

World Class Commissioning Panel Report

NHS Mid Essex

Mar 2010



Overview

First, the Panel thanks Mid-Essex PCT for participating in this round of assessments for World Class Commissioning.

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

The Panel identified 5 main recommendations that the PCT will need to consider as the PCT positions itself to drive transformation of health and healthcare in Mid-Essex.

Commentary 1/3

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

1. Significant progress informed in part by last year's Panel's messages

Observations:

- Last year's Panel suggested Mid-Essex could, if it stepped-up, be a leading PCT in the country. The PCT has acted on last year's Panel's suggestions and was open to input from Panel again this year
- CQC Good/Good in 08/09 (improved from Fair/Fair in 07/08, Weak/Weak in 06/07 – 13 most-improved PCTs)
- Successfully managed financial turnaround and has been in financial balance 2007/08 onwards
- Improvement in several outcomes over past year (smoking quitters, patient experience). Poor performance on the latter was highlighted as an issue last year and PCT has taken steps to address it, e.g., Patient Tracker
- PCT has been quite innovative, e.g., doc at home, Sainsbury's health centre, virtual ward
- PCT acknowledges how difficult the road ahead will be and has invested in bottom-up-analysis-based initiatives to try to mitigate this
- PCT is aware of where it needs to develop further

Recommendation: Ensure PCT takes a strong outward focus and builds sustainable relationships with partners e.g., PBC, acute, as needed to deliver the strategy

2. Strategy is based on thorough analysis of health needs and the PCT acknowledges it needs to map-out impact on health outcomes

Observations:

- At least partly in response to last year's feedback, PCT thoroughly reviewed how its strategy was addressing its strategic commitments and designed new initiatives to close gaps
- PCT is actively bringing-in external best practices e.g., integrated care learnings from Torbay, Castlefields, Canada
- Strategy is very focused with a manageable number of initiatives and clear risk identification
- PCT acknowledges it needs to define a targeted impact on health for each initiative, e.g., how initiatives C and D will affect CHD
- The detail of some initiatives is not yet as developed as needs to be, especially those depending on primary care
- Impact of financial scenarios on initiatives not mapped-out – PCT plans to re-prioritise as it goes along

Recommendation: PCT should accelerate its intended work to define expected impact on health outcomes, and detail of delivery, for each initiative as well as a pre-agreed plan for the worst-case scenario

Commentary 2/3

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

3. Finance: High levels of ambition for savings to re-invest, but detail of delivery and worst-case scenario need fleshing-out

Observations:

- PCT recently recovered from deficit
- Last year's Panel suggested the PCT be more ambitious. It has opted for more challenging financial planning assumptions resulting in higher estimates of savings required
- Transfer of activity out of acute is core to cost savings:
 - PCT is following tried-and-tested model of emergency avoidance through integrated care
 - 15% reduction in acute emergency admissions is ambitious especially without a triage service in place – and PCT is investigating options for this
 - Incentives are being built-in to the community services contract but not the acute
 - PBC is still emerging from a bad period and GP buy-in will be critical to the integrated care teams
- Unclear whether all parts of the system are signed-up to all proposed changes and whether workforce will be an issue
- Worst case scenario (due to economics or failure of savings initiatives) not fleshed-out, e.g., which initiatives will be dropped/curtailed and impact of that on health and services. PCT plans to re-prioritise as it goes along

Recommendation: Get a system-wide plan for change signed-up by the acute Trust, Local Authority and PBC including level of savings involved, and implications for workforce, beds, etc

Commentary 3/3

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

4. Panel observed a very good Board today, although it has some concerns about oversight of risk

Observations:

- Board is clearly very engaged and has strong oversight of performance
- Board was very open to challenge and had taken-on the messages from last year's Panel
- Board is much more confident and mature than last year
- NEDs bring valuable skills as well as challenge
- Some concerns about Board oversight of risk, e.g.:
 - Over-activity risks such as continuing care were not front of mind for NEDs
 - Worst-case scenario (either economic or failure of planned savings) not fully mapped-out (e.g., which initiatives to drop/curtail and impact on services and health)
 - Board is clear about the process to deliver the strategy but has yet to map-out and track the milestones for impact on health outcomes
 - Clinical responsibility at Board is unclear, e.g., who the medically-accountable officer is (see area number 5, below)

