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THE FIGHT OVER COMPETITION

**BLAIR'S ADVISER PAUL CORRIGAN CLASHES WITH
ANDY BURNHAM. READ BOTH VIEWS: 12-15**



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EDITOR'S CHOICE



NEWS

72% of acute trusts are planning to cut their headcount

An *HSJ* survey has revealed there has been a big jump in the number of NHS organisations planning to cut staff. *HSJ's* quarterly survey of finance directors reveals headcount reductions are most common at acute trusts.



Page 4



OPINION



INSIDE Andy Burnham fleshes out his belief that the NHS should be the “preferred provider” of services, while Paul Corrigan argues that competition is central to delivering quality and efficiency. **Leader, page 3; page 12; page 14**

RESOURCE CENTRE



World class commissioning means facing up to the hard decisions required to decommission services which no longer offer the best quality and value to patients and the NHS. We look at some strategic advice as well as a caveat against careless cuts. **Page 20**



SUPPLEMENT

A centralised model of renal healthcare no longer meets the needs of an older kidney disease population with more co-morbidities. Our 12-page supplement looks at how autonomous units and regional networks are reshaping services.



BLOGS

‘Get rid of a load of policy wonks at the top of the upside down pudding, er pyramid, and maybe that could result in improvement’

Inside Out

www.hsj.co.uk/blogs



EVENTS



Intelligent Information for World Class Commissioning, 8 December, Birmingham www.hsj-infowcc.com

Urgent and Emergency Care 2010 19 January 2010, London www.hsj-urgentcare.com

HSJ JOBS

11 PAGES OF JOBS BEGIN ON PAGE 26

Salary band 9 starts on page 27

Finance director; deputy chief executive, Coventry

Salary band 9 starts on page 27

Chief operating officer, Cornwall

Salary band 8 starts on page 32

Public health consultant, London; public health consultant, Sheffield

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NIHR Service Delivery and Organisation programme



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Call for Research Proposals

The NIHR Service Delivery and Organisation (SDO) programme improves health outcomes for people by commissioning research evidence that improves practice in relation to the organisation and delivery of healthcare. It also builds research capability and capacity to carry out research amongst those who manage, organise and deliver services and to improve their understanding of the research literature and how to use research evidence.

Call for scoping studies in emergency planning in health care (Ref: 09/1005)

In light of the acknowledged gaps in the research about emergency planning in health care, the SDO programme wishes to commission a scoping study which will include:

- A literature review of existing research;
- Identification of emergency planning research within health and non-health sectors within the UK and other countries;
- Highlighting gaps in the existing evidence base;
- Engaging with relevant stakeholders to identify issues of practice and policy relevance and where further evidence is needed;
- Ensuring the review is relevant to the current UK context;
- Recommending themes for further research.

Application process

Applicants are asked to submit full proposals for the above call by **1pm on Wednesday 23 December 2009**. Please note that applications received after this deadline will not be considered. Applicants will be notified of the outcome of their application no later than the end of March 2010. The commissioning brief and application form are available on the NIHR SDO programme website at www.sdo.nihr.ac.uk/09_1005.html Please quote advert reference **HSJ08**.



NIGB

National Information Governance Board for Health and Social Care

PUBLIC MEETING

Thursday November 12th 2009 at the Central Hall Westminster,
Storey's Gate, London SW1H 9NH from 2.00pm until 4.00pm

You are invited to attend the second annual public meeting of the
National Information Governance Board for Health and Social Care.

The NIGB is a statutory advisory body reporting to the Secretary
of State for Health which provides advice, guidance and leadership
to promote improvements in information governance across health
and social care.

The NIGB Chair, Harry Cayton, and members of the Board will
describe the work of the NIGB and review its annual report.
Following this you can give your views on the Social Care Record
Guarantee which is being launched to services users and the public
at this meeting and also on NIGB guidance on requests to amend
care records which has recently undergone public consultation.

Attendance is free and anyone interested is welcome to attend

www.nigb.nhs.uk email: nigb@nhs.net



COMPETITION

Burnham's flawed regime will stifle commissioning ambitions

The row over NHS competition policy played out over the pages of this week's *HSJ* goes to the heart of Labour's leadership of the NHS.

On one hand, Paul Corrigan is an architect of Tony Blair's health reforms who sees competition from both inside and outside the state-owned sector as an essential driver of NHS service quality and efficiency.

On the other hand, health secretary Andy Burnham argues that the best way to achieve the scale of reform needed is to work to improve existing services. Competition from the independent sector will be a last resort to deal with the poorest services (see pages 12-13).

Mr Burnham's reasoning is flawed. He talks about taking the health service from good to great, but also argues that "where existing NHS services are delivering a good standard of care for patients, there is no need to look to the market".

This means that, where a good service exists, commissioners are barred from commissioning an even better one from another provider. Excellence is no longer the aim; good is good enough.

And under the new regime, patients will often be kept waiting for "good". Where a service is inadequate it is now deemed more important to keep the staff happy than to deliver a better service as soon as possible, so primary care trusts will have to provide at least two formal chances to improve before considering tendering.

This could take months – how many patients will have their care compromised in the meantime?

This 'if you don't succeed at first, try, try again' approach is spelt out in Mr Burnham's extraordinary letter to TUC general secretary Brendan Barber explaining the new rules (news, 22 October, page 7).

It says: "Only if there was insufficient improvement within a reasonable timescale, and the scale of underperformance was significant, would the PCT consider engaging with other potential providers."

'Where a good service exists, commissioners are barred from commissioning an even better one'

So much for the minister's pledge that "quality must always come first".

The role of the third sector should not be forgotten in all this. They have a great deal to offer the NHS in their deep understanding of the needs and desires of patients. They are exactly the organisations that can spark innovations which transform services, the management of long-term conditions being an obvious example. But they are not part of the NHS, so Mr Burnham's new policy will push them away.

The rule change demolishes the central pillar of world class commissioning – namely that

everything PCTs do must be geared to improving the patient's experience of NHS services and outcomes of care.

No amount of sophistry and spin can hide the fact that this guiding principle of the entire commissioning programme has been ditched.

If the Department of Health was to spell out the true implications of this change it would tell PCTs: "As long as services are deemed good enough, commissioners must stick with existing providers even if there is a service down the road offering to do a better job for less money."

As public finances tighten, managers are faced with trying to do much more with much less. There could not be a worse moment to choke off competition as a means to improve efficiency.

The secretary of state is reversing a central tenet of Labour's renewal of the NHS. He risks taking us back to a service focused on the needs of staff, not patients – the NHS we have been trying to leave behind. Managers and clinicians are far more ambitious than merely achieving "good". They want to provide the best possible services, working with existing teams, other NHS organisations and the private and third sectors – whatever mix of provision comes closest to delivering excellence.

The health secretary should leave local commissioners free to do what they believe is best for patients. ●

CONTACT THE NEWS DESK ON
020 7728 3757, hsjnews@emap.com

NHS recruitment feels the squeeze half of organisations plan to a

HSJ SURVEY

Finance directors reveal junior managers and administrators are most at risk

Sally Gainsbury
sally.gainsbury@emap.com

There has been a big jump in the number of NHS organisations planning to cut staff, an *HSJ* survey has revealed.

The magazine's quarterly survey of NHS finance directors shows the proportion planning staff cuts has increased from 11 per cent in June to 53 per cent at the start of October.

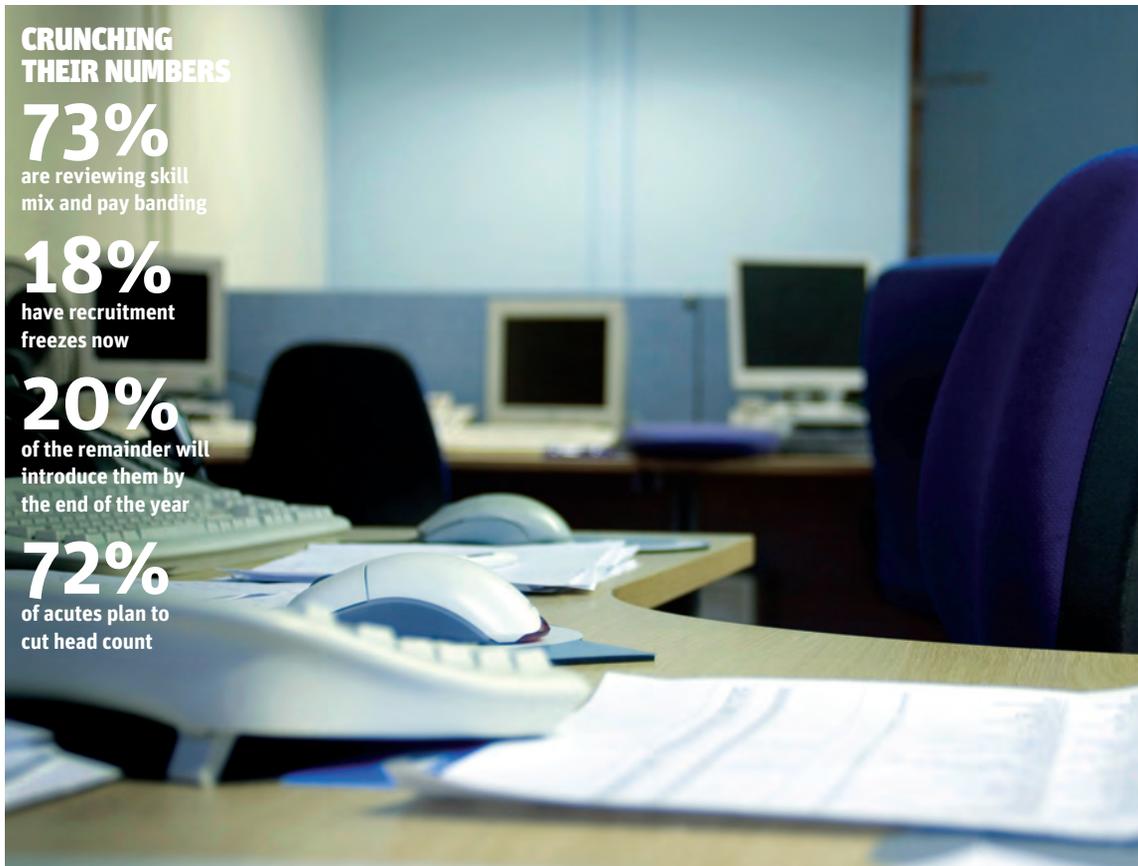
Headcount reductions are most common at acute trusts, where 72 per cent of finance directors say they are planning reductions.

The survey – which involves detailed telephone conversations with a panel of 45 finance directors from across the NHS – shows the most vulnerable staff groups are junior managers and administrators.

At the time of the first quarterly survey in June, 34 per cent of participants said they expected a “moderate” reduction in junior managers at their organisations and 37 per cent said they expected cuts in administrators. That has now increased to 45 per cent and 50 per cent of all respondents.

The single most vulnerable group of staff are administrators working in acute hospitals, where 72 per cent expect to make “moderate” reductions in administrative staffing.

The survey was conducted in the first nine days of October



CRUNCHING THEIR NUMBERS

73%
are reviewing skill mix and pay banding

18%
have recruitment freezes now

20%
of the remainder will introduce them by the end of the year

72%
of acutes plan to cut head count

and so coincided with shadow health secretary Andrew Lansley's pledge to cut NHS administration costs, chiefly at quangos, primary care trusts and strategic health authorities.

The increase in vulnerability for managers and administrators over the last three months has been balanced by a decrease in vulnerability for clinicians. In June over a quarter of participants said they expected to make cuts in their clinical workforce; that has reduced to fewer than one in 10.

But for all staff categories the biggest single response was for the numbers to remain unchanged – indicating provid-

ers would attempt to treat more patients but with the same number of staff.

The proportion of participants saying they had a recruitment freeze at present has increased threefold since June from just 6 per cent to 18 per cent. This is most significant in PCTs, of which just under a third say they now have a recruitment freeze in one or more parts of their organisation.

Of those without recruitment freezes at present, a fifth said they planned to introduce them later this financial year. Those plans are most focused on administrators at acute hospitals.

The survey also asked partici-

pants to compare their current financial outlook with their outlook last year.

PCTs were the least optimistic, with a third describing their financial outlook for this year as “substantially” worse than last year – a marked deterioration since June when just 6 per cent said this year was “substantially” worse than last.

By contrast just over a fifth of acute hospitals described their outlook as “moderately worse” than last year – an improvement since June when 46 per cent described their outlook as worse. But that optimism came before *HSJ* revealed the DH is considering capping the volume of

eeze as xe jobs

WHO WAS SURVEYED

The *HSJ* quarterly finance survey has been running since June this year. We have recruited an anonymous panel of 45 finance directors from a representative cross-section of NHS organisations. The panel members are interviewed on the phone by market research specialists Explomarket and except for minor changes and fine tuning, the questions in each survey are the same, allowing us to track changes and trends over time. The next survey will take place in January.

patients for which commissioners will be required to pay the full tariff under next year's payment by results regime (news, 22 October, page 4).

Foundation Trust Network director Sue Slipman said it was in "everyone's interest" that the system as a whole was kept in financial balance but it would be unfair to continue to block foundation trust involvement in demand management – for example by refusing to allow them to run community services.

"You cannot deny people the ability to manage demand and then penalise them if that fails to happen," she said.

Professor of health economics at York University Alan Maynard agreed, saying the last time a "two-part" tariff was used "allowing the hospital to get 50 per cent was really quite a good imbursement so the incentive to get things into the community was muted".

He said he would urge the DH to reduce the payment further, but it would be hard to apply that to elective procedures as well as emergency care because it would conflict with waiting list targets.

COMMISSIONING Health secretary says revamp will speed reform

Burnham stands ground after taking fire on competition rules

Richard Vize
richard.vize@emap.com

Health secretary Andy Burnham has insisted to *HSJ* that his rewriting of the competition rules will accelerate, not slow, the pace of NHS reform.

His remarks come as Paul Corrigan, who as Tony Blair's health adviser was one of the architects of competition in the NHS, calls on commissioners in an article in this week's issue to ignore the secretary of state's advice.

Mr Corrigan claims that rewriting the rules contradicts the world class commissioning framework, compels the recently formed co-operation and competition panel to be anti-competitive, interferes with local decision making, undermines the drive for better value for money and reneges on a central commitment in Labour's 2005 election manifesto.

The row has erupted after Mr Burnham used a recent speech to the King's Fund to ditch the policy of commissioning services from "any willing provider" in favour of making the NHS the preferred provider, and giving poor services ample opportunity to improve before they risk losing the work (news, page 7, 24 September, and page 7, 22 October).

Mr Burnham's policy has been criticised by former health secretary Alan Milburn (news, page 7, 1 October).

In an article for this week's *HSJ*, Mr Burnham says that delivering further service improvements means "winning the hearts and minds of public and staff that it is change they can believe in. It means change being led by staff rather than imposed from above. It is for precisely this reason that we will need to find more engaging, less polarising ways of mak-

ing change happen in the NHS than we have managed in the past".

He adds: "In essence, 'preferred provider' status amounts to a chance to improve to the new quality standards that will be required. Where existing NHS services are delivering a good standard of care for patients, there is no need to look to the market."

He wants any use of competition to focus on the worst services. By contrast, Professor Corrigan insists commissioners' sole objective should be "improving the health and healthcare of their population".

"Commissioners should decide to continue with this duty rather than follow the secretary of state," he argues.

Read Andy Burnham's defence of the new competition rules on pages 12-13 and Paul Corrigan's arguments for ignoring the secretary of state on pages 14-15



'We will need to find more engaging, less polarising ways of making change happen'
Andy Burnham



'Commissioners should decide to continue with this duty rather than follow the secretary of state'
Paul Corrigan

Consultant costs

The amount the NHS spends on external management consultancy will be published next summer. The Department of Health said it would announce its own spending and that of the NHS, after the Commons health committee called for annual information. The DH is working with the Management Consultancies Association on a code of conduct for firms' relationships with the NHS.

Personal budgets

Care services minister Phil Hope has announced consultations with primary care trusts to consider schemes for direct payment of personal health budgets. Talks are underway on how to evaluate pilots and method of payment. The power to make direct payments is in the Health Bill now before Parliament, and is expected to receive royal assent next month.

