



COMPETENCY 5

GRASPING THE KEY TO SUCCESSFUL WORLD CLASS COMMISSIONING



The Information Centre

for health and social care



CONTENTS



Supplement editor
Sarah Dahlgren
Production editor
Amit Srivastava
Design
Nicola Kerr
Picture editor
Frances Topp

PERFORMANCE



What do PCTs need to do to gather the data they need and use it well? Read our 12-step guide to success...
Page 6

LOCAL PROFILES



From the groundbreaking Milton Keynes data observatory, to tackling obesity in children in Rotherham, to filling dental gaps in Bristol – local examples of information management from forward-thinking PCTs.
Pages 12 to 21

INFORMATION SOURCES



With the huge amount of data out there, it can be hard to find the analysis that is relevant to your PCT. But new support tools such as The NHS Information Centre's world class commissioning data pack can help you raise your game.
Page 22

GARY BELFIELD FOREWORD

World class analysis must lead to world class action

World class commissioning means major changes for primary care trusts. As local leaders, they are increasingly analytical and expert organisations, whose central role is to commission outstanding services for their populations. Professionalising commissioning and properly recognising commissioners' skills, knowledge and experience, is helping PCTs find a new focus and energy for adding life to years and years to life.

The co-production approach we took to developing the vision, competencies and assurance system seems to have paid off: 90 per cent of participants believe WCC will improve governance and commissioning.

The first year of the assurance process was about assessing ability and building a platform for future improvements. We now need to begin to see PCTs translate their burgeoning commissioning skills into improved health outcomes for their local populations.

Alongside this, the context of WCC is changing: PCTs can no longer count on funding future service improvements through growth. Commissioners will need to make tough commissioning decisions, driving efficiency and productivity in their providers and reducing cost or activity while not compromising on quality.

Understanding current and future population needs, data analysis, needs assessment, benchmarking and knowledge management, as described in competency 5, are all vital tools. The insights they provide should firmly underpin the development of coherent and robust plans and their implementation.

Two-thirds of PCTs received a level 2 for competency 5 in year one. There is, however, clear room for improvement, with panels highlighting areas such as analysis of future needs, translation of strategic needs assessment into service design and use of qualitative patient and clinician feedback. The analysis in this supplement also demonstrates the relationship between good performance in competency 5 and good performance in the other competencies.

PCTs are already rising to these challenges,

working with external experts or pooling resources with neighbours to supplement their own skills. To support them, The NHS Information Centre and other organisations are working to improve the availability of an enhanced range of data and tools. At the Department of Health, we are focusing on

developing a range of metrics to capture health improvements, working with the NHS, local authorities, patients and the public.

Sponsored by The NHS Information Centre, England's authoritative source of health and social care information, this guide sets out how PCTs

could do better on competency 5. It showcases pockets of excellence: Nottingham and Milton Keynes PCTs, for example, have used population segmentation, focus group research and online information gathering to deliver bespoke services that match the needs of their populations. By benchmarking themselves against higher achieving peers, they know when it is possible to make a bigger difference and use this knowledge to drive progress.

All PCTs can learn from the examples in this supplement. I hope it inspires commissioners to take innovative approaches to seeking out, analysing and acting on data, and improving health outcomes as a result.

Finally, please send us your feedback on competency 5, this guide or world class commissioning in general. Contact us via our new website, <http://wcc.networks.nhs.uk>. ● Gary Belfield is director of commissioning at the Department of Health

Find out more

Details of events and practical resources for PCTs at
→ <http://wcc.networks.nhs.uk>



TIM STRAUGHAN ON COMPETENCY 5



How to take a rounded picture of local needs

With its focus on knowledge management and needs assessment, competency 5 underpins all 11 competencies within world class commissioning and is the one primary care trusts need to master to deliver high quality services for local people.

For some, its emphasis on analytical skills, understanding need and benchmarking will have long been part of their approach to commissioning.

That was certainly the case for Milton Keynes and Nottingham City PCTs, which scored highest on competency 5 in last year's WCC panel assessments, achieving level 3. No trust achieved the top level 4.