Recommendation: To be a great Board, focus more on risk and clinical engagement

5. Clinical engagement has improved since last year; more such improvement will be needed to deliver the strategy

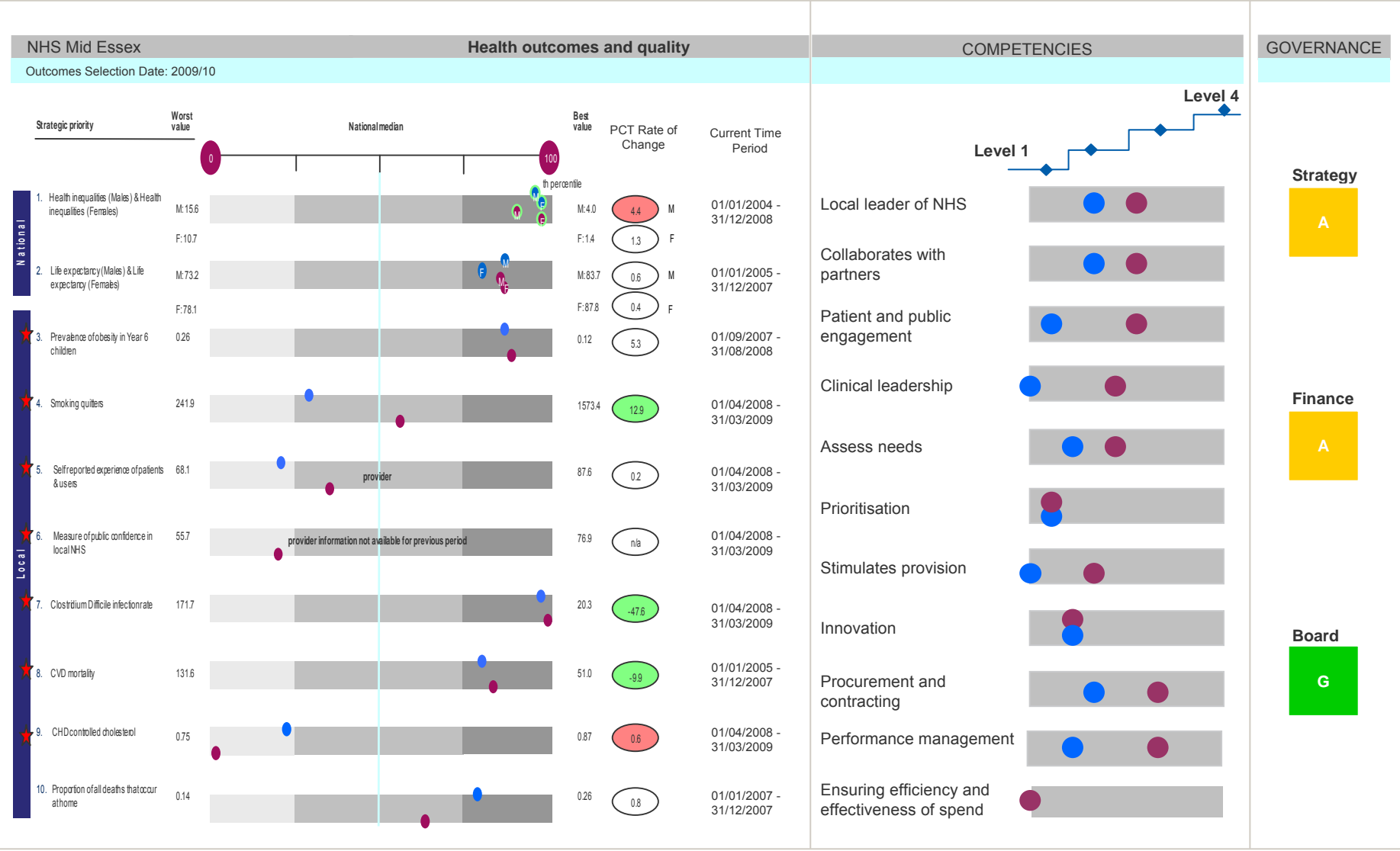
Observations:

- The TDBs sound wonderful and are quickly being implemented including delegation of significant authority. TDB Chair present at Panel Day seemed very clear about his role. It is still early days, however, and it is unclear whether PBCs have fully bought-in to the TDBs (although they are being involved)
- PCT is doing well at engaging clinicians across disciplines, e.g., Physiotherapist chairing a TDB and social workers, pharmacists, etc, signed-up to join them
- PBC relationships have improved since last year (better survey results, PBC review conducted). There is still a ways to go, however, especially given the radical service change (integrated care, etc) and demand management required and performance challenges (e.g., CHD). PBC didn't feature in Panel Day strategy discussions, for example. 11 PBCs may be too many to involve. Adding the TDB clinical structure on top of PBC, as opposed to developing PBC into that structure, may challenge PBC relationships even further
- Board includes 1 clinical member but unclear how Board will dialogue with TDBs and clinicians

Recommendation: Ensure PBC buys-in to TDBs by giving them an early success story on an issue close to their hearts, e.g., CHD. Given the PCT's role as a leader of the local system, consider what fully-engaged clinical leadership looks like, how current state compares to that, and what needs to be done to close gaps – including clinicians across all settings and social care

