Age equality

Health secretary Andy Burnham has pledged age discrimination will be outlawed in the NHS and social care in Britain from 2012, following a review of the treatment of older people. Mr Burnham's predecessor Alan Johnson earlier this year asked NHS South West chief executive Sir Ian Carruthers to look at barriers facing the elderly.

Greener Scotland

Fresh targets for the NHS in Scotland's energy efficiency and greenhouse gas reduction are expected following the latest NHS carbon dioxide emissions study. The research, commissioned by Health Facilities Scotland and carried out by Arup and the Stockholm Environment Institute, revealed the service accounted for a quarter of the country's public sector CO2 emissions.

Bowel cancer care

The national bowel cancer audit has revealed improvements in patient care but large regional differences in treatment. Mortality for surgery has consistently improved but the percentage of patients undergoing major surgery requiring a colostomy bag ranged from 2.9 per cent to 66.7 per cent.

NHS EMPLOYERS Subscription package includes recruitment Outsourcing service 'will save NHS millions' on HR

Charlotte Santry
charlotte.santry@emap.com

NHS Employers is launching a subscription service it hopes will save the NHS "many millions" of pounds by outsourcing human resources functions.

Members signing up to an enhanced package will have their recruitment processes and criminal records bureau checks managed centrally by NHS Employers, carried out with the support of Capita.

Organisations would be able to save £150,000 for every £35,000 a year invested in the service and if lengthy recruitment processes were cut in half the NHS would save "many millions," said NHS Employers director Sian Thomas.

Additional services being developed include health and well-being products and training for healthcare assistants.

Ms Thomas said: "We're facing a difficult time for staff in the NHS and will have to focus



Sian Thomas: says millions can be saved in the recruitment process

on the well-being of the people who work for us. People need these products to help them as employers."

Thirteen organisations have already signed up to the service and NHS Employers is aiming to increase this to 200 by March. Products will be available to the NHS, social care organisations and the voluntary sector.

Ms Thomas said the changes may mean the NHS needs to

employ fewer HR staff. But she said it also meant HR professionals would be able to concentrate on adding value to organisations' workforce functions and supporting clinical services, without the burden of bureaucratic processes. She called the quality of HR departments in the NHS "very variable".

She said: "Every HR function has at least one example of good practice. What we're not very good at is spreading that around. We need to learn lessons from other sectors, even within the public sector, and embrace technology.

"People haven't had the money to go out and make the massive investment in support functions. It's difficult for small departments."

Initially, subscribers will have to sign up for three years. Organisations can also opt for a more basic service called "core membership", offering existing services such as pay and pension reviews.

PUBLIC HEALTH

Furious letter rescues stop smoking funding

Charlotte Santry
charlotte.santry@emap.com

The NHS will continue to fund the "most effective smoking cessation intervention in the UK" following a furious letter from dozens of public health bodies and royal colleges.

The 24 organisations, including the Faculty of Public Health and Royal College of Physicians, wrote to health secretary Andy Burnham last month expressing concern that the Department of Health was threatening to withdraw funding from No Smoking Day.

The letter, seen by *HSJ*, said the £250,000 grant was "essential to the continued existence of the charity".

It adds: "We believe No Smoking Day to be the most effective smoking cessation intervention in the UK, if not internationally."

Research showed it costs just £26 per life year saved, compared with £658 for combined



Popular appeal: the DH will not give up funding No Smoking Day

interventions involving nicotine replacement therapy, specialist cessation services and advice.

One in 10 smokers attempt to quit on No Smoking Day and almost 20 per cent are still not smoking two months later, the letter says.

Faculty of Public Health pres-

ident Alan Maryon-Davies told *HSJ* the NHS was focusing on alcohol, obesity, pandemic flu and global warming more than smoking.

Professor Mayon-Davies said: "The service is pushing smoking down the agenda even though it's the biggest avoidable killer and has a huge impact on health inequalities."

Cutting the funding would have sent the wrong signal to commissioners, he said.

He said: "It almost says we don't think smoking is as important as it was. That's very wrong and would be an own goal."

The DH has now confirmed it will fund No Smoking Day at "around the same level" as last year, on a regional basis.

As *HSJ* went to press all but one region had agreed to the funding. A DH spokeswoman said: "The funding for No Smoking Day 2010 is in place. We remain committed to improving public health and encouraging people to stop smoking."

DEFICIT PLAN SHA invites private and foundation trust tenders

Hinchingbrooke opens to bidding for franchise

Sally Gainsbury
sally.gainsbury@emap.com

East of England strategic health authority has advertised for a franchisee to take over deficit-hit Hinchingbrooke hospital.

The SHA said it may be prepared to pay a subsidy to keep the hospital running and has not ruled out incorporating community services into the franchisee's contract – which could make it more attractive to potential bidders.

Hinchingbrooke health care trust has an annual income of around £92m and an accumulated deficit of £39m. It made the decision to franchise out its management last year, after ruling out the options of a sale or service cuts.

The SHA this week formally asked for bidders to run the hospital under franchise for approximately seven years. Staff and

assets will stay in the NHS but the SHA is open to bids from either foundation trusts or private companies.

SHA director of strategy Stephen Dunn told *HSJ* bidders would be expected to increase the hospital's operating surplus but not to clear its debt in full over the franchise period.

He said the SHA would be willing to pay a subsidy over the NHS tariff rate if the mark-up was "competitively determined" through the tender process. He said the SHA would see that as "the price of maintaining the range of services" as it would not tolerate cuts to services.

Potential bidders are also interested in extending the franchise to community services, as profitability might be increased through vertical integration – for example by reducing bed days using "step down" facilities in the community, or by taking

over entire patient pathways to reduce admissions.

Asked whether community services could be included in the franchise, Mr Dunn said: "We are happy to enter into dialogue. We are keen to explore all proposals which will drive up quality, innovation and safety."

That could include a joint bid with a local community services provider arm, but any successful franchisee would need to be approved by the local commissioner, NHS Cambridgeshire.

The SHA will be looking for an annual franchise fee from the successful bidder, likely to comprise a fixed annual fee plus a variable element, based on a percentage of annual income.

The SHA will consider a one-off fee, but is mindful such bids could prove poorer value to the NHS as the franchisee would probably need to borrow the cash and incur interest payments.

AVON AND WILTSHIRE

Mediator to help reconcile FT row staff

Charlotte Santry
charlotte.santry@emap.com

A mediator has been called in to a bitter dispute between managers and clinicians at a trust applying for foundation status.

The row at Avon and Wiltshire Mental Health Partnership Trust was sparked after more than 100 clinical staff signed a letter saying the trust will never be able to fulfil the commitments set out in the next stage review without radical changes to its ethos and structure.

In particular, the clinicians want decisions to be more devolved and for managers to take more account of their views.

The letter was in response to a consultation that is part of the trust's bid for foundation status.

HSJ understands NHS South West chief executive Sir Ian Caruthers met consultants and nurses to discuss their concerns and consultant Neil Goodwin has been asked to step in to mediate.

HSJ has been told Mr Goodwin will meet the executive team before they and clinicians discuss the concerns together.

One of the letter's signatories told *HSJ*: "We have examples of care pathways being compromised by the management structure. We have to go right up to the top and down again and that's a very clumsy way of managing clinical situations."

A trust spokesman said: "We believe effective partnership working between management and clinicians is crucial and is why this is reflected in all our structures and lies at the heart of our business planning process."

"As part of our foundation trust consultation we received a submission from a number of Bristol clinicians. Their views on the involvement of clinicians and the requirement for patient-centred and clinically driven change are largely mirrored by those of the trust's board."

He said: "We are not prepared to comment on any confidential meeting which the trust may or may not hold."

An NHS South West spokeswoman said: "The strategic health authority works with and supports all trusts to drive forward improvements in services and care for their local populations."



Hounslow takes pride in polyclinic

NHS Hounslow is congratulating its Heart of Hounslow polyclinic (pictured) for a successful and locally popular first six months, with more than 2,000 patients now registered at the new GP practice and 11,000 people already having used its walk-in service.

JOINT FINANCE

Councils and NHS urged to drive joint funding

Councils and the NHS should examine how joint funding could help improve health and social care outcomes, according to an Audit Commission report.

Means to an End: joint financing across health and social care, published today, says instead of concentrating on the "mechanics" of joint financing and the "processes of partnership", councils and the NHS should look at how it can improve lives.

It advises them to review how they provide services and their financial frameworks. It also says the focus should be on outcomes for older people and those needing mental health and learning disability services.

Audit Commission chair Michael O'Higgins said: "Pooling funds can secure improved services for patients and those in need of social care, but often the actual financial arrange-

ments can become the focus of attention.

"Councils and the NHS can achieve better value for money this way [by joint financing], which should be an added incentive with the financial squeeze ahead," he added.

Later this year the Audit Commission will publish its first comprehensive area assessment, rating each area on the quality of all its public services.

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NIHR Service Delivery and Organisation programme



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Call for Research Proposals

The NIHR Service Delivery and Organisation (SDO) programme improves health outcomes for people by commissioning research evidence that improves practice in relation to the organisation and delivery of healthcare. It also builds research capability and capacity to carry out research amongst those who manage, organise and deliver services and to improve their understanding of the research literature and how to use research evidence.

NHS responses to financial pressures (Ref: 09/1006)

The NHS is facing severe funding constraints following years of substantial resource growth. For many NHS managers the period ahead will be the first time they experience financial 'austerity'. The SDO programme wishes to commission primary research that can report quickly, and provide useful and timely results. The programme is particularly interested in proposals for research into the following broad headings:

- ▶ variations in clinical practice including disinvestment and more effective use of interventions
- ▶ use of the NHS workforce
- ▶ service reconfiguration and redesign
- ▶ financial management in the NHS

Application process

Applicants are asked to submit outline proposals for the above call by **1pm on Wednesday 23 December 2009**. Please note that applications received after this deadline will not be considered. Applicants will be notified of the outcome of their outline application by end of February 2010. The commissioning brief and application form are available on the NIHR SDO programme website at **www.sdo.nihr.ac.uk/09_1006.html** Please quote advert reference **HSJ09**.

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NEWS, ANALYSIS + PRACTICAL ADVICE FOR HEALTHCARE PROFESSIONALS



COMMISSIONING Lansley sets out payment by results reforms

Tories pledge marginal pricing under PbR tariff

Steve Ford
steve.ford@emap.com

Shadow health secretary Andrew Lansley has promised the payment by results tariff would allow “marginal pricing” under a Conservative government.

Speaking last week at the NHS Alliance annual conference, Mr Lansley said he would reform payment by results so that it becomes a “powerful tool” for GP-led commissioning.

Mr Lansley said a range of changes was needed, including basing the tariff on the most efficient providers and aligning it with patient pathways as well as procedures.

It also needed to be a maximum price, not a uniform price. “If you get to February in the financial year and you have limited budget and the hospital has capacity, you want to be able to match limited budgeting capacity on marginal pricing – and at the moment you are frustrated because you can’t negotiate around the price.”

Mr Lansley told delegates the tariff needed to be “disaggregated” to stop trusts “taking the cream off the top by doing simple procedures that are relatively cheap”. It should be aggregated “back together again along the patient pathway” so that the tariff supported the development of integrated services, he said.

He told the primary care audience that GPs would have the freedom to draw up their own



Andrew Lansley said PbR would become a powerful tool for commissioning

contracts with providers, but there would also be standard contracts available.

“The burden of creating contracts for every referral was one of the things that wore down fundholding in the past. It is substantially different from that. I think we’ve learnt,” he said.

He added that he wanted GPs to have responsibility for commissioning services such as NHS Direct, out of hours and walk-in centres, which would be collated under the title of “urgent care” and would sit between primary care and emergency services.

Mr Lansley’s comments on payment by results follow health secretary Andy Burnham’s announcement last month that it would in future be tied more closely to quality and patient satisfaction (news, page 12, 24 September).

HSJ revealed last week that the DH is considering capping the number of patients that each hospital will be paid in full for treating in response to concerns that attempts to cut the tariff will be met with a surge in acute activity (news, page 4, 22 October).

CARE QUALITY COMMISSION

CQC will face some ‘tricky decisions’

Steve Ford
steve.ford@emap.com

The Care Quality Commission has some “tricky decisions” ahead on using its powers to shut down failing services, its chair has admitted.

The CQC has the power to suspend and ultimately close services that repeatedly fail to meet the quality requirements necessary to join its register, which trusts will be required to legally sign up to from April next year.

Speaking at the NHS Alliance annual conference in Manchester last week, CQC chair Barbara Young said: “If at the end of the day, in spite of all the improvement processes, the quality of service is seriously unacceptable, we will have to decide whether... as a last resort that service has got to be provided elsewhere and ultimately withdraw registration.

“We don’t think that ‘nuclear option’ is going to be used often because we want to be an improvement process. But at the end of the day there will be some services that just can’t make it,” she told delegates.

However, she said the “big tricky one” will be what to do about failing services that are located in the “middle of nowhere”, and which would be hard for vulnerable patient groups to reach if re-located elsewhere.

“There’s going to be some really tricky judgements for us,” she said.

In reply to a question from conference chair Phil Hammond, Baroness Young also said the regulator had received no guarantees that it would be immune to the Conservatives’ planned quango cuts.



Young: difficult judgements ahead

EUROPEAN UNION

DH to challenge Europe on overseas treatment

The Department of Health is preparing itself for a challenge through the European Court of Justice on the rights of UK citizens to be treated abroad at the NHS’s expense.

Draft guidance issued by the DH last week warns that a draft European Union directive on the internal EU market means NHS commissioners have “limited grounds” to refuse to reimburse UK citizens the cost of their care if they opt to have it elsewhere in the EU.

It says that in general, pri-

mary care trusts must reimburse the patient up to the NHS price of the treatment. It says that should include treatment carried out privately, but PCTs should not pay for care that would not have been provided by the NHS, such as certain cosmetic surgery.

But the guidance suggests the DH is gearing up for a battle as it will demand that patients wanting expensive or “hospital” treatment ask their PCT’s permission first.

Although the European Court

of Justice has ruled that a pre-authorisation requirement can be justified for “hospital care” it has not defined that.

Draft regulations from the DH define this as: services requiring at least one night’s stay; surgery – including dental surgery if under general anaesthetic; services using “specialised and cost intensive medical equipment” – particularly diagnostics; expensive and specialist services and any other services specified by the PCT or health secretary.

MICHAEL WHITE ON POLITICS



Rare indeed is a Sunday night call by this column which yields a mention of primary care trusts and ancient Greek philosopher cum intellectual hard man Plato, virtually in the same breath.

It happened this week, courtesy of Liberal Democrat MP John Pugh. I rang him because he caught my attention mid week. Just after a dull but cruel session of prime minister's questions (dour Gordon Brown bullied by Dave "Flashman" Cameron) the MP rose to introduce a Ten Minute Rule bill.

These bills, designed to draw attention to an issue, rarely become law and nowadays are rarely challenged unless they are particularly offensive or absurd. Pugh's Local Health Service and Democratic Involvement bill was neither.

In fact it was a slimline variant of

“Pugh proposes a trip wire to make PCTs responsive”

official Lib Dem policy, which is to solve the problem of unaccountable primary care trusts by creating elected health boards – unlikely to happen whoever wins on 6 May.

Pugh's starting point was that of an ex-councillor. Before being elected to succeed his colleague Ronnie Fearn as MP for Southport at the posh end of Merseyside, he was leader of local Sefton council. Both as a councillor and MP you get the chance to decide all sorts of things, he reminded the Commons. But local NHS decisions are not one of them – the “democratic deficit” is evident.

“These decisions are made by enlightened quangos or trusts, and they are usually a combination of medical experts and appointees who may – or may not – bring relevant expertise.” They have been “whisked humbly or smugly” into office by like-minded people, said Pugh.

Here we get to what lies behind the MP's outrage – and to Plato. In the mid-noughties, Southport and Formby hospital lost services to Ormskirk district general hospital within the trust they share, a familiar process all over Britain.

