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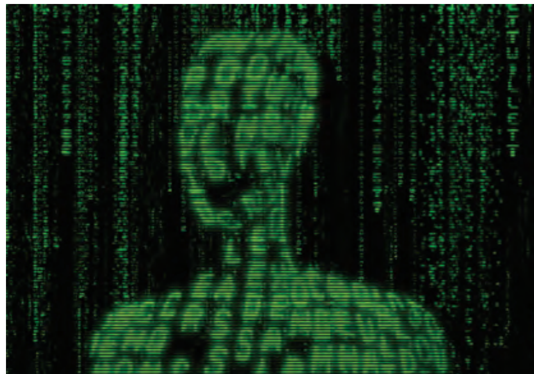

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FOREWORD BILL McCARTHY

The difference is tangible

Improving health and healthcare in Yorkshire and the Humber is at the heart of everything we do. The passion and commitment of the 14 primary care trusts has shown how barriers to collaboration can be overcome where this best serves patient and the community interests.

The vision of the Yorkshire and Humber PCT Collaborative is clear – to achieve better outcomes for patients by sharing expertise and learning and getting better value for money, working on projects once rather than 14 times.

'Clinicians are able to have one conversation rather than the 14 they had in the past'

And this has already made a tangible difference to people's lives. For example, the PCT collaborative has a common process for reviewing new treatments, working to ensure Yorkshire and the Humber patients are treated the same, wherever they live in the region.

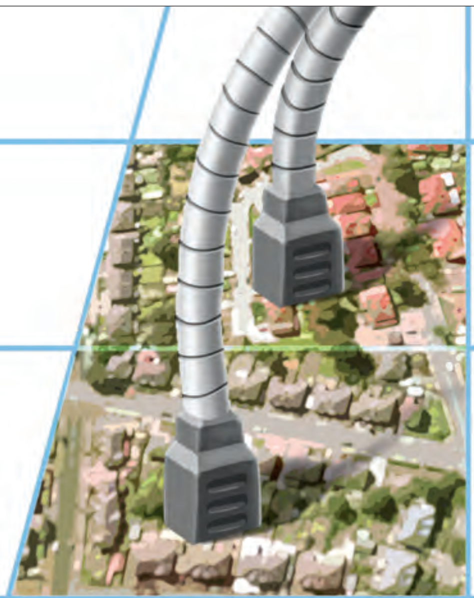
This has also ensured better dialogue between clinicians and decision makers – with clinicians able to have one conversation rather than the 14 discussions they had to have in the past.

Co-production and expertise are at the heart of our philosophy – a base on which to build in tackling the financial challenges ahead. ●

Bill McCarthy is chief executive of NHS Yorkshire and the Humber

COVER: MALCOLM WILLET

PLUGGED IN TO THE PUBLIC



Yorkshire and the Humber primary care trusts pooled their commissioning resources to command the best value for their communities, writes Stuart Shepherd

The opening of the Hillside Bridge Healthcare Centre in Bradford on 28 November 2008 by then health secretary Alan Johnson was a significant event not only for local service users and primary care trust NHS Bradford and Airedale but also for NHS Yorkshire and the Humber and the wider health service

Sited in Barkerend, an area already identified as under-doctored and having a population with high rates of long term and acute illness and poor health outcomes, the GP-led Hillside Bridge was the first service to be procured under the Equitable Access to Primary Medical Care programme.

The centre is open every day from 8am to 8pm and offers a full range of family health services over extended hours to registered patients, as well as a walk-in service to non-registered patients. The list of registered patients currently stands at 2,900 with a proposal for this to expand to 6,000 over the next five years.

"Essentially the centre took over the ongoing care of about 2,000 patients from a previous practice," says GP and director for clinical governance at NHS Bradford and Airedale Andy McElligott. "We believe that the new patients are a mix of people who previously were not registered with a doctor and some who were registered with neighbouring practices."

The social enterprise Local Care Direct won the bid to run the centre – advertised in April 2008 for a December 2008 start – under an alternative provider of medical services contract.

At the time, experience of this method of procurement across NHS Yorkshire and the Humber was limited. In spite of this, however, NHS Bradford and Airedale was able to successfully stick to a demanding timetable. One of the principal reasons for this, along with pre-identified premises as part of the local improvement finance trust scheme, was the guidance they received from the Equitable Access Support Team (EAST) (see box overleaf).

This team, set up to provide support to local PCTs throughout the GP-led health centre procurement process, was established by the Yorkshire and Humber PCT Collaborative. This is the main vehicle for agreeing collaboration priorities and funding in the region. It had been in embryonic form for some months before this. Importantly, however, EAST was one of the earliest examples whereby the chief executives of the region's 14 primary care trusts all committed funding to a central pool for a common resource.

"The critical issue was to collaborate and ensure the constituent PCTs weren't faced with too many compromises in relation to their local populations," says collaborative commercial partnership manager Lois Bentley.

"EAST was adopted as a model for shared working on the proviso that it fulfilled a number of critical success factors, which included practical help to PCTs, skills transfer and widening of regional learning."

Steep learning curve

Negotiating a steep learning curve, the PCT project teams and EAST worked together using elements of the alternative provider contract to closely examine their local and differing population needs while sharing documents, expert help, legal advice and understanding across the region, which was paid for just the one time.

Because this additional resource was entirely PCT owned, there was never any sense that any of this process was being "done to" the people using it. With the PCTs leading, they got the right clinical services for their communities, cheaper than if they had done it by themselves, and hitting all the Department of Health milestones.

"The three big benefits – efficient process, development of capability and the right clinical model – demonstrated the value of working together and laid the foundation for further work around accredited standards for procurement and market development and management," says NHS Calderdale chief executive Rob Webster.

A widely appreciated feature of the equitable access procurement was the production of an internally shared electronic timeline of procurement activity – a spreadsheet of activity across five phases from clarification of population health service needs through specification to tendering and contract award.