For other PCTs, however, particularly the 41 scoring the lowest level 1, the first round of assessments will have spurred them into giving knowledge management greater priority and ensuring they have the right skills and resources in place.

By the time the second round of assessments takes place early in 2010, PCTs will need to demonstrate they have embedded needs assessments right across their organisation.

Assessment panel members will want to see a direct, causal link between the initial assessment of health need to the services delivered on the ground. They will also want to see evidence that commissioners are analysing the effectiveness of services in meeting need and improving outcomes.

From last year's assessments, it was clear that the joint strategic needs assessment (JSNA) is a vital component of competency 5. PCTs that got their JSNAs right tended to do well across the competency.

The hallmark of a strong joint strategic needs assessment was the extent to which it was part of a "live" relationship of information sharing between strategic partners and, crucially, the extent to which it was actually acted upon.

A further feature of the best JSNAs was the rigour with which they captured a rounded picture of local need that extended beyond purely NHS data. In the best examples, commissioners recognised that factors such as educational attainment, housing quality and employment levels act as key determinants of health and are therefore powerful indicators of potential health need which can support better targeting of interventions.

The NHS Information Centre provides a wealth of health and social care data that is invaluable at every stage of commissioning. Our expanding range of indicators helps commissioners understand local health and social care needs and outcomes. Tools such as our popular NHS Comparators and Compendium of Public Health Indicators help PCTs compare themselves with others and access programme budgeting information.

Last year's assessments revealed some commissioners are not familiar with core sources of data and where to access them. As a result, we are developing our website so it will signpost users to the information they need, whether from inside or outside the NHS.

We also believe the private sector plays an important role in tailoring national data to deliver value-added tools and services that support commissioners. The NHS Information Centre

“
The best PCTs recognised factors such as housing quality and employment are key determinants of health
”

NHS

The
Information
Centre

for health and social care

provides the private sector with market insight and access to national data which is vital to improving PCTs' understanding of the wider population. We work with more than 200 health information service providers and details of some of the leading organisations can be found on our website at www.ic.nhs.uk/work-with-us.

Gaps in nationally collected data – for example, in community services – can be a major problem for commissioners. We are working with others to tackle this. However, as a short-term solution, we are looking to see what community data is already held at local level that we may be able to start to standardise.

The new, massively upgraded data packs for WCC are now available online for PCTs to test. Covering some 252 indicators, we have developed the pack to offer greater functionality than its predecessor and more regularly updated information.

For many, publication of the packs will be a signal that the second year of world class commissioning is formally under way and that preparations need to begin straight away.

To support you in your efforts, The NHS Information Centre is sponsoring this guide to competency 5 as a way of sharing some of the many examples of good practice up and down the country.

We hope that this is useful and informative and inspires you to put high quality information at the heart of your decision making. ●

Tim Straughan is chief executive of The NHS Information Centre. The new WCC data packs are now available for testing at www.wccdatapacks.ic.nhs.uk

FACTFILE

A guide to competency 5 – and how PCTs performed on it

GIVE ME FIVE

What is competency 5?

Competency 5 is one of 11 competencies in the world class commissioning assurance process. It examines how well PCTs manage knowledge and conduct regular assessments of current and future local health needs.

Which sub-competencies does it include?

Analytical skills and insights; understanding of health needs

and trends; and use of health needs benchmarks.

What does the Commissioning Assurance Handbook say?

“Commissioning decisions should be based on sound knowledge and evidence. By identifying current needs and anticipating future trends, PCTs will be able to ensure that current and future commissioned services address and respond to the needs of the

