

World Class Commissioning Panel Report

NHS City and Hackney

3 March 2010



Overview

First, the panel thanks NHS City and Hackney for participating in this round of assessments for World Class Commissioning (WCC)

The panel asks the PCT to accept this report in the spirit in which it is intended: a support tool on the journey to WCC and as a considered view of the organisation's strengths and weaknesses based on the insight the PCT itself gave the panel into its commissioning approach.

The PCT has a clear vision but an unclear path towards delivering it. The PCT needs to develop an action plan beyond Year 1 with goals, milestones and actions for achieving them. The PCT also has a large number of initiatives and needs to focus on the key initiatives, which will help it to deliver its strategy and meet the milestones it has set. Polysystems are critical to the PCT's strategy and it should work with the SHA to finalise these, aligning PBCs to them and delivering improved primary care performance to support their development.

The panel feels that the results from the competency self-assessments do not generally match the panel's perceptions during the assurance test.

The panel identified 5 main recommendations that the PCT will need to consider as it positions itself to drive transformation of health and healthcare in City and Hackney.

Commentary

The panel identifies 5 major areas for consideration by the PCT at this stage on its journey

1. **Headline: Maternity as a model to be rolled to other pathways**
Observation: The panel was very impressed with your understanding of the needs of your population, and how you used this to good effect in your maternity pathway redesign. The PCT made specific interventions at various points of the pathway geared towards affecting outcomes and engaged with clinicians, public and patients throughout the process.
Recommendation: The PCT should use its maternity work as a best case example of working effectively to effect positive change in patient outcomes, learn the lessons from it and roll out the approach to other areas

2. **Headline: Clear vision but an unclear path to achieve it**
Observation: The PCT has developed an operating plan with actions, timelines and milestones for 2010/11. These actions are ongoing and do not appear to be year-specific. It is unclear that the PCT is effectively thinking about the more strategic actions and events, or the specific in-year actions after year 1, that will be required to deliver its vision
Recommendation: The PCT should develop a clear 5 year delivery plan. The plan should outline the end-state, major milestones and actions required to get there

3. **Headline: Prioritisation of work**
Observation: The PCT's initiatives are linked to HfL pathways and include cross-cutting themes. However, these are very broad and far-reaching initiatives. The PCT has also developed work plans underneath these initiatives. It is unclear that the PCT has prioritised its initiatives, work plans and funding to meet the necessary milestones to achieve its vision
Recommendation: The PCT should ensure that its priorities for each year align with its strategic milestones in order to deliver its vision

4. **Headline: Development of polysystems and improvement in primary care are critical to meeting financial challenges and delivering vision**
Observation: The PCT has plans in place for the development of polysystems and is finalising these with the SHA. The PCT has acknowledged the geographical misalignment of PBCs and polysystems and is addressing this through the development of a common set of principles to underpin polysystem development with PBC GPs. The PCT has variable but improving primary care quality and successfully addressing this, with a focus on ensuring informed patient choice, is critical to the successful delivery of the polysystems models
Recommendation: The PCT should finalise its polysystem plans with the SHA, ensuring these are robust and affordable. It should also consider aligning the PBCs with the proposed polysystems and use a variety of methods to address poor quality primary care performance. It should also develop a strategy to ensure that patients are informed of their choices and can make effective decisions

5. **Headline: Refresh organisational development priorities**
Observation: In an environment requiring reduced management costs, the organisation may need to assess its capacity and capabilities, and how it works with the sector, to ensure it can deliver on its vision and goals
Recommendation: Following the development of a 5 year delivery plan, the PCT should reassess and align its required capacities and capabilities

Potential for Improvement Commentary

PCT trajectory

Commentary

- The PCT has moved from Green to Amber in both Strategy and Finance, whilst retaining Amber in Board
- The panel noted the need for the PCT to develop a clear delivery plan to meet its vision and ensure polysystem plans were finalised and agreed with SHA

Areas for development

- Continue to develop its competencies, particularly those where the need is greatest (e.g., 6, 7, 8 and 11)
- Ensure that the PCT works to align its clear strategy with an equally detailed delivery plan
- Work with the SHA to agree and roll out polysystem plans and develop strong primary care performance across the patch

Organisational development

Commentary

- Alignment
 - The Board is aligned on the challenges the PCT faces and its biggest risks
- Execution
 - The PCT needs to focus on the actions required to deliver its key milestones and targets
- Renewal
 - Variation in primary care performance will need to be significantly reduced in order to support the delivery of polysystems and necessary activity shifts

Areas for development

- Alignment
 - Ensure the Board is aligned with the delivery plan for the PCT's strategy
- Execution
 - Ensure the Board and PCT are focussed and prioritise the key deliverables for each year of the PCT's operating plan
- Renewal
 - Work with SHA and utilise best practice examples from across London on improving primary care performance

Overall PCT scores, reflecting sector assessments

The WCC process in London reflects the development of sector commissioning. Sectors began to take responsibility for acute commissioning and performance management on behalf of PCTs during 2009/10. Sectors were assessed for specific governance elements and certain competencies most relevant to these responsibilities:

Strategy

- Vision and objectives
- Initiatives to ensure delivery of strategic goals
- Consistency of financial plan with the strategy
- Board challenge ownership, ownership and monitoring of strategic plan delivery

Finance

- Robustness of planning assumptions

Competencies

- Competencies 4 and 7-11

The sector assessment process followed the PCT process – sectors completed self-assessments, these were analysed and sector panel assessments held.

Sector scores for the above governance elements and competencies have been combined with PCT scores to give an overall rating for the PCT. This is to ensure that, as in other parts of the country, a PCT's score reflects the full range of commissioning activity for which it remains formally accountable. Ratings were combined to reflect the judgement of the panel and confirmed at regional calibration.

The way in which the ratings have been combined, in order to give an overall rating is set out in the next four slides. The rest of the panel report (slide 9 onwards) reflects the panel's assessment of the PCT. The Sector assessment is available in a separate report.