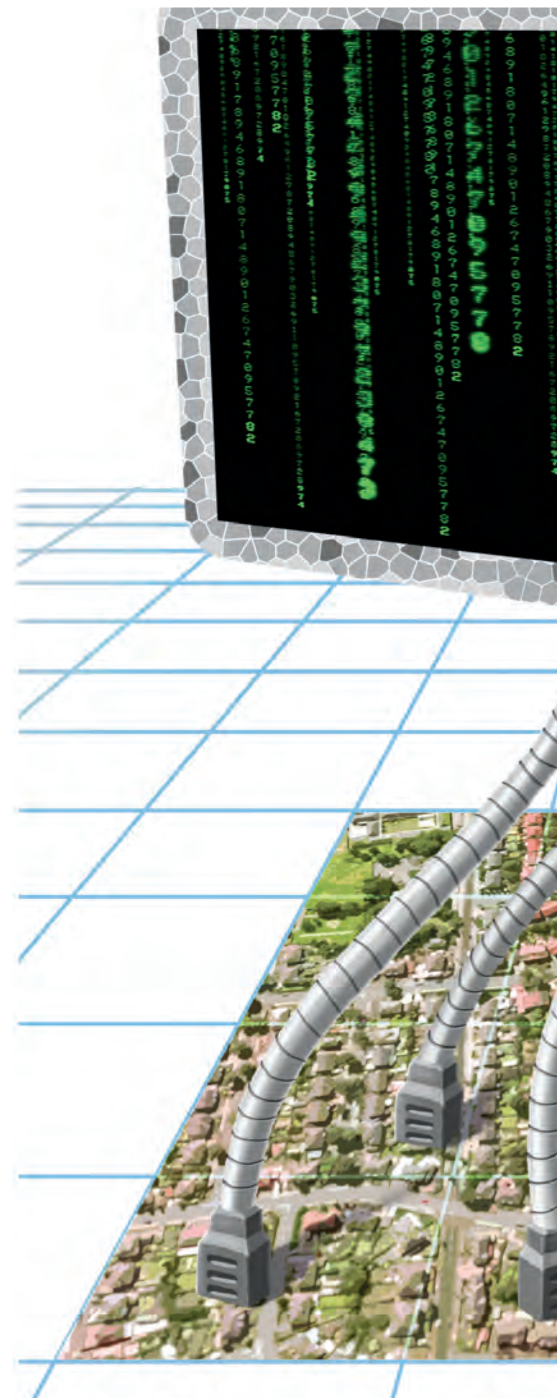
This simple mechanism encouraged people to pick up the phone to speak with and learn from colleagues in other PCTs about their work.

Under the collaborative's programme for accredited standards of procurement, which supports improvement in world class commissioning competency nine, this has been expanded into a healthcare procurement pipeline. Each PCT has a designated person who updates this live window on activity with forthcoming procurement activity. The procurement data sits alongside sets of standardised templates and case studies.

As part of an action learning road map, PCTs also look to improve capacity and capability by identifying any deficits between the resources they have and those they need to carry out their projected procurement activity. The collaborative helps the trusts identify sources of expertise, such as a neighbouring PCT or the commercial procurement collaborative, to plug these gaps and acquire new skills. Work based accredited learning for commissioners further complements this.

Market development and management has seen the collaborative and the 14 PCTs

> ‘Working together helps primary care trusts get more done more quickly at a much reduced cost’



work with professional health economists to look at the market levers commissioners have at their disposal to improve quality.

“Market analysis helps commissioning organisations understand how their healthcare market is currently functioning,” says Ms Bentley. “A diagnostic tool allows them to measure quality, choice, the behaviour of service users where quality is considered poor, provider concentration and barriers to entry.”

“The diagnostic enables clinicians and commissioners alike to understand the wider dynamics of healthcare provision and quality and the actions they might take to influence that,” she continues. “Our intention is that this analysis becomes a part of normal business where PCTs are facing a service improvement.” (See dental services in Hull box opposite.)

One point that the diagnostic tool has been helping people to understand is that, in some markets, monopoly provision of services, especially where these are high-tech and require limited specialist skills, is absolutely the right thing. Where this is the case, analysis provides PCTs with a better understanding of the quality of that service and, if needed, what demand and supply side levers – such as informing choice, delivering innovation, performance measures, contract changes, introduction of competition – might be explored.

“We are determined to get the best possible return on the £430m of investment we are making,” says NHS Rotherham chief executive Andy Buck. “It is clear to me we need to develop a far more critical appraisal of the return we are obtaining from all the providers with whom we currently work.”

He says: “As we do that, we see both the potential and the need for greater diversification with the local health economy. If we want to obtain that, we need to apply and embed commercial skills to the processes of procurement, contract management and market management that complement other skills already present within the commissioning workforce.”

Resource support team

Equitable access was a national programme that ended early in 2009. Valuing the support it had given to regional and organisational commercial development, the chief executives of the collaborative decided to further invest in a small Commercial Resource Support Team, which will run until early 2010. By this time, NHS Yorkshire and the Humber’s commercial support unit model will have taken over its functions (see below). Regional commercial support units were highlighted in the DH report of May 2009, *Necessity – Not Nicety*, as a pivotal element of the NHS’s new commercial operating model.

“The DH believes that PCTs developing their commissioning competencies in isolation is not the best way of moving forward,” says James Gooding of the resource support team. “It is calling for economies of scale with leverage for avoiding duplication. Working together, as we have found in Yorkshire and the Humber, helps PCTs get more done more quickly and at a much reduced cost.”