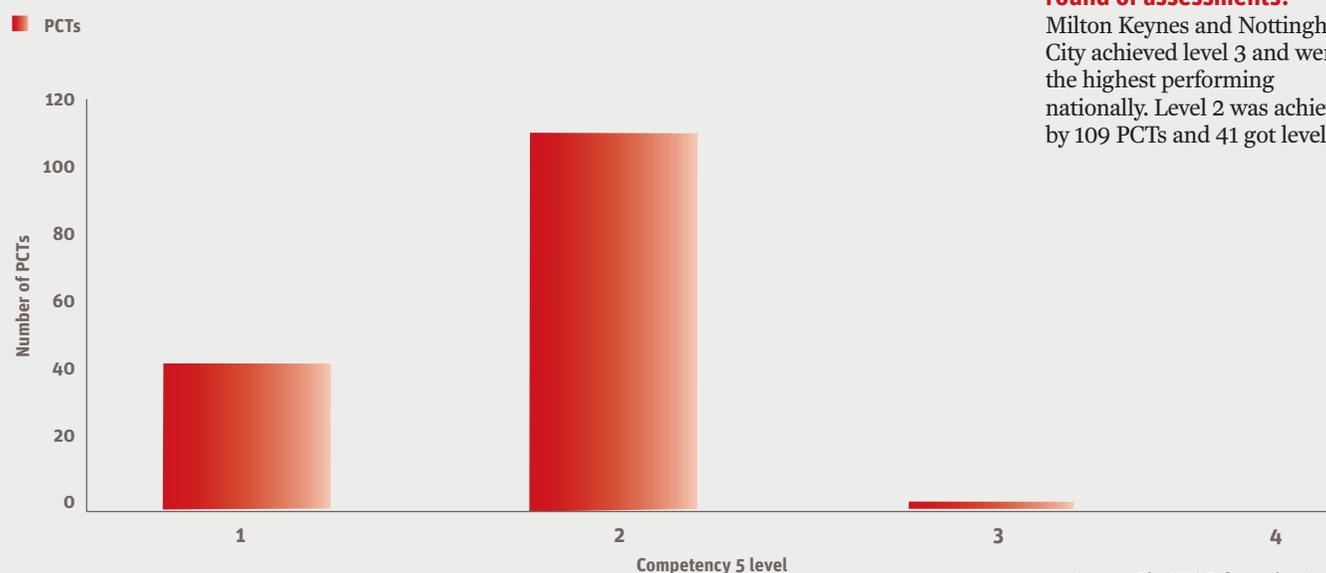
whole population, especially those whose needs are greatest. The joint strategic needs assessment (JSNA) will form one part of this assessment but when operated at world class levels will require more and richer data, knowledge and intelligence than the minimum laid out in the duty of the JSNA. Fulfilling this competency will require a high level of knowledge management with associated actuarial and

analytical skills.” (Department of Health, 2008.)

How is competency 5 scored?

Competency 5 is one of 10 competencies that are scored on a scale of 1 to 4 in the WCC assurance process (the 11th, finance, was assessed as part of governance in 2008-09). In the last round of assessments, no PCT scored the highest level 4 on competency 5 while two scored level 3.

Distribution of competency 5 levels



How did PCTs do in the first round of assessments?

Milton Keynes and Nottingham City achieved level 3 and were the highest performing nationally. Level 2 was achieved by 109 PCTs and 41 got level 1.

Source: The NHS Information Centre

When will the world class commissioning data packs be available?

They are available for testing now by PCTs at www.wccdatapacks.ic.nhs.uk. A final version with complete data and full functionality will be available from August.

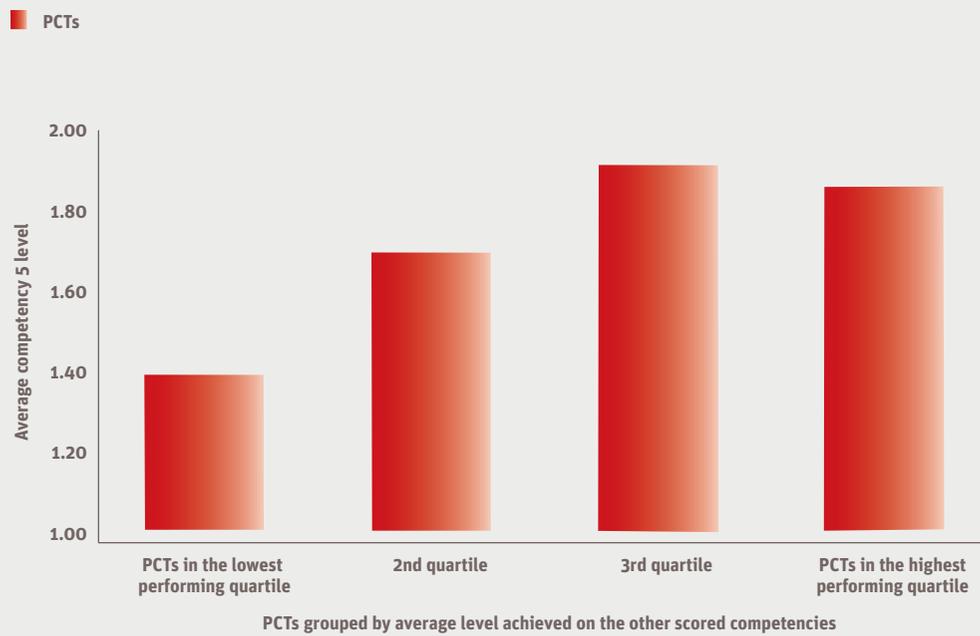
Where can I get information about the work of top performing trusts?