Panel scorecard

● Previous
● Current



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

















- Vision and goals clearly linked to local health needs (based on thorough analysis) and national context (QIPP). Vision is ambitious but difficult to measure. Strategic initiatives and outcomes do not clearly map to strategic commitments. For example, it is unclear how initiative J (services for children and young people) delivers strategic commitments 5 and 6. Timelines for delivery are not always credible
- Most initiatives address the strategic commitments. Clear criteria (stakeholder-agreed ethical decision-making framework were used to prioritise the initiatives. Size of investment/ disinvestment based on benchmarks. Detail behind initiatives (impact on health outcomes, health outcome milestones) still to be developed. Risks and mitigations clearly identified. PCT has not stated how investments/ disinvestments will change in worst-case scenario nor impact on health and services - PCT plans to reprioritise using its criteria 'as it goes along' (which precludes a Green rating). PCT engaged on its strategy with stakeholders at ~25 events but difficult to show impact of that on the strategy or to say that with clinicians, in particular, engagement has been full and on-going
- Investment/ disinvestment for each initiatives is explicit for base but not best/ worst cases. Investment/ disinvestment timelines for some initiatives are ambitious. PCT has yet to flesh-out how it will handle economic worst-case or failure of planned savings. There is little additional expenditure not related to strategic priorities
- Board is engaged in strategy development and discusses performance. NEDs could clearly explain vision and goals. Board reviews strategic initiative scorecards which are being developed to be more user-friendly
- PCT has achieved and exceeded many targets and milestones. As part of its strategic plan refresh it reviewed progress towards its vision and strategic commitments together with stakeholders and developed current strategic initiatives to address gaps. When IAPT target (50 practices by Dec) was missed root cause were identified (primary care estate) and remedial actions planned. Similar story for 18 weeks

Recommendations going forward

- PCT should accelerate its intended work to define expected impact on health outcomes, and detail of delivery, for each initiative as well as a pre-agreed plan for the worst-case scenario

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




















- PCT met SHA expectations in 06/07 but in 07/08 reported a surplus of £2.8m against a planned breakeven and in 08/09 reported a deficit of £0.8m against a planned surplus of £1m. PCT has explained that the 08/09 deficit was due to a re-statement of accounts after a re-valuation of estates, for IFRS purposes. This still constitutes meeting SHA expectations.
- There is a robust financial management process in place. At each meeting, Board reviews its in-month and forecast end-of-year financial position vs. plan – flagged using RAG ratings - and can cite examples of where it has challenged executives about the financial position. Board could describe its invoice monitoring process and currently has £1.5m disputed with its providers. Estates strategy is in place.
- Planning assumptions align with SHA guidance. Savings assumptions are backed-up by extensive analysis and benchmarking (local e.g., inter-GP-practice), regional and national benchmarking; McKinsey EoE work; external best-practice models such as Torbay for integrated care), pilots (e.g., orthopaedics) and examinations of what has and hasn't worked in the past. To progress to a Green rating:
 - The PCT's plan to deliver the cost savings (both efficiencies and disinvestments) needs to be strengthened; and
 - Contracted provider capacity needs to be aligned to activity projections. Work has started to build the planned shift of activity out of acute into integrated care teams into the community services contract. Discussions about the change have started with the acute and GP providers but there is no movement to build it into their contracts.
5. In all 3 funding scenarios, the PCT forecasts a surplus of £1m, which is in line with SHA expectations. This requires cost savings of ~£75m, ~£95m and ~£100m in each of the best, base and worst funding cases. However delivery plans for these savings are not sufficiently developed to be credible, and the plan for scenario where they don't materialise has not been agreed (i.e., which initiatives will be dropped/ curtailed first and the impact of this on services and health)

Recommendations going forward

- PCT is planning challenging levels of savings and further work is needed on both the detail of how these will be delivered and the plan for the worst case scenario.

Governance – Panel assessment on Board

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

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

Rationale for scoring

- PCT has developed a robust OD plan which outlines a clear org structure, roles and accountabilities; identifies capacity and capability gaps and actions to address them; values and their communication to stakeholders; and actions in response to the staff survey. The Transformation Delivery Boards and Commissioning Support Unit are particularly innovative initiatives to address identified capability and capacity gaps
- Board manages risk using the Assurance Framework, which identifies key risks and mitigation plans. Board has reviewed the effectiveness of PEC as advisors. However Panel observed that the Board's process for assuring clinical input into the decisions could be clarified, including who at Board level is medically-responsible. Over-activity risks such as continuing care were not front of mind for NEDs. The scenario where sufficient cost savings cannot be delivered has not been mapped-out (which initiatives to drop/ curtail and impact on services and health). Board is clear about the process to deliver the strategy but has yet to map-out and track the milestones for impact on health outcomes
- PCT Board reports and provider performance and quality reports are appropriate
- PCT reviews provider performance monthly. Board (bimonthly) reviews PCT's clinical, quality, service and financial performance and progress on key initiatives (RAG with a commentary). There are examples where Board has acted to address a performance issue, e.g. when missing 18-week and Chlamydia targets and when there were issues with phlebotomy. As of Jan 2010, PCT is hitting all Vital Signs targets with the exception of 1 existing commitment (62 day wait all cancers)
- Roles and responsibilities and decision-making/ governance processes for main delegated commissioning arrangements are clear (SCG, PBC) and a thorough process is underway to define the same arrangements for the TDBs. There are examples where Board has challenged delegated commissioning performance, e.g., Children's Trust. The PCT's strategic plan made no reference to the SCG; 1 reference in the initiatives to PBC; 2 references in the initiatives to the Council. PCT could make clearer the role of these delegated commissioning arrangements in delivering the strategy
- Board is fluent in the PCT's strategy, and in how priorities were defined using the prioritisation criteria