“How that collaboration should be organised is the big question,” he continues. “Some regions in the UK will go for central regional organisation that to a greater or lesser extent will manage the PCTs’ procurement exercises. NHS Yorkshire and the Humber is keen not to do that. The

EQUITABLE ACCESS SUPPORT TEAM (EAST)

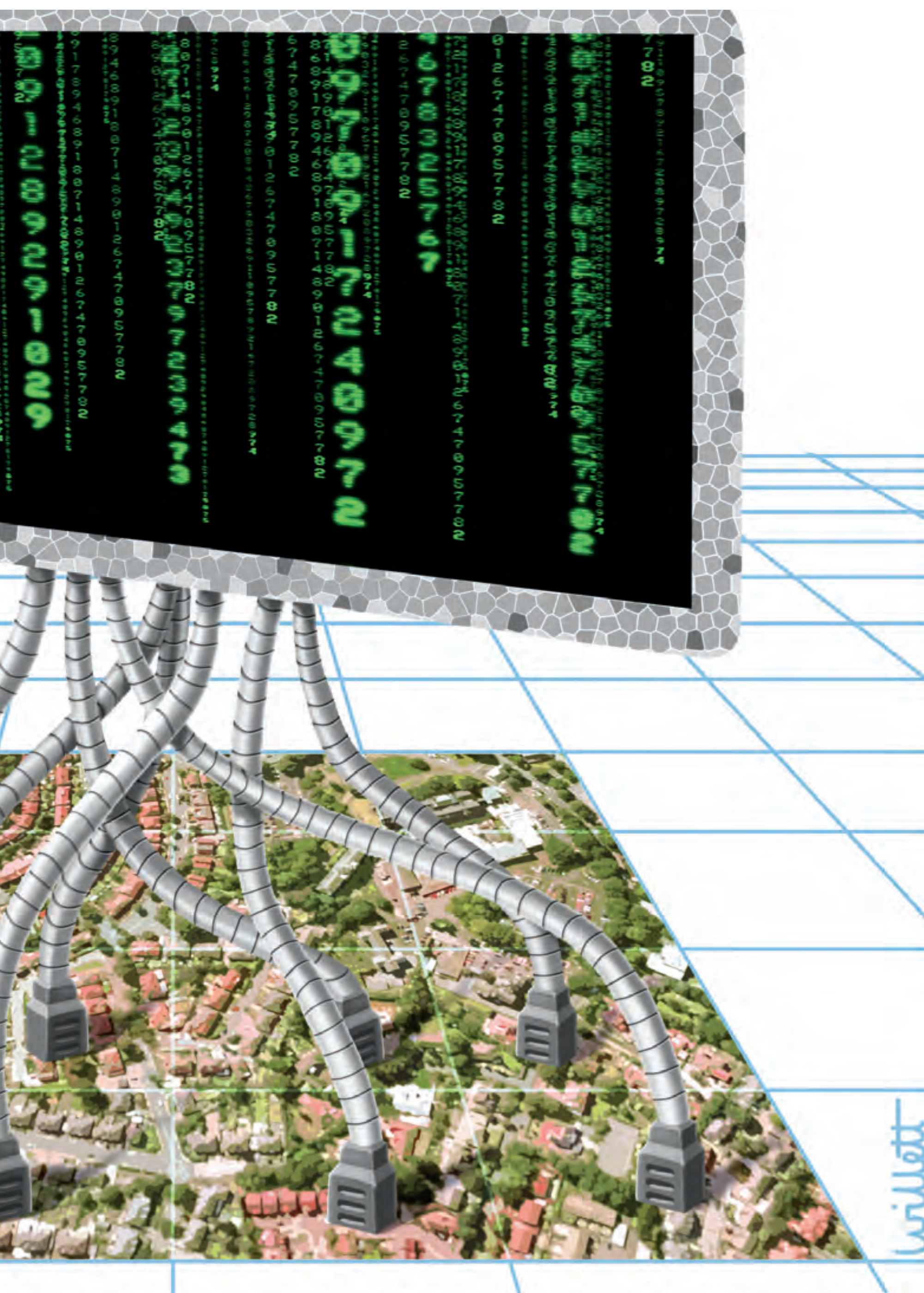
Earlier community mapping and market analysis allowed NHS Bradford and Airedale to identify a site, with a new facility in situ, for Hillside Bridge GP-led extended hours health centre.

“The EAST team drew together Yorkshire and the Humber project managers to facilitate a number of process workshops, establish a network and ensure consistency across the patch,” says PCT project lead for Hillside Bridge Helen Woodhead.

“We used the DH template documents, but EAST had to get hold of them early for us, because we were in front of the timeline and going out to tender before everyone else,” she says. “We worked closely with EAST and members of the clinical and performance teams to ensure that there was some clinical challenge and put key performance rather than simply quality and outcomes framework indicators in the alternative provider of medical services contract.”

These include, under broad headings: access, quality of care, addressing health inequalities, value for money and patient experience. The provider’s achievements are reflected on a sliding scale of payments.

Ms Woodhead says: “EAST helped each PCT get a health centre to meet its particular requirements, sharing the learning and avoiding duplication of effort.”



MEASURING QUALITY

From *High Quality Care for All*
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- Clinical effectiveness
- Patient experience

Extended to include all elements from the international Organisation for Economic Co-operation and Development healthcare quality indicator
- Efficiency
- Equity
- Responsiveness

DENTAL SERVICES IN HULL

NHS Hull is at the expression of interest stage of a major procurement of new capacity in dental services.

"The new emphasis on market management reflects the fact that some services, such as dentistry, already have NHS and independent provision, have fewer barriers to entry and are patient driven," says NHS Hull assistant director of primary care commissioning Keith Parsons.

"Dentistry is relatively unique in that it is not catchment based and our analysis showed us that the local market is relatively competitive, without concentration and a widespread of providers," Mr Parsons continues.

"What we hadn't been aware of is that the distribution is focused on the main arterial route into the city."

Mr Parsons adds: "We are looking to introduce new services that will add competitive tension and drive up quality while giving patients more information about what they should be able to expect and getting providers to think about how they engage with patients.

"We would want to develop more sophisticated measurements of quality, and a better means of quantifying patient switching between providers, to map that in performance monitoring information."

feeling is that a lot of the information that you need to do good health service commissioning sits in the PCTs themselves. In this case, the answer to getting the efficiencies and leverage of a central solution is in the creation of a commercial professional network."

Thanks to the lessons learned from earlier collaborative programmes and not a little foresight, NHS Yorkshire and the Humber had been making a start on this network before the publication of *Necessity – not Nicety*. Membership consists of a director and associate director of each PCT and the commercial procurement collaborative.

