

# World Class Commissioning Panel Report

## Wolverhampton City PCT

May 2010



# Overview

First, the panel thanks Wolverhampton City 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 report sets out four main areas for consideration by Wolverhampton City PCT. It also sets out the panel's assessment on the Governance ratings and the Competency scores and the Potential for Improvement Commentary relating to the PCT Trajectory and Organisational Development.

# Commentary

The panel identifies 4 major areas for consideration by the PCT at this stage on its journey

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The panel were impressed by the following strengths of the PCT:

- An excellent board with united non-executive and executive corporate strength
- An organisation with a real focus on the needs of the population of Wolverhampton
- Mature partnership working with the Local Authority and wider community
- An excellent strategic plan with robust processes and structure for delivery
- Strong financial position forming a sound foundation for transformation
- Robust business alignment with Royal Wolverhampton Hospitals Trust

## 1. **Headline: Prioritise the patient experience metric**

Observation:

- There is Board coherence with a shared vision and understanding of its outcomes aligned to the needs of the population
- There are significant improvement in outcomes, in particular, reduction in prevalence rates for obesity in year 6 children and smoking quitters
- There is evidence of targeting initiatives to community need, however, there could be further refinement to meet the needs of diverse communities
- Patient and public engagement is intrinsic to the work in Wolverhampton; but the PCT should consider a comprehensive patient care experience outcome on its top 10 dashboard.

**Recommendation: The Board to consider adopting the patient experience outcome measure**

## 2. **Headline: Robust strategy aligned across the health economy**

Observation:

- There is an excellent strategic plan with a clear vision, set of goals and initiatives including a robust and health economy QIPP plan
- There is opportunity to significantly stretch the strategic aspiration to improve care in Wolverhampton and accelerate the pace of transformation.

**Recommendation: The Board should consider setting a higher aspiration for the strategic goals especially with regard to the pace of improvement**

# Commentary continues

## 3. **Headline: Sound financial plan with robust integrated QIPP plan**

### Observation

- The PCT has an underlying sound financial position that meets the requirement of the operating framework
- The financial plan is sustainable but cautious and opportunities exist for flexibility and earlier return on investment
- The Board has a robust understanding of the financial position, however, given the political uncertainty and likelihood of further budget reduction the Board should prepare for shaping disinvestment decisions.

**Recommendation: The Board to drive earlier and higher return on its investment and consider acceleration of the QIPP programme**

## 4. **Headline: Strong cohesive board with potential to move the organisation from 'good to excellent'**

### Observation:

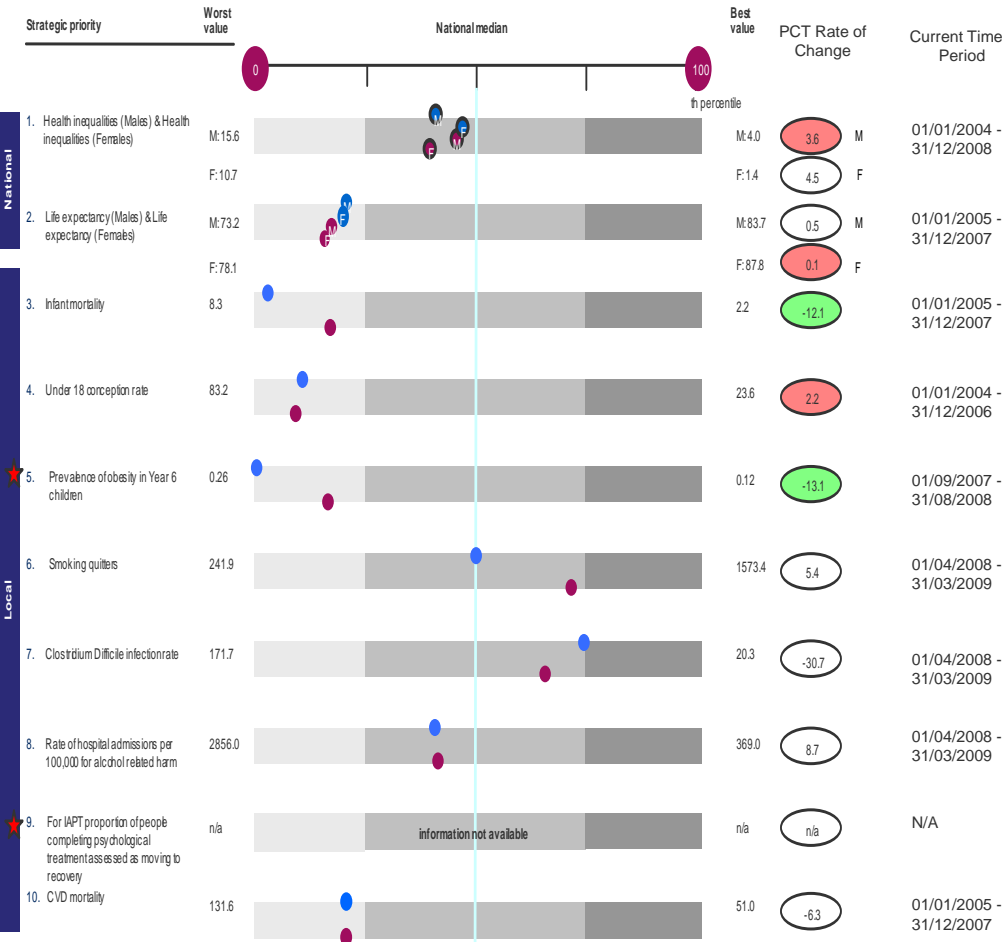
- The Board is committed to its diverse communities and exhibits robust and cohesive corporate governance behaviours
- There is real opportunity for the PCT to seize and 'locally lead the NHS' to set out and deliver systems transformation and service improvement
- There are evident developing clinical engagement capabilities, however, there is a real requirement for a step up with clinicians leading comprehensive system wide service improvement to industrialise and accelerate the transformation across the health system.