Overall PCT scores - governance

Ratings were awarded points on the basis that R=1, A=2 and G=3. For governance areas where Sectors were assessed, the PCT and sector points were combined. For elements where the sectors were not assessed the PCT points were doubled. The total number of points was then converted to an overall RAG rating using the banding scales indicated.

Strategy

	Vision	Initiatives	FP	Board	Milesto.	Overall
NHS City and Hackney Points	A 2	R 1	R 1	G 3	A 2	
INEL* Points	G 3	A 2	G 3	G 3		
Combined points	5	3	4	6	4	A 22

Overall score	
24-30	Green
17-23	Amber
10-16	Red

Finance

Robustness of planning assumptions is the only Finance element for which sectors were assessed and sector and PCT scores have been combined.

	Historic	Fin Mgmt	Assump	Base	Scenarios	Overall
NHS City and Hackney Points	G 3	G 3	A 2	A 2	A 2	
INEL* Points			G 3			
Combined points	6	6	5	4	4	A 25

Overall score	
26-30	Green
17-25	Amber
10-16	Red

Board

The Board scores for the PCT were not influenced by those of the sector. Therefore the 2010 Board scores for the PCT are those from the panel assessment that are found later in this document.

Overall PCT Scores, reflecting sector assessments (1/2)

Competencies

Sectors were assessed for competencies 4 and 7-11 and so for these the Sector and PCT scores have been combined to give an overall PCT score.

- For competencies 4a, 7a, 7c, 9, 10 and 11 the competency must be achieved for all services. Hence the lower of the two levels achieved by the PCT and Sector was taken as the overall score.
- For competencies On items 4b, 4c, 7b and 8 the competency does not need to be achieved for all services. Hence the higher of the two levels achieved by PCT and Sector was taken as the overall score.

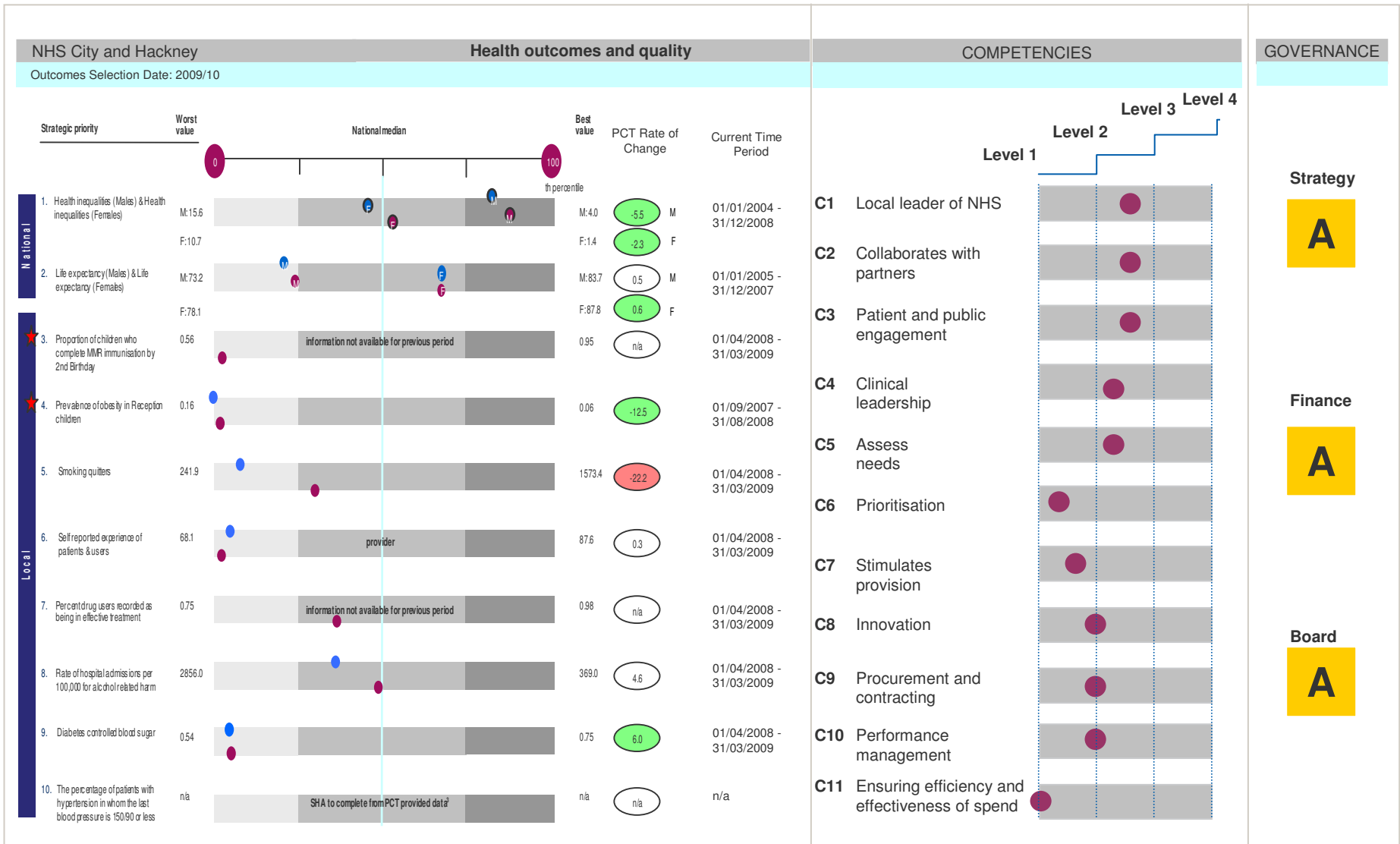
The final score for 2010 WCC is in the column at the far right, highlighted in grey.

