPP agenda for commissioners by improving quality, cost effectiveness and prevention – but also requires the courage to innovate.

“With an ageing population, we are reframing our thinking, says Professor Thomas. “Death is not a failure but a bad death is – and caring well for people nearing the end of their life is a vital indicator of our success as organisations, as a health service and as a society.” ●

HSJ AWARDS¹²

20th November 2012
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CONGRATULATIONS TO

■ Acute & Primary Care Innovation

- Gnosall Surgery
- NHS Nene Clinical Commissioning Group
- North West London Integrated Care Pilot
- Peterborough and Stamford Hospitals Foundation Trust and Drinksense
- South Devon Healthcare Foundation Trust
- St Levan Surgery
- The North West London Hospitals Trust
- Walsall Healthcare Trust

■ Chief Executive of the Year

- John Adler, Sandwell and West Birmingham Hospitals Trust
- Martin Barkley, Tees, Esk and Wear Valleys Foundation Trust
- Glen Burley, South Warwickshire Foundation Trust
- Sir Andrew Dillon, National Institute for Health and Clinical Excellence
- Dr Gillian Fairfield, Northumberland, Tyne and Wear Foundation Trust
- Katrina Percy, Southern Health Foundation Trust
- Professor Philip Sugarman, St Andrew's Healthcare
- Paula Vasco-Knight, South Devon Healthcare Foundation Trust

■ Clinical Leader of the Year

- Dr Caroline Allum, Whittington Health
- Dr Dan Dalton, Hertfordshire Partnership Foundation Trust
- Chris Webster, Liverpool Women's Foundation Trust
- Professor Opinder Sahota, Nottingham University Hospitals Trust
- Dr John Walsh, Nottingham University Hospitals Trust
- Dr Rhidian Bramley, The Christie Foundation Trust
- Dr Sanjeev Nayak, University Hospital of North Staffordshire Trust
- Dr Paul Grundy, University Hospital Southampton Foundation Trust
- Professor Siobhan Quenby, University Hospitals Coventry & Warwickshire Trust
- Professor Jason Gardosi, West Midlands Perinatal Institute

■ Commissioning Organisation of the Year

- NHS Bassetlaw Commissioning Organisation
- NHS Blackpool Clinical Commissioning Group
- NHS Nene Clinical Commissioning Group
- NHS Nottingham City Clinical Commissioning Group
- Warrington Clinical Commissioning Group

■ Enhancing Care with Data and Information Management

- Barts Health Trust
- Birmingham Prostate Clinic
- East Midlands Ambulance Service Trust, National Ambulance Clinical Quality and Research Groups and University of Lincoln
- NHS London
- NHS North West London
- North of England Cardiovascular Network
- The Royal Marsden and McKesson

■ Good Corporate Citizenship

- Barts Health Trust
- Bradford Teaching Hospitals Foundation Trust
- Derbyshire Community Health Services Trust
- Liverpool Primary Care Trust and Liverpool Clinical Commissioning Group
- Northumberland, Tyne and Wear Foundation Trust
- Sandwell and West Birmingham Hospitals Trust
- Sussex Community Trust
- Yorkshire Ambulance Service Trust

■ Improved Partnerships between Health and Local Government

- The Ayr Clinic (Partnerships in Care) & Scottish Government
- Christchurch Locality Commissioning Group
- NHS Blackpool
- Norfolk Community Health & Care Trust
- South Essex Partnership University Foundation Trust
- The Gateshead Housing Company and Gateshead Primary Care Mental Health Team
- The Healthy Urban Team, Bristol
- The Merton, Kingston and Sutton Multi Systemic Therapy Team
- Torbay and Southern Devon Health and Care Trust

■ Improving Care with Technology

- Cornwall Partnership Foundation Trust
- EMIS
- NHS Bolton and d2 Digital by Design
- NHS Midlands and East
- NHS South of England
- Nottingham University Hospitals Trust
- Oxford University Hospitals Trust
- Saxmundham Health
- University of Stirling, Dementia Services Development Centre