**Recommendation: The Board needs to aim high and develop system leadership capability to lead service transformation. The PCT needs to consider the step change in clinical leadership to develop improvement and innovation capability across the system to leverage change and achieve breakthrough performance.**

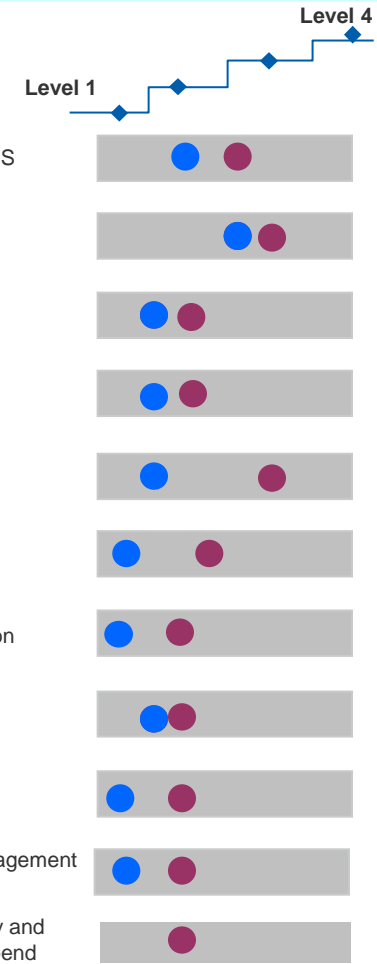
# Panel scorecard

## Wolverhampton City PCT Health outcomes and quality

Outcomes Selection Date: 2009/10



## COMPETENCIES



## GOVERNANCE

### Strategy



### Finance



### Board



# Potential for Improvement Commentary

## PCT trajectory

### Commentary

- This assessment has confirmed the substantial progress that the PCT has taken since WCC year 1. We are extremely impressed by the Board strength across all governance areas with robust Chair and Chief Executive leadership.
- The strategic plan is an excellent document with aligned goals and initiatives to deliver health improvement to the diverse communities in Wolverhampton. The PCT has a sound financial position and is well placed to deliver the QIPP challenge. The robust alignment with Royal Wolverhampton Hospital Trust and the Local Authority have enabled the health economy opportunity to ensure a sustainable position to 2013/14.
- The PCT is on a trajectory to a world class commissioning organisation. The panel congratulate the PCT on achieving green governance ratings with improvement in all of its competencies.

## Organisational development

### Commentary

- Alignment: There is robust alignment between Wolverhampton PCT and RWHT with shared ownership of the QIPP programme ensuring an agreed delivery structure and a sustainable health economy.
- Execution: Robust programme management structure established to ensure tracking of the initiatives and enabling the run rate of savings to be clearly reported to the Board.
- Renewal: Clear programme of practice based commissioning development and excellent evidence of systematic clinical engagement setting a strong foundation for service change.