	Sub-competency	Sector score	PCT score	PCT combined score
Competency 1	• 1a- Reputation as local leader		• 3.00	• 3.00
	• 1b- Reputation as change leader		• 3.00	• 3.00
	• 1c- Employer of choice		• 2.00	• 2.00
Competency 2	• 2a- Creation of LAA based on joint needs		• 3.00	• 3.00
	• 2b- Effective partnerships		• 2.00	• 2.00
	• 2c- Reputation as active, effective partner		• 3.00	• 3.00
Competency 3	• 3a- Influence on local health opinions		• 3.00	• 3.00
	• 3b- Public and patient engagement		• 3.00	• 3.00
	• 3c- Improvement in patient experience		• 2.00	• 2.00
Competency 4	• 4a- Clinical engagement	• 3.00	• 2.00	• 2.00
	• 4b- Dissemination of information	• 2.00	• 2.00	• 2.00
	• 4c- Reputation as leader of clin. engage.	• 3.00	• 3.00	• 3.00
Competency 5	• 5a- Analytical skills and insights		• 2.00	• 2.00
	• 5b- Understanding of health needs trends		• 3.00	• 3.00
	• 5c- Use of health needs benchmarks		• 2.00	• 2.00

Overall PCT Scores, reflecting sector assessments (2/2)


	Sub-competency	Sector score	PCT score	PCT combined score
Competency 6	• 6a- Predictive modelling skills and insights		• 2.00	• 2.00
	• 6b- Prioritisation of investment		• 1.00	• 1.00
	• 6c- Incorporation of priorities into invest.		• 1.00	• 1.00
Competency 7	• 7a- Knowledge of provider capacity	• 3.00	• 1.00	• 1.00
	• 7b- Alignment of capacity and needs	• 3.00	• 2.00	• 3.00
	• 7c- Creation of effective patient choices	• 2.00	• 1.00	• 1.00
Competency 8	• 8a- Identification of improvements	• 2.00	• 2.00	• 2.00
	• 8b- Implementation of improvements	• 2.00	• 2.00	• 2.00
	• 8c- Collection of quality information	• 2.00	• 1.00	• 2.00
Competency 9	• 9a- Understanding of provider economics	• 2.00	• 2.00	• 2.00
	• 9b- Negotiation of contracts	• 2.00	• 2.00	• 2.00
	• 9c- Creation of robust contracts	• 2.00	• 2.00	• 2.00
Competency 10	• 10a- Use of performance information	• 2.00	• 2.00	• 2.00
	• 10b- Performance discussions	• 2.00	• 2.00	• 2.00
	• 10c- Resolution of contract issues	• 2.00	• 2.00	• 2.00
Competency 11	• 11a- Measuring efficiency, effectiveness	• 1.00	• 1.00	• 1.00
	• 11b- Identifying opportunities to maximise	• 2.00	• 1.00	• 1.00
	• 11c- Delivering sustainable efficiency	• 2.00	• 1.00	• 1.00

Overall PCT position, reflecting sector assessment



Governance – Panel assessment on Strategy

● Last year's rating □ This year's self-rating
 ✓ Panel Assessment

Assessment	Measure	Red	Amber	Green
	1. Vision and goals	●	✓	●
	2. Initiatives to ensure delivery of strategic goals and the PCT's programme of change	✓	●	□
	3. Consistency of financial plan with the strategy	✓	●	●
	4. Board challenge, ownership and monitoring of strategic plan delivery	●	●	✓
	5. Achievement of milestones to date	●	✓	□

Rationale for scoring


- The vision and goals reference the regional and national context and pay particular attention to the needs of local populations (e.g., initiative to target Kurdish male smokers). Whilst the PCT gave rationale for its outcome aspirations, these do not appear to be very ambitious. Is unclear that, with such a large programme of work and past performance, the PCT can deliver its vision and priorities
- Whilst the PCT has identified 11 initiatives linked to HfL pathways and cross-cutting themes, these are very broad and far-reaching, with large workplans attached. It is unclear that the PCT has sufficient prioritisation of initiatives to ensure focus on the key strategic deliverables that will help it to achieve its vision. Investment decisions for initiatives beyond 2010/11 are generally unclear and disinvestment decisions were not robustly detailed. The PCT has engaged thoroughly with stakeholders and has an awareness of the risks to delivery
- There is some evidence of investment expenditure under each initiative (p.58, CSP) but this lacks detail beyond 2011. Disinvestment decisions, which will save £37m over the next 5 years, were not robustly detailed
- It was clear from the panel's discussions that the Board, including NEDs, were fully engaged in strategic development and in particular the selection of outcomes (e.g., NEDs suggesting sensitivity analysis around the selection of outcomes criteria). The Board also appears to take an active role in reviewing performance and working to agree actions to address disparities (e.g., breastfeeding improvements)
- Submitted documentation did not provide evidence of the PCT consistently reviewing past performance and identifying the causes of non-delivery. It is also unclear if the PCT is aware of the impact of missing milestones on achieving the PCT's goals, since key milestones have not been set

Recommendations going forward

- The PCT should develop a clear 5-year delivery plan. The plan should outline the end-state, the major milestones and actions required to get there. It should ensure that key priorities for each year align with the strategic milestones that it has set in order to deliver its vision
- The PCT should develop a clear 5-year financial plan linked to its 5-year delivery plan, which shows clear investment and disinvestment at initiative level

Governance – Panel assessment on Finance

● Last year's rating □ This year's self-rating
 ✓ Panel Assessment

Assessment	Measure	Red	Amber	Green
	1. Historical financial management	●	●	✓
	2. Robust financial management	●	●	✓
	3. Robustness of planning assumptions	●	✓	●
	4. Sustainable financial position as 'base case'	●	✓	●
	5. Sustainable financial position under different financial scenarios	●	✓	□