■ Innovation in Mental Health

- Avon and Wiltshire Mental Health Partnership Trust
- Birmingham and Solihull Mental Health Foundation Trust
- Cornwall Partnership Foundation Trust
- Hertfordshire Partnership Foundation Trust
- Kent and Medway NHS & Social Care Partnership Trust
- Pennine Care Foundation Trust
- South London and Maudsley Foundation Trust
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■ Managing Long Term Conditions

- Ashford and St. Peter's Hospitals Foundation Trust
- Derby Hospitals Foundation Trust
- Isle of Wight Trust
- Liverpool Community Health Trust
- NHS Nene Clinical Commissioning Group
- Tameside & Glossop Shadow Clinical Commissioning Group
- Royal Borough of Kensington and Chelsea
- SEQOL
- Southern Health Foundation Trust and Portsmouth Hospitals Trust

■ Patient Centred Care

- Bedfordshire Partnership for Excellence in Palliative Support hosted by Sue Ryder
- Central Manchester University Hospitals Foundation Trust
- Chelsea and Westminster Hospital Foundation Trust
- Cheshire and Wirral Partnership Foundation Trust
- East Kent Hospitals University Foundation Trust
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- The London Pathway



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- University Hospital Southampton Foundation Trust
- West Midlands Perinatal Institute

■ Primary Care and Community Service Redesign

- Birmingham Community Healthcare Trust
- GP Care
- Imperial College Healthcare Trust
- NHS Blackpool
- NHS Nene Clinical Commissioning Group
- North Bristol Trust
- Partners4Health and West Cheshire Clinical Commissioning Group

■ Progressive Research Culture

- King's College Hospital Foundation Trust
- NHS Bradford and Airedale
- Nottingham CityCare Partnership
- Pennine Acute Hospitals Trust
- South Staffordshire and Shropshire Healthcare Foundation Trust
- Sussex Partnership Foundation Trust
- University Hospital Southampton Foundation Trust
- Wrightington, Wigan and Leigh Foundation Trust

■ Provider Trust of the Year

- Birmingham Community Healthcare Trust
- Derbyshire Community Health Services Trust
- Liverpool Heart and Chest Hospital Foundation Trust
- Nottingham CityCare Partnership
- Tees, Esk and Wear Valleys Foundation Trust
- Torbay and Southern Devon Health and Care Trust

■ Quality and Productivity

- Birmingham Women's Foundation Trust
- Fulham Road Collaborative
- Isle of Wight Trust
- NHS Blood and Transplant
- NHS Erewash Clinical Commissioning Group
- NHS South Essex
- Oxford University Hospitals Trust
- South East Coast Ambulance Service Foundation Trust
- South Tees Hospitals Foundation Trust

■ Secondary Care Service Redesign

- Great Western Hospitals Foundation Trust
- Hertfordshire Partnership Foundation Trust
- NHS Greater Manchester
- NHS South West London
- Oxford University Hospitals NHS Trust
- University Hospital Southampton Foundation Trust
- The James Cook University Hospital
- University Hospital of North Staffordshire Trust

■ Staff Engagement

- Birmingham Women's Foundation Trust
- Blackpool Teaching Hospitals Foundation Trust
- Bolton Foundation Trust
- Hull and East Yorkshire Hospitals Trust
- NHS Merseyside, Development of the Merseyside Commissioning Support Service
- NHS Merseyside, Leading our people through transition
- NHS Nottingham City Clinical Commissioning Group
- Sandwell and West Birmingham Hospitals Trust
- The Walton Centre Foundation Trust
- West Hertfordshire Hospitals Trust

■ Workforce

- 5 Boroughs Partnership Foundation Trust
- Advanced Training Practices Pilot
- Barts Health Trust
- Hull and East Yorkshire Hospitals Trust
- The South West Peninsula Deanery, Advanced Care Planning and Medication Reviews in Care Homes
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“ Information to support commissioning abounds, but the challenge is to make it locally meaningful and applicable. Clinical commissioning groups will look to providers of commissioning support for the intelligence needed to guide them in commissioning decisions. The BMJ Group has a long history of providing tools to help clinicians. It is now building on these to support planning and implementation of evidence-based commissioning decisions.