What struck Pugh was that no amount of petition and protest could save children's accident and

emergency. Successive governments and NHS managers “work on the mistaken assumption that the general public are too stupid to notice they are powerless”. Sops like community health councils and the patients advice and liaison service or local involvement networks are powerless, too.

“It all goes back to Plato's attack on democracy, the fundamental issue that people do not know what they are doing and will opt for popular but unworkable solutions,” explains Pugh – a philosopher by trade.

As such, ex-councillor Pugh realises that “if public opinion was asked if they want the NHS run by local authorities I know their answer” (ie, “no, thanks”). As for successive well meaning Commons bills he has worked on,

“ministers will offer people consultation; the one thing they never give them is power”.

So what his little bill proposes is a modest trip wire to make PCTs more responsive.

Councils are not perfect, but – unlike trust and primary care trust chairs – they usually stick around to take the consequences of bad traffic or planning decisions. Unlike bad PCT decisions they rarely kill anyone.

Pugh's bill would seek to bridge the current position and the ideal Lib Dem solution by requiring PCTs to lay their annual plans before the health scrutiny committee of the local council “for approval, agreement and amendment... a kind of democratic lock on the local NHS”.

There would be rows and the health secretary might have to arbitrate. All healthy stuff, says Pugh.

He has a point. By coincidence I noticed that during health question time his Lancashire colleague Paul Rowan was moaning about shortsighted closure of maternity units in Rochdale and Bury.

Michael White writes about politics for The Guardian.

APPRAISAL PROCESS

PCTs defend closer working with NICE

Sally Gainsbury
sally.gainsbury@emap.com

Primary care trusts and the National Institute for Health and Clinical Excellence have defended a £300,000 a year contract designed to help PCTs influence NICE appraisals.

The three-year contract means the agency Commissioning Support Appraisals Service will effectively represent all 152 PCTs in future NICE appraisals.

The new service was criticised in the *Daily Mail* last week, as a “sinister bid to reduce funding for life-saving drugs”. But NICE centre for health technology evaluation director Carole Longson said a dedicated agent representing PCT perspectives could have the opposite effect.

She said low PCT engagement in NICE appraisals had been “the issue” for some time and improvements in that could help PCTs “understand the process overall” and make it “easier to at least make the case for implementation”.

She said arguing the case had been “difficult when we haven't got NHS stakeholders. We do ask for them but they can't come forward”.

For each of its technology appraisals NICE asks two randomly selected PCTs to represent the commissioning view.

But Ms Longson said PCT stakeholders often had not engaged well in the process.

“That voice really hasn't been heard,” she said.

The lead commissioner for the new service is Birmingham East and North PCT. Chief operating officer Andrew Donald said PCTs had struggled to engage because of a lack of capacity and expertise. Having one central body would overcome that, he said.

He defended the £300,000 a year cost of the contract, which he claimed was the biggest collaborative procurement in the UK.

“A lot of money is spent on appeals which could be saved if we were there [as part of the approval process] in the first place. If you worked out the cost of appeals if we don't engage, it will pale into insignificance,” he said.

He agreed increased engagement from PCTs would enhance the “credibility” of NICE guidance, which could lead to greater compliance. He denied PCTs were trying to “lobby” to cut costs.

But he said PCTs should be providing NICE with information about the “consequence on other things” that approvals for certain high cost drugs and technologies could have.

PATIENT SAFETY

Close drug info gaps urges CQC

Clare Lomas
clare.lomas@emap.com

The Care Quality Commission has urged hospitals and GP practices to ensure they share “timely, complete” information on changes to patient medication.

A CQC survey, published on Tuesday, found information shared between GPs and hospitals when a patient moves between services is often “patchy, incomplete and not shared quickly enough”, increasing the risk of medication-related patient safety incidents.

The survey of 280 GP practices found almost a quarter are not systematically providing hospitals with information on previous drug reactions, and

more than one in 10 are not providing information on allergies when a patient is admitted to hospital.

Additionally, 81 per cent of the GP practices surveyed said details of prescribed medicines contained in hospital discharge summaries were incomplete or inaccurate “all of the time” or “most of the time”.

CQC chief executive Cynthia Bower said the NHS needed a “change of attitude” in recognising how important it is that clinicians “pass the baton smoothly between services”.

Effective management of medicines will be a requirement of trusts' registration with the CQC, which comes into force in April 2010.

FOUNDATION TRUSTS Tory calls for health committee probe

MP slams 'uncontested' FT governor elections

Charlotte Santry
charlotte.santry@emap.com

Foundation trust governing boards have been criticised by a Conservative member of the Commons health select committee as "self-selecting cliques", after figures revealed up to a third of elections for foundation trust governors are uncontested.

A parliamentary answer last week revealed one in five elections were uncontested in 2008-09, rising to 31 per cent of those for staff governors.

Conservative MP Peter Bone, whose question prompted the release of the data, said: "The reason so many are uncontested is they're carried out very quickly with little publicity."

Calling the bodies "self-selecting cliques", he said people had to register to vote and were not given enough time to nominate themselves as candidates.

There were 12,742 registered voters on average at each of the 115 foundation trusts. This is expected to rise by 12 per cent, to 14,267 in 2009-10.

On average, 27 per cent of registered electors who were members of the public turned out to vote, compared with 26 per cent of patients and 19 per cent of staff.

Mr Bone suggested elections should take place every four years alongside local elections to improve turnout.

He also said the matter war-

GUIDANCE ON FT GOVERNANCE POWERS

- Before governors remove a trust chair there should be a vote of no confidence, a period to investigate and consult, a written report and a second vote. The annual report should contain an explanation.

- Trusts should consider seeking governor approval before appointing a chief executive, to reduce delays after a decision has been taken.

- Consideration should be given to the level of training needed by governors on nominations committees.

- Governors should consider board directors' views on the qualifications, skills and experience required for chair positions.

Source: *Your Statutory Duties: a Reference Guide for NHS Foundation Trust Governors*, Monitor.

ranted investigation by the health committee.

"There's a number of [committee] members who are concerned about foundation trusts. We have some opportunity to bid for short investigations next year. That may be the way forward," he said.

Foundation Trust Network head of communications Saffron Cordery said: "The average figure hides the fact that in some FTs the votes are contested to a much higher degree."

More established foundations were likely to have embedded their governance processes and have better turnouts and more people standing as candidates, she said.

But she admitted the staff figures "stand out", saying this was because there were often existing structures through which employees could raise issues.

Health committee chair Kevin Barron (Labour) said it was important to remember governing bodies were in their infancy.

But he said: "We're looking at doing one-off evidence sessions before we get into the election and this is a subject we could look at in a bit more detail."

Members had already discussed calling ministers in to discuss foundation trusts, he said. Mr Barron also plans to use an upcoming debate to probe ministers on whether foundations should be told to put patient safety on their board agendas.

Foundation trust regulator Monitor declined to comment on the figures on uncontested elections. Last week it published guidance clarifying governors' statutory duties, including removing chairs and non-executive directors (see box).

HSJ's conference Fundamentals of NHS Governance is on 17 November. For details, visit www.emapconferences.co.uk/fundamentalsgovernance/

MEDIA WATCH



The Nintendo Wii Fit Plus has become the first computer game to be endorsed by the Department of Health, the papers trumpeted this week.

According to *The Times*, the DH has allowed Nintendo to use its Change4Life logo in its advertising and in shops. And from next year "it is possible that the logo will be used on the product itself in an unprecedented partnership with the government".

As the paper reveals, this is a reversal of the health campaign's relationship with the games console industry, after one of its earlier Change4Life adverts "featured two characters playing video games, suggesting this was something children should avoid".

But will the partnership extend to the two press offices? Guess which of these quotes in the *Daily Telegraph* version of the story was

'This is a reversal of Change4Life's relationship with the games console industry'

from a DH spokesperson, and which from the British spokesman for Nintendo.

1. "Active video games, where kids need to jump up and down or dance about as part of the game, are a great way to get kids moving."

2. "If you are worried about your bingo wings or your flabby bum, the game will give you specific exercises to target those areas."

Perhaps the partnership was prompted by the DH's success with its other computer game – I mean comprehensive information service, NHS Choices.

The *Financial Times* reported this week that after "a very slow start" over the last 18 months, the number of people using their right to choose private hospitals for their NHS treatment quadrupled from 2,100 a month in April last year to 8,400 this August.

And if sustained promotion and a tie-up with technology is enough to get people exercising their choice, no doubt the government is hoping the same approach will get people exercising their bingo wings.

Rebecca Evans

Young video artists jockey for acclaim

Trainers view a VJ performance which young people in contact with mental healthcare services created in a partnership project between Mersey care trust's early intervention team and Liverpool's Foundation for Art and Creative Technology, culminating in a presentation at the FACT centre.





Embrace new era of redesign to take NHS from good to great

Health secretary Andy Burnham explains the thinking behind his recent assertion that the NHS should be ‘our preferred provider’, setting it against a wider future of ‘re-engineered’ services – and a renewed sense of purpose among staff

The next decade in the NHS will look and feel very different from the one just ending.

Where once it was all about building up capacity and getting more people through the door, all thoughts are now on getting more for the public out of what we’ve got. So, an era of expansion is about to give way to an era of re-engineering.

It’s a very different challenge, and we need to recognise that doing it successfully will require a different approach. That means building on our reforms of the last 10 years, but refocusing them for the new times we are in. It means more choice, more empowerment, more autonomy for the frontline, better focused on the new challenges of a more preventative, more personalised and higher-quality NHS.

The scale of today’s challenge is no less daunting than the mountains that faced us in 1999. It’s possibly harder. But, far from approaching it with a gloomy outlook – or a sense that the good times are over – my argument is that this is the moment of greatest opportunity for the NHS. In recent speeches I have sought to expand this through three core points:

First, that rather than retrench or retreat, the NHS can make further progress in the next decade. It has gone from poor to good and, because of that, has put itself in a position to go from good to great.

For me that means two

things: a more preventative and more people-centred service.

Second, if we are to make that kind of progress possible – and release the savings to pay for it – there will need to be more reform, not less. Any suggestion that there can be a “go slow” on reform is straightforwardly wrong. But where there was much focus on organisational and process reform in the last decade, the next will have to see much more change in the shape of services on the ground. Any politician who spends the run-up to the election denying this point is not credible.

Radical redesign

And, third, while we need more reform, the kind of approach that takes you from good to great will need to be very different from that which took you from poor to good. Top-down efforts must give way to a bottom-up approach – principally led by empowered patients and engaged staff. It means taking patient choice further, such as our plan to abolish GP practice boundaries.

It also means making the radical mindset shift of linking payment to quality and patient satisfaction to get the focus where it needs to be.

What this all points to is the need for a radical redesign of services and patient pathways, as set out in the 2006 white paper *Our Health, Our Care, Our Say*, which was, arguably, a little before its time. That document

shows the route to the financially sustainable, high-quality and people-centred services the new era demands.

The last decade has essentially seen the expansion of the traditional hospital-based model of providing healthcare. Our collective challenge in the next decade is to re-engineer that traditional model.

That is essential if we are to realise the Darzi vision for a high-quality and preventative NHS. However, refashioning existing provision is also potentially a far harder task than bringing in additional capacity.

It means winning the hearts and minds of public and staff so that it is change they can believe in. It means change being led by staff rather than being imposed from above.

It is for this reason that we will need to find more engaging, less polarising ways of making change happen in the NHS than we have in the past. Clearer rules about managing change are needed so that everyone knows where they stand and what is expected of them.

Why does this matter? Because failure to find a better approach to reform could mean change doesn’t happen as quickly as it should, or that change is howled down by protest, and that would risk the NHS slipping back when it should be moving forward.

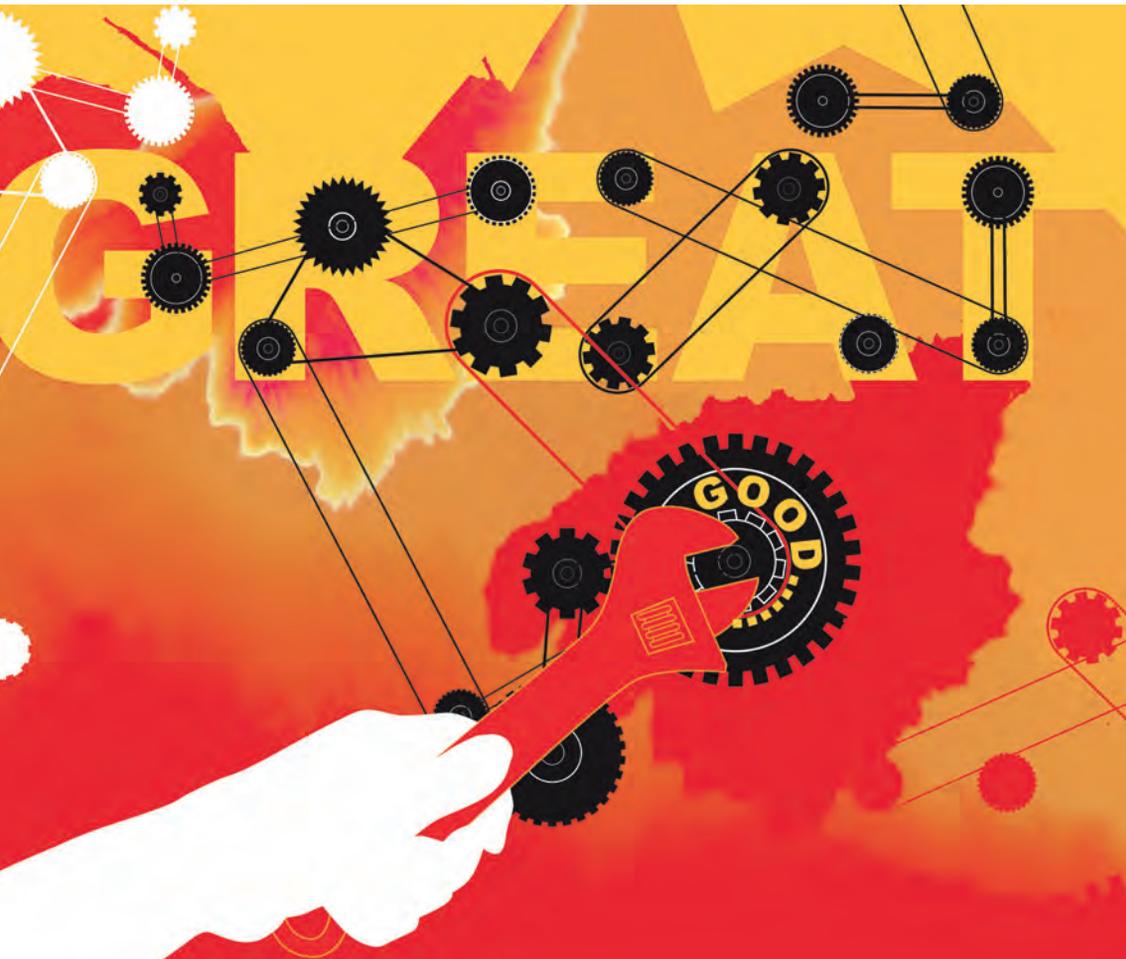
This is the context for why I have chosen to be clear that there are times when the “NHS

is our preferred provider”. We need clear rules through which services can be challenged or changed in a range of scenarios. This is necessary as we expect primary care trusts to challenge poor performance more, not less, in the coming period.

In essence, “preferred provider” status amounts to a chance to improve to the new quality standards that will be required. Where existing NHS services are delivering a good standard of care for patients, there is no need to look to the market. We need to remember that it matters to staff that they work for the NHS. Its values are inspiring and that brings an added public value.

For this reason, I do not believe it is sensible to be agnostic about provision: where it is good, the NHS should remain our preferred provider. This has always been the government’s guiding principle, but in this period of increasing change I think it is right to be absolutely straight about it.

But “preferred provider” doesn’t mean tolerating poor provision simply because it is NHS provision. In the end, it is quality that matters. If existing providers are failing – or if they can’t or won’t meet new standards – they should make way for those that can or in some cases be taken over. There should be a clear, staged process with a timetable for improvement leading to open tender. Where PCTs are commissioning new



‘Where it is good, the NHS should be our preferred provider’

services, or significantly redesigning existing services, then they will be expected to engage with a range of potential providers before deciding whether to issue an open tender. Where services are genuinely new we would expect an open tender on the “any willing provider” principle.