Rationale for scoring

- The PCT delivered a small surplus in 2008/09 of £100k. This was within their control total range. The PCT delivered a surplus in 2006/07 and 2007/08 of 1.3% and 2.3%, respectively. The PCT states that it has a history of good performance management of finances and has a new PMO which will feed into the Board. The PCT described processes for monitoring of acute sector in documentation and of CHS and primary care on the Panel Day. The panel heard that the PCT has an invoice auditing, and debt and asset management process in place.
- Inflation and population assumptions are aligned with the SHA and the PCT explained its assumptions for polyclinic activity. Financial scenarios align with SHA guidelines and contingency appears to be appropriate for relevant risks. However, the panel did not feel that assumptions on savings were justified by evidence or a credible action-orientated delivery plan with appropriate milestones. Documented evidence shows capacity planning by HIU across acute hospital, primary and community care
- Whilst the PCT is not projecting a deficit over the next 5 years in base case, the panel was not satisfied that the PCT had a credible plan in place to address all significant financial challenges over the next 5 years and felt a more detailed plan was required
- Similarly, under all financial scenarios, the PCT is not projecting an operating deficit over the next five years, but the panel was not satisfied that the PCT had a fully developed plan with milestones, targets and actions for each scenario over the next 5 years

Recommendations going forward

- The PCT has developed a clear vision with an end point, but it needs to ensure it maps out the milestones and steps it will need to take over the next 5 years to get there. These should show planned activity shifts, savings and the underlying financial results

Governance – Panel assessment on Board

● Last year's rating □ This year's self-rating
 ✓ Panel Assessment

Assessment	Measure	Red	Amber	Green
A	1. Organisation	●	●	✓
	2. Risk	●	●	✓
	3. Information	●	✓	□
	4. Performance	●	✓	●
	5. Delegation	●	●	✓
	6. Board interaction	●	✓	●

Rationale for scoring

1. The PCT has a well-defined structure with clear roles, responsibilities and accountabilities. The PCT has a set of values which appear to be communicated to stakeholders. The PCT has a good OD plan which outlines its capacity and capability gaps and it also led development of this work for the sector. The OD plan also shows what actions are to be taken in response to staff survey results
2. The PCT has a Board Assurance Framework which ensures that priority risk report is a standing item at Board meetings and Board members form part of all the sub-committees that identify and manage risks when initially identified. Board members spoke of the highest priority risks facing the organisation. The PCT has an appropriate process for ensuring clinical input and has reviewed its PEC
3. The PCT acknowledged that it currently gets provider performance and quality reports from a variety of sources and it is working to develop these into integrated reports
4. The PCT is currently refreshing its Primary Care scorecard. Whilst the PCT did give examples of CHS and MH reports, which its Board see, (e.g., complaints, Community Services Board report), it was not clear that these reports are integrated and reported on at all Board meetings
5. The panel was satisfied that the PCT had clear joint collaborative and specialised commissioning governance arrangements, which clearly laid out roles, responsibilities, accountabilities as well as performance metrics and frequency of reporting
6. The panel was confident that the PCT Board had played a role in shaping strategy, prioritising investments and making trade-off decisions, but the Board was not always able to articulate these interactions

Recommendations going forward

- Although the panel received a green rating on Organisation, the PCT, following its setting of a delivery plan for the next 5 years, will need to review its organisational capacity and capabilities and its work with the sector
- The PCT needs to utilise its PMO to gather all relevant data in functional dashboards to support decision making

Outcomes

X Top quartile rate of improvement
 Upper Quartile
 ★ Newly Selected
X Bottom quartile rate of improvement
 Lower Quartile
 ● Previous
● Current

NHS City and Hackney health outcomes and quality
 Outcomes Selection Date: 2009/10

Strategic priority	3 year historic rate of improvement (CAGR, %) ¹				PCT aspiration (CAGR)	
	PCT	National	ONScluster	Top decile ⁴		
National	1. Health inequalities (Males) & Health inequalities (Females)	-5.5	0.8	-2.9	-3.9	-1.2
		-2.3	1.2	-7.6	-9.4	-1.3
	2. Life expectancy (Males) & Life expectancy (Females)	0.5	0.4	0.5	0.8	0.5
		0.6	0.3	0.7	0.6	0.4
★ 3. Proportion of children who complete MMR immunisation by 2nd Birthday	n/a	-0.4	5.1	5.4	6.1	
★ 4. Prevalence of obesity in Reception children	-12.5	0.0	-11.3	-21.8	-1.7	
5. Smoking quitters	-22.2	3.0	-2.2	22.1	-0.4	
Local	6. Self reported experience of patients & users	0.3	-0.1	n/a	1.5	1.4
	7. Percent drug users recorded as being in effective treatment	n/a	n/a	n/a	n/a	3.6
	8. Rate of hospital admissions per 100,000 for alcohol related harm	4.6	5.7	5.7	-0.9	-2.4
	9. Diabetes controlled blood sugar	6.0	-1.0	-1.2	3.1	3.5
	10. The percentage of patients with hypertension in whom the last blood pressure is 150/90 or less	n/a	n/a	n/a	n/a	0.6

Changes in outcomes from last year

- Outcomes relate directly to the PCT's goals
- Hypertension prevalence and TB treatment were removed for rational reasons and replaced by obesity, immunisation and blood-pressure measures

Performance over last year

- Forward progress on 5 and 8
- Bottom 25th percentile performance on 3/10 outcomes
- Backward on 6

However, the PCT specified some of this data was out of data and not representative of its current position

Aspirations

- The panel has confidence in the level of aspiration for these 3 outcomes: Immunisations, patient experience, drug treatment, alcohol-related admission, blood pressure
- Other outcomes might be under-ambitious given past performance and PCT focus: Life expectancy, health inequalities, obesity, smoking quitters and diabetes controlled blood sugar