Recommendations going forward

- Panel recommend the Board take a greater risk focus, develop a pre-agreed worst-case scenario, track the initiatives against health outcomes as well as against process, and ensure it has a clear process for clinical responsibility and clinical input to its decisions

Outcomes

MID ESSEX worldclasscommissioning

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

NHS Mid Essex health outcomes and quality

Outcomes Selection Date: 2009/10

Strategic priority	3 year historic rate of improvement (CAGR, %) ¹				PCT aspiration (CAGR)	
	PCT	National	ONS cluster	Top decile ⁴		
National	1. Health inequalities (Males) & Health inequalities (Females)	M	0.8	1.7	-3.9	3.2
		F	1.2	0.0	-9.4	-1.0
★	2. Life expectancy (Males) & Life expectancy (Females)	M	0.4	0.6	0.8	0.6
		F	0.3	0.4	0.6	0.4
★	3. Prevalence of obesity in Year 6 children		8.5	3.8	-7.5	-1.0
★	4. Smoking quitters		3.0	2.7	22.1	15.6
★	5. Self reported experience of patients & users		-0.1	n/a	1.5	1.1
★	6. Measure of public confidence in local NHS		n/a	n/a	n/a	1.8
★	7. Clostridium Difficile infection rate		-35.5	-33.1	-65.3	-11.4
★	8. CVD mortality		-7.1	-4.8	-9.9	-9.6
★	9. CHD controlled cholesterol		1.6	1.5	3.6	2.8
★	10. Proportion of all deaths that occur at home		1.8	0.8	6.5	10.2

Changes in outcomes from last year

- New outcomes (public confidence, CVD, CHD and deaths at home) have strengthened the link from vision and strategic commitments
- Rationale for C-Diff is unclear given PCT is best-in-class

Performance over last year :

- Great progress in smoking and patient experience, although the latter still poorly performing overall. More moderate improvements in obesity, C-Diff and CVD – for all of which performance is good
- Significant worsening of CHD and one of the worst-performing PCTs nationally. PCT perceives this as an issue with primary care not assuring patient compliance. Plans are still being developed and will likely focus on worst-performing practices (performance management, education) as well as introduction of vascular checks
- Little relative improvement in deaths at home – PCT has attributed this to removal of community-based services as part of financial turnaround – now reinstated. Acute bed census showed ~10% purely palliative; working with stakeholders on a palliative care strategy including 24-hour community nursing, hospice at home, electronic end of life registers including preferences

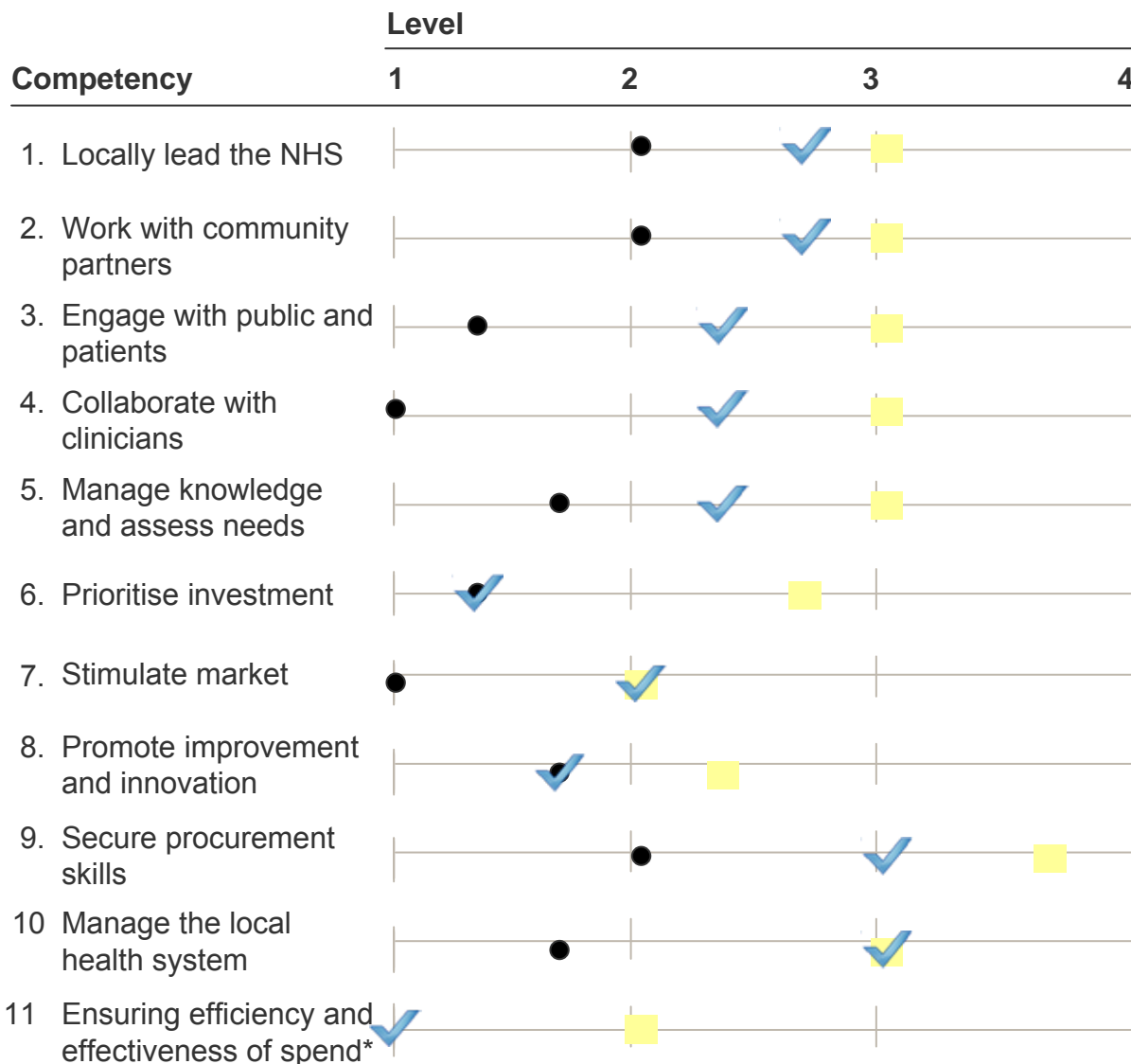
Aspirations:

- The Panel has confidence in the level of aspiration for:**
 - Female health inequalities
 - Life expectancy
 - Patient exp
 - CVD mortality
 - Smoking quitters
 - Deaths at home: reinstating previously-cut services will hopefully make this possible
- The Panel feels that aspirations for obesity and CHD may be **over-ambitious**
- The Panel believes that aspirations for male health inequalities and public confidence **might be more aggressive**

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

Overview – Competencies



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

- Overall, the PCT should celebrate its successes and move forward with confidence to further develop its commissioning competencies
- The Panel's assessment is relatively close to the PCT's on most competencies
- The PCT has made very good progress since Year 1, moving from an average competency rating of 1.6 to 2.3(excluding C11 for consistency – 2.2 if we include it)
- Its relative lack of progress in:
 - C6 is attributable to the tightening of criteria this year
 - C8 is due to a lack of evidence of rigorous risk mitigation around service changes and some remaining development opportunities on data collected
- It is worth noting that most PCTs will be rated at level 1 for C11 this year

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

- 1a: Stakeholder feedback survey shows the PCT is recognised as the local leader of the NHS (PCT 4.89, SHA 5.01). Communication strategy includes actions to improve the local leadership reputation. PCT provided examples where it led the local health agenda leading to service changes e.g. GP opening hours and the media analysis shows a good attempt to target stories. Public perception survey shows only 32% agree local NHS is improving services – this will need to increase to achieve a level 3 rating. Dedicated patient experience team handles comments, concerns and complaints.
- 1b: Key stakeholders agree the PCT has a significant influence on their decisions and actions (PCT 4.89, SHA 4.87,). PCT is working with key partners on improving quality of services e.g., working with ECC and Braintree LSP on project delivered by Rural Communities for Essex. PCT is working to increase collaboration with other local commissioners, e.g., with Essex PCTs on the Essex CSU.
- 1c: Positive commissioning staff survey results (80% received relevant training in the last 12 months (SHA 76%); 87% agreed they had an interesting job (SHA 81%) and 61% agreed they could develop their potential at work (SHA 48%)). Board talked about building the PCT's reputation as an 'employer of choice', using programmes to attract, develop and retain quality staff, e.g., the Commissioning Academy and Workforce Advisory Group.

Recommendations going forward

- Panel is confident PCT can make further progress in this competency building on its existing work with the local population to increase public perception that it is improving services.
- Panel was impressed with the Commissioning Academy and Workforce Advisory Group. PCT might consider opening the Commissioning Academy to local commissioning partners to enhance joint commissioning.

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


- 2a: LAA priorities were based on joint needs as assessed through the JSNA and refreshed annually to reflect delivery and changing needs e.g., obesity. LAA targets address key local needs and are jointly-held by the LA and the PCT. PCT is clearly engaged in negotiating, delivering and performance-managing the LAA.
- 2b: Stakeholder feedback survey shows stakeholders only somewhat agree PCT engages them in strategic planning (PCT 4.08, SHA 4.30). PCT worked with partners to refresh the JSNA which is highly health-focused. Partnership effectiveness was discussed at the Leadership Strategic Partnership Boards but evidence of a more formal evaluation needed to reach level 3. Joint posts are in place with Essex County Council and 3 District Councils leading multi-agency action plans but it was unclear what governance and accountability arrangements are in place. PCT is lead commissioner for MH in NE Essex but limited evidence of active influencing of the SCG to ensure Mid Essex population's needs are met by it.
- 2c: Stakeholder feedback survey shows that key stakeholders agree the PCT is an effective partner (PCT 4.51, SHA 4.70). LSP Boards have clear action plans and monitoring of progress. PCT are actively involved with the Children's Trust. There were success stories of delivery provided through the partnership centre on the LAA targets

Recommendations going forward













- PCT will need to evidence that that local partnerships are formally evaluated for effectiveness; that there are appropriate governance and accountability arrangements for joint posts; and that the PCT influences the EoE SCG's agenda.