### Areas for development

- The Board is in a sound financial position with a good strategy and has the opportunity to accelerate the pace of change and deliver improved health care to Wolverhampton people. To develop to world class the Board should seek partners and identify innovative and creative solutions for the Wolverhampton healthcare system e.g. transformation of the urgent care pathway.
- The PCT has a solid foundation of competence and the panel considers that the PCT should work within the cluster to share capacity and capability. The organisational development plan is comprehensive and some further prioritisation may help focus the organisation :
  - prioritise the development of competency 3 including the systematic measurement of patient /public engagement and ensure best use of the new West Midlands Digital Service to improve information flows and shape opinions/aspirations
  - identify PCTs that scored highly in competency 6 and adapt approaches for the Wolverhampton population
    - give particular attention to competency 4 and 8 developing clinical leadership and systematic world class service improvement capability across the system, which will be critical to delivery of the transformational plan
    - work on competencies 7, 9, 10 and 11 in partnership with West Midlands Healthcare Commissioning Services to optimise the committed resources.

### Areas for development

- Alignment: New cluster arrangements in the Black Country will enable the PCT to build on opportunities for leverage in commissioning decisions to reshape services out of hospital.
- Execution: The transformation plan is focused on major service pathway redesign, which requires a step up in clinical leadership across the system and world-class service improvement capability embedded in the organisation.
- Renewal: The Board needs to build its ability, and that of the senior executives and clinical leadership, to lead this transformational change. This would be helped by developing links with Kaiser Permanente or another established integrated care system to draw on experience and learning.

# Governance – Panel assessment on Strategy

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

Assessment	Measure	Red	Amber	Green
G	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 PCT vision is grounded in the needs of the local population, national requirements and financial context. It is ambitious, credible, with well-aligned initiatives and timelines.
- Strategic initiatives are focussed and the initiatives have been prioritised and detailed. The impact of initiatives on health outcomes is explicit, credible and measurable and is supported with milestones. The PCT has a detailed financial plan with 5 year horizons for investment/disinvestment and savings for QIPP initiatives. However, activity impact has been evaluated for only a few initiatives and does not demonstrate the effect on efficiency and effectiveness.
- On panel day the PCT demonstrated a clear and robust link between investment decisions and health outcomes, reduced inequalities, and efficiency and effectiveness of health services.
- The Board is aligned on the vision, goals and initiatives and is involved in strategic development with some degree of Board challenge. On panel day Board engagement in strategic development was evident.
- The PCT has reviewed historical milestones, has a history of achieving them and has demonstrated the impact of achieving milestones. There has been a review of performance from 2008 and factors of success have been outlined and a robust plan has been put in place.

## Recommendations going forward

The Board should consider setting a higher aspiration for the strategic goals especially with regard to the pace of improvement

# 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 surplus of £24.5m in 2008/09 and a £6.5m in 06/07 and £13.8m in 07/08 all in line with SHA expectations.
- The Board receives regular detailed financial performance reports covering key financial indicators and reviews, challenges and agrees required actions. The PCT has introduced monthly invoice reporting in light of the better payment practice code. The 2008/09 Use of Resources score of 2 for Managing Finances indicates no significant issues regarding debt and asset management.
- The PCT's inflation, activity assumptions and financial scenarios are in line with the SHA's expectations and fully meet the Operating Framework requirements. Most of the PCT savings have been identified through benchmarking. The PCT plan is aligned with provider capacity and demand. On panel day the PCT explained its QIPP savings plan as well as investments required to achieve those targets.
- Within the base case scenario the PCT is forecasting delivery of surplus in 10/11 and 11/12 reducing to a breakeven outturn in the following two years. The PCT is not showing an operating deficit over the next five years and the carry forward of significant surpluses reduces financial pressures.
- The PCT does not project an operating deficit in any year. The strategic plan outlines the recovery plan and associated actions that need to be taken in order to avoid deficits within the downside scenario.