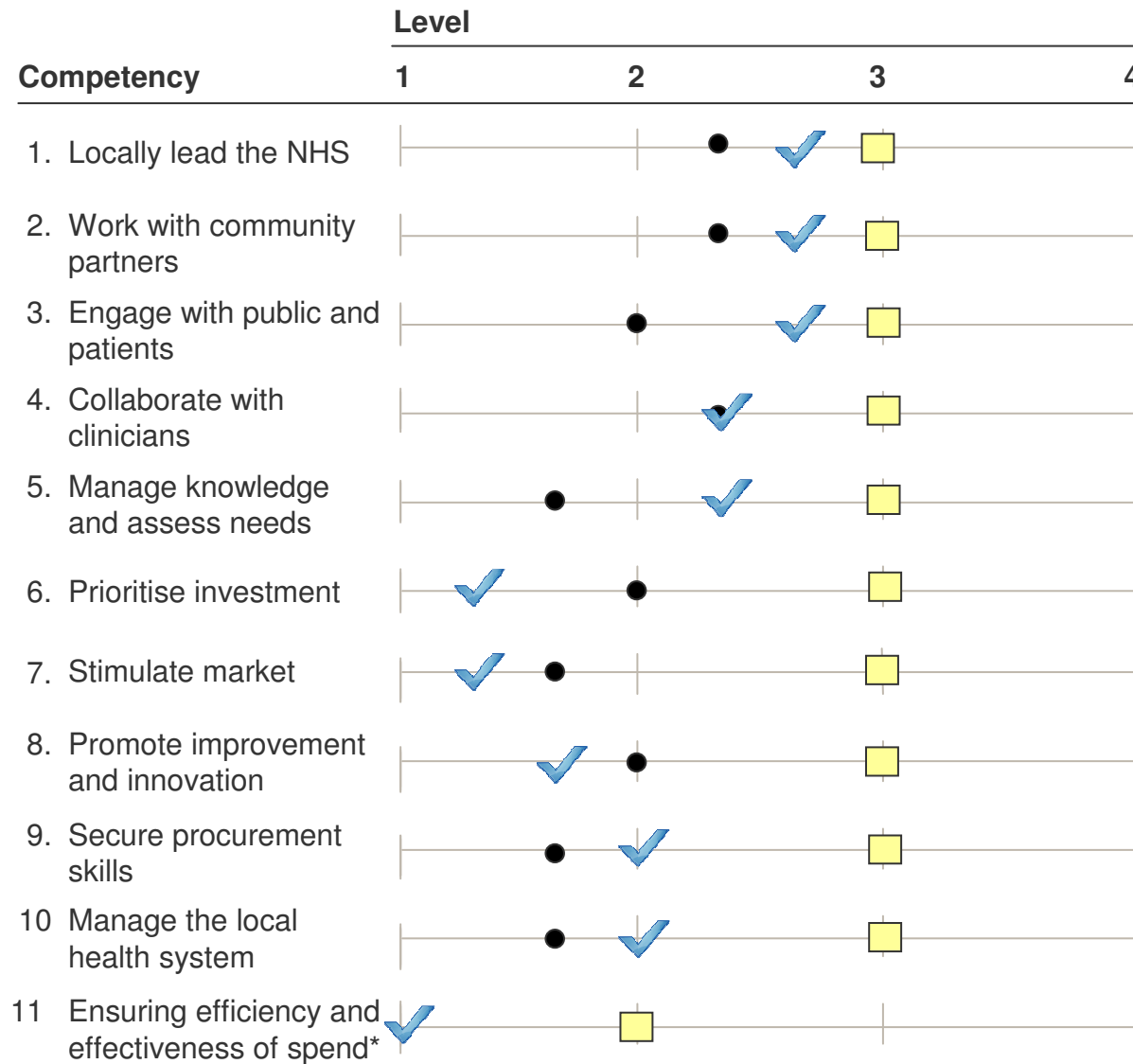
Recommendations

- As the PCT begins to execute its plans, it should continually reassess its ambitions vs. achievements
- It should also ensure that its outcomes are clear measures of its action plan to deliver its strategy

1 3 year period where available – please see appendix for variations where applicable for some indicators
 4 Top decile defined as the PCTs with the largest rate of improvement
 SOURCE: Team analysis

Overview – Competencies

- This year's self rating
- Last year's rating
- ✓ Panel Assessment



Topline introduction

- The PCT provided evidence to meet their self-assessment in competencies 1 and 2.
- The PCT did not show evidence to meet their self-assessment on competencies 3, 4, 5, 6, 7, 8, 9, 10 and 11
- The PCT appears to have fallen back in competencies 6, 7 and 8

* Competency added this year, hence last year's rating not available

Competency 1 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Are recognised as the local leader of the NHS	• Reputation as the local leader of the NHS	●	●	☑	●
	• Reputation as a change leader for local organisations	●	●	☑	●
	• Position as an employer of choice	●	☑	●	●

Rationale for scoring

- Survey feedback revealed the PCT to be above the SHA average of 5.1 with the PCT scoring 5.27. The local population agree that services are improving, and there is evidence of patient feedback being used to inform plans to improve services. There is very active participation in the health agenda in City and Hackney, e.g., changing boundary arrangements in City and Public Health team in Hackney supporting local needs. MORI results show patients have a positive perception of the PCT's work in improving services
- PCT strategy is set alongside engagement with the LA and a wide range of stakeholders, with the PCT influencing its partners, e.g., 6 of the 29 LA targets have a health focus. The PCT has successfully led and influenced partnership working with good outcomes in areas such as safeguarding children and childhood obesity, stroke rehabilitation and winter and swine flu planning
- Commissioning staff were significantly less satisfied with their current employment than the SHA average (PCT score of 3.3 on staff intention to leave jobs compared with SHA average of 2.8), and the temporary staff paybill (18%) is above the SHA average of 14%. The PCT has not had very good staff survey results, but has subsequently done a lot of work around staff recognition and staff focus groups to test ideas for what could make things better. In response they have introduced better communication across the organisation, a newsletter, and Star Awards. They are also commissioning a leadership programme from the Sector, and drawing on CSL's internal leadership programme. Staff are also encouraged to pursue further education, with some now undertaking MA studies. Staff recruitment planning has been undertaken and the PCT feels prepared for challenges ahead

Recommendations going forward

- The PCT should keep working towards a reduction in their temporary staff paybill, and implement a programme of staff development
- The PCT should systematically track staff satisfaction and staff responses to new PCT initiatives to learn what would make the most difference to staff. These initiatives should then be embedded in the wider organisation