These decisions will be made locally and we will not choose to exclude either NHS or private providers on grounds of ideology – quality must always come first. If commissioners want to redesign services, those new demands should be clearly spelled out and the NHS, where there are good providers, given a chance to rise to the challenge.

Clever commissioning in my view does not needlessly destabilise good provision. But nor does it let poor provision drift on. The Care Quality Commission’s Annual Health

Check found many of the organisations ranked as weak last year received the same ranking this year. That is not acceptable.

Improvement journey

Our approach will mean more challenge, more improvement. Far from meaning less independent or third sector provision, we will focus the potential benefits of external providers where we need them most – on improving underperforming services and on bringing innovation, where they can, in new services such as the new GP-led health centres we are setting up.

I welcome the diverse provision we have in today’s NHS. The independent and voluntary sectors have an important role to play in helping us rise to the challenges of the new era. If we are serious about

‘If commissioners want to redesign services, the NHS should be given a chance to rise to the challenge’

quality and we challenge underperforming services in the ways I suggest, then it is possible that their role will increase rather than diminish.

The logic underpinning this approach is that re-engineering existing provision is a new and more difficult challenge for the NHS. Going from good to great will mean the NHS working harder to engage and empower staff in this improvement journey. It was possible to move services from poor to good with top-down levers. Greatness can’t be mandated.

Such is the scale of the productivity and efficiency challenge that building a sense of common purpose will be crucial. It is why I said in my recent speech to the King’s Fund that, alongside patient satisfaction, we should more systematically measure and publish staff satisfaction data.

This next decade in the NHS has the potential to be the most exciting in its history. For the first time it starts with a large budget close to the EU average, with the heavy lifting on waiting times behind it, and with the high-quality services that every professional aspires to provide within our reach.

The NHS can be a great service by 2019. But it means finding common purpose – firm ground under the consensus of the next stage review – and taking people with us on a challenging journey. ●



Why Burnham is wrong to rip up the competition rulebook

Health secretary Andy Burnham's rewriting of NHS competition rules undermines local decision making, conflicts with Labour's manifesto and could breach competition law, argues Paul Corrigan. He claims commissioners should ignore it

On 17 September, Andy Burnham entered what he called "the debate" on the role of competition in the NHS. He said: "Let me begin with where I stand in this debate. The NHS is our preferred provider."

In his speech to the King's Fund he went on to say that while "it is important for the commissioner to test whether these services provide best value and real quality", they should "provide an opportunity for existing providers to improve before opening up to new potential providers". He has now begun to clarify this personal preference through a letter to Brendan Barber, general secretary of the TUC.

What Mr Burnham will know is that over the last few years the NHS has moved from a single organisation with an individual at the top to a system which he and others are managing.

So while he may have a preference for one provider over another, it is also the case that commissioners have been given a clear duty to carry out their work with a single clear preference for the best patient outcomes. This duty overrides any preference they may have for one provider or another.

And within the system there are a range of reasons why commissioners should decide to continue with this duty rather than follow the secretary of state's individual preference.

First, commissioners have a clear duty to commission care

that improves the health of their populations. Of course, on many occasions commissioners will look at the best interest of patients and, as a direct result of this, commission care from an NHS provider. On some other occasions they may recognise a struggling provider is improving and needs to be given some time to improve. Often this is clearly in the interests of patients.

But there will be those times when their view of how to improve outcomes will lead to different actions. They may have the opportunity to bring in a new provider that will provide better services at better value. They will do that because it is in the best interest of patients.

Detrimental impact

If there was a clash between the health secretary issuing guidance about his preference for a particular kind of provider, the board of a primary care trust would be correct to interpret their duty as one of improving the health and healthcare of their population.

Second, in the same speech, Mr Burnham said he wanted to dismantle some of the old apparatus of top-down changes. Given this belief in local drivers for improvement he would not want to tell every commissioner how to make every decision about commissioning healthcare.

Most PCTs have taken the government policy of local commissioning for local people to heart. It would be strange for

a health secretary who argues for local decision making to then undermine that local process.

Third, denying commissioners the opportunity to make such a decision will also, on those occasions when they feel they have to go out to the market, have a detrimental impact on quality. The link between commissioning different providers to provide quality was made clear in one of the main announcements in Mr Burnham's speech.

He announced an intention to extend the quality element in the payment by results programme, suggesting an important extension of the tariff to add payment for quality. The aim will be to encourage improved outcomes by rewarding providers for better quality. Better providers will gain more commissions and less resource will go to those that are not so good.

This adds a new quality improvement element to the competition that already exists. Given this, it would be odd to expect commissioners to stop the competition.

The fourth issue concerns the independent providers that are now to be discriminated against. The government has spent time helping a new and larger third sector of providers to develop. They recognise this is a vital and growing part of our society. It provides services and organises social capital in new and exciting ways.

The third sector is already

looking to realise the increased opportunities in primary and community care. The Department of Health had many discussions with commissioners and third sector providers about how this market could flourish. Indeed the DH has spent public money on developing this area. But third sector organisations are not "the NHS" and therefore would, as far as Mr Burnham is concerned, not be "preferred" by him.

Legal dilemmas

Patients and the public deserve this choice and I am sure commissioners will want to go on providing them with that opportunity. Any guidance from the health secretary about his personal preference will not stop commissioners from using the third sector.

Fifth, there is the role of the cooperation and competition panel. Andy Burnham's predecessor, Alan Johnson, recognised the NHS would have to commission services working within competition law, so he set up the panel to provide guidance to commissioners and providers to keep on the right side of that law. It was there to show everyone that anti-competitive behaviour would not be allowed.

Apparently Mr Burnham is now looking at changing the rules the panel works to. If these are amended to enforce the preferred provider policy, the panel will be enforcing anti-competitive behaviour. Under



‘Commissioners have a clear duty to commission care that improves the health of their populations’

these circumstances an organisation that was set up to protect the NHS from the application of competition law would have become anti-competitive. Commissioners would then have to make their own judgements about whether their actions were legal.

Sixth, the day before this speech the DH published its world class commissioning assurance regime. Over the next few weeks every PCT in the country will be judged against its capacity to deliver on these competencies.

Several of the competencies demand that PCTs are able to make markets, intervene in them and procure health services to create the best value for money. For example, competency seven says PCTs need to stimulate markets and “the benefits of changing providers”. Competency nine on

procurement says that PCTs should have contracts with defined break clauses.

World class commissioning does not say PCTs should tender everything all the time. It does say they should have the opportunity and the skill to do this when they think it is right for the health and healthcare of their population.

Weapon of competition

PCTs’ success in meeting these competencies will be judged on a four-point scale. If PCTs follow the health secretary’s provider preference they will all be at risk of getting the lowest grades on these competencies.

Apparently Mr Burnham wants to issue new world class commissioning assurance guidance that would in some way back up his provider preference. Does that mean he will tear up what was issued a

‘If rules are changed to enforce the preferred provider policy, the panel will be enforcing anti-competitive behaviour’

month ago and instead issue a set of guidance which gives high marks to PCTs that don’t create markets and that don’t procure? Or in fact is the new guidance going to have to wait for next year and therefore, for this year, PCTs will still be expected to make markets?

Seventh, the health secretary says he expects PCTs to improve value for money at a much faster rate. To achieve this they will need every possible lever of power and influence over the health system.

As a result, this is not the best time to deny the NHS the weapon of competition to drive up value for money.

PCTs have been working with these seven different policies to improve the outcomes they commission for patients. They should continue to follow that approach.

PCTs are non-political organisations. But, as part of the NHS, they could look to the manifesto the government was elected on. There they would find the policy people voted for said: “Whenever NHS patients need new capacity for their healthcare, we will ensure that is provided from whatever source.”

So both the electorate and commissioners place a preference for patients over that of any single provider. ●

Paul Corrigan is a management consultant and executive coach. See Resource Centre, pages 20-21

FEEDBACK

hsj.feedback@emap.com



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Out of hours focus

High quality out of hours GP services begin with commissioning decisions taken by primary care trusts.

Generally commissioners are presented with the option of a local, not-for-dividend service supported, influenced and fully staffed by local clinicians with an interest in local healthcare who are willing to undertake shifts at an appropriate rate, including the opportunity to superannuate those earnings.

There will be alternative proposals from providers intending to generate dividends for shareholders by offering rates which will mean recruiting clinicians who have little commitment to local health services, or who are brought in from overseas to fill shifts.

With the cost of clinical cover being 50-70 per cent of the costs of out of hours service provision, the savings and dividend opportunity is quite limited and comparable across providers.

There is still the same pool of GPs as there was before the GMS contract changes of 2004. Commissioners need to base decisions on the whole system costs arising from out of hours GP services, as any apparent savings are soon dwarfed by the costs of inappropriate hospital admittance, accident and emergency attendances and referrals to other urgent care services. Figures reported in *HSJ* comparing A&E attendances per 100,000 population to PCT spending on out of hours GP services make that point very well (news analysis, 8 October, page 12).

Primary care trusts can avoid being caught in the "save now, pay much more later" trap by taking more time to explore the philosophy of the competing providers, which is often "patient-focus versus dividend-focus" and manifested in commitment to employing local clinicians.

Mark Cockerton, chief executive, Herts Urgent Care (a community benefit society)



Unfair image

The cover of *HSJ*'s 8 October issue says: "Going nowhere – why can't PCTs sack underperforming GPs?" and the news analysis inside is headlined: "Clunky contracts raise questions on GP quality".

They both display a cartoon of an older, white, male GP surrounded by cobwebs.

This is highly offensive to older, white, male GPs and represents age, race and sex discrimination.

Would you have used a cartoon of a young, black or minority ethnic, female doctor? I think you would not have as it might have attracted allegations of discrimination.

Uinseann Padraig Og O hArgent, Friston, East Sussex

Staff survey sense

How can the annual staff survey be anonymous when today half my team received reminders to complete their questionnaires?

If the health secretary wants honest answers then the questionnaires have to be sent out without bar codes on them.

Also he has to accept some staff will not return them for a number of reasons, including just not having time for it on top of all the other paperwork his department demands of us. What would he rather nurses and other clinicians did, fill in his questionnaire or care for patients?

David Harding-Price, mental health nurse

'Is all of the work in collating and reporting information helpful?'

Audit overload

Audit Commission managing director of health Andy McKeon "struggles with the notion that real savings can be delivered without reducing the number of frontline staff, unless everyone takes a real terms cut for several years or we have indeed created a fantastically bloated bureaucracy" (*HSJ*, opinion, 22 October).

Perhaps he should reflect on the vast disparity between investment in health (doubled) and improvement (not commensurate); perhaps he should wonder whether the addition of layers of management help or hinder; indeed, is all of the work involved in collating and reporting information for the Department of Health, Audit Commission and others helpful?

Mr McKeon might be surprised to learn that tariffs create costs; and tariffs are only part of the problem. Adult care illustrates the dysfunctional bureaucracy across health and social care services.

Studying demand for care services reveals predictable volumes of need for routine things like bathing and feeding.

Yet when the progress of the demands is traced through the multiple agencies responsible for responding, what people experience is anything but routine.

They have serial assessments, with no one responsible for treating the whole person. The duplication represents massive waste, creates very long end-to-end times, confuses those in need, and many who need help deteriorate, raising costs. Each service provider gatekeeps, to protect its budgets; arguments about "care" versus "health" needs and whose budget should be used contribute to delays; services are often constrained by what has been "commissioned", meaning the service does not fit well with the need.

All this is exacerbated by reporting to the centre. Mr McKeon's people are part of the problem.

Professor John Seddon
www.thesystemsthinkingreview.co.uk

Tariff trade

I agree with *HSJ's* leader that simply reducing the tariff to drive down costs without putting a cap on activity would create a strong incentive for hospitals to trade their way out of financial difficulties by increasing activity or up-coding activity to higher price bands (22 October).

While this may seem like a drastic policy shift, we have seen



FTs can learn from FTSE companies

something similar when PCTs paid a differential tariff for non-elective admissions over a certain threshold. This proved useful for both PCTs and acute trusts budgeting.

'If PCTs are to manage demand as finances tighten, a stronger policy framework is needed'

If PCTs are to manage demand as finances tighten – something they try to do but are often frustrated in by the way the system is constructed – a stronger policy framework is required.

All organisations need to prepare for the financial challenges ahead and this is just one option floated that proposes how PCTs and trusts can work together to best plan services.
David Stout, director, PCT Network

FT-friendly FTSE

Mike Hay's view that foundation trusts should take note of the "perils of success" that beset Britain's largest FTSE companies (*HSJ*, resource centre, 22 October) is perceptive.

Clearly FTs can learn from the mistakes – and successes – of FTSE companies. The Foundation Trust Network set up the FT-FTSE Link project in 2006 as a "marriage bureau" to introduce individual FTs and FTSE companies so they could develop long term relationships and learn from each other.

We are now widening the scheme to open it to mutuals and co-operatives that hold many similar values to FTs as well as continuing to encourage dialogue, mentoring and other forms of cross-fertilisation across a wide spectrum of enterprises.

Sue Slipman, director, Foundation Trust Network

READERS' RESPONSES ONLINE

A selection of comments readers have posted online.
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DH eyes patient cap for new tariff rules

The PCTs are currently unable to manage demand despite being penalised by having to pay for every patient. Local referrals are up by 8 per cent in some specialties despite assurances demand would be managed. If activity is capped to this year or, heaven forbid, last year, there will be no option but to refuse treatment to needy patients near year end.

GPs are already being paid incentives to lower referral rates with little success. Hospital conversion rates have not changed so it is not gaming that is bringing more patients through.

David Nicholson warns NHS of nightmare winter ahead

Talk is cheap. We need practical examples of how better planning can enable us to achieve all targets when we have a 20 per cent increase in demand for emergency care while 20 per cent of the staff are away either ill or caring for sick relatives. If we can do that we should have no problem in reducing costs with no ill effects to the frontline service, when the flu has gone.

Minority of NHS boards put targets before quality, says DH

Of course the Commons health committee is going to claim that this is a minority of health boards. To admit the widespread response to targets has been to game the statistics would be to accept the approach it has taken over the last decade has been wrong – to admit it has failed because it did not question the methodology used.

Whenever questions about flawed methodology and flawed management thinking arise, the health committees and government immediately argue this is a minority and then go on to claim vast improvements in other areas.

To question their own methods is to open the floodgates of doubt.

What if the methods were wrong? What if targets, scoring and money linking to league tables actually damaged organisations? What happens if standards instead of continuous improvement were the wrong thing to do?

NHS managers' career progress barred by prejudices, confidential study finds

Given the recent discussion about pensions, what about the other unmentioned barrier – age? What are your chances of being promoted once you have peaked in your early to mid fifties? How much talent are we wasting by assuming older people can't be dynamic and innovative and therefore are not worth promoting? Anyway, they will all get cleared out at the next re-organisation, won't they?

Community contraception clinics grow in popularity

The teenage pregnancy strategy has been going for over 10 years now. Data always seems to be taken from 1998, the peak after the pill scare of October 1995 that pushed up rates for several years. But the teenage pregnancy strategy did not spend any money until April 2000, and posts were not filled to 2001. If you take from the 2001 data the teenage pregnancy strategy has not had any impact at all.

And the significance of a few more patients going to community contraception clinics?... None. There is no evidence that better access to community clinics reduces teenage pregnancy rates...

Alcohol admissions could hit one million a year

Misuse of alcohol is a huge problem in the UK, and it's getting worse. The Government and Political Parties are continuing to run away from producing policies which will tackle it. This is in part due to the influence of the multi-billion pound alcohol industry, which is behaving in the same way that the smoking industry did in the past.

These are uncertain times.

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Simon Carter- Urologist- Imperial College NHS Trust

"Videoconferenced clinical meetings have proven challenging for cancer teams. However this solution has transformed the way we hold these meetings in North West London"
Fiona Bonas – North West London Cancer Network Director

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**STEVE PRESTON
ON PERSONALITY
PROFILING**



A personality profile delivers a remarkable insight into you, your characteristics and your communication style. A personality profile gives the opportunity to know who you are, what you can offer and, most importantly, how your managers and your team perceive you.