The experiences of Milton Keynes, Nottingham City, Bristol, Western Cheshire and Rotherham PCTs in approaching competency 5 are covered on pages 12-21. They are also available as case studies at The NHS Information Centre's website at www.ic.nhs.uk. A database of good practice on commissioning will be available from the NHS Institute for Innovation and Improvement from the end of July at www.institute.nhs.uk/pctportal.

Where can I get data and services to support my PCT's competency 5 performance?

The NHS Information Centre is the central, authoritative source of health and social care information and provides a wide range of products and services to help commissioners. For details of these, see pages 24 and 25, or go to www.ic.nhs.uk.

Average competency 5 level after grouping PCTs by their average level for the other scored competencies



Source: The NHS Information Centre

Did strong performance on competency 5 translate into good, overall levels of achievement?

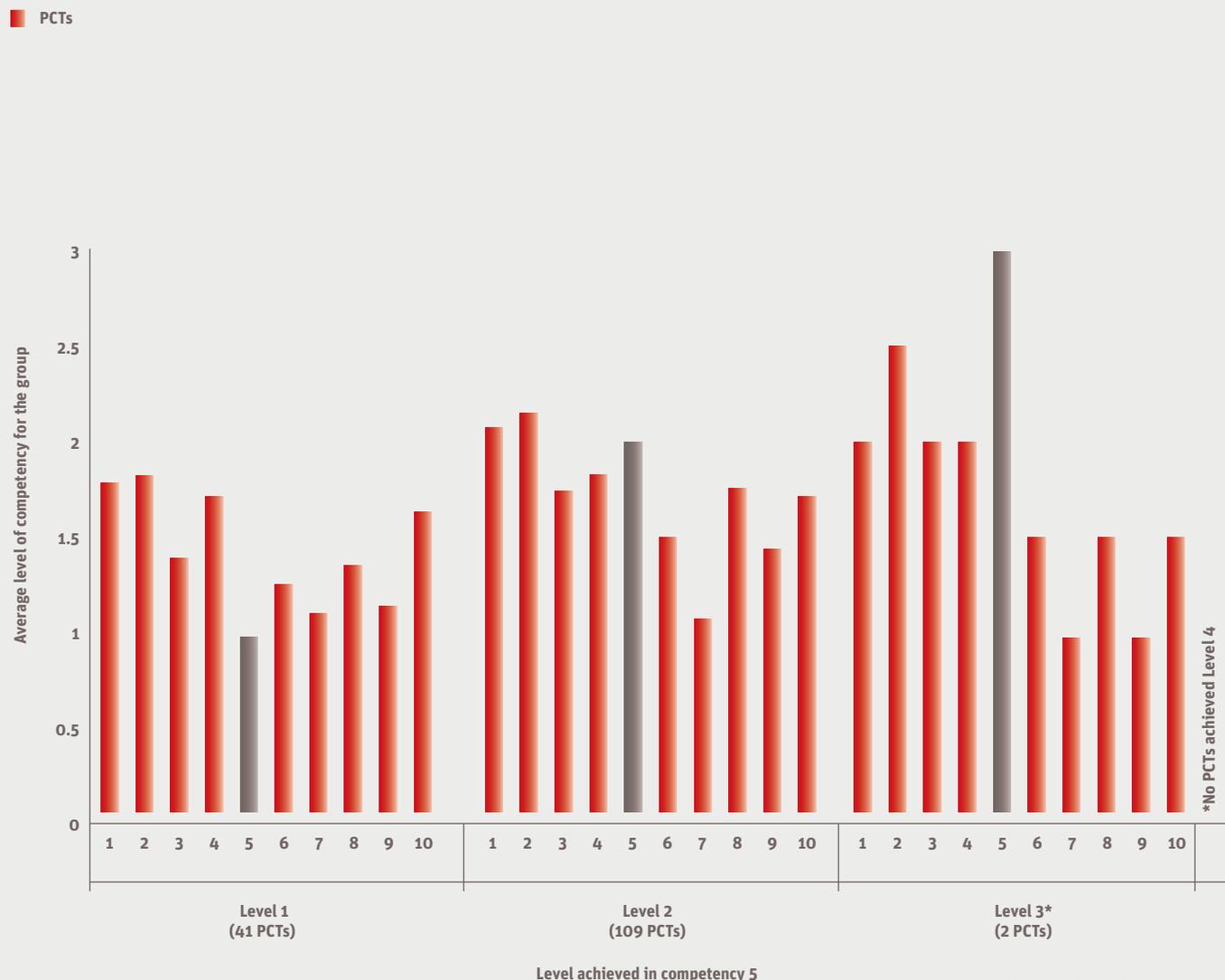
PCTs that were the bottom performers across competencies tended to score lowest on competency 5 too, as the graphic (left) shows. This suggests poor competency 5 performance may impact on achievement in other competencies...