## Recommendations going forward

**Board to drive earlier and higher return on its investment; consider acceleration of the QIPP programme**

# 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

- The organisational and governance structures are well set out with clear roles and accountabilities. The PCT has a core set of values that align to the organisational development plan and are consistently communicated to stakeholders. The PCT has a full programme structure in place to deliver QIPP including NED involvement in governance. Joint development needs and initiatives are in place with the Local Authority. The key capabilities to be developed are around leadership and social marketing.
- The PCT Board receives the Risk Register and Assurance Framework at every Board meeting, these documents describe risks relating to all areas of delivery including strategic initiatives and describes corrective actions. The PEC was last reviewed during 2006/07. On panel day the PCT evidenced PEC ownership of quality e.g. the PEC have carried out walkabouts with a range of providers to monitor quality and provide recommendations.
- Board performance reports are of a consistent nature and include accurate timely data and when underperformance occurs recovery plans are also presented. Acute and Community Provider reports contain a high level dashboard against key contractual requirements and detail against quality and operational indicators.
- The Board receives a comprehensive performance report which covers all deliverables including those supporting initiatives, underperforming targets have improvement plans presented and as a result the Board usually only agrees actions to be taken to improve. The PCT is delivering 74% (red) of its Vital Signs Tier 1 and 2 and Existing Commitments (based on DH assessment criteria for WCC).
- The PCT has described roles and responsibilities for delegation in the Terms of Reference for all groups, this is particularly evident in the refreshed PBC Governance Arrangements. A large number of initiatives are dependent upon delegation and partnership work. On panel day it was stated that the Board receives regular reports on performance and reports that come through the LSP – the ‘Keep it safe’ campaign was given an example where multiple partners achieved improvements. There is a joint governance group with the LA which reports back into the PCT Board.
- Board engagement and ownership was clear from submitted evidence. On panel day the Board demonstrated ownership and the ability to describe priorities and investment trade-offs.

## Recommendations going forward

**Board to aim high and develop system leadership capability to lead service transformation. PCT to consider the step change in clinical leadership to develop improvement and innovation capability across the system to leverage change and achieve breakthrough Performance.**

# Outcomes

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

## Wolverhampton City PCT health outcomes and quality

Outcomes Selection Date: 2009/10

Strategic priority	3 year historic rate of improvement (CAGR, %) <sup>1</sup>				PCT aspiration (CAGR)	
	PCT	National	ONS cluster	Top decile <sup>4</sup>		
National	1. Health inequalities (Males) & Health inequalities (Females)	3.6	0.8	1.5	-3.9	-0.3
		4.5	1.2	0.6	-9.4	-0.4
National	2. Life expectancy (Males) & Life expectancy (Females)	0.5	0.4	0.5	0.8	0.5
		0.1	0.3	0.5	0.6	0.3
Local	3. Infant mortality	-12.1	-3.0	-6.3	-14.5	-1.9
Local	4. Under 18 conception rate	2.2	0.0	0.2	-6.2	-2.0
Local	5. Prevalence of obesity in Year 6 children	-13.1	8.5	8.8	-7.5	-2.8
Local	6. Smoking quitters	5.4	3.0	5.2	22.1	7.3
Local	7. Clostridium Difficile infection rate	-30.7	-35.5	-46.2	-65.3	-4.0
Local	8. Rate of hospital admissions per 100,000 for alcohol related harm	8.7	5.7	1.0	-0.9	5.2
Local	9. For IAPT proportion of people completing psychological treatment assessed as moving to recovery	n/a	n/a	n/a	n/a	27.8
Local	10. CVD mortality	-6.3	-7.1	-9.5	-9.9	-4.1

### Observations from the Analytical Phase

#### Changes in outcomes from last year

- No deselected outcomes from the nationally defined list
- #5 and #9 have moved from local to national indicators

#### Performance over last year :

- Improvement on the following: #1(m), #3, #5, #6, #8, #10 with significant improvement on #5, #6
- #3 and #5 show top quartile rate of improvement
- Deterioration on the following: #1(f), #2, #4, #7

#### Aspirations:

- **The level of aspiration for 5 outcomes appear credible:**
  - #1, #2, #4, #6, #10 aspirations are in-line with ONS cluster median but do however fall below national median
- **The aspiration for #5 appears to be over-ambitious**
- **The aspiration for #3 might be more aggressive:**

#### Panel Recommendations:

Board to consider adopting the patient experience outcome measure

<sup>1</sup> 3 year period where available – please see appendix for variations where applicable for some indicators

<sup>4</sup> Top decile defined as the PCTs with the largest rate of improvement

# Outcomes Briefing

## Local Outcomes and Those Lacking Data

### Wolverhampton City PCT

PCTs were able to select outcomes from a menu provided by the national WCC team based on existing indicators, or where appropriate, develop their own local indicators.