Personality profiles often show that people are using behaviours they are not comfortable with. This leaves them unfulfilled and stressed as they are most likely in the wrong job or the wrong career.

The DISC personality system, developed by William Moulton Marston, is the universal language of behaviour. People with similar personality profile styles tend to exhibit specific behavioural characteristics. DISC stands for four personality styles. All people share these four styles in varying degrees of intensity:

- D (Driver, dominant)
- I (Influencing, inspiring)
- S (Steady, stable)
- C (Correct, compliant)

The DISC profiling highlights how you appear to other people, how you cope under pressure and how you see yourself.

The results of the DISC profile report are designed to provide insights and strategies for interpersonal success through more effective communication, understanding and tolerance.

Understanding personality types is helpful for appreciating that while people are different everyone has a value, special strengths and qualities. Also, understanding behavioural styles benefits personal and professional relationships by improving communication skills and reducing conflict.

Examples are:

- Driver

General characteristics: direct,

decisive, strong ego, problem solver, risk taker, self starter. Motivated by: new challenges, power and authority to take risks and make decisions, freedom from routine and mundane tasks, changing environments in which to work and play.

Value to team: bottom-line organiser, places value on time, challenges the status quo, innovative.

Possible weaknesses: oversteps authority, argumentative attitude, dislikes routine, attempts too much at once.

Greatest Fear: being taken advantage of.

Profiles often show people using behaviour they are not comfortable with

● Compliant

General characteristics: accurate, analytical, conscientious, careful, fact-finder, precise, high standards, systematic.

Motivated by: standards of high quality, limited social interaction, detailed tasks, logical organisation of information.

Value to team: perspective: "the anchor of reality", conscientious and even-tempered, thorough to all activities, defines situation, gathers, criticises and tests information.

Possible weaknesses: needs clear-cut boundaries for actions/relationships, bound by procedures and methods, gets bogged down in details, prefers not to verbalise feelings, will give in rather than argue.

Greatest Fear: criticism.

Steve Preston is the director of SMP Solutions and a career development coach with Zenon Consulting.



ONE MINUTE REVIEW

The human touch of creative types

Meet a gallery of creative personas who we can imitate, says Julia Wells

The Ten Faces of Innovation

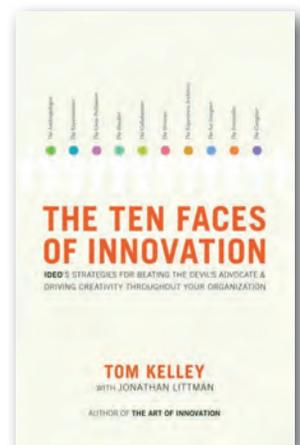


The Ten Faces of Innovation deals with how to foster creativity within your team. Written by Tom Kelley, founder of world renowned innovation company IDEO, the book is, in the words of its author, "about the human touch". It is about the roles people can play in innovation. Individuals need to adopt these personas at different times for different purposes. The 10 faces fall under three headings:

- Learning personas – described as the anthropologists, experimenters and cross pollinators. They understand the importance of looking outside the organisation, often to other industries.
- Organising personas – the hurdlers, adept at overcoming obstacles and the collaborator, whose skills bring people together. The director works with creative people and the sum ends up bigger than the individual parts.
- Building personas – like the experience architect, who "focuses relentlessly on creating remarkable customer experiences". The care giver sounds like a persona common in the health service, but it is not just about those who have this written in their job description – it is a skill that makes the patient or family feel that nothing is too much trouble in meeting their needs.

All roles contribute to a powerful mix that stimulates creativity and innovation. Tom Kelley is dismissive of "the devil's advocate", who often has only criticism and no fresh ideas. He suggests the 10 faces of innovation can combat such people before they have the chance to quash inspiration and ideas. ●

Julie Wells is an independent consultant, juliewells@transforminghealth.co.uk



The Ten Faces of Innovation: strategies for heightening creativity, Tom Kelley with Jonathan Littman, Allen and Unwin 2006

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Are you up to speed with the latest management thinking? If you would like to review management journals or books for *HSJ*, email your suggestions to hsjresourcecentre@emap.com



DECOMMISSIONING

Face the facts of changing needs

World class commissioning has to include deciding when current services no longer fit the bill. Helen Mooney looks at how to decommission services successfully

As Paul Corrigan, health adviser to former prime minister Tony Blair and most recently director of commissioning at NHS London, recently said: "You cannot have world class commissioning without world class decommissioning."

Notwithstanding the recent confusion over the health secretary's preference for NHS providers, primary care trusts should now be in the throes of decommissioning services so they can successfully become world class commissioners.

The government has tasked them with flexing their muscles to stimulate the market. It is a case of not if but when they will decommission some provider services. But this does not mean simply riding in roughshod, cutting back and dumping services, as has happened in the past.

To become a world class commissioner PCTs will be expected to exercise a collective intellectual approach to decommissioning. In some cases they may decide currently held contracts are no longer fit for purpose and tender for existing services. However, in many cases services will need to be retailored and redesigned to

ensure they are fit for purpose both now and for the future needs of their local populations.

A sophisticated approach will see PCTs working alongside service providers to jointly ensure that services are improved and are what their local communities both need and want.

Calm decision making

Getting the right services in place will also help PCTs to weather the financial storm in public services over the coming years. To do this now makes for calm decision making and more effective planning for the long term.

NHS Birmingham East and North chief operating officer Andrew Donald admits decommissioning is not easy. "We have to make sure we are forming explicit partnerships with providers and deciding what we need to stop doing and make sure that actually happens at the start of the process," he says.

Mr Donald says PCTs are constantly commissioning and decommissioning parts of services but to decommission services successfully a number of key things need to happen.

"PCTs need to have drawn up

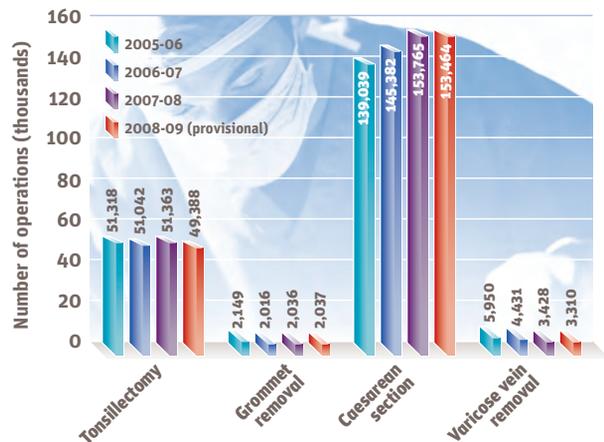
a strategic plan, which they have been obliged to do under world class commissioning; that strategy is the underpinning base to commissioning and decommissioning.

"They should be sharing that strategy with providers so it does not come as a surprise: you can't do it successfully without partnership and in communicating with providers you have to be explicit and have a robust business case and an outcomes analysis.



ACTIVITY ANALYSIS IS VITAL TO BUSINESS CASES

Finished consultant episodes



Source: hospital episode statistics, NHS Information Centre for health and social care



PUBLICISE YOUR ORGANISATION'S IDEAS

In the next few weeks we will be publishing articles on demystifying data, admission guidance for older people and effective use of assessment centres. If you would like to highlight your organisation's ideas and examples of best practice both in *HSJ* and at the online Resource Centre, email hsjresourcecentre@emap.com



Head in the sand: PCTs need to draw up strategic plans and share them with current providers so they are not surprised by decisions

10 TOP TIPS

- Understand the impact on the relevant provider of services and involve them in proposals at an early stage
- Engage the local population and service users in planning and ensure that the service is designed with them and with them in mind
- Develop a strategic plan for the PCT which incorporates proposals for decommissioning
- Engage and involve clinicians in the discussion – their support will be crucial
- Deal in fact – have a well developed financial and clinical case for your decision
- Consider whether it is possible to introduce new services to compensate for services that are being decommissioned
- Ensure that no sector of the provider market is given unfair advantage during the process
- Retain an auditable documentation trail regarding all key decisions
- Carry out an impact assessment to identify the anticipated or actual impacts of the change to services
- Ensure that reasonable timescales are determined and applied across the whole process

“And you have to consult and engage local people and service users on your proposals,” he explains.

In considering decommissioning PCTs must understand they need to describe the value of any new proposals to the public. They need to recognise the value of services provided outside of the traditional hospital setting and why the service will be better and they also need to ensure they have the full support of clinicians in making changes.

Mr Donald says strong commissioning and

decommissioning will ultimately move the NHS away from a “chaotic to a sophisticated managed system of care”.

The charity **Turning Point** provides social care services to local communities and contracts with a number of PCTs. Chief executive Lord Adebowale warns that too often decommissioning is confused with cutting services.

“PCTs have to understand the needs of the individual and where they live; unless they understand that they will procure the wrong things,” he says.

“To understand the needs of the community they must

engage with that community, they need to understand what they want from their point of view and build services they would use right down to the colour of the walls. Nine out of 10 times once they have done that they will have an end service which looks different and is cheaper to provide... slash and burn will not work.”

He continues: “PCTs need to ensure the client is at the centre of the debate and understand why what they are proposing is going to make the difference rather than already having the plan in place.” ●



HSJ's Commissioning 2010 and Disinvestment Masterclass events are being held in Birmingham on 18 and 19 March 2010. For details go to www.hsj.co.uk/conferences

STOP SMOKING SERVICES

Keep quitters winning

The last decade of stop smoking services has seen great progress in getting people to quit, but if that good work is to continue managers will need accurate, meaningful data about local populations and their habits

The NHS has rightly recently celebrated the success of its stop smoking services over the past 10 years. But new research from the London Health Observatory shows services are not targeting communities with the highest levels of smoking effectively because they lack crucial data – and to continue the good progress this needs to be addressed.

The Observatory's findings from the "London Boost" of the annual Health Survey for England show major contrasts in smoking rates between different local authorities and primary care trusts. For example, figures for 2006 show this ranges from 13 per cent in Ealing to 32 per cent in City and Hackney. And more routine and manual workers in London smoke than in any other socio-economic group. They also identified significant ethnic and gender differences in smoking which mean some communities are more at risk and need more help to quit smoking.

However, in the smoking cessation data the Observatory collected, 15 per cent of records did not have a specified ethnicity.

Poor recording

Observatory director Bobbie Jacobson says some of the stop smoking data is poorly and inconsistently recorded and managed.

"This results in major limitation in what we can learn about the delivery and effectiveness of smoking cessation services in London," says Dr Jacobson.

Observatory analysis found the 24 PCTs in the London sample were effectively targeting stop smoking services at the most deprived communities with high smoking rates. But the proportion of people quitting at four weeks was greatest in wealthier areas (52 per cent compared with 45 per cent in the most deprived areas).

Nearly one in five clients using London's services did not have a valid postcode, so there is no information on where service users actually live, rather than where they use a service. For example, London stop smoking clinics are often used by commuters who live outside the city. The rates also need to be based on the number of people smoking in a particular area, rather than the whole population. If this information were available it would be possible to calculate accurately the quit rates, and which communities are using stop smoking centres.

The four-week quit rate figures are impressive, between three and 11 per 1,000 of the adult population. However, this underestimates the true impact of smoking cessation services in London because not all adults smoke. Estimates of the size of the smoking population in the 24 London PCTs in this survey suggest that between 13 and 45 people per 1,000 smokers quit at four weeks. But the London Boost, the Observatory's own measure of smoking prevalence, shows the quit rate is higher at between 15 and 55 people per 1,000 smokers.

52%
Stop smoking service users quitting at four weeks in London's wealthier areas

45%
Stop smoking service users quitting at four weeks in London's most deprived areas

8%
Proportion of London stop smoking service clients who are recorded as still not smoking after one year

There is also little information tracking long term quit rates and the success of services – achieving long term quitting at one year was only recorded for 8 per cent of clients across London. The Observatory argues for better monitoring of stop smoking services with a follow-up a year after giving up.

However, several PCTs have demonstrated that long term follow-up is possible. **Redbridge** followed up 100 per cent of quitters and **Brent** 70 per cent, while **Ealing and Hounslow** monitored 59 per cent.

Data warehouse

Dr Jacobson says the creation of a pan-London stop smoking data warehouse "to support London's PCTs in monitoring London's stop smoking services could help to form the basis of better data and better informed, equitable commissioning".

She says: "Alongside the reporting of more meaningful nationally reported data, this could help us greatly to play our part in meeting the national inequalities target for reducing smoking."

The good news is the analysis has identified some important good practice which PCTs can share. A number of London PCTs are using effective approaches demonstrably targeting communities at risk.

NHS Islington takes a systematic approach to using data and intelligence to identify need, and believes starting from the client's perspective before developing initiatives. It uses a creative and proactive approach



SUPPORTING SELF CARE

HSJ's conference in London on 12 November tackles the practical side of embedding patient self-care in mainstream health services
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Resource Centre is online too. Log on to hsj.co.uk for practical advice from readers, and tell us about your own work as well
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TOP TIPS

- Value data quality – missing data means you can never fully know how effectively your services are in targeting those most in need
- Use the data to profile your client group against what you know about your local population
- Use the latest smoking prevalence estimates available for your area to find out how many of your smokers you are reaching
- Think long term: will those quitting at four weeks still be tobacco free in a year?
- Find out what others are doing to target hard to reach communities

with a focus on deprivation to target specific areas. For example, the PCT has commissioned local community based organisations to work with the Turkish and Somali communities, which are known to have high rates of smoking.

The Observatory's analysis shows that in south London, **NHS Sutton and Merton** targeted services effectively to school age smokers. This has resulted in a higher than average proportion of young smokers using local stop smoking services than in the rest of London (12 per cent compared with 2 per cent).

By working in partnership with local secondary schools in Merton the PCT is providing stop smoking support during school time. Its latest data (for 2007) shows it has achieved a 30 per cent four-week quit rate.

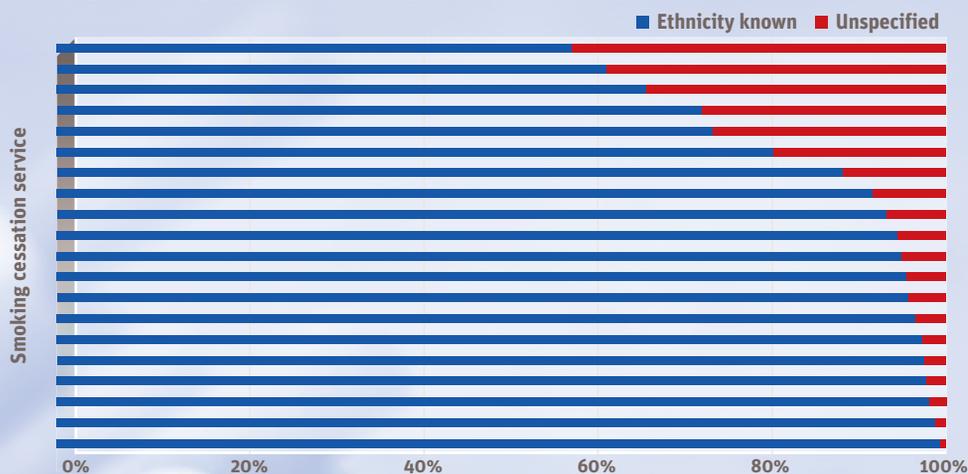
Dr Jacobson adds: "Our report demonstrates the benefit of analysing and assessing data from PCT stop smoking services. Better monitoring and targeting means better outcomes – and more people helped to quit." ●

FIND OUT MORE

London Health Observatory information and links on smoking
→ www.lho.org.uk/LHO_Topics/National_Lead_Areas/Smoking.aspx
NHS Sutton and Merton
→ www.suttonandmerton.nhs.uk
NHS Islington
→ www.smokefreeislington.nhs.uk

THE IMPORTANCE OF DATA IN PLANNING SERVICES

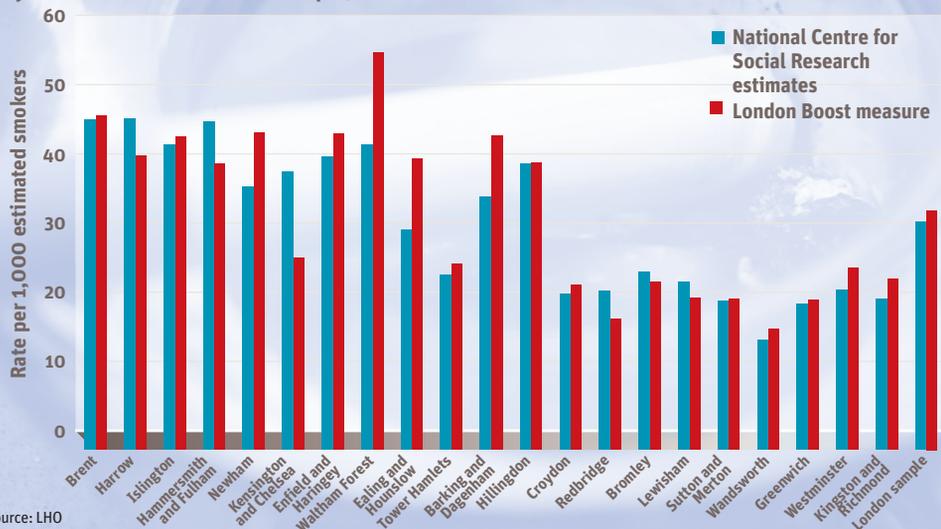
Recording of ethnicity by PCT stop smoking service. London sample, 2005-07



Access rate: number per 1,000 estimated smokers aged 16 years and over setting a quit date with a London service, by deprivation. London sample, 2005-07



Quit rate: number per 1,000 estimated smokers aged 16 years and over quitting at four weeks, by PCT of residence. London sample, 2005-07



Source: LHO

HUMAN RESOURCES

The momentum to drive change

Make sure your strategy is a success by getting management on board, say Diane Allsopp and Georgia McHardy

Your strategy is set. You have stretching goals and you want your managers to lead change and drive reform. How will you know if they have the “right stuff”? What support and development will they need along the way? Do they understand what will be expected of them and can they get there? Achieving measurable behavioural change is no mean feat.