Anecdotally, GPs view the promotion of evidence in the commissioning workflow as a strength of clinical commissioning compared to what has gone before. However, unlike the trial data that underpins evidence-based clinical practice, evidence to underpin commissioning comes in many forms. Clinical data must mesh with population, financial and activity data as well as evidence from published literature to build up a comprehensive picture of the services required to meet local health needs.

Crucially, all commissioning evidence must be robust to drive, where necessary, the case for change. Providers of commissioning support will have expertise in different areas and collaborative working between organisations will ensure the generation of the best available information. The BMJ Group is uniquely placed to be part of this. As an organisation renowned for producing evidence-based resources, BMJ

‘GPs view promotion of evidence as a strength of clinical commissioning’

Group evidence specialists are able to carry out high quality evidence reviews to underpin both clinical pathway and larger scale service redesign. These answer questions of clinical and cost effectiveness when comparing different service models or clinical interventions. Years of producing internationally respected literature syntheses ensure these reviews are timely and apply to specific commissioning environments.

Developing intelligence with local relevance is essential. BMJ Group health economics specialists can take local financial data and build economic analyses. For example comparing the costs of different service models according to the clinical outcomes they achieve enables commissioners to understand how much “bang” they get per “buck”. This intelligence combined with data on local need is much in demand and vital to planning services.

The challenge CCGs face in developing their intelligence requirements is significant. The BMJ Group, an organisation run by doctors for doctors, can support this by providing a robust evidence base as one chapter in the overall local commissioning story.

Dr Anita Jolly is clinical lead for BMJ Healthcare Knowledge Services group.bmj.com

COMMISSIONING INFORMATION

HARD EVIDENCE

In a sea of information, how can GPs and CCGs pick out what they need to support their work? By Alison Moore

The next year will be hectic for clinical commissioning groups. As they take over the reins of commissioning from PCTs, they will have many immediate priorities including accreditation, balancing the books and developing their capacity to act as independent organisations.

In the midst of all of this, it would be easy to forget the role that clinical information and evidence will play in helping organisations meet their goals. The white paper *Liberating the NHS* made this obvious: “Information, combined with the right support, is the key to better care, better outcomes and reduced costs.”

Making the right decisions about services will also be crucial in controlling costs and using the money available to CCGs wisely. Commissioning the right services has benefits for patients who will receive optimal care and stand a better chance of recovering good health.

But, as the financial constraints on the NHS continue, it will also be important for CCGs to get the most out of the money they spend. That means evidence of effectiveness of both clinical treatments and service models will be crucial for CCGs making decisions on what to commission; they will also want to look at how this evidence relates to their own areas and priorities.

There is no shortage of clinical evidence to guide clinicians; indeed, they may feel rather swamped by what is available. But the sheer volume of research can pose a challenge: it may need to be summarised and interpreted to be of immediate use to busy clinicians and commissioners alike. Different pieces of evidence will need to be assessed – some will be given more weight than others (although there may be gaps in the evidence) and the relevance to the clinical setting will vary.

And the evidence base does not stand still. While the National Institute for Health and Clinical Excellence does update its guidelines in response to changes in the evidence, this takes some time. And NICE is

by no means comprehensive – there are some areas which it has not considered.