This page provides information regarding local indicators where the PCT provided their own data for analysis or where national data was not available for a range of reasons against one or more of the 'pick list' indicators.

Outcome(s) lacking detail	Commentary	Panel Steer
IAPT Services, the number of people entering IAPT treatment	Wolverhampton City PCT part of third wave, programme to roll out IAPT services. Implementation of scheme planned to commence from 1st April 2010 (including training of staff). Therefore no historic data available.	<ul style="list-style-type: none"> <li>• PCT currently achieving 241. Target number for year 5 (2012/13) is 40. Trajectory could be more ambitious to reflect current performance.</li> </ul>

# Overview – Competencies

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



**Topline introduction**

PCT has provided evidence to meet or go above their self-assessment on 9 competencies

PCT has showed evidence to improve on their rating last year on all competencies

\* 1 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

- a) Key stakeholders agree that 'the PCT is recognised as a local leader' of the NHS (score of 5.37 out of 6), which is above the SHA average of 5.08. The PCT actively participates in and leads the local health agenda through various mechanisms, for example the PCT has taken a leadership role in the development of the City Involvement programme and has driven the growing pace of the personalisation agenda – Putting People First, Personalised Health Budgets. The local population agree to some extent that the NHS is improving services (MORI survey). The PCT understands and reacts to patient experience, it has created a framework for patient experience which comprehensively lays out engagement opportunities and ensures feedback on the performance of the trust which is then reported to the Board regularly for action. The MORI survey supports a level 2 score.
- b) Key stakeholders agree that the PCT 'significantly influences their decisions and actions' - score 4.93 out of 6 . The PCT has led the following: a Strategic Alcohol Commissioning Group with representatives from RWHT, Commissioning, Joint Commissioning, Public Health, Finance, Procurement and PBC localities. This includes a 'Keep it Safe' campaign led and funded by the PCT with police, which is having a positive effect. The PCT has also appointed Humana to lead clinicians and PCT and Joint and Practice Based Commissioners on a new strategy. Commissioner feedback is captured in regular interface meetings.
- c) The Staff survey indicates that 83.2% of staff have received job-relevant training, learning or development in the last 12 months, which is above the SHA average of 77.2%. 72.2% of commissioning staff agree that they have an interesting job, this is below the SHA average of 76.8%. On panel day it was reported that the latest staff survey shows relatively little movement, there are slightly better scores on staff agreeing they understand their role and where it fits in, as work has been done on scene setting and WCC. Staff focus groups have been undertaken to understand the results of the survey. Commissioning staff have been given exposure to SHA commissioned development programmes and there are two staff doing a Masters in commissioning.

## Recommendations going forward

Please see Potential for Improvement Commentary on page 5

# 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

- a) LAA priorities 2009/10 are produced through a process of engagement with stakeholder organisations within the Local Strategic Partnership (LSP)s annual meetings and partnerships, including the H&WBP. LAA targets are based on the needs highlighted in the JSNA and are linked to the strategic plan initiatives. The PCT were active contributors to the refreshed plans and were part of the cross cutting delivery planning inception. The PCT and LA are jointly accountable for LAA targets. The LSP Board receives quarterly performance reports showing performance against each indicator highlighting exceptions to current performance, proposed remedial actions, risks, etc.
- b) In the key stakeholder survey respondents agree that the PCT proactively engages with a score 4.87 out of 6. This is above the SHA average of 4.4. The JSNA refresh was developed by the Needs Analysis Governance Group of the LSP, this included PCT, Voluntary Sector Council, City Council and Police. The PCT has some shared posts and governance arrangements which are set out in an establishment agreement which defines the responsibilities of the PCT, WMSCG & LCCB. The PCT have senior Director level input into the LCCB and takes ownership of the specialised commissioning agenda for example, WMSCG commissions services for rarer conditions on behalf of PCTs to achieve efficiencies and improved quality of care. On panel day it was shared that the CCA has provided a glowing report around the partnership. All partnership working is internally reviewed and a work programme with links to the LAA developed. As a result changes have been made in areas such as alcohol, domestic violence and teenage pregnancy – changes were then made to the teenage pregnancy strategy.
- c) The feedback survey suggests that key stakeholders agree that the PCT is an effective partner 4.9 out of 6 (above the SHA average of 4.73). The PCT has several success stories of delivery through partnerships for example Wolverhampton received a CAA green flag of “Keep it Safe”, which reduced alcohol-related harm, improved safety and reduced health and police costs. It was led and resourced by the PCT and reached the CMO award finals.