Here we describe the model we used to successfully build momentum across four primary care trusts on Teesside.

Begin with the end in mind

Visualise your leaders of the future. Will they need to think more strategically, search for more innovative solutions, and motivate and inspire their teams within tighter financial constraints? Generate discussion and capture the behaviours they will need in a clear and meaningful framework that describes “what good looks like”.

Get senior level endorsement for your development programme

Without this, participants may fail to appreciate the value or misunderstand its importance. Having agreed who will go through it and having gained commitment from the executive team, involve a board level director or even your chief executive in making a statement of introduction either in person, via video or by letter.

Provide a baseline assessment for managers

Examine their strengths and development gaps against your leadership framework. A tailored

development centre will provide them with valuable feedback on where to concentrate their effort in the future.

Asking your most senior staff to go through an assessment process for development can be a daunting prospect, but not only will they gain a clearer picture of themselves against your framework, the organisation can also benefit from an analysis of common themes to inform succession plans and decision making on development budget spend.

Create a safe, constructive environment

Providing participants with a stretching challenge with this protection will allow them to have frank and honest conversations about their leadership potential and style. They should emerge with a realistic, dynamic development plan and feel empowered to achieve it.

If you outsource the design and delivery of this part of the process, select a partner with a track record in senior level assessment and with experience across a number of sectors, not just the NHS.

They need to quickly understand the complexity of your organisation, win over cynical participants and create a programme to dovetail with other existing HR processes.

Secure line manager engagement

Without this element, your aims and objectives may not be realised. At the outset, brief line managers on the purpose of the development centres and on



Fly the flag for your strategy

what their direct reports will gain. Explain their role and responsibilities and make a follow-up meeting between participants and their managers’ part of the process. Encourage regular dialogue on progress and offer “refocusing sessions” to challenge participants to stay on track. **Communicate openly and honestly** Prospective participants need to understand how the development centre relates to organisational strategy and how it will benefit them. Set the programme in context and explain how the development centre will work. Be upfront and totally honest about the boundaries of confidentiality and how the data generated by assessment will be used. There should be no hidden agendas.

As the numbers taking part and working on their development plans grow, behavioural change will reach a “tipping point” and momentum toward leadership that will deliver your strategy will be under way. ●

Diane Allsopp and Georgia McHardy are consultants at Wickland Westcott.

CASE STUDY: TEESIDE

Galvanised by a desire to achieve world class commissioning standards, Hartlepool, Redcar and Cleveland, Middlesbrough and Stockton-on-Tees primary care trusts gave high priority to developing leadership.

They developed a new set of leadership and management attributes and commissioned a baseline assessment for assistant directors and senior managers against this new framework.

Participants were assured that data about individuals would not be shared with the organisation; only common themes would be reported. But participants agreed to share the details of their assessment with their managers.

Consultants met people one on one and took them through exercises and psychometric questionnaires. They received feedback and development reports to take back for discussion with their managers. In addition, key themes were summarised, which enabled the PCTs to focus on the issues that will have the most impact on the organisation as a whole.



LEGAL

Money back guarantee

Daniel Purcell explains how to recover losses as part of a counter-fraud strategy

The NHS Counter Fraud Service has transformed fraud response and prevention in the NHS. In measuring and minimising exposure to fraud, NHS bodies have achieved a remarkable success rate with criminal convictions, they have identified and removed fraudulent employees and contractors, they have “designed out” some patterns of fraud and they have increased stakeholder confidence, through media coverage, engagement and, occasionally, investigations.

However, the greatest challenge is sometimes in recovering the financial loss.

Objectives of fraud response

An NHS body that uncovers fraud is likely to identify two principal strategic objectives:

- recovering the sums of money fraudulently obtained;
- preventing a recurrence, both by this fraudster and through deterrence of others.

Criminal or professional disciplinary proceedings deliver a strong deterrent message, and a criminal prosecution can lead to recovery of part or all of the sums lost. However, this may not happen in every case, either because no prosecution is brought, or because it relies on a small number of sample cases, or because the court does not award compensation.

Therefore, civil recovery can be a key weapon in promptly recovering losses, and delivering a clear message that fraud will not pay.

Tactical benefits

Civil litigation offers key tactical advantages in fraud response:

Dishonesty Critically, unlike criminal and professional disciplinary proceedings

concerning fraud, it is not always necessary to demonstrate “dishonesty”, or a guilty state of mind, to prove a claim. Often, a straightforward breach of contract can be enough to entitle an NHS body to recover losses.

Freezing injunctions Where there is evidence of a strong claim and a risk of assets being hidden or disposed of, a court will order a suspected fraudster to disclose their assets, and prevent them (and third parties, such as banks) disposing of assets up to the value of the fraud. This order is obtained at the outset of proceedings – without the knowledge of the fraudster – so denying them time to conceal their assets. This order gives some security to the NHS body, increases the pressure on a fraudster to settle the claim, and sends a clear deterrent message.

Disclosure There are a number of ways to make disclosure orders requiring information and documents to be provided in response to fraud, such as:

- through a court order, before proceedings have started, where this will help to determine whether a claim can or cannot be made, and against whom

‘A freezing injunction denies fraudsters the chance to dispose of their assets’

- against third parties, where it will help identify whether fraud has occurred, and if so by whom;
 - against the defendant, requiring disclosure of material undermining their case during the course of the litigation.
- Settlement** Court rules can be used to increase the risk of high costs for the fraudster, and so the pressure to repay the NHS promptly and without the cost and delay of a full trial.

Parallel sanctions

Civil proceedings can be used as part of an overall strategy of “parallel sanctions”.

Criminal proceedings There is no rule that says civil proceedings must automatically stop when a criminal investigation or prosecution is under way. Although care must be taken to avoid “tipping off” a fraudster,

civil proceedings can go ahead alongside criminal proceedings. The higher “standard of proof” in criminal cases means that a successful civil claim can be made even where there is no prosecution. A civil claim can often be resolved more quickly.

Contract enforcement NHS bodies can prevent repeat fraud by an individual perpetrator, where they are a contractor or service provider, by terminating their contract or registration. Primary care performers can also be prevented from obtaining contracts with other bodies.

Regulatory action Professional disciplinary bodies can “strike off” those who defraud the NHS, even where no criminal conviction is obtained, which can be a powerful deterrent in parallel with a civil claim.

Funding

Litigation is often seen as a last resort for NHS bodies, due to the costs it might face. The risk can be managed in a number of ways, including:

Planning and management Early evaluation, strategy formulation and budgeting can ensure that litigation remains on track and within projected costs.

Conditional fee agreements The NHS can enter into contracts with its solicitors under which fees are either discounted or deferred pending a successful outcome, in which case the defendant is liable for the costs.

ATE cover NHS bodies can take out insurance against liability for an opponent’s costs, for which the premium is recoverable from the defendant at the conclusion of the case, if successful. ● *Daniel Purcell is a partner in Capsticks and leads the firm’s commercial dispute resolution and fraud practice areas.*



Paper chase: disclosure orders force fraudsters to expose damning files

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SALARY BAND 9 & HIGHER: 27

Chief Executive	27
Director of Finance and Productivity Improvement	28
Deputy Chief Executive	28
Medical Director	29
Chief Operating Officer	29
Director of Nursing	29
Head of Psychology and Psychological Therapies	30
Senior Management Consultant in Healthcare	30

General Manager – Unscheduled Care	30
Director of Public Health	31
Director of Finance and Deputy Chief Executive	31
Director of Finance	32
Deputy Director Of Public Health	32

SALARY BAND 8: 32

Funding Partners	32
Consultant in Public Health (Public Health Strategy)	33
Team Leader	33

Patient Access Manager Corporate Management	33
Management Accountant	34
Associate Director of Finance	34
Chief Operating Officer	34
Walk-in Health Centre Manager	35
Market Development Manager	35

TRAINING & CONFERENCES 35

TENDERS 36

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news

Chief Executive

Medway 
NHS Foundation Trust

Competitive salary

Gillingham, Kent

Medway NHS Foundation Trust is a well regarded provider of acute care to the population of Kent. Employing approximately 3,700 staff and with a turnover in excess of £210 million, the Trust is a major critical care centre and provides a range of sub-speciality services to the population of the Medway Towns, Swale and wider Kent. Following on from a Chief Executive who has taken the Trust from a zero star rated organisation to a Foundation Trust over a 7 year period, we are now looking to appoint a new Chief Executive to orchestrate the next chapter of our on-going development.

Achieving authorisation as a Foundation Trust in April 2008, we are keen to make the most of our freedoms where these can aid developing our long term strategic vision. Working closely with our governors and members you will ensure that the Trust is responsive to the local community and provides healthcare which is second to none. We have ambitious plans to significantly progress the patient safety agenda which saw us win the CHKS patient safety award for most improved hospital earlier this year. We are looking for a dynamic leader to drive through sustainable change, during what we know, will be financially turbulent times.

We are committed to making sustained improvements in patient experience and further improving our patient's perception of the hospital so that we are seen as a provider of choice. We aim to reinvest our planned surpluses into a significant estates strategy which will see 50% of our patients treated in en-suite rooms with state of the art facilities.

The Role

- Support the Chairman and Trust Board in creating a vision and setting strategic direction, whilst ensuring the balance between strategic thinking and execution, ensuring that the Trust fulfils its statutory and legislative responsibilities
- Use your skills and insight to make the most of our Foundation Trust freedoms for the benefits of our patients
- Provide inspirational leadership and guidance to a highly committed executive team, integrating new appointments with highly experienced executives
- Maximise impact on the culture of our organisation ensuring it is governance focused and committed to excellent patient care

Your Credentials

- An excellent track record of success at CEO or senior director level, working in an organisation of relevant size and stature, where comparisons with our Trust can be made. Consideration will be given to candidates not currently working in Healthcare
- Proven experience in developing and delivering creative strategies to improve the patient/customer experience and have the ability to translate strategic thinking into operational reality
- An inspirational leader, who believes in creating a culture where an excellent employee experience, leads to an excellent patient experience
- A thorough understanding of the challenges facing NHS Foundation Trusts, and a natural passion for improving the services received by patients
- Resilient, relish significant personal and organisational challenge and be prepared to take calculated risks

This is a unique opportunity to join a vibrant Foundation Trust working with an outstanding group of clinical and managerial colleagues.

For further information, please visit our microsite at
www.harveynash.com/medway

For a confidential discussion, please contact Frank McKenna, Director, NHS & Healthcare on +44 (0)20 7333 1577 or Chris Davies, Senior Consultant on +44 (0)20 7333 1555. Please email your CV and covering letter to: pippa.hogg@harveynash.com or write to Harvey Nash plc, 13 Bruton Street, London W1J 6QA quoting reference number HN5312HSJ. Closing date is 5pm Friday 20th November 2009. Harvey Nash is a global executive search consultancy.

Complying with the BERR: We are an Employment Agency.

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SALARY BAND 9 & HIGHER

hsjobs.com

No Ordinary Trust, No Ordinary Challenge

Director of Finance and Productivity Improvement

VSM – Competitive salary



Barking and Dagenham

NHS Barking and Dagenham serves a population of approximately 170,000 and we recently became the first "Commissioning Only" PCT in London having externalised our Provider Services. We are on a journey to become a truly world class commissioner and we are now seeking a dynamic and exceptional individual to build on our recent successes by maximising the PCT's finances and lead on the delivery of our Productivity, Efficiency and Transformation programme.

The process of preparing and participating in the last World Class Commissioning assurance process has had a significant impact on raising our ambition and sense of urgency for improvement and further success. With a track record of delivering, NHS Barking and Dagenham enjoy a high level of the support from our partners. We are acknowledged externally as an organisation which is 'very well run' and much of our work is recognised as both innovative and good practice.

You will provide executive level leadership on investment and ensure that the PCT achieves its financial target. A key part of your role will be to advise the Board on the implementation of national and regional initiatives which stimulates best practice and value for money.

With a successful track record of delivering financial and wider organisational priorities, you will have the ability to think strategically whilst also delivering the outcomes that we seek.

If you would like an informal discussion regarding the role, please contact Stephen Langford, Interim Chief Executive, NHS Barking and Dagenham on 020 8532 6346.

Application packs can be accessed via www.jobs.nhs.uk quoting reference number 523-437-MQ.

Closing date: 13 November 2009.

We offer a wide range of family friendly policies, career development opportunities and many other benefits. NHS Barking and Dagenham is committed and working towards equality in employment and service delivery.



H42403B9



Herefordshire

Someday, all partnerships will look like this

Deputy Chief Executive

To £130,000, Hereford

The partnership between Herefordshire Council and NHS Herefordshire was groundbreaking when it began two years ago. The joint Chief Executive and senior management team have a strong shared focus on delivering the best outcomes for their customers – the people of Herefordshire.

The partnership continues to develop and has been host to many visitors who are hoping to make a similar transformation. As Deputy Chief Executive you will be responsible for the effective delivery of efficient corporate services, supporting the Chief Executive in maintaining the partnership relationships – including the wider work across the LSP – and ensuring that governance is effective.

We are looking for someone who shares our vision and is able to organise public services around 'Place'. You'll need to be resilient, sophisticated around some of the political issues and able to see deliverable outcomes from complex beginnings. Most importantly, you will bring significant senior experience of public services with the ability to work effectively across the entire partnership.

To find out more about life in Herefordshire and the opportunity to set the path for others, contact **Jemma McPherson** on 0121 644 5714 or **David Slatter** on 0121 644 5704 at our recruitment partners GatenbySanderson or visit www.developingherefordshire.com

Closing date: 16th November 2009.

GatenbySanderson
www.gatenbysanderson.com



H42301B9



It's not just the spectacular scenery you'll get.
Challenge. Change. Opportunity.

Attractive six figure salaries

The Royal Cornwall Hospitals NHS Trust provides acute care services across the county of Cornwall. With a budget of over £290m and a workforce of 5,000 strong, the Trust provides services from three sites. It is also a teaching Hospital with links to the Peninsula Medical School. Following the recruitment of Peter Colclough as Chief Executive, the Trust is ambitious for its future and is focused on delivering its strategy for the provision of leading edge patient-centred services. Three exceptional leaders are now sought to join the Executive team bringing commitment, passion and the capability to deliver against the organisation's challenging agenda.