Competency 2 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities and deliver increased productivity	• Creation of Local Area Agreement based on joint needs	●	●	☑	●
	• Ability to conduct constructive partnerships	●	☑	□	●
	• Reputation as an active and effective partner'	●	●	☑	●

Rationale for scoring

- The 2 LAAs (Team Hackney and The City Together) were agreed by the PCT and local partners. The JSNA was reviewed in November 2009, and LAA target address the needs highlighted in the JSNA, e.g., breastfeeding, teenage pregnancy and Chlamydia screening, however, further work is required to identify strategic priority areas for collaboration. TB was moved as a target last year as an outcome of joint work with the LA. PCT and LA are jointly accountable for LAA targets. Clinical engagement within the LAA ensured by input by PBC consortia
- The PCT has worked constructively with partners to produce a JSNA and is part of the JCPCT. The PCT role in the LAA is clear and communicated. Collaborative commissioning of services has been undertaken. There are joint public health appointments, with officers reporting directly to both the PCT and the LA; a formal section 75 agreement underpins these arrangements. The PCT was 'excellent' in 5 out of 7 outcomes on the CAA. A recent review of the Hackney partnership showed strong performance
- The LAA for Team Hackney demonstrates that the PCT and the LA are working together to deliver agreed priorities. The PCT is effectively managing 2 sets of partnerships, as they are a 2 borough PCT. The PCT public health clinician has aided the City in developing services for its new BME and deprived population, and has successfully influenced positive change e.g., in safeguarding

Recommendations going forward

- The PCT should identify priority areas for collaboration (based on its strategy) to ensure depth of partnership in key areas

Competency 3 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health	• Influence on local health opinions and aspirations	●	●	□	●
	• Public and patient engagement	●	●	□	●
	• Improvement in patient experience	●	✓	□	●

Rationale for scoring

- Survey feedback indicates that the PCT proactively shapes the health opinions and aspirations of the local population (score of 4.69 is more than the SHA average of 4.4). The CSP promotes independence of the population. There is a 600-person older people's reference group and the PCT takes steps to encourage healthy lifestyles through a number of channels (e.g., visits to local libraries and posters for schools)
- The PCT is communication strategy sets out many examples of ways that it engages with patients and the public. Part of the strategy is a Board-public engagement programme, where e.g., NEDS informally meet with the public and listen to their views. The PCT has used feedback from the PPICAP to develop the JSNA. The PCT communicates through a range of channels, and has launched a customer feedback process. The PCT uses a variety of ways to proactively disseminate information, including leaflets, posters and Twitter. Public engagement comes through the PPICAP. There are several patient reference groups, e.g., older people, learning disability and MH - guides and trainers have been very good at reaching formerly hard-to-reach groups. The public has helped co-design some services, e.g., maternity services. In response to patient feedback, there are now extended hours in primary care, and better access to and improved dental services. There are 2 LINKs in the PCT area, who serve on the Health Partnership Board
- Patient feedback is sought through the 'Outrageous Box' device and relayed directly to the Chief Executive for action. There is some evidence that public and patients agree that the NHS is helping to improve health and well being. The PCT does access some data on patient experience and feedback, but does not appear to use a systematic or triangulated approach

Recommendations going forward

- The PCT should be commended for its patient engagement in areas such as maternity services. Going forward they should aim to be more systematic in their approach and embed the same level of engagement in other services
- The PCT should aim for triangulation of information – bringing together multiple data sources to make decisions

Competency 4 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Lead continuous and meaningful engagement of a broad range of clinicians to inform strategy and drive quality, service design, and efficient and effective use of resources	• Clinical engagement	●	✓	□	●
	• Dissemination of information to support clinical decision making	●	✓	□	●
	• Reputation as leader of clinical engagement	●	●	✓	●

Rationale for scoring

- The PEC within the PCT is now called the Commissioning Clinical Executive (CCE). While clinical engagement is referenced in certain areas, there is a lack of evidence to show that this engagement covers all healthcare and well-being delivery methods. The PCT seeks the views of a wide range of clinical groups and has set up 6 PBC consortia with clear governance arrangements. The PCT has delegated authority to clinicians through the PBC consortia to drive the agenda. Whilst there is a great deal of clinical engagement, it appears to be mainly by and with GPs. For instance, the PBC consortia are largely GP led, with only ad hoc invitations extended to nurses and other health professionals.
- The CCE is the forum in which the PCT reviews quality and outcome reports, but no evidence was submitted to illustrate the regularity, content or quality of this information. There were only 3 survey respondents to the questions about the quality and frequency of information provided by the PCT. The Health Intelligence Unit (HIU) has web-accessible robust data, and GPs are trained to use it, but it is not clear how many GPs or other allied health professionals use it and how regularly they access it
- Survey results show that the PCT proactively engages clinicians with the PCT scoring 4.67 out of a possible 6. Clinicians have led improvement efforts, e.g., a joint prescribing formulary and reduction in OP referrals of 13%. The PCT also demonstrates a record of intervening in under performance, including removing 8 under performing GPs in the last 5 years

Recommendations going forward

- The PCT should seek to engage with multidisciplinary groups of clinicians
- Quality data is available via the HIU, but the PCT should work to ensure it is widely accessed and used, and also track the use of this unit and its impact
- Measure the impact of clinician led improvements on quality and productivity
- The PCT has made progress in its engagement with Newham and TH since last year and now needs to raise its sights and engage London-wide, and track and promote its successes

Competency 5 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements	Analytical skills and insights	●	✓	□	●
	Understanding of health needs trends	●	●	✓	●
	Use of health needs benchmarks	●	✓	□	●