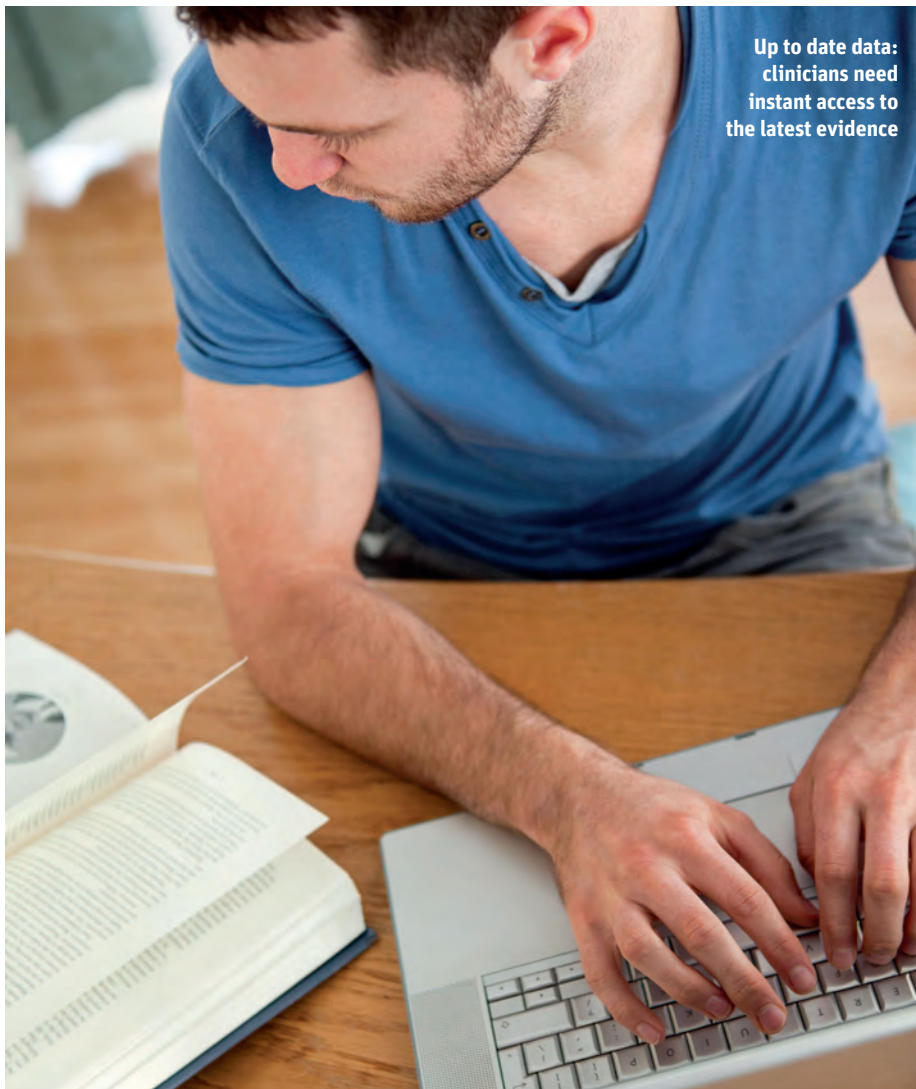
But assessing the evidence base can be a difficult task for small organisations. Dr Andrew Jones, head of clinical engagement at the BMJ Evidence Centre, points to the volume of clinical papers published every year – 35,000 – and the impossibility of keeping up with all of these, or even all those applicable to one specialty. While GPs understand the nature of evidence based medicine and can assess and search for relevant papers, there is only so much time they can devote to it.

“Although we can all do it on an informal basis, turning that into an industrialised process is hard,” he says. “The amount of evidence out there is enormous. Analysing it in a systematic way and condensing it down to a few key messages can be very difficult.”

Dr Klara Brunnhuber, product manager for Clinical Evidence and Best Practice, two clinical knowledge products from the BMJ Evidence Centre, highlights the benefits of using experts when determining the evidence to underpin new models of care or treatment pathways. “It takes considerable effort and time to acquire the necessary skills of searching and appraising the research literature, assessing the quality of the evidence and summarising results in a meaningful way.”

Evidence experts can look at how compelling the evidence is and help address questions of applicability to certain patient groups. “Some of this work needs to be done by specialists because of the complexity of the methodology,” she says. The approach can also take in local priorities such as addressing particularly prevalent chronic conditions.

One advantage of knowing the appraisal methods are sound is that it makes potentially contentious decisions harder to challenge successfully. Individual patients may also find it harder to claim they were not treated appropriately if their pathway is based on the best available evidence.