Chief Operating Officer

- An innovative, dynamic leader who will provide visible, effective leadership across all sites and directorates to ensure the efficient delivery of all operational services.
- An individual with considerable experience of managing service change and a track record of improving organisational performance, able to ensure high standards of care, efficiency and a clear customer focus. **Ref CAG/30220**

To apply, please visit www.odgers.com/30220

Closing date for applications is Monday 23rd November 2009.

Medical Director

- An individual of stature with demonstrable political skills and a strong commitment to patient-centred care who will ensure the highest standards of clinical governance throughout the Trust.
- Experience gained as a Medical/Clinical Director with the ability to work collegiately to add value at a corporate and strategic level. **Ref CAG/30221**

To apply, please visit www.odgers.com/30221

Director of Nursing

- Experienced and respected Director of Nursing with a strong track record of change management and performance improvement, who will provide clinical and strategic leadership and advice on all matters of nursing practice and other professional development.
- An inspiring and motivational leader who will act as a role model for the nursing and other health professional staff across the organisation, developing professional standards and best practice as part of a robust clinical governance framework. **Ref CAG/30222**

To apply, please visit www.odgers.com/30222

Royal Cornwall Hospitals 
NHS Trust

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London W1S 1JJ
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H42406B9



Dudley and Walsall 

Mental Health Partnerships NHS Trust

Head of Psychology and Psychological Therapies

Band 9 £75,383 to £95,333

This position is a unique role within Dudley and Walsall Mental Health Partnership NHS Trust. It has been created to take responsibility for co-ordinating and bringing together both psychology and psychological therapies into a cohesive unit, providing support across the operational services of the trust.

In order to get the best out of this position we are looking for some who can "Think outside of the Box", and is innovative and visionary within their field and confident in their own ability to deliver.

A key objective of the position will be to increase clinical time, integrate the more effective usage of psychological therapies into a range of menu options of which staff can utilise when assessing and treating clients.

Are you

- Able to think outside of the box
- Innovative
- Visionary
- Experienced at service redesign
- Passionate about client care
- Striving to develop and achieve a centre of excellence within 12 months
- Able to deliver research which can be utilised and incorporated back into service provision

Closing date: 12.00 pm 16th November 2009.

Assessment Centre will be 1st December after which successful candidates will be invited back for interview on 2nd December 2009.

For an informal discussion please contact Amanda Rose, PA to Director of Operations and Nursing, on 01384 365708.

Please apply on line at
www.dwmh.nhs.uk/careers

This post will be subject to a Criminal Records Bureau Disclosure.

The Trust is committed to equal opportunities and is a no smoking organisation.

www.dwmh.nhs.uk



H42407B9



SENIOR MANAGEMENT CONSULTANT in HEALTHCARE

Manchester or London

Collinson Grant is a firm of management consultants that has worked in Healthcare – public and private – for over 20 years. We form stronger relationships with our influential clients than larger consultancies can. Some senior managers have been using us for more than twenty years.

Most of our work is about organisation, people and costs. We know how to design and install better business processes, to improve effectiveness, to set up new managerial controls, and to manage people. We are sensitive to the unique culture and demands of the Healthcare sector.

Our ambitions now demand another senior colleague with substantial working experience of acute hospitals. You are likely to have had experience as a senior manager in a large healthcare organisation, and to have worked as a management consultant in Healthcare.

Able to demonstrate a strong commercial acumen, you will have a sound academic record, and proven experience of introducing change and redesigning systems to improve the care of patients. Effective, collaborative, and highly credible at Board level, you will be able to challenge internal and external stakeholders constructively, and to form productive and durable relationships.

With us, you will be expected to lead projects, to shape opinion, and to make a difference. You will not be working in a corporate straightjacket.

If you are interested, please send your CV to Tony Green:
agreen@collinsongrant.com

Collinson Grant Healthcare Limited, Ryecroft, Aviary Road, Worsley,
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www.collinsongranthealthcare.com

H42603B9

Excellence is standard

General Manager – Unscheduled Care

**£63,833 - £79,031 (Band 8d)
plus competitive relocation package**

The Great Western Hospital is located in Swindon in the beautiful county of Wiltshire, with excellent access to London and the South West.

As a new progressive Foundation Trust we have more than 600 beds, a turnover of £193 million and we serve 340,000 people in our state-of-the-art hospital campus. We are looking for a talented General Manager to lead our Unscheduled Care Directorate to develop and deliver services built around patient and carer needs.

This means taking responsibility for the performance of a Directorate which includes Emergency Care, Acute Medicine, Cardiology and Medicine for the Elderly. This crucial role lies at the heart of our Trust with responsibility for managing multi-million pound budgets. The ideal candidate will combine operational delivery with service redesign.

You will be responsible for the development of our endoscopy project, second cardiac catheter lab and our newly established stroke service.

For an informal chat or to arrange an informal visit please contact our Interim General Manager on 01793 605275.

To apply online please visit our website www.gwh.nhs.uk

Closing date: 12 November 2009.

The interview date is scheduled for 4 December 2009.



The Great Western Hospitals 
NHS Foundation Trust

H42410B9



Director of Public Health



NHS Knowsley/Knowsley Council – joint appointment Circa £100,000 plus relocation



In Knowsley, we are committed to ensuring that in everything we do we are *improving people's lives*. One of the first places to have a jointly appointed Director of Public Health, the groundbreaking partnership between NHS Knowsley and Knowsley Council enables us to put the needs of our communities at the heart of everything we do. We have just won the Municipal Journal 'Reducing Health Inequalities Achievement' award for the third time in five years. The Award recognises our shared success in improving health and reducing health inequalities in the Borough over the last decade.



Our fantastic achievements have been made possible due to our unique partnership arrangements including the use of pooled budgets and a long-term relationship with our communities, which have provided the foundation to achieve real improvements for our population.

Despite the success we have enjoyed, we also recognise the challenges that we face to realise our vision that the people we serve will be more informed and involved in decisions that affect them, and will experience better health and wellbeing and improve health and wellbeing services.



Reporting to both Chief Executives, this post is a superb opportunity to work across two high-performing organisations and the wider community to ensure that our citizens are able to enjoy the excellent physical and mental health they deserve. Providing strategic and inspirational leadership, you will promote and protect health and wellbeing, tackling health inequalities, improving quality and working collaboratively to improve the health and wellbeing of the population. You will help to promote and develop a culture of continuous improvement, ensuring the

widest possible participation in the health and wellbeing agenda to support the development and delivery of our ambitious strategic objectives. You will focus strongly on making the best use of resources to do so.

We're looking for an appropriately qualified and experienced public health professional, who is able to operate successfully across both the health service and local government, and within a range of partnership settings. A proven 'change agent', you will be able to really engage with the community and other stakeholders and will possess the skills to act as a health champion and consultant on public health issues across the two organisations. We want your help to move even further and faster!

Can you step up to the challenge? If the answer is yes, then visit www.gatenbysanderson.com to hear what some of our citizens think about us. For a confidential discussion, call our advising consultants at GatenbySanderson – **Nick Raper** on **0113 205 6076** or **Simon Potts** on **0113 205 6283**.

Closing date: 16th November 2009.



H42402B9

Working for the people of Coventry to help them live longer and healthier lives.



Director of Finance and Deputy Chief Executive

£Competitive Salary

NHS Coventry is ambitious about improving health and transforming services in a growing, changing and needy city of 300,000 people.

The public sector financial challenges have only strengthened our resolve to ensure that we continue to improve services, whilst transforming productivity, cost effectiveness and service integration. The partnership with Coventry City Council is strong and we are facing the challenge together with NHS Warwickshire across the wider health economy.

We need to

- commission joined-up health and care services to improve the well-being of local people.
- transform the services available to local people through world class commissioning.
- narrow the health inequalities gap between some of the most affluent and most deprived areas in the city.

With the impending retirement of our existing Director of Finance, we are looking to appoint an outstanding individual to

our Board and Executive team. We need strategic leadership and vision, a commitment to using finance as a tool to lever service and health improvement, as well as an excellent technical understanding of the role, where success will be hard earned against a background of tough resource constraints and financial challenge.

You will need to demonstrate a track record of achievement in a complex, high performing healthcare-related organisation. In addition to being a first class finance professional, you will be skilled in:

- Leading strategic change through effective negotiation and value for money programming.
- Implementation of major public service strategies.
- Improving public services, partnership working and a focus on high quality, cost effective delivery.

Your financial and commercial acumen will be matched by your passion for helping us transform the city, development of your team and your own personal growth.

Interested candidates should contact Kyn Aizlewood at ATM Consulting for further details on 01785 224854 or e-mail kyn_aizlewood@atmconsulting.com

For a candidate pack, please e-mail eileen_rock@atmconsulting.com

Closing date for applications: Friday 20th November 2009.



H42503B9

SALARY BAND 9 & HIGHER

hsjobs.com

Director of Finance

Plymouth Hospitals 
NHS Trust

Attractive Salary

Our aim is to offer safety, quality, efficiency and better health to the people we serve in Plymouth and across the South West Peninsula. We are a large ambitious University Trust in a good position to meet this challenge. We have recognised that achieving our aim will only be possible if we manage our resources effectively and operate as an efficient business, particularly as we enter a period of unprecedented pressure on resources. We are well placed to meet this challenge because our experienced Finance Director has led the Trust to a CQC rating of "good" for financial management but he is now moving to a new NHS role. This post is about more than financial management. It will include responsibility for a range of resources, currently being reviewed by the Board, which support the delivery of excellent patient care. We are therefore looking for someone who has moved beyond the challenge of the finance discipline.

The Role:

- Develop and lead the implementation of a five year financial strategy. To provide financial leadership and advice to the Trust Board and the organisation.
- Provide Board level leadership for a range of other resources which support the delivery of patient care.
- Contribute as a full Board member to the performance and direction of the Trust as a whole.

The Candidate:

- Significant Board level experience in a complex organisation.
- Be at the forefront of experience in and knowledge of NHS business and financial management.
- Excellent communication and leadership skills. A CCAB recognised qualification and preferably further postgraduate qualifications.

Please reply in confidence, with full career and current salary details, quoting reference CAG/30210 or go to www.odgers.com/30210 Closing date for applications is 20th November 2009.

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NHS CORNWALL AND ISLES OF SCILLY

Deputy Director Of Public Health

Consultant Starting Salary: £74,504 p.a.

or AFC Band 9 Starting Salary: £75,383 p.a. Ref: 741-09-1078

Cornwall - Camborne, St. Austell or Saltash

An exciting opportunity has been created for an experienced Consultant in Public Health Medicine/Public Health Consultant to join an enthusiastic and award winning public health team.

You will support the Director of Public Health who is accountable to the Cornwall & Isles of Scilly Primary Care Trust, Cornwall Council and the Council of the Isles of Scilly.

You will be expected to provide executive leadership, vision and direction in planning, developing, implementing and evaluating programmes and services and lead specific priority areas of public health work including healthy weights and immunisations. An understanding of high quality primary and secondary care services and the challenges of delivering this in a rural economically deprived community is essential.

This is a full time post working 37.5 hours.

For further information please contact Felicity Owen, Director of Public Health, 01726 627802.

To access the job pack and apply on-line for any job, go to www.jobs.nhs.uk and enter the appropriate reference number. For those unable to access the internet, order a job pack by ringing 01726 627878.

Benefits include optional pension and life assurance.

Closing date for completed applications: 12th November 2009.

Working Towards Equal Opportunities

The NHS Cornwall & Isles of Scilly is a non-smoking organisation. Smoking will not be permitted on any of the sites.

Cornwall & the Isles of Scilly



H42409B9



Burdett Trust Seeks Funding Partners

The Burdett Trust for Nursing is interested in receiving bids from organisations that wish to be considered as 'Funding Partners' to manage grant programmes on its behalf in the following programme areas:

- **Building Nursing Research Capacity:** to support clinical nursing research and research addressing policy, leadership development and delivery of nursing care.
- **Building Nurse Leadership Capacity:** supporting nurses in their professional development to create a cadre of excellent nursing and allied health professionals who will become leaders of the future and foster excellence and capacity-building in advancing the nursing profession.
- **Supporting Local Nurse-led Initiatives:** to support nurse-led initiatives that make a difference at local level and are focused explicitly on improving care for patients and users of services.

The Trustees are interested to hear from organisations that meet all of the following criteria:

- The organisation is well-placed to manage a grant programme on Burdett's behalf, within one or more of the three funding programmes listed above.
- The organisation has a proven track record of making strategic healthcare grants.
- The organisation has the necessary infrastructure in place to maintain a grant programme over two to three years.
- The organisation is in a position to 'scale up' to deliver the grant programme without exposure to operational risk at the end of the grant.
- In most cases the organisation will not be just a direct provider of clinical or educational services, but a facilitator or umbrella body supporting service provision.

Please visit the Trust's website www.burdetttrustingtrust.org.uk for details about how to submit a bid.

Closing Date for Bids: Midday Friday 27 November

H42602B9

H42601B8

The Health Protection Agency: Protecting the nation's health



Consultant in Public Health (Public Health Strategy) – Two Posts

Holborn Gate, London (Division of Public Health Strategy)

New Consultant Contract or Agenda for Change Band 8d ■ £63,833 - £100,446

The Health Protection Agency plays a unique role in the nation's health and well-being. Whether providing health protection expertise, microbial epidemiology, co-ordinating investigations into outbreaks or responding to international health alerts, we help protect the health of everyone in the UK.

These posts are an exciting opportunity to gain experience within public health at a strategic level. They will be based at Holborn Gate in London and you will work within the newly formed Division of Public Health Strategy at the Health Protection Agency, which is led by the Director of Public Health Strategy (DPHS). These are full-time substantive posts, although part-time or flexible working will also be considered.

The DPHS has a number of wide-ranging responsibilities including swine flu, international health, professional development, training, medical director responsibilities and health protection governance. You will be expected to be involved in some of these areas and work will include: preparation of reports; papers and guidelines; public health evaluation and assessment; development of public health strategy and policy; attendance at key meetings; and working with internal and external partners. In addition, you may be expected to have line management responsibility for defined staff.

You will be required to have a sound understanding of health protection practice in the wider NHS context and have good generic public health skills (these are general public health consultant posts and expertise in health protection is not essential). A high level of intellectual rigour, negotiation and motivation skills, and flexibility are also required to deal with complex public health issues.

For an informal discussion about these posts, candidates are encouraged to contact: Professor Anthony Kessel, Director of Public Health Strategy at the Health Protection Agency on 020 7759 2746 (anthony.kessel@hpa.org.uk)

To find out more and apply visit our website: www.hpa.org.uk/careers

Please quote reference: 919-Med-EN-1334330

Closing date: Wednesday, 18 November 2009. Interviews: Early December 2009.

The Health Protection Agency promotes diversity in the workplace and is an equal opportunities employer. If you require this document in large print, please email: hpa@tmpw.co.uk

H42502B8

SALARY BAND 8



**Team Leader – National Pay and Negotiations
(Doctor & Dentists Pay)**

Based in Leeds with regular travel to London

Salary – progression is through an incremental scale starting at £42,103 per annum

We are seeking a Team Leader to manage national (UK) negotiations and discussions for NHS medical and dental staff pay and conditions of service. In conjunction with the Head of Doctors Pay and Pensions you will successfully facilitate the achievement of strategic and business objectives related to pay and reward.

Relationships are mainly with HR Directors, National Trade Union Officers and senior managers in government departments.

The core elements of the job are:

- Managing the national negotiations for employed doctors and dentists in the NHS;
- Preparing evidence to the Doctors and Dentists Review Body;
- Engaging and communicating with employing organisations on pay and conditions of doctors and dentists;
- Managing the internal team.

You will possess knowledge of NHS workforce issues, experience of involvement in negotiations or engagement with Trade Unions in the NHS or other sectors and strong people skills. You should be CIPD qualified or be able to demonstrate equivalent knowledge and experience.

In addition you will manage the Doctors and Dentists Pay and Negotiations team by providing clear leadership and a focus on service delivery and achievement of key business objectives.