...and those that achieved level 2 or above on competency 5 also tended to achieve higher levels on the majority of the other competencies, as seen below. So it appears there is a link between stronger performance on competency 5 and higher overall WCC achievement.

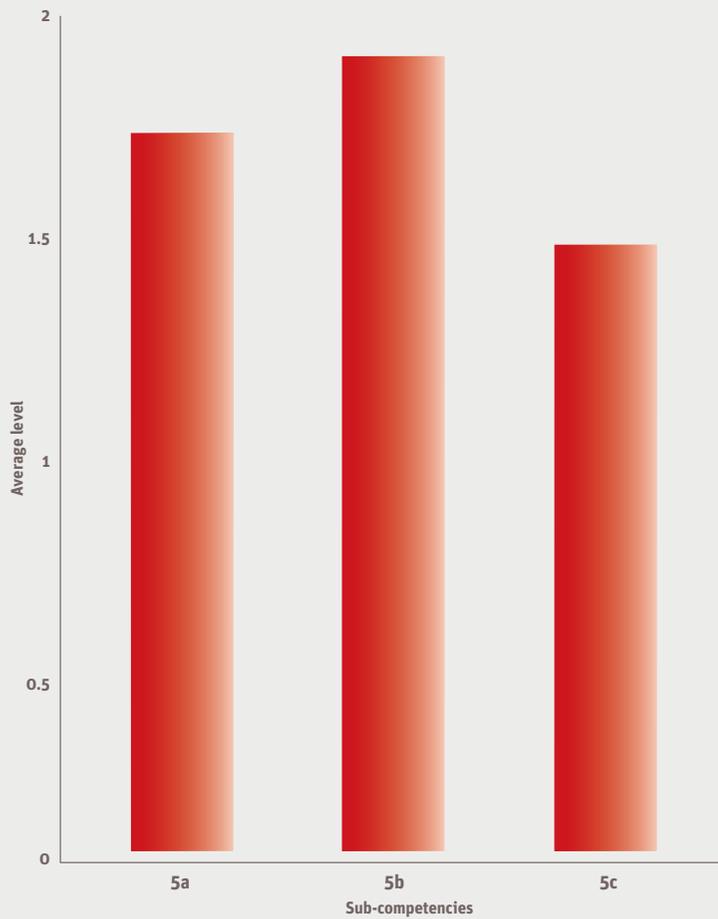


PCT performance for each of the scored competencies, grouped by achievement level