Up to date data:
clinicians need
instant access to
the latest evidence

Dr Jones says that decision making in commissioning will become increasingly professional in terms of its governance, having to justify the decisions that are taken, and having the information which will back up those decisions. But CCGs will need help to link clinical evidence on effectiveness with the needs of their local communities. This may be prominent in prevention campaigns for example.

BMJ Informatica software – one of the BMJ Group’s existing products – allows this evidence to be acted on within consultations. Prompts on the computer screen can help GPs to remember to ask about lifestyle factors or consider certain treatments. “How can we help individual doctors apply the information more effectively?” says Dr Jones. “There is little point in commissioning new and innovative services if we do not then help GPs to guide their patients towards them.”

But do other types of information also need to be more meaningful to clinicians? Paul Barbour, head of the clinical data team at the BMJ Evidence Centre, points out that

‘Patients may find it harder to claim they were not treated appropriately if their pathway is based on the best available evidence’

a lot of data is currently aimed at managers rather than frontline clinical staff, although all GPs are expected to engage with clinical commissioning at some level. One of the BMJ Group’s aims is to produce data that meets the needs of clinicians better, he says. “From a clinician’s perspective it is about having actionable information. They need the minimal information they can take action on.”

This may be about knowing the likely outcome for a patient: understanding the relative risk that, without intervention, a patient will be admitted to hospital can help guide clinicians’ actions, for example. Joining up the information available in secondary care with primary care can be very revealing, he adds. “We hope to facilitate that joining up of information so people get the full local picture”.

One way in which the BMJ Evidence Centre has produced useful but compact guidance for doctors is through its work with healthcare group Kaiser Permanente. This looked at screening policies around seven sexually transmitted infections (including HIV) to formulate guidelines for clinicians. The joint project set parameters for questions it wanted answered and set up a search strategy to look at evidence.

From over 5,000 screened abstracts, the BMJ Evidence Centre team filtered 129 studies from 36 countries which were assessed against strict criteria, such as relevance, quality and whether they had been superseded by more recent evidence. This body of evidence was then summarised and handed over to the Kaiser Permanente clinical guideline team to create – in collaboration with its expert panel – a single nationally agreed guideline on STI screening which could be locally implemented. In addition to a comprehensive guideline report, a short guideline tool was designed for busy clinicians to use in their surgeries or consulting rooms.

So information and intelligence will help CCGs achieve their goals – but failing to get the information needed could threaten their ability to deliver what is needed. Dr Jones points out that, unlike PCTs, CCGs have to go through an authorisation process and can, in theory, have managers imposed on them or have their functions removed. This will place a responsibility on them to show they have good processes in place and a robust approach to strategic decision making.

Getting the right information and making effective use of it will be crucial in this. In two or three years’ time, the CCGs that will be most successful will be those that have managed to focus on the quality of their decision making, he suggests: and having access to the right information will be a big part of that. ●

COMMISSIONING INFORMATION: CASE STUDIES

RIGHT TURNS

Technology that prompts doctors during consultations also delivers a wealth of data to help commissioners

MEDWAY CCG

The clinical guidelines available to GPs can provide a road map to providing better care for their patients. But road maps can be time-consuming and are difficult to use when you are already on a journey.

As many motorists know, a satnav has many advantages over a map. It can be used more easily mid journey and provides targeted guidance rather than simply a mass of information which can be hard to interpret on the move.

GPs in Medway are using Audit+ from BMJ Informatica – a decision and benchmark support system that operates more like a satnav than a map. It offers “prompts” during a consultation to guide the GP towards the destination of improved care for the patient in front of them. It can pinpoint patients at risk of serious diseases, helping GPs to offer early treatment or encourage lifestyle changes.

But the system – which has a number of different components – also provides a wealth of information for the clinical commissioning group, allowing it to pinpoint patient groups across a wider area and drill down to discover what level of care they are being offered. It can also compare how practices are doing – what proportion of smokers are identified during a consultation and offered interventions, for example.

Dr Peter Green, accountable officer designate of the Medway CCG, is an enthusiast for such systems. They enable GPs to work smarter, not harder, he says, and help to embed clinical guidance – such as that produced by the National Institute for Health and Clinical Excellence – in routine consultations.