The procurement collaborative supports procurement capability and, as well as a centrally agreed plan, is currently focused on three main areas of work:
- Looking at issues of regional intelligence to inform developments across markets and services
- Technical support and timelines for market analysis and procurement processes
- Organisational and leadership development across the network.

There are three cross-cutting approaches to getting the work done: sharing and learning across PCTs, working and implementing together and investigating and advising on technical queries.

"None of us across the PCT collaborative, the specialist commissioning group or the commercial procurement collaborative wanted to take apart the established mechanisms that have been working so well," says procurement collaborative chief operating officer Helena Fuller.

She says they proposed a solution to the DH that maintains the sovereignty of the PCTs while aligning the work of the procurement collaborative with the specialist commissioning group and PCT collaborative "to ensure an integrated approach on particular initiatives that fulfils the commercial support unit requirements".

So where will the developments of Yorkshire and Humber PCT Collaborative's work programmes take its 14 constituent organisations next?

NHS North Lincolnshire chief executive Allison Cooke, who is CEO sponsor of the market development and management programme, says the next critical steps are to ensure "the follow through of all the capacity and product building enables a self-facilitating process of sharing and learning and that, by using this approach, tangible market shaping issues and procurements really start bearing fruit".

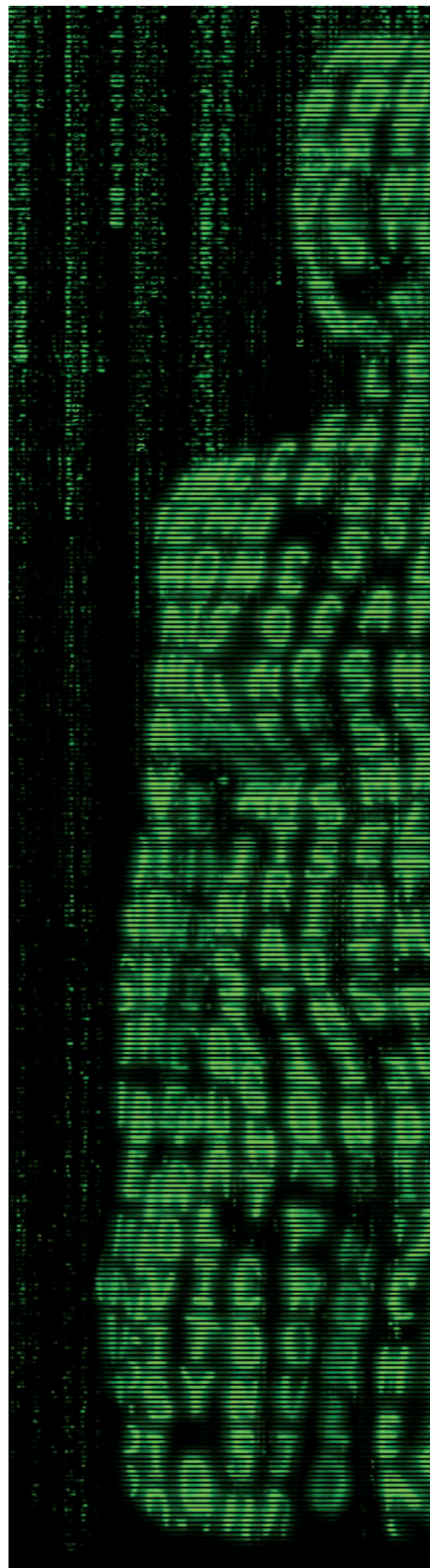
She continues: "Down the line, the challenges will be around using collaboration as a vehicle to secure improvements in quality, efficiency and productivity.

"How we drive these developments forward has got to be against the backdrop of sustaining improvement and managing within finite resources." ●

MALCOLM WILLET

POWER TO THE PEOPLE

Shared data is providing a critical tool through which NHS services can improve their understanding of their local populations. Stuart Shepherd explains



World class commissioning requires good health insight and intelligence. Two programmes across the Yorkshire and Humber PCT Collaborative are enabling primary care trusts to improve the way they understand the needs of their communities through the better use of data they already hold and more specific information they can go out and collect.

One of these programmes aims to put in place a single learning, governance and development infrastructure for social marketing.

"All the PCTs across Yorkshire and the Humber have been getting levels of insight from mechanisms such as joint needs assessments for specific groups, such as people in poorer health, without going on to use it," says NHS Barnsley chief executive Ailsa Clare. "We are now collecting that regional information alongside national insight to create a shared database and learning network that we can all access for different purposes, such as encouraging young women to go for cervical screening."

'We are now looking at the ways that we could organise services differently to encourage people to make healthier decisions'

"In the past we have used understanding like this to drive people to services," she continues. "Now we are turning it around and looking at what motivates people to make the decisions they do about their health – smoking; not exercising – and the ways that we could organise services differently to encourage them to make healthier decisions."

The Yorkshire and Humber Public Health Observatory Health Intelligence Programme (HIYAH) addresses issues of in-house capacity and capability in the application of health intelligence at both local and regional levels (see box). The observatory is leading work with the 14 PCTs on a range of projects that include a regional health intelligence training programme, a regional insight hub with links to the regional social marketing forum, insight briefings for *Healthy Ambitions* and other regional priorities and health economics support.

"We aim to help PCTs address some of the issues that came out in the world class commissioning first round assessments, particularly competency five – manage knowledge and assess need – but also with other competencies", says YHPHO deputy director Jake Abbas.

"Some of what we are trying to do covers the more traditional approach on health intelligence, such as small area data and forecasting," he continues. "There is a real focus, however, on consumer insight and I see this as an opportunity to mainstream that into health intelligence so that it is seen as more than a standalone approach for social marketing." ●

GETTING PEOPLE INVOLVED AT CALDERDALE

David Wild is a GP at the Hebden Bridge group practice in Calderdale. As part of the YHPHO support to world class commissioning during the development of HIYAH, the practice used the newly developed primary care dataset.