Rationale for scoring

- The PCT organised the JSNA into 8 sections, one of which analyses the people within the PCT and the other seven analysing their needs through a wide range of data sources. The PCT reports steady progress on teenage pregnancy and infant mortality, however, it is not clear how this progress is tracked. Segmentation of the population in the PCT is clearly understood and differentiation is made between the residents of Hackney and the City where appropriate. There are plans to use a balanced scorecard in primary care, but these are not yet well-developed
- The JSNA has examples of population analysis at ward and locality for deprivation and life expectancy, and the PCT is able to address LA ward specific issues. E.g., child immunisation in the orthodox Jewish community; the IT system captured the relevant data which was then shared amongst GP practices. The PCT then provided training for practice nurses and started to offer immunisation services on a Sunday rather than a Friday which resulted in much better uptake. The PCT can disaggregate to super-output area
- The PCT regularly benchmarks its performance against national targets and peer PCTs on stroke and trauma services, but it is not clear how systematic its approach is. The PCT has developed trajectories for its top 10 strategic outcomes, most of which make reference to benchmarking. HIU is said to report on all key outcome indicators

Recommendations going forward

- A consistent and validated methodology for analysing gaps and reducing inequalities is needed.
- The PCT is on a journey towards the constructive use of health need benchmarks - it now needs to ensure this is done systematically and in a consistent manner (e.g., progressing with the planned primary care balanced scorecard)

Competency 6 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Prioritise investment of all spend in line with different financial scenarios and according to local needs, service requirements and the values of the NHS	• Predictive modelling skills and insights to understand impact of changing needs on demand	●	✓	□	●
	• Prioritisation of investment and disinvestment to improve population's health	✓	●	□	●
	• Incorporation of priorities into strategic investment plan to reflect different financial scenarios	✓	●	□	●

Rationale for scoring

- Scenarios for financial activity have been provided. The PCT has provided a paper on demand and capacity planning, and is using a sophisticated demand capacity modelling tool. It is not clear, however, that the PCTs scenarios are on an individual or case basis, identifying specific treatments required for high cost or high usage individuals or groups.
- Prioritisation for investment / disinvestment has been carried out at sector level, using the HfL best practice pathway. However, multiple meaningful examples weren't given a specific disinvestment as an outcome of this (e.g., PCT disinvested in grommets, but says they are still working with ACU to be more systematic in their approach to disinvestment) . Strategic investment and disinvestment has been made at sector level through Health4NEL. Evidence did not illustrate how proposals are considered for their impact on outcomes and inequalities. Clinical engagement is mentioned, but there is little evidence to show that this took place during initiative evaluation (although there is evidence of clinical engagement in Health4NEL, it is not clear there is clinical engagement in all other priority initiatives)
- The CSP covers the 8 Healthcare for London Pathways, analysing need and then the gaps in service provision compared to best practice. Investment in each area is shown clearly in the delivery section of the CSP, but there is little evidence of disinvestment. There is little evidence to show how investment /disinvestment would change under different financial scenarios. Cross-cutting initiatives that don't map to a health need have not been identified

Recommendations going forward

- Ensure the robust model for analysing scenarios is utilised to identify specific treatments or interactions
- Use the prioritisation criteria to make disinvestment decisions
- Build capacity in the organisation to develop prioritisation skills for both investment and disinvestment

Competency 7 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes	• Knowledge of current and future provider capacity and capability	✓	●	□	●
	• Alignment of provider capacity with health needs projections	●	✓	□	●
	• Creation of effective choices for patients	✓	●	□	●

Rationale for scoring

- The PCT, through Health4NEL and working with other PCTs, has prioritised acute and maternity services for analysis and improvement. It has evidenced analysis and commensurate recommendations across a number of providers and services and has identified potential costs and benefits from its reconfiguration of acute providers. However, it is unclear whether this has been done for primary care. The PCT has conducted a market mapping exercise for community services, identifying 80 providers across the HfL pathways, but did not seem to involve their LA partners in doing so, despite mapping joint services
- The PCT, through the sector, uses a variety of assumptions around demand management, population growth, shifts in care to polysystems, productivity gains and others to predict activity volume and capacity required per provider. As part of the planned reconfiguration of acute services, the sector has identified some gaps in market supply, risks to supply structure and has addressed these in its plans. The PCT has analysed entry barriers for third sector providers, and has worked with that provider group to overcome some of these barriers, and is now working with the LAs on a compact. However, there is not evidence that the PCT has commissioned higher quality care at increased efficiency and effectiveness in its priority segments.
- There is no evidence that the PCT regularly reviews the healthcare marketplace and has clear aims for creating more choice. The PCT has been working with GPs for 2 years to develop an effective strategy to improve uptake of choice, but it is not clear that this has yielded a measurable improvement. Whilst the PCT states that a recent NHS London MORI survey placed it in the top 5 PCTs for giving people choice of treatment, WCC survey results show that the PCT has regressed on choice offered to patients and availability of first choice by 2 and 5 percentage respectively. The PCT also performed worse than SHA and national averages on both counts. It is unclear how patients have been involved in creating the choice offer. The PCT reports responding to patient and public choice at a strategic level by developing polysystems which will give patients a choice between practices, but it is not clear what kind of information about choice is actually provided to patients and public

Recommendations going forward

- The PCT should draw on best practice from other PCTs, and work with the LAS, to embed the approach used for community health services across all segments of the market.
- The PCT should commission higher quality care at increased efficiency and effectiveness in its priority segments
- A clear strategy needs to be developed to ensure patients are informed about choice and are able to exercise choice both at practice level and for acute services; patients should be involved in creating the choice offer

Competency 8 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Promote and specify continuous improvements in quality (e.g., CQUIN, IQI) and outcomes through clinical and provider innovation and configuration	• Identification of improvement opportunities	●	✓	□	●
	• Implementation of improvement initiatives	●	✓	□	●
	• Collection of quality and outcome information	✓	●	□	●