# 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

- a) The communication and engagement strategy plan has effective strategies for communicating with the public and patients, for example the PCT is a lead site for Race for Health, for Pacesetters, Positively Diverse and DRE. The implementation of Mosaic has ensured better reach to diverse communities. Key stakeholders somewhat agree that the PCT proactively shapes health opinions and aspirations of the public and patient, feedback score of 4.39 out of 6. The PCT actively promotes independence, health, well-being, and personalisation of services.
- b) A new patient experience framework has been developed and is overseen by the patient and public involvement network group. A patient engagement database has also been developed and there is evidence that this engagement has led to improved health and service experience e.g. SSDP site acquisition. Local people have been involved in reviewing services. The PCT captures patient/public views which have affected commissioning plans, for example, PALS quarterly report and liaison with services on direct patient feedback, PET patient tracker scores routinely reported. Public and patients, somewhat agree, that the local NHS listens to the views of local people (MORI survey). On panel day the PCT described work that has been done using interpreters within primary care. There has been strong public feedback on site selection for a LIFT building resulting in selection of a new site. When patients reported dissatisfaction on out patient cancellations the PCT introduced new CQUIN schemes resulting in a reduction of cancellations from 20% to 12%. A major mental health review has been carried out that is heavily influenced by the public.
- c) The PCT has collected information using patient engagement and feedback. The public and patients agree the NHS is improving the health and well being of the population (MORI survey). On panel day it was reported there is a systematic approach to collecting patient feedback which is analysed and assessed for trends which are reported back to the Board and providers.


## Recommendations going forward













Please see Potential for Improvement Commentary on page 5

# 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				
<b>Rationale for scoring</b>					

- a) The PBC survey results suggested that the consortia had no influence over service redesign, and no involvement in developing the Darzi clinical pathways. Subsequent feedback (from the SHA) suggests that the view of PBC is now quite different from at the time of completing the survey. The PCT seeks views of a broad range of clinical groups such as the creation of a programme of locality engagement, bringing together managers of the local neighbourhood partnerships and PBCs to debate local issues from the perspective of commissioners and citizens, however, the PBC survey suggests that the relationship between the PCT and PBC is fairly poor. The PCT has reviewed the methods barriers and routes of clinical engagement and produced action plans but has not shown that it has delegated authority to clinicians as required to drive the agenda. On panel day it was described how a non-PEC GP was integral to the redesign of dermatology services. Clinicians in primary care, secondary care and mental health have formed a transfer of care board looking at taking work out of acute care. PBC has been restructured and involves 3 locality groups – service impact examples include cellulitis and diabetes. Problems in orthopaedics have been addressed by a group of secondary care and PBC clinicians. The strategic services development plan was refined after consultation. A non-PEC clinician is driving change in MH, particularly crisis response. The PEC includes a nurse, a patient representative, GPs and clinical observers from the acute and community providers. The PCT held a series of workshops with the clinical community relating to QIPP and agreed the way forward e.g. standardised care pathways. Care pathways have been led by GPs such as COPD and ENT.
- b) Both PBC groups rated the quality of support, quality of information, format and timeliness as neither good nor poor. The PCT has PBC governance arrangements which outline the process for financial management, local incentive schemes and agreement of indicative budgets but it is not clear how effective these are. On panel day it was clarified information-sharing is through a web based system, analytical support is made available to the PBCs through the information support function. The PCT have recognised this needs to move into a more evidence-based clinical information type support so have made a new appointment to address this. Currently the PCT have some comparative clinical information e.g. different referral rates but the PCT are planning a more ambitious approach.
- c) Key stakeholders agree that the PCT pro-actively engage clinicians, score 4.68 out of 6. The PCT has a track record of implementing some initiatives to redesign care for example Mental Health, childhood obesity and CVD pathway. The PBC survey results show that speed of PCT decision making for businesses cases and quality of feedback on business case decisions is neither good nor bad. On panel day the PCT confirmed that a process was in place to turn around business cases within 8 weeks.