The primary care datasets or "practice profiles" bring together data in the public domain, including basic practice demographics and populations and add it to a lot of data that we collect for the quality and outcomes frameworks and other uses. This is all reliable and accepted data and much of it is what our payments are based on.

This is linked with comparative data across the PCT and the strategic health authority, and can also link with national data. It not only profiles the practice but, by using your practice demographics for inequalities and other things, it can also help you make comparisons with practices that you can see are of a similar "cluster" profile.

There are nine different kinds of cluster profile – on the map ours is pink – and we can compare ourselves with a very similar practice in the same region. Where I work in Calderdale, there are only 29 practices and there are big differences between them. If you start linking across practices with similar profiles across the region, however, it brings validity to any comparison you make.

You can also look at the dataset of how you are performing on quality and outcomes framework data. The profile compares how you treat your diabetics not only in Calderdale and across the SHA and nationally, but also with your cluster practices. You are comparing like with like so there is no excusing yourself.

A practice in Leeds with a similar profile to ours in Calderdale may, for instance, be giving care to its patients with diabetes to a different standard. You start to get an understanding of why this might be happening and how you can learn from different practices, how they behave with their populations to get different health outcomes.

Because it uses the demographic profiling of the practices it actually builds up what your present health requirements are and what the future health requirements may be. Particularly from a commissioning point of view, it would be very useful to know in advance that your practice will need to be profiling differently in 10 years time because of a baby boom that presents you with a very different set of needs.

In Calderdale, we have shown it to the practice-based commissioning group, clinical executive and other practices across the patch. I have asked them to get involved with the project and start looking at their profiles, because it is their data. Our practice nurses, who deliver a lot of the care for diabetes and chronic disease, have seen the data and are very interested to see how they perform in comparison to other practices. This has enthused the whole practice, from the administrators who set it up, to the GPs and practice nurses who deliver it. Because the data has credibility it gets people involved in a proactive rather than reactive way.

IMPROVING UPTAKE THROUGH SOCIAL MARKETING

Fiona Jordan is a consultant in public health with NHS Doncaster and has been leading a cervical screening social marketing project

In Yorkshire and the Humber we noticed from the data we had about the uptake of cervical screening that there was a decrease in women between 25 and 34. That concerned us greatly. In 2007-08 uptake dropped to 68 per cent against a target of 80 per cent and the situation was particularly acute among 25 to 29-year-olds.

We commissioned a social marketing project with the objective of improving uptake, therefore increasing early diagnosis and hopefully saving lives. The first stage was data collection, which for the first time we managed to get postcoded. This was geodemographically mapped against a number of segmentation products.

Interestingly it showed us that there was a particular segment of women, present in all 14 PCTs in the region, more likely not to attend. The team then undertook qualitative work, via focus groups, with women from that particular segment to try to understand the reasons for their non-attendance. The groups also interviewed relevant healthcare professionals at the same time.

We gained an insight into what these people thought and what stopped them from going. We also learned that, regardless of whether they were from Harrogate or Halifax, this was the same insight – based on experience or perceptions, they were embarrassed about the procedure. Some women also had a fear of pain, because of accounts from friends or because of previous equipment. There were access issues about getting there, having to get babysitters, getting time off work. There was a fear that screening was a test for cancer and some fatalism about the likelihood of getting it and not wanting to cope with the news. There was some perceived irrelevance of the test, because the women thought they would be symptomatic and would know if there was something wrong.

There was also a lack of faith in the process, because they had heard of some people getting inconclusive results or recalls.

All of this told us that if we were to look at how we might improve our main promotional messages, delivered at an early stage, to get these women into cervical screening, we could use the same approach across Yorkshire and the Humber.

It also got us thinking that if we get all these women in, will the services be fit to receive them and make them want to re-attend? That is important, because it is a three-yearly screen for this age group. We have to look at clinical and process standards. We need to think about how we invite them, what happens when they get here, asking them how easy the journey was and whether we should be asking them about their experience of the procedure.

Once we have put these measures into place we will also need to design an evaluation framework. We will review our progress in the autumn before hearing how the work is taken further forward.

MALCOLM WILLETT

THE MANY ROADS

Partnership between the NHS and local government is allowing a high level integrated care pathway to be defined for mental health. By Stuart Shepherd

As commissioners of mental health services we are committed to understanding best practice and getting the right approach of understanding the difference we are making for service users," says Yorkshire and Humber PCT Collaborative director Amanda Forrest. "Work is centred on two key areas that will make all the difference to the way mental health is commissioned."

Two programmes – Mental Health Commissioning and Contracting and Mental Health Care Pathways and Packages Payment by Results Currency Development project – are both born from the recognition that the quality and standard of mental health commissioning and service specification across the patch has been variable.

Unlike the acute services, mental health trusts have never had healthcare resource groups or codes.

Additionally, there is no "currency" or means of commonly describing the effect of interventions, no way of assessing their quality, or of attaching a tariff to them, and no framework for measuring the outcomes they may or may not be achieving.

"That leaves us with a lot of discretion as to how we apply the mental health resource, which is not necessarily based on need or evidence linked to treatment outcomes," says South West Yorkshire Partnership Foundation Trust chief executive Steven Michael. "That means it is difficult to say how much money a provider should get for what they do."

This could all change. A methodology originally driven by clinical need to better understand the pathway for mental health and assist decisions on meeting service user needs forms an essential part of Yorkshire and Humber PCT Collaborative work programmes.

The development of service specifications to deliver the models of care for *Healthy Ambitions*, (the regional response to the next stage review) takes in wider pathways, including prevention and social care. The Association of Directors of Adult Social Services co-sponsors the programme and Yorkshire and Humber Improvement Partnership has been commissioned to support the work together with the collaborative.

'Health and social care commissioners, with providers, are looking for practical tools that will help them work together across the whole system of mental healthcare'

"Health and social care commissioners, with providers, are looking for practical tools that will help them work together more closely across the whole system of urgent and non-urgent mental healthcare," says improvement partnership mental health programme lead Steven Stericker.