Rationale for scoring

- Some but not all of the PCT's priority outcomes state that their trajectory is based on benchmarking. This is the case for London-wide stroke and trauma work. Pathway improvement has been evidenced in areas such as maternity, stroke and trauma. From the pathway information provided there is little evidence that the PCT has reviewed each pathway in a systematic way from prevention to rehabilitation. Patients were consulted in the redesign of pathways as part of H4NEL. In identifying opportunities for improvement for a specific patient group - e.g., COPD - the PCT drew on a variety of data sources, but did not appear to use a systematic way of aggregating the different data regularly.
- The PCT has a comprehensive model for quality monitoring, which includes proposed actions. Although the improvement model for acute is clearly explained in Health4NEL, the model for improving out of hospital care through polysystems and improved primary care performance is not explained. PCT demonstrated some evidence to show how improvement techniques have been linked to quality, productivity, workforce and measurement of progress (Health4NEL table of milestones). There is some evidence of risk mitigation, e.g., with regard to inappropriate discharge from a chronic disease pathway
- Quality and outcome metrics for providers are clearly communicated within provider performance reports. (Provider Performance Report). There is little evidence of how metrics have been developed in conjunction with relevant stakeholders.. Monitoring of major providers takes place on a monthly basis as evidenced by a performance report. However, it is not clear what action is taken when targets have been missed (e.g., the 62 day cancer target has been missed all year, Provider Performance Report

Recommendations going forward

- The PCT needs to aggregate system data to run patient risk analysis and target patients.
- The PCTs needs to outline the specific interventions required at each point in the pathway and develop criteria for moving them along the pathway

Competency 9 – Panel assessment

✓ Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Secure procurement skills that ensure robust and viable contracts	• Understanding of provider economics	●	✓	□	●
	• Negotiation of contracts around defined variables	●	✓	□	●
	• Creation of robust contracts based on outcomes	●	✓	□	●

Rationale for scoring

- The PCT submitted acute information and also reports longstanding work on understanding the economics of their primary care and community services providers. Despite the initial paucity of data in community services they now have a more granular understanding and are leading on the development of a community tariff. The PCT monitors patient experience (e.g., surveys), however, practice scores on 48-hour access show that the practices have declined in the last year. Contracts state that tendering is in line with Principles and Rules of Cooperation and Competition.
- The PCT evidenced use of variables in Enhanced Service contracts, and in the APMS contract for the new practice they are bringing in. There is no evidence in documentation of this for CHS. The PCT received support from the DH primary care procurement unit in 2005 and states that they prepare for negotiation (e.g., APMS negotiation). There is no evidence that providers carry significant risk across care setting contracts
- There is no evidence of PCT-defined cost, productivity and activity expectations for primary care (e.g., LES) although the PCT has defined 2 KPIs per service line in community care as part of their tariff work. There is no evidence that the PCT employs national and PCT-defined outcome and quality metrics to negotiate all new contracts. There is no evidence to suggest that contracts, in all settings, are agreed and signed in advance of activity commencing

Recommendations going forward

- The PCT should build on what they have achieved thus far (e.g., community tariff work) by defining targets for service quality and productivity improvements in contracts across all care settings, specifically in primary care

Competency 10 – Panel assessment

Panel Assessment ● Last year's rating □ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money	• Use of performance information	●	●✓	□	●
	• Implementation of regular provider performance discussions	●	●✓	□	●
	• Resolution of ongoing contractual issues	●	●✓	□	●

Rationale for scoring

- Data submitted for acute but not for primary care or community health services (CHS). The PCT admits that data is nascent in many of these areas. The PCT is tracking data on CHS (productivity and quality) through its community tariff work, but primary care is in an early stage. The Board gets more frequent updates on lower-performing providers
- No evidence in documentation to show that there is regular reporting for community and social care. KPIs and remedies for deviation that are mentioned are performance based. The PCT holds regular meetings addressing the performance of major providers (e.g., with lowest performing GP practices). The PCT could name the practices that perform in the bottom decile in key metrics. The PCT shows evidence of performing some risk analysis
- The PCT has highlighted areas for intervention based on reporting performance against contracts (contracting form example 2 p 102). The PCT shared an example of terminating a contract and tendering out a service to a different provider. There is no evidence of proactive management tailored to providers

Recommendations going forward

- Ensure that performance information is improved across all care settings (e.g., MH, LA, primary care) in the way you have improved performance information and tracking in community health services
- Demonstrate actions you and providers have taken as a result of performance discussions (e.g., the GP practices that are in the bottom decile of performance on key indicators)

Competency 11 – Panel assessment

Panel Assessment ● Last year's rating ■ This year's self-rating

Competency	Measure	Level			
		1	2	3	4
Ensuring efficiency and effectiveness of spend	• Measuring and understanding efficiency and effectiveness of spend	●	■	●	●
	• Identifying opportunities to maximise efficiency and effectiveness of spend	●	■	●	●
	• Delivering sustainable efficiency and effectiveness of spend	●	■	●	●

Rationale for scoring

- The PCT agreed that this is a new competency that is difficult to manage. Little evidence of detailed financial information collected by pathway across primary, CHS, and mental health. There is evidence of outcome benchmarking (e.g., p.51 CSP) but little evidence of output efficiency benchmarking. Sector reconfiguration outputs have demonstrated the optimal provision of major care settings. It is unclear whether provider economics is truly understood at a PCT level. The PCT described the use of NICE guidelines and JSNA priorities to guide spend, but there was little detail offered beyond these priorities
- Sector reconfiguration has identified areas of efficiency improvement but there is little evidence to suggest the PCT understands the impact on outcomes of its initiatives in specific local populations and has acted accordingly. Opportunities for operational and spend efficiencies are clear and are the basis for savings initiatives. However, there is little evidence of identified capital efficiency savings
- Initiatives and their respective savings have been defined. The PCT has effectively engaged key stakeholders in delivering its initiatives, but there is little evidence that the PCT has a clear understanding of the initiatives' impact on health outcomes. The PCT cited an example of improving efficiency in neurology, which has experienced a 13% output reduction from pathway redesign. However this was the main example cited, and it focussed on a pathway that is seemingly more acute (and therefore more about the work of the sector) rather than an example in primary care or mental health

Recommendations going forward

- The PCT needs to ensure the development of a robust and systematic process measuring the effectiveness and efficiency of spend by outputs, spend level, output efficiency and relevant outcomes. These should be benchmarked against national best practice and help the PCT to understand the optimal economics of provision of care
- The PCT needs to systematically identify improvement opportunities, implement sustainable solutions and measure the effect of these