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	<ul style="list-style-type: none"> Influence on local health opinions and aspirations 				
	<ul style="list-style-type: none"> Public and patient engagement 				
	<ul style="list-style-type: none"> Improvement in patient experience 				


Rationale for scoring


- 3a: Comprehensive communications and public involvement strategy is in place, including stop-smoking initiative targeting hard-to-reach groups and cultural awareness for health professionals. There were two minority-group-focused community development workers in place. Stakeholders only somewhat agree that PCT proactively shapes health opinions and aspirations of the public and patients (feedback survey PCT 4.15, SHA 4.06). Some examples of use of social marketing (e.g., leaflets for awareness of IAPT services) but no evidence of 'clear success stories of delivery' in influencing local health opinions and aspirations.
- 3b: PCT includes patient and public views in reviewing services and held meetings and events to get feedback on the strategic plan. Initiative-specific consultation has directly influenced service provision such as the model of delivery for new primary healthcare centre in Chelmsford. PCT demonstrated evidence of working with LINKs, e.g., is tackling obesity through engagement with parents who are not keen on current services. Dedicated staff working on engagement with hard-to-reach groups including using social marketing methodologies. On public perception survey question, "I can influence decisions affecting local NHS services in my area," only 26% agreed while 54% disagreed, suggesting public and patients do not agree the local NHS listens to the views of local people
- 3c: Patient experience team regularly seeks feedback from patients and follows-up on actions taken. Patient experience reports are discussed at Board and at provider performance meetings. The Transformation Delivery Board (TDB) terms of reference identifies how patient data and PALs queries will drive commissioning decisions. On public perception survey question, "My local NHS helps improve the health and wellbeing of me and my family," 82% of respondents agreed and only 10% disagreed. PCT provided examples of using patient and carer feedback to drive commissioning decisions, e.g., dissatisfaction with waiting times for inpatient treatment was addressed through a CQUIN scheme – won't know till next quarter report whether this has worked (hence provisional level 3 rating)

Recommendations going forward













- Panel would encourage PCT to further develop the elements of its communications strategy relating to influencing people's health opinions and aspirations (as distinct from listening to them or involving them in decisions) and explore innovative ways to do this other than media campaigns, e.g., identifying champions, staff health improvement programmes, encouraging frontline staff intervention, helplines, etc.

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


- 4a: Clinicians across disciplines have been engaged but are not yet playing a true leadership role:
 - Pathway redesigns have involved clinicians across multiple disciplines
 - PBCs have led some relatively-minor improvement initiatives and used to partake in PBC Commissioning Board but do not seem fully engaged
 - Examples of where primary and secondary care clinicians have worked together on redesign e.g., orthopedics, pain
 - Monthly meetings with secondary care clinicians have led to some improvements
 - TDBs are seen as the main vehicle going-forward for clinical leadership and PCT is still working-out how to integrate these with PBC
- 4b: ~50% of the 6 PBC survey respondents thought information and data from the PCT was fairly good. Primary care scorecard has been circulated once and PCT would like to do so monthly but this is not yet agreed. Prescribing and acute activity data are circulated to GPs monthly. Case studies show examples of clinical engagement in monitoring clinical variations and there have been ad-hoc discussions with under-performing practices. However some metrics (e.g., cholesterol) vary widely across the patch and no evidence that there is a systematic approach to reducing such variation
- 4c: PCT has track record of clinicians leading initiatives to redesign care, however it is too early to assess to what extent these have led to improvement in quality and productivity. Key stakeholders somewhat agree that the PCT proactively engages clinicians (PCT score 4.15 vs SHA average 4.28). PBC survey Dec 09 shows most of the 6 respondents feel they have a little influence with the PCT and that it involves them a little or not at all in its business

Recommendations going forward













- Make actively engaging with PBC a top priority and give them the opportunity to influence the agenda
- Follow-through on intent to send monthly comparative quality data (such as the existing GP scorecard) to practices and publish on website. Possibly make use of the DH Primary Care tool?
- Proactively engage with clinicians to reduce clinical variations, e.g., CHD. One intervention may be to facilitate learning across high- and low-performing practices on specific metrics

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

- 5a: Consistent methodologies used and insights from a range of stakeholders taken in determining health needs for local population.
- 5b: PCT has a view of unmet needs for its local population by locality and can identify trends in major health and wellbeing issues e.g. increase in obesity due to lifestyle challenges.
- 5c: As part of its strategic plan refresh, PCT benchmarked itself against national targets, top 10%, peer PCTs in England on priority health outcomes as well as local health needs. It then shared this information with the stakeholders involved in the refresh but not more widely. It plans, going forward, to do monthly benchmarking and share with providers, partners, public, but has not done so up to now

Recommendations going forward

- Ensure the PCT follows-through with its plans to share regular quality reports with all stakeholders

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	<ul style="list-style-type: none"> Predictive modelling skills and insights to understand impact of changing needs on demand 	●	☑	●	●
	<ul style="list-style-type: none"> Prioritisation of investment and disinvestment to improve population's health 	✓●	●	□	●
	<ul style="list-style-type: none"> Incorporation of priorities into strategic investment plan to reflect different financial scenarios 	✓●	●	□	●