To find out more about this exciting role please contact Bill McMillan on 07789 653204. A full job description can be found on our website: www.nhsemployers.org

To apply, please email your CV plus covering letter and completed equal opportunities monitoring form, available on the website, to jobapplications@nhsemployers.org identifying the post for which you are applying.

Consideration will also be given to applicants wishing to apply on a secondment basis.

Closing date for all applications is 16 November 2009. Interviews are anticipated to take place on 3 December 2009.

H42411B8



Yeovil District Hospital **NHS**

NHS Foundation Trust

Clean. Caring. Responsive.

Patient Access Manager Corporate Management

Band 8a £37,996 - £45,596

37.5 hours per week

Ref: 386-SS2076

Yeovil District Hospital has an excellent track record in the delivery of its elective access targets. We are looking for an Access Manager to take the lead in meeting the challenges of sustaining our performance and ensuring day to day delivery of patient access targets.

You will also play a key role in improving the efficiency of the elective and outpatient patient pathways to maximise the use of resources, therefore experience in service improvement and redesign would be advantageous.

We are looking for a highly motivated person to fill this demanding role. You will be responsible for the management of the Access Team, and will work closely with General Managers and Clinicians across the Trust.

You will need experience of leading teams as well as first class analytical, communication and negotiation skills. You will be able to demonstrate proven operational managerial experience within a healthcare setting.

For informal enquiries please contact: Karen Farnham, Deputy Director of Operations on 01935 384592.

Closing date: Monday, 9th November 2009.

Interview date: 20th November 2009.

Please visit www.jobs.nhs.uk for further information on this position and job description. Please apply on this site using the relevant reference number as quoted above.

Yeovil District Hospital NHS Foundation Trust
operates a Smoke Free Policy and is an
Equal Opportunities Employer



H42405B8

hsjjobs.com

Chesterfield Royal Hospital 
NHS Foundation Trust

FINANCE DEPARTMENT

Management Accountant

Full-time: 37.5 hours per week

SALARY RANGE: £37,996 - £45,596 per annum (Band 8a)

Please quote vacancy reference: VAC00127

We are a successful Foundation Trust with a solid financial track record, and are currently looking for a committed and qualified CCAB professional with substantive experience in a complex financial environment.

You will require well-developed communication skills and a passion to ensure resources are used to optimise patient care. In addition, your self-confidence will enable you to influence clinicians and managers, and establish effective working relationships at all levels.

The post is one of four Management Accountants, each leading a small team responsible for the provision of a comprehensive management accountancy service to a range of clinical and non-clinical directorates.

As a key member of the clinical directorate's management team, working closely with general managers and clinical directors, your responsibilities as lead financial specialist for the directorate include:

- Ensuring all financial targets are met.
- Financial input into business cases, strategies and operational plans.
- Development of Service Line Management.

For informal enquiries please contact Eileen Peacock, Assistant Director of Finance on Tel: (01246) 512029.

For application forms and job descriptions contact the following sources:

- The Jobline (01246) 512760 (24 hour, 7 day answerphone service).
- The Recruitment Office (01246) 513150/513176.

Closing date: Thursday 12 November 2009.

Interview date: Week commencing 23 November 2009.

Visit our website:
www.chesterfieldroyal.nhs.uk

We value diversity and welcome applications from all sections of the community.

This is a non smoking site.

"Improving your working life"



H42409B8

Sheffield 
Primary Care Trust

Sheffield PCT Provider Services has just achieved Autonomous Provider Organisation (APO) status, as a stage in the Transforming Community Services journey. We are a respected provider of high quality primary and community services within the Sheffield Health economy.

As part of a restructuring of the senior team, we are seeking to recruit two high calibre individuals to join our progressive and developing organisation.

Associate Director of Finance

Band 8d £63,833 - £79,031 pa Ref: PS 3659

As Associate Director of Finance, you will be an experienced and highly able financial professional, an exceptional accountant with successful post qualification experience including operating at Deputy Director of Finance level, or equivalent, in a comparably large and complex organisation. A key element of the post will be leading the finance function through a period of significant change and organisational financial challenge.

Chief Operating Officer

Band 8d £63,833 - £79,031 pa Ref: PS 3660

As Chief Operating Officer, you will have responsibility for the management and operation of our high quality clinical services. You will be a highly visible, transformational leader who thrives on working with clinicians and staff to ensure continuous improvement of our services. You will have worked at a senior level in a similarly complex organisation for a number of years, with a track record of delivery.

For an informal discussion, please contact **Simon Gilby, Managing Director of Provider Services** on 0114 226 4611, email: simon.gilby@sheffieldpct.nhs.uk

An application pack is available from Sheffield PCT, Human Resources Directorate, West Court, Hillsborough Barracks, Langsett Road, Sheffield S6 2LR or visit www.jobs.nhs.uk Alternatively, call (0114) 226 4661 (24 hour answerphone) or email: recruitment.admin@sheffieldpct.nhs.uk Please quote the post reference number.

Closing date for both posts:
Thursday, 12th November 2009.

Sheffield Primary Care Trust is committed to promoting equality and diversity within the workforce and welcomes applications from all sectors of the community



H42404B8

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Slough, Berkshire

Ref: BE801

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For an informal discussion please contact Siobhan Melia, CHS Director for Business and Strategy on 07990 508539.

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SALARY BAND 8

TRAINING & CONFERENCES

NHS**East Lancashire****NHS East Lancashire Community Dermatology Service**

NHS East Lancashire invites expressions of interest from all suitably qualified organisations and consortia for the provision of an 'intermediate' level community dermatology service across East Lancashire.

East Lancashire PCT requires a community dermatology service for the assessment, treatment and management of most skin diseases, as well as skin surgery. The service will deliver high quality care for dermatological conditions that are appropriate to be treated in a community setting. The service will be available to patients registered with an East Lancashire GP, and will meet all national guidance for accreditation of services, facilities and those delivering the service.

Bidders will be expected to provide services from community locations that deliver equitable access for all East Lancashire patients (approximately 385,000 population). In addition, the provider will demonstrate high quality clinical outcomes, improved user experience for the patient and deliver value for money for the commissioner. Also, providers will ensure appropriate integration with secondary care dermatology providers and primary care services.

The intention is for the procured service to operate from 1st September 2010. The length of the contract will be for 3 years, with the option to extend for a further 2 years (Subject to SHA approval).

To express your Interest please register via E-Bravo Portal (<https://candlpcts.bravosolution.co.uk>). Tender documents will be available via Bravo week commencing 2nd November 2009. A bidder event will be held on 16th November. Closing date for 'Expressions of Interest' is 1700hrs on 20 November 2009.

H42203TEN



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Primary Medical Care Services**NHS Brent**

NHS Brent delivers primary care services to a diverse and expanding population of over 350,000 people, from a wide cultural spectrum, with a broad range of health needs. NHS Brent is moving its primary care strategy forward to meet the needs of its residents and as such is calling for Expressions of Interest for the provision of three established GP Practices and related services.

As part of improving the future of health care in Brent, the provider arm of NHS Brent feels it is no longer appropriate to manage GP services as part of its core business. The primary care market has now sufficiently developed that other primary care providers are also willing to provide this service and can offer higher quality outcomes and better value for money.

In addition, as NHS Brent is working toward transforming primary care for its residents making care more convenient and accessible to all. In response to this need NHS Brent is also advertising an 8am-6pm, 7 day a week GP Led Walk in service, offering the same services as a GP Practice, without registration. This will be located within the same building as one of the practices and NHS Brent would expect the providers of these two services would work closely together.

NHS Brent invites Expressions of Interest from all suitably qualified and experienced healthcare providers (including general practitioners, social enterprise and third sector organisations). Potential bidders can express interest for any combination of the proposed schemes, including only one scheme.

The service to provide a range of primary care services and enhanced services, for registered patients only, five and a half days a week, 10 and a half hours per day weekdays, and 4 hours on a Saturday AM, in three established GP practice across Brent located at:

- Willesden Centre for Health and Care, Robson Avenue, Willesden NW10 3RY
- Wembley Centre for Health and Care, 116 Chaplin Road, Wembley, HA0 4UZ.
- Sudbury Primary Care Centre, Vale Farm, Watford Road, HA0 3HG

The service to provide GP services to unregistered patients will be located at:

- Willesden Centre for Health and Care, Robson Avenue, Willesden NW10 3RY

The procurement timetable is as follows:

Milestones	Date
Advert published and Expressions of Interest invited	29/11/2009
MDI Published (web based)	29/11/2009
Deadline for receipt of Expressions of Interest	04/12/2009
Bidder Information Day	12/12/2009
PQQ issued to potential Bidders who have expressed an EOI	08/01/2010
Deadline for receipt of potential Bidder Clarification Questions	28/11/2009
Deadline for receipt of PQQ submissions	15/01/2010
Completion of PQQ evaluation and communication of result	29/01/2010
Invitation to Tender (ITT) issued to Bidders	01/02/2010
Deadline for receipt of ITT bids	08/03/2010
Evaluation of ITT Bids complete	26/03/2010
Bidder Interviews week beginning	29/03/2010
Preferred Bidder Selected	02/04/2010
Contract Signature	23/04/2010

The proposed schemes are subject to public consultation, in accordance with the requirements of the Health and Social care Act 2001. Consultation has already commenced in relation to all schemes. For further information about each of the above schemes and the procurement process, interested parties are directed to the memorandum of Information, which can be found at www.brentpct.nhs.uk from Friday 30th of October 2009.

Those wishing to submit an Expression of Interest in tendering for either one or all contracts are asked to do this in accordance with the instructions set out in the Memorandum of Information, to arrive before 4.00PM ON FRIDAY 4TH December 2009 USING THE EMAIL ADDRESS IN THE MEMORANDUM OF INFORMATION.

H42202TEN

NHS Plus

CALL FOR EXPRESSIONS OF INTEREST TO CONDUCT A NATIONAL CLINICAL AUDIT OF DEPRESSION SCREENING AND MANAGEMENT OF STAFF ON LONG-TERM SICKNESS ABSENCE BY OCCUPATIONAL HEALTH SERVICES IN THE NHS

NHS Plus is a Department of Health funded programme concerned with increasing the quality and delivery of health and work services through;

- helping develop the NHS as a model employer,
- delivering services to other public sector bodies and smaller businesses
- and supporting the development of quality occupational health practices.

In 2008, we commissioned the first round of a national clinical audit of occupational health care for NHS staff in England on depression screening and management of staff on long term sickness absence. We now wish to commission the completion of this first audit cycle over the period January - December 2010.

Expressions of interest in the form of a completed PQQ are invited to be submitted to NHS Plus by **12th November 2009**. Invitations to proceed to full tender will be issued on **13th November 2009**.

Further details of this opportunity are available on the NHS Plus website www.nhsplus.nhs.uk or by email from keithjohnston@nhs.net

H42201TEN

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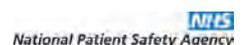
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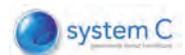
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OFF DIARY Cheese balls

Last week the health policies of the two leading political parties were made to look decidedly cheesy.

NHS Alliance practice-based commissioning lead David Jenner neatly summed up the current political situation at the alliance's annual conference in Manchester:

"The Labour Party is like a ripe Camembert, which has got so mature it is now flowing off the plate, but we're promised more of the same. With the Tories, we've got a nice pert Emmental, but there are so many holes in the policy," he told delegates.

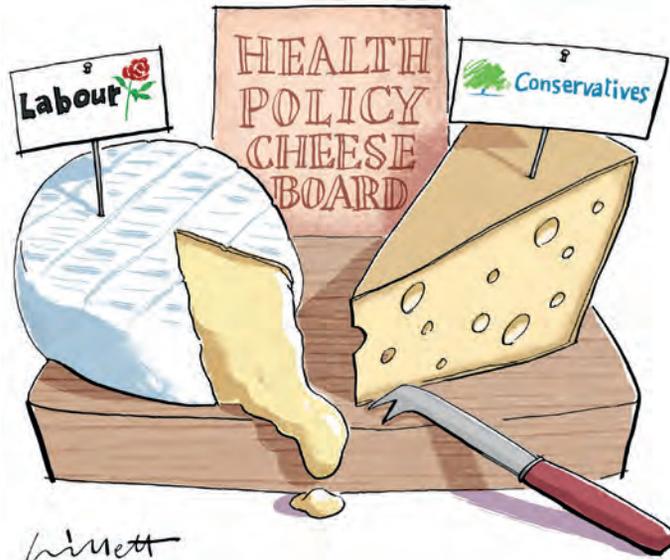
- Hospital infection experts from all over Europe descended on London last week to hear the NHS success story in combating rates of hospital associated infections.

Things took an interesting turn at the Department of Health conference, however, when a speaker fell off the stage. Shocked gasps turned into stunned silence, before said speaker re-emerged looking more than a little embarrassed but thankfully unhurt.

Whether it was the shock of hearing the NHS had saved £80m in a year by reducing *Clostridium difficile* rates that caused the speaker to fall, or a celebratory stage dive, Endgame cannot comment.

- Nothing inflames (geddit?!) the public like hospital parking fees – but the people of Hastings have gone a step further. The bonfire society built three 40ft pig effigies with snouts in a giant trough, which were torched in an early bonfire night celebration.

One was labelled "bankers", the second "politicians", and the third "NHS car parking" – a reference, the society says, to high car parking fees at hospitals.



- Politically incorrect chuckles abound in one unnamed NHS trust's board. The trust is looking to invest in and expand its weight loss surgery facilities but has been struck by a lack of, er "space" in its current buildings.

- It's good the hand hygiene message is getting through loud and clear – perhaps a little too loud and clear.

On a recent visit to meet young people, health minister Ann Keen was surprised when a little girl said she did not want to be a nurse when she grew up.

"Why not?" asked Ms Keen, herself a former nurse.

"Because they have to wash their hands all the time," was the baffling reply.

- Times are hard. Amid talk of pay freezes and "tough decisions" it seems some NHS hospitals are helping staff sell their jewellery.

A press release from

Hillgrove PR last week trumpeted that "Las Vegas gold party organiser Ounces2Pounds" would visit NHS hospitals in the lead-up to Christmas to help employees exchange old jewellery for cash.

The original press release said a "three month contract with the NHS" would enable staff to "bring in old pieces of jewellery in exchange for cash". Funnily enough, that sentence was removed after HSJ started asking questions. Instead, staff would merely be able to find out about pawning their jewels, not actually do so there and then.

So much for charity Christmas cards and cake bakes.



Dirty protest: kids nurse career doubts

To: Don Wise, chief executive
From: Paul Servant, assistant chief executive
RE: Andy Burnley

I went to the party conferences this year and am none the wiser about what's going to happen to the NHS in the next few years – or who is going to be running it.

If we are to judge the key priorities for the service by what our political masters are saying, the top three challenges are to increase funding, reduce managers and sort out parking. Oh, and above all we should trust the doctors and nurses to run things because they're really, really lovely.

Labour might argue that it has already set out its stall and has its track record to fall back on. In fact, w so assured of it are they that they felt relaxed enough to pull a major announcement out of the bag. In the future, outpatients would subsidise parking for inpatients. And choice would be stimulated by making the NHS the preferred supplier.

Ok, so Andy Burnham was playing to the gallery, no doubt more interested in the real election next year for leadership of the Labour Party.

Andrew Lansley on the other hand has a real problem. It's the same one that Chris Smith and Frank Dobson had back in 1997. Like them, Andrew doesn't have a health policy, because he is using his opponent's one.

What Andrew does have is a thesaurus, and he has been throwing Labour's policies into it and coming up with new names. So out go targets and income outcomes (that reads well). Outcomes also have the benefit of not being measurable for many years.

Andrew's other great new idea is to reintroduce fundholding. Hmmm that makes as much sense as David Cameron saying we shouldn't regulate bankers two years ago.

So Labour's policy is actually Ken Clarke's policy from all those years ago, and the Tory's policy is actually Alan Milburn's.

NEXT WEEK

Integrated care
How a scheme to avoid unnecessary hospital admissions in older people has improved their quality of life and reduced costs

Human resources
An assessment centre approach enabled one trust to ensure managers had the skills they needed to take on foundation status

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