TO QUALITY CARE

MENTAL HEALTH COMMISSIONING AND PERSONALISATION

The move to the "personalisation" agenda – which includes personal budgets for people in need of social care – changes the relationship between state and citizen. It brings implications for the choices that individuals can make about the support they want and for mainstream services that may no longer meet personal needs.

"The significant development for those of us in social care is the consensus among NHS and local authority commissioners that we need to weave personalisation into commissioning," says Kirklees Metropolitan Council partnership commissioning manager Ian Smith. "In the past, the NHS stuck to health and local authorities did social care, but this goes a long way to developing a shared approach."

Several strands of work in the region make this possible: bringing together peer audit and service specifications, and developing outcomes based in wellbeing that evidence service impact.

"There are things like payment by results, care pathways and packages and contracts that don't necessarily include local authorities or may not be sensitive enough to the social care agenda," says Mr Smith. "But NHS performance frameworks are not that dissimilar to social care's and there is still a lot of work we can do together. We all have the same outcomes in mind."

"We have been developing a high level integrated pathway and set principles led by the national service framework consultation document *New Horizons* that support consistency in commissioning at all levels of mental healthcare, from the promotion of wellbeing to acute inpatient care, a peer review audit framework and a model service specification and outcomes framework. This framework identifies socially inclusive outcomes – such as housing, education and employment – that all commissioners are ultimately aiming for."

Peer audit allows for the fact that partnerships may implement aspects of the wider care pathway differently, but toward the same outcomes. A process is being designed to train commissioners to use tools to examine how their own and other organisations can demonstrate, under the pressure of challenge, that they are getting the outcomes they assured their stakeholders they could and would deliver.

The Mental Health Care Pathways and Packages currency project is also developing service outcome measures – patient experience, organisational and system – and

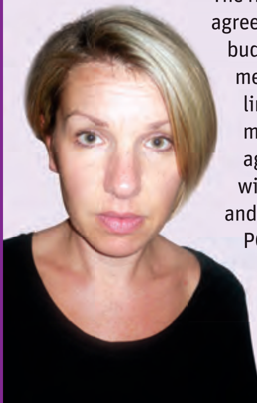
JOINT COMMISSIONING OF LOW SECURE SERVICES

In 2007, the specialist commissioning group of NHS Yorkshire and the Humber agreed to move to a collaborative approach for the commissioning of low secure services across all of the region's 14 primary care trusts. Senior commissioning manager of the secure services commissioning team Louise Davies explains how the transition has taken shape

"Up until that point services across the patch had been commissioned very differently. We decided we needed to be very clear from the outset what were low secure services. Patients from services passed over to us that were not low secure were risk assessed and, where appropriate, passed back to the PCTs.

We underpinned this with a system of robust case management mirroring that already in place across the high and medium secure services and looked to ensure equity of access and egress through a secure service pathway protocol.

We recently implemented standard mental health contracts, across both the NHS and independent commissioned services, with financial incentives that include a number of service user driven elements.



The financial risk share agreement and the budget setting methodology are linked to the financial management agreement, which sits within the contracts and is agreed across the PCTs. Consultation on a low secure strategy five-year plan is set to finish in the autumn."

ALAMY

MENTAL HEALTH CARE PATHWAYS AND PACKAGES ON THE FRONT LINE

Services for early intervention in psychosis receive significant investment and are intensively driven by quality. The introduction of a care pathway for a client group or "cluster" that tends to have a range of similar needs affords practitioners the opportunity to provide a consistent package of interventions that delivers quality outcomes, which can be evidenced.

A working group from Rotherham, Doncaster and South Humber Mental Health Foundation Trust's early intervention in psychosis services has been consulting with service users and carers on what interventions work well and what a new service user should expect.

"We are now at the point of agreeing those interventions along the pathway," says the Rotherham group's team manager Jo Painter. "It is quite difficult in terms of what you would expect for one person. However, we can identify what care everybody should be in receipt of initially and then dip into a toolkit of interventions to personalise the pathway."

Pathway development will be formed by both emerging evidence and outcome review.

"The pathway gives us a framework for a process through which, if the results of an intervention show lots of variance, we can introduce changes and influence practitioner behaviour," says Ms Painter.

"Outcome indicators that include standardised symptom assessments empower service users and help them hold us to account.

"If for instance, [service users] think their medication isn't working they can compare the objective results of an assessment with one done earlier."

IN PURSUIT OF QUALITY COMMISSIONING

NHS Confederation mental health network director Steve Shrubb explains why mental health commissioning matters

"I think, if we were to go back a few years, most people would accept that the focus for commissioners was not on mental health but models of acute and physical health.

"More recently, that focus has begun to switch. The Sainsbury Centre for mental health estimates that the impact of mental health on the economy is somewhere in the region of £77bn a year. The impact on the health service is significant, and there is a growing realisation that to be able to commission efficient and cost effective healthcare there must be equally good commissioning of mental healthcare.

"There is recognition also that this goes beyond the statutory provision of mental health services and mental illness. Increasingly care pathways of patients with physical illnesses include elements that address mental wellbeing. Promoting prevention and delivering good care runs through all commissioning activity.

"I think we are moving to a tipping point, where the majority of health commissioning bodies now understand this and are seeking to ensure that they improve their capacity and capability.

"NHS Yorkshire and the Humber has taken some very clear steps to developing and supporting integrated models of commissioning at the local level. In Barnsley, for example, the primary care trust and local authority have come to understand they cannot deliver good mental healthcare or support mental wellbeing on their own, and have brought the two systems together.

"This integration is a challenge that requires the absolute commitment of leadership, working hard to be appreciative of each other's agenda and priorities. In Yorkshire and the Humber there is a real commitment to developing this approach and understanding the true level of need across all the region's communities through mechanisms such as local strategic partnerships, comprehensive assessments and joint needs assessments."

care pathways and packages for 21 different types or clusters of mental healthcare that have a currency, a tariff and outcome measures that underpin commissioning and contracting.