Rationale for scoring

- 6a: Predictive modelling of demand and activity including scenarios (e.g., for demographics) and quality done using PWC tool for care pathways, e.g., pain and smoking control
- 6b: Ethical Decision Framework used to prioritise investments. Strategic (dis)investment initiatives have been generated using public health data, JSNA and stakeholder feedback and have been evaluated with stakeholders. However (dis)investment proposals and strategic initiatives do not yet have quantified predicted impacts on health and inequalities. No evidence of full annual impact reviews of (dis)investments
- 6c: Strategic initiatives have been developed based on gap analysis and have explicit (dis)investment requirements. Priorities include investment and disinvestment. Financial scenarios align with SHA guidance. Cross-cutting initiatives are identified and prioritised (e.g., estates, IM&T and workforce). However PCT has not yet reprioritised its investments and disinvestments for all 3 funding scenarios – for example, which initiatives will be dropped/ curtailed in the worst-case scenario where base case funding and/or planned savings do not materialise - and with what impact on health and services; PCT plans to re-prioritise as it goes along

Recommendations going forward

- Quantify the expected impact of each strategic initiative on health and inequalities, including milestones such that Board will know whether each initiative is working
- Include disinvestments and enabling initiatives in the prioritisation exercise – on the basis of, 'If this were a new investment, would it make the grade?'
- Take its prioritised list of investments, disinvestments and enabling initiatives, and identify the 'cut-off' points for each of the 3 financial scenarios. Then assess impact on services and health of dropping/ curtailing initiatives below the cut-off - and accordingly reprioritise if needed

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

- 7a: PCT has developed a robust market analysis using the PWC and McKinsey work. PCT's primary care team used the reports to identify areas requiring further work and performance management. PCT has identified a full range of core providers. Health market analysis identified the criteria for future providers for each care setting. The work on the Braintree Community Hospital demonstrates the PCT has assessed relative cost, quality and patient feedback of providers, including having a patient representative on the project team during the procurement process
- 7b: PCT uses projections of population need and demand to forecast required capacity by specialty. In its strategic plan the PCT identifies that acute provider capacity will need to reduce along with PCT spend. The benchmarking and cost analysis performed for key areas identified gaps in the market supply, e.g., in mental health, resulting in an action plan to address this. Number of ITTs registered with Supply2Health in 2009 was double SHA and national average (PCT 12, SHA average 6, national average 5)
- 7c: Submitted pathway redesigns (obesity, integrated care and minor oral surgery) included clear strategies to create more choice for patients. Patient choice survey 2009 showed 35% of patients received choice of hospital for first appointment (SHA average 43%) and 61% went to hospital of choice (SHA average 68%) – these results comparable to the 2008 results

Recommendations going forward

- Expand its success in identifying gaps in market supply for mental health to other areas like primary and acute care
- Perform cost/benefit analysis on opportunities to change or manage providers in priority market segments, to help overcome the financial challenges ahead while maintaining quality of services

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


- 8a: PCT has progressed to level 2. PCT shows clear ability in fact-based identification of improvement opportunities:
 - As part of its strategic plan refresh, PCT benchmarked itself on a large number of indicators against national, top 10%, ONS, etc in England to identify improvement opportunities
 - Some improvements based on cost/ productivity benchmarking (top-5-by-cost specialties including orthopaedics)
 - Others identified based on patient and provider complaints, even where indicators were good (stroke)
 - Integrated care based on a need to reduce costs and a clear need for better care of the elderly


Patients involved in all improvements. GP system data aggregated and analysed for integrated care work, and roll-out of predictive risk models as part of this will enhance ability to risk-stratify patients. Few and relatively minor redesigns led by PBC. Submitted pathways show specific interventions at each point in the pathway. To move to level 3 PCT needs to work more regularly and closely with providers – including PBC - to identify improvement opportunities
- 8b: Some good examples of improvement including orthopaedics, pain, integrated care and the very innovative 'Doc at Home' pilot. TDBs are the PCT's model for clinically-led quality improvement. No evidence of an improvement methodology such as Lean. Progress against objectives seems to be routinely measured for all new pathway redesigns. PCT clearly understands implications of improvements on quality and productivity. It has recently begun using a 'hotspot model' to map the workforce implications of improvements, but in the past was less rigorous about this (leading to problems with the new pain management pathway, for example). One great example of working with providers to mitigate risk is the development of a win-win tariff for the virtual hip clinic, but not clear how robustly PCT works with partners to identify and mitigate risks associated with improvements – again, pain management was an example where (workforce) risks not mitigated in advance
- 8c: PCT has maintained level 2 competencies to do with identifying quality and outcome metrics and monitoring them regularly. It has examples of near-real-time monitoring of measures where it could act to address issues arising, e.g., acute bed-state including waiting times, ambulances and hospital cleanliness. However as most improvement initiatives seem to be underway as opposed to fully implemented, it is difficult to evidence whether information collected is detailed enough to identify drivers of performance and quality. It is also unclear to what extent the PCT actively seeks and monitors opportunities to do better for less (link between quality and efficiency), although both quality and cost metrics are routinely tracked for improvements