## Recommendations going forward

Please see Potential for Improvement Commentary on page 5

# 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

- a) The PCT works in partnership with the LA and conducts regular needs assessments. The PCT commissioned specialist support to enhance its knowledge management capability. The methodology draws heavily upon “Window on Wolverhampton” which is led by the City Council in collaboration with partner agencies; health gaps have been re-analysed using techniques similar to the national inequalities tool. The PCT analyses progress towards reducing gaps (including health inequalities) and identifies the key causes of variance from expectations. The JSNA assesses current and future needs e.g. composition of Wolverhampton’s population projected to increase in BME groups and rise in older people which will have implications for future configurations of mental health services. On panel day it was demonstrated that the PCT triangulate data across a broad range of data. The PCT uses experience for segmentation and has looked at alcohol specific segmentation and adjust plans depending on findings.
- b) The PCT has a fact based list of major health risks and priorities facing its local population detailed in ‘We’ll live longer, healthier lives’ and risk factors are listed by age and gender, ethnicity and family history within the JSNA . On panel day the PCT evidenced Learning Disability and Mental Health that were chapters in the JSNA as driven by clinical leadership. The PCT has identified gaps at ward level and uses Mosaic for segmentation. Work has been done with the local partnership at the ward-level and progress is monitored by the PCT. The PCT has mechanisms for monitoring data e.g. early mortality information.
- c) The PCT benchmarks against national and international best practice to set progress milestones and has developed a systematic process called the DIUD process. This was first applied in the CVD pathway. The PCT’s outcome aspirations are clearly detailed and supported by actions / initiatives. On panel day it was noted that the PCT publicly reports and has information that goes out to the whole city population. There is also data shared on the PCT and LSP website. The PCT uses London HO tool, looks at ONS comparators and internal benchmarks such as QOF data – Oldham was used to learn lessons around teenage pregnancy, Bolton for emergency care. Patient experience reports and trends are submitted to locality boards on a quarterly basis.

# 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

- a) The PCT has carried out financial scenario planning for three scenarios. Predictive modelling has been demonstrated in the Cardiovascular Disease Model which uses indicators such as cholesterol and BMI. On panel day in the best and worst case scenarios, the impact on activity was demonstrated using the model provided by the HCS at HRG level. Changes proposed were assessed for quality impact as shown in the bubble chart, these were clinically driven. The PCT also looked for approaches that addressed quality and savings e.g. orthopaedic pathways which have been streamlined.
- b) A prioritisation framework was developed by the PCT in conjunction with Deloitte. All stakeholders are consulted in PCT decision making e.g. patients involved in procuring new GP practices . The PCT has described QIPP and initiatives on health outcomes. The PCT have developed a new local strategic partnership community engagement strategy.
- c) There is strong alignment between needs, vision, initiatives and investment plan. The PCT complete financial planning annually and investment/disinvestment decisions are articulated for three scenarios , these are selected to ensure alignment with the strategic plan and are shown across the whole system. The PCT engages with patients, public and partners including the LA.

## Recommendations going forward

·Please see Potential for Improvement Commentary on page 5

# 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













- a) The PCT has carried out a high level market analysis and a range of providers have been identified in detail. The PCT has looked at the relative cost for all providers and the relative quality and patient feedback is given for large providers.
- b) On panel day the PCT evidenced the dementia care hospital at home service as an example of a service commissioned and adjusted based on local need. The PCT has identified gaps in the financial plan, QIPP programme, IT and workforce and has devised mitigation plans to manage risks in the supply structure. On panel day different forms of market management were evidenced through examples such as dental contracts being re-negotiated with activity based on local needs and changes in dermatology activity and provision.
- c) The PCT reviews the market place and choice is created as evidenced by EAPC practices. Choice is limited in the Trust because only 1 major provider exists. However, choice is offered through 12 acute regional trusts and the Nuffield hospital and booking choice is offered at primary care. On panel day the PCT evidenced work with GPs to improve uptake of choice including monitoring if patients are offered choice e.g. appointment booking at GP practices. The PCT also carried out a marketing campaign to educate patients about choice.

## Recommendations going forward

Please see Potential for Improvement Commentary on page 5

# 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

- a) Childhood obesity, CVD is measured against regional and national benchmarks. The levels of improvement in childhood obesity in Wolverhampton was a result of the creation of a specific pathway with specific interventions identified for both the CV disease and obesity pathways. The CVD programme board has a patient representative.
- b) On panel day PDSA was evidenced as a quality improvement model used for key projects e.g. ophthalmology, with evidence of it being used and understood by key project staff. In the redesign of the mental health pathway the PCT demonstrated work with 5 providers to mitigate the risk associated with redesign. The PCT benchmarks progress through the JSNA.
- c) The PCT has described a range of key performance indicators and performance monitoring has been designed using ONS, and NICE with local and specific benchmarks. The PCT monitors pathway performance using local and national indicators and involves clinicians and patients. The PCT has robust systematic monitoring processes which are built into the contract to monitor providers monthly.