In 2006, six mental health trusts across NHS Yorkshire and the Humber and NHS North East tested the care pathways and packages methodology and its common needs assessment tool.

Findings showed that more than 90 per cent of service users across the organisations could be placed into one of the cluster groups.

Furthermore, the trusts believed it had great clinical utility and service users said it improved their understanding of services and choice.

Ways forward

These outcomes were subsequently used to inform the DH consultation on the future of payment by results on a national basis. The consultation reported that mental health was being prioritised as the next area for the expansion of payment by results and that care packages and pathways was considered one of the most sensible ways forward.

Further testing of the methodology across eight pilot sites has included: formalisation of and training for an assessment and risk tool; the collection of data to refine and validate the patient clusters; and the continued work on distinct service user and clinical focused outcome models that equate with the developing "currency" model.

"This approach starts to give us the kind of good quality information that up until now has been lacking in mental health," says Jon Painter, care pathways and payment by results manager at Rotherham, Doncaster and South Humber Mental Health Foundation Trust.

'Appropriately allocating money to different levels of need would appear to be common with the personalisation agenda and payment by results'

"In relation to commissioning, the premise would be that clusters of service users with similar sets of need should require similar kinds of interventions and cost similar amounts to provide for," he continues.

"It also allows us to use a universal language so that conversations about service users can focus on their needs rather than their diagnosis. Quality and outcome measures can be tailored to individuals within clusters."

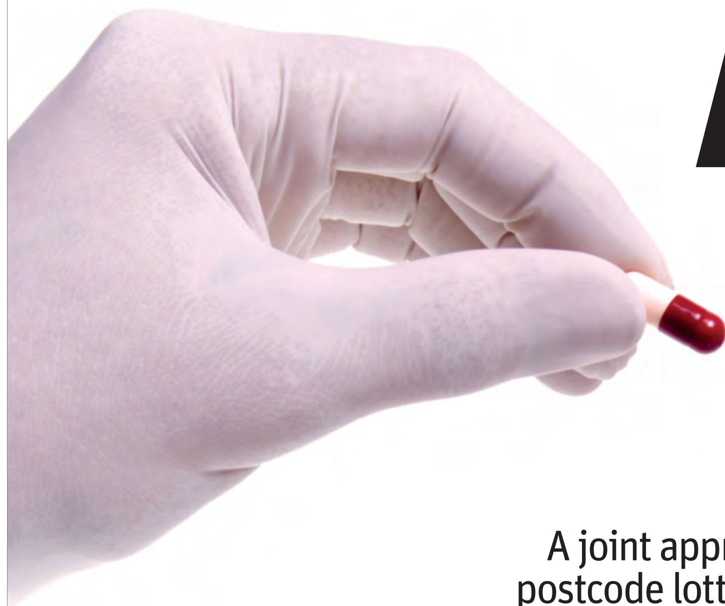
Historically, mental health service users have tended to end up in pre-designated services that seem to best meet their needs. A trust that understands how many service users it provides with commonly understood and evidenced interventions, however, can start to look at capacity modelling and service redesign that responds to presenting needs.

The notion of trying to appropriately allocate money and services to different kinds and levels of need would appear to be common to both the personalisation agenda and payment by results (see box). Making the processes behind them complement each other is a challenge, but certainly not one that is insurmountable.

"It will probably be a few years yet before there is clarity around a model of costing for the mental health pathway," says South West Yorkshire Partnership's chief Mr Michael.

"Whether that leads to a national tariff or not is unclear at the moment. But that doesn't detract from questions about how meaningful are the activities that people are being commissioned to provide through the mental health contract.

"The data that is driven through the methodology, which is a needs based model and soon to be an outcomes model, will undoubtedly go on to form the model of contracting with PCTs." ●



A NOT SO BITTER PILL

A joint approach to clinical decisions hopes to end the postcode lottery that denies treatment to some patients while granting it to their neighbours. By Stuart Shepherd

When a clinician with a sick patient wants to use a drug or procedure for which there is no NICE guidance or regional policy, they are usually faced with the prospect of having to apply to the primary care trust for funding.

The delay and variation in responses to requests made under all but identical circumstances – approval in one primary care trust, refusal 10 miles down the road – familiarly known as the "postcode lottery" does more than just make headline news in the local press. It leaves families in acute distress, often at a time when they are trying to cope with the impact of a life-threatening condition and least equipped to deal with what can only come as more bad news.

Excellence in Decision Making is a common process signed up to by the PCTs in Yorkshire and the Humber that reviews these emerging treatments, making them available for use with patients from across the region and helping to remove the distressing variation.

"There is a process steering group at which members of the specialised commissioning group (SCG), the PCTs and the School of Health and Related Research (SCHARR) at Sheffield University, meet and agree a work programme and priorities," says Cathy Edwards, director of the SCG.

"The PCTs put in a list of drug treatments or interventions they want people to look at, the steering group finalises the work programme and priorities and then pushes them through the process. Once complete, the discussion paper and recommendations go to the SCG."

With a particularly complex intervention or where clinical engagement with consultants and clinicians is critical there is a shared seminar. SCHARR collects literature reviews and an appraisal of the economic analysis, talks to clinicians about current views on the use of the treatment and then brings this as a structured presentation of the evidence around clinical and cost effectiveness for discussion with commissioners and clinicians.

A consensus on how to use the treatment – or not – goes forward as a paper to the SCG. The recommendations are then either agreed, not agreed or modified. The decision becomes a policy statement for the public domain. The NICE work programme is reviewed constantly to avoid duplication.

"We've got away from individual PCTs saying they don't agree with a particular way of using a drug or telling us their people looked at this and found a different answer," says Kevin Smith, regional medical adviser in health specialist services to the SCG.