“It is not trying to dictate what you do but it is helping you to remember to consider certain aspects ... it is helping GPs to do a better job,” he says. Within a 10 minute

consultation with a patient with multiple co-morbidities, it is difficult to remember all the bits of guidance which should be followed, he adds.

But as well as helping individual GPs, the CCG also benefits from a wealth of data about what is happening in practices. This can enable comparisons of what is happening across the CCG area and help support for practices that are struggling.

Dr Green is adamant that this is not about heavy-handed performance management by the CCG but creating a supportive environment, giving GPs and practices information they can use. GPs want to do the right thing for their patients and there is an element of professional pride: comparative information can support this and encourage GPs to improve.

“It’s the relationship between people using the system and people who can see the CCG level view – how you can provide support and encouragement, how you can work with practices. It is not a contractual relationship,” he says. “We work on the assumption that people want to provide good care and we are making it easier.”

Whereas clinical audit tended to tell people about what they had not done, this system does that but also focuses on helping clinicians get it right at the right time.

Nor is it intended as a substitute for the doctor’s own judgement. “The prompts are there to help you look after the patient. The patient is not there to help you tick off the prompts. There are some consultations where it will be inappropriate to address any of them,” he adds.

Evolution of care

He sees such systems as part of an evolution of medical care. “The health of the population of Medway is not where we would like it to be. What we are trying to do with this is help move primary care from a reactive model,” he says.



“Twenty years ago we would wait for people to feel unwell and then visit their doctor. Now we are trying to detect people with often asymptomatic long term conditions such as hypertension and diabetes and keep them well – secondary prevention. We are now trying to move this a step further forward and prevent these conditions – primary prevention.”

And there are good outcomes. For example, many people with atrial fibrillation ought to be on warfarin to reduce the risk of a stroke. The system has helped GPs identify those patients who should have been on warfarin and ensure they are offered it. “We had over 70 per cent of our patients with AF who should have been on warfarin put on it before it came into the quality and outcomes framework,” says Dr Green.

The system has also been used to identify patients who may have familial hypercholesterolaemia. By screening records, a third more patients (over 100 patients) have been identified in six months.

Small groups of people who may be at particular risk of devastating conditions may



Right road: decision support software can guide GPs, in the same way that satnavs offer timely advice to drivers

be targeted – for example, men over 64 with a family history of aortic aneurysms – can be identified and prompted to attend screening. A piece of work at the moment looks at patients with kidney disease who may need haemoglobin monitoring.

There are also more practical issues for practices: through the QOF, increasing the prevalence of patients on disease registers attracts additional money. A system that helps identify patients who ought to be on the register helps them claim the income.

Longer term, there are advantages to patients getting better care for a CCG: it is likely to reduce costs. “The better you manage diabetes, or any other long term condition, in primary care, the less you are going to be spending in secondary care. There may be a lag between what you do in primary care and what we see in secondary care. The sooner you start doing things the better,” says Dr Green.

Information can also be shared with the public health team, to reveal where resources around preventative or awareness campaigns may need to be directed.

‘A system which helps identify patients who ought to be on disease registers helps practices claim income’

So what makes the system work so well? Dr Green points out one of the advantages is that it works on almost all GP software systems – something which is crucial as GPs can choose their own systems.

“From a CCG perspective, we can see what is happening across the area,” he says. It also helps embed public health priorities in general practice – for example, through prompts for checking smoking, BMI and consumption of alcohol. Historically, GPs have been good at addressing smoking with patients, but the prompt system also looks at BMI and alcohol. Brief interventions from GPs to encourage lifestyle changes in patients are known to be particularly successful and this system drives GPs to ask the right questions, so they can intervene.

Acceptance from colleagues has been good overall, and the CCG has tried to encourage use, building on the momentum generated by enthusiastic GPs. Dr Green says it is a “win win win” system. “It helps patients get better care. It helps practices because it makes it easier for them to do the job better. And it helps the CCG.” ●

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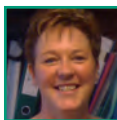
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