## Recommendations going forward

Please see Potential for Improvement Commentary on page 5

# 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

- a) The PCT has completed a review for each category of provider to detail economics and market dynamics. The PCT has created a framework for patient experience, VOICE and ECHO to provide comprehensive feedback to the Trust. Procurement compliance has been met.
- b) A variety of variables are used in contract negotiation including cost and outcomes. On panel day the PCT evidenced the process for evolution of negotiation strategy before each contract negotiation.
- c) PCT contracts include measures of clinical audit results, service level clinical outcome indicators and quality and safety indicators which reflect local priorities and targets, including infection control, equality, patient experience and public engagement. The PCT has a toolkit which provides national benchmarking and is used when negotiating contracts. All three contract examples have been signed in advance of activity being delivered.

## Recommendations going forward

Please see Potential for Improvement Commentary on page 5

# 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

- a) The PCT uses data to show the monitoring of performance for all providers, monthly data is provided and is less than 2 months old. In the refreshed PBC Governance arrangements the PCT’s responsibility to “provide agreed, timely budget and activity information each month” is clearly set out. Data is collated for a wide range of performance and quality outcomes.
- b) The PCT has a monthly performance report in the form of BAP (Board Assurance Plan) and is updated monthly by leads. Service managers provide report updates against plans on a monthly basis e.g. risk assessment PAP (Performance Assurance Plan) and underperformance has to be addressed with a PIRAT ( Performance Improvement Risk Assurance Template), risk analysis is completed as part of BAP and covers all areas of business.
- c) The PCT includes clinical quality indicators in all contracts , these also dictate that providers must give evidence that they are complying with defined quality standards etc. When contract terms are not met the PCT is ‘supportive and developmental’ in the first instance, providers are expected to self monitor contract compliance.

## Recommendations going forward













Please see Potential for Improvement Commentary on page 5

# 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

- a) QIPP indicators 'Better Care, Better Value, NHS opportunity locator, ONS cluster data and support from Deloitte have been used to benchmark the PCT. The PCT has shown how it is working with providers on the QIPP scheme with regard to benchmarked information. There is some evidence that the PCT has an understanding of the impact of the PCT's strategy on provider activity seen. On panel day it was explained that the ophthalmology pathway was being reviewed as the system is overburdened and requires more work to be undertaken in primary care. The PCT has reviewed the whole of their investment base and prescribing analysis has been done. A number of major opportunities have been identified through the QIPP work such as dermatology which was benchmarked, with a high number of follow-ups identified and the service redesigned for provision in the community. The PCT has used Better Care, Better Value data and Dr Foster information and found it was a significant outlier for first and follow-up attendances which prompted pathway work. The QIPP savings programme and elective growth has been agreed with RWHT. The QIPP plan shows how, over a 4 year period, the hospital gains in the first 2 years and then loses (total net loss of £173,000). There is a recurring problem of £3m at the end of 2013/14 and the PCT and hospital will work together to take the cost base down.
- b) Efficiency opportunities have been identified for the PCT's selected outcomes and improvements in care pathways which will result in savings of up to 10% of pathway cost through standardisation of follow up outpatients. The PCT has identified a number of areas including operational costs, and capital costs, for example, estates, travel, potentially sharing back office functions with other PCTs or public sector bodies where it can make efficiencies.
- c) The PCT has identified initiatives to deliver efficiencies which are linked to the QIPP programme. In delivering efficiency and effectiveness initiatives: the PCT has shown engagement of clinicians for example the development of the Gem Centre for Children and Young People but has not detailed any agreement of working arrangements with partners and providers, risks, impact measurement, performance management and enforcement of responsibilities. On panel day it was reported clinicians are engaged in driving efficiency and effectiveness of spend such as joint working in children's out of borough placements where cost and quality issues were addressed with a new process resulting in a recurring saving of £1.5m and better patient experience. The PCT described risks including boundaries around budgets across organisations; this was mitigated by creating a joint budget and sharing the risk and savings.

## Recommendations going forward

Please see Potential for Improvement Commentary on page 5