"The main benefit for the clinicians is that instead of 14 or more conversations with commissioners about new services, drugs or developments, they are involved as a group across the region in one conversation where they know their views will count." ●

> **'The main benefit for clinicians is that instead of having conversations with many different commissioners, they are involved as a group'**

KEEP COMMUNICATING

John Snowden is a consultant haematologist at Sheffield Teaching Hospitals Foundation Trust with an interest in haemato-oncology and bone marrow transplantation

I work in an area of care with some very expensive drugs and procedures. What's important for me is that there are good dialogue and communication channels between clinicians and commissioners and an evidenced based policy. This allows hands-on practitioners like me to deliver quality treatments to people often in very difficult and tragic circumstances without bureaucratic delays processing individual applications for treatment.

For those patients of ours who need bone marrow transplantation Excellence in Decision Making avoids lots of paperwork, telephone conversations and personal attendances at appeal hearings – all of which can have a significant impact on the delivery of care.

TWO OF A KIND

Marian Opoku-Fofie is lead network pharmacist for the Humber and Yorkshire Coast cancer network

Over the course of the 18 months that Excellence in Decision Making has been running, the process has made two drugs – lenalidomide and thalidomide – accessible to cancer patients.

For some of the people concerned there may not have been another pharmaceutical option. Being able to offer this treatment can help to limit the progress of the cancer and extend and improve the quality of their lives over several months or even years.

We are now using the process to look at the use of a drug called cetuximab for patients with colorectal cancer who have stopped progressing or had no progress with their first line of drug treatment.

ALAMY

THE FUTURE IS IN YOUR HANDS

A programme to nurture the next generation of board level leaders is giving managers and clinicians their first step on the climb to the top, writes Stuart Shepherd

Of all the competencies required for world class commissioning, leadership sits at the top of the list. World class commissioners, the competency document says, are visionary and operate with tact, assertiveness and skill. They engage with communities and partners and "put the 'mission' into commissioning".

The NHS Yorkshire and the Humber regional leadership executive group, drawn from chief executives from commissioning and provider organisations across the region with support from the strategic health authority, recognises the central role of strong senior leadership in transforming healthcare systems through quality, innovation and productivity, and has set up work streams to develop and nurture not just talent but also a leadership community.

The Aspiring Director programme provides opportunities for managers and clinicians with the potential and drive to become directors to get the right balance of on-the-job experience, coaching and theory to make the move up to board level.

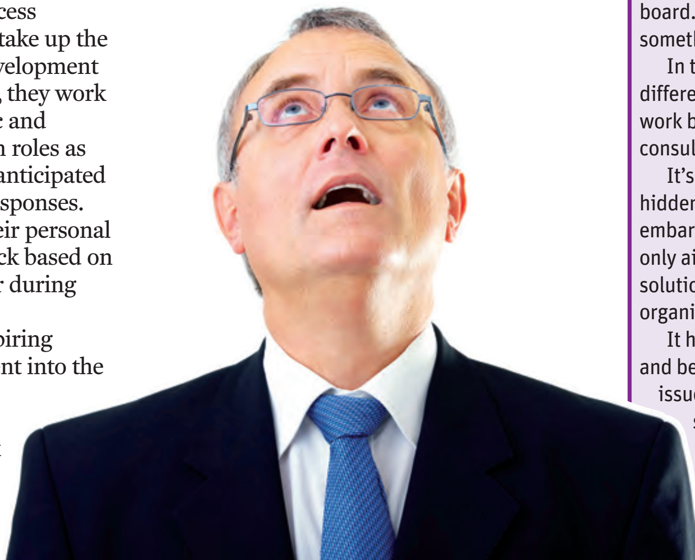
After a rigorous selection process candidates assessed as ready to take up the challenge go on to a two day development centre. Here, under observation, they work in groups on simulated strategic and operational challenges. Actors in roles as journalists or relatives make unanticipated demands of them to test their responses.

Participants start to shape their personal development plans from feedback based on this work and focus on it further during facilitated action learning sets. Masterclasses encourage the aspiring directors to put their development into the broader context of the NHS.

Stretch assignments – block or part time placements over six months – give programme members access to director level posts on secondment away from their own organisation and often in a different directorate. Support from coaches and mentors is available throughout the 12-18 month programme.

NHS Sheffield chief executive and chair of the regional leadership executive group Jan Sobieraj says: "In their relationships with partner agencies, PCT executives can exert significant influence as civic leaders managing complex systems to drive up standards and tackle health inequalities. The Aspiring Director programme is developing the people who will be leading on this in the future." ●

'PCT executives can exert significant influence as civic leaders managing complex systems to drive up standards'



ALAMY

OUT OF THE COMFORT ZONE

Alijan Haider is deputy director for equality and diversity at NHS Bradford and Airedale. After several years in his current role, an MBA and King's Fund management training he was ready for a programme that helped him untap his potential for decision making and "supported me stepping up into leadership rather than theorising about it"

"My director told me about the programme and was very much behind my application," says Mr Haider. "Once I had gained a place and even though I was incredibly busy at work she told me to clear my diary and keep it clear for the week of the development centre activity."

"I am considering a placement with NHS Hull," he continues. "This would be in a commissioning role and would help me test some of the director level competencies I have been developing. It will certainly take me out of my comfort zone, in a new environment and with the challenges of a more senior and unfamiliar role."

"I look forward to it. I am sure it will be of great benefit and I hope it will also be beneficial for my hosts."

CHANGING PERCEPTIONS

Sarah Fatchett is director of operations at Yorkshire Ambulance Service, an appointment she took up following a three month secondment into the post while on the Aspiring Director programme

I had already been in a large scale operations role in a mental health trust, taking on senior responsibilities but without ever sitting on the board. I wanted to turn that experience into something substantive.

In the learning sets you meet colleagues from different organisations and work together on work based issues. It's like getting a free consultancy session with a panel of experts.

It's all in complete confidence, there are no hidden agendas and there's no risk of embarrassing yourself in front of the boss. The only aim is to support you in working towards a solution and being able to take that back to your organisation.

It has really changed some of our perceptions and behaviours in relation to how we tackle issue. Those of us in the set felt that this was such a good development opportunity that we got our facilitator to train us to be able to carry on once the programme finished.