Recommendations going forward













- Planned redesigns sound good
- PCT may wish to more rigorously risk-assess pathway redesign initiatives especially around hand-offs
- PCT should ensure it has quality and efficiency metrics for all pathways especially integrated care

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

- 9a: PCT understands provider economics and market dynamics (PWC market analysis) and identified economic impact of changing provider activity volumes and service spec (PFI sign-up, new mental health provider for IAPT). PCT is in the process of refreshing its fact base of providers building on the PWC market analysis work. Contracts include a broad range of available patient experience, quality of care and productivity metrics, e.g., Braintree Community Hospital contract
- 9b: PCT has locally-defined negotiation variables and provided examples of providers carrying significant risk to deliver agreed improvements, e.g., shifted PFI risk in the Braintree CH contract to provider. Examples of negotiating risk, e.g., in contracts with local GPs if activity exceeds contracted level, no payment - resulted in ~£1m saving. Too early to say whether negotiations have delivered a positive position for the PCT and providers to achieve a level 4 (world-class) rating
- 9c: PCT includes specified, measurable and practical outcome and quality metrics in negotiations. Contracts include local incentives such as for patient experience and clinical quality. PCT included clinical leadership in its negotiation teams and consulted on areas such as quality indicators for inclusion in contracts. Contracts include clearly-defined break clauses linking to quality variables where appropriate. However PCT did not demonstrate how contract incentives have resulted in health improvements, preventing a level 4 (world-class) rating

Recommendations going forward

- PCT has made progress in this competency and should strive to build on this. For example, it could develop its provider database through the Commercial Support Unit (CSU) to extract a variety of metrics and benchmarks by provider and disease group. It will need to demonstrate that contract incentives are delivering desired provider performance resulting in health improvements. Also that negotiation of contracts delivers a positive position for the PCT and providers (e.g., GPs) thus building stronger strategic relationships between the two as well as between providers

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

- 10a: Performance data includes KPIs covering all domains (quality, access and workforce). Performance information is included in Public Board Minutes published to the PCT's website. Data is less than 6 weeks old. Data is analysed monthly. Data is shared with providers when requested. Examples of near-real-time monitoring include Patient Tracker for patient experience in acute providers
- 10b: Regular reports on performance of main providers and discussions with them. Risk analysis of data on quality, access, patient feedback, workforce performed via contract management and visits to practices are made when issues arise. Provider performance is segmented by type and care setting. PCT works with providers to address issues focusing on root causes, e.g., elective caesarean services were not delivering on quality and safety and PCT took action by revising consultants' scorecard
- 10c: Contract compliance management in place through discussions in contract management meetings and escalated to Board if necessary, e.g., for 18-week targets. Mitigating action was taken and financial penalties imposed as a last resort. Improvement plans are actively monitored and tracked with strong record of delivery, e.g., achieved Chlamydia screening target through contractual levers

Recommendations going forward

- PCT has significantly developed this organisational competency. Panel recommends PCT develop near-real-time monitoring measures already in place towards a 'live ' dashboard of key performance indicators to drive fact-based continuous improvement in quality and outcomes

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

- 11a: EoE wide analysis and benchmarking of output efficiency has been of use and relevance to this competency, but has not been a determining factor for ratings. Recent pathways were developed based on analysis of outputs, spend level, spend by specialty, and outcome proxies (e.g. re-admission rate) – e.g. integrated care pathway. However not evident that the PCT analyses and benchmarks the output efficiency of all priority pathways (i.e., cost per patient-year for long-term conditions or cost per episode for short-term illnesses). PCT appears to have a good understanding of economics of major care settings, based on the economic modelling it has commissioned in the last year – taking it closer than average to a level 2 rating
- 11b: PCT has identified opportunities in priority pathways to:
 - Improve efficiency and effectiveness of spend (e.g., shifting care out of acute into the community, e.g.: minor oral surgery; integrated care)
 - Maximise impact into targeted local populations (e.g., elderly people – integrated care)
 - Minimise non value interventions (e.g.: avoiding unnecessary admissions through several pathway redesigns; uses NICE guidelines in pathway redesigns)
 - Capture provision efficiencies (e.g., more effective contract management of Braintree)

Within its own cost base the PCT is identifying opportunities for improved:

- Operational efficiency (running cost reductions)
- Capital efficiency (estates strategy)

...but not yet spend efficiency (no examples of PCT seeking to optimise its spend on supplies, IT, etc)

However the examples above are too early-stage and too few to justify a level 2 rating

- 11c: PCT has identified initiatives to deliver on some of the efficiency potential, though it is not clear which initiatives relate to what quantity of savings. PCT has engaged clinicians and worked with providers and partners in delivering initiatives such as integrated care. Delivery risks are identified in the strategic plan but not mitigation plans. Measures of success for initiatives are identified and measured. In general providers are performance managed. It was clear in Board discussions who is accountable for current initiatives. However completed efficiency and effectiveness initiatives are too few to say that all of this is systematic/ comprehensive enough to constitute an organisational competency

Recommendations going forward

- Seek to develop systematic output efficiency analysis and benchmarking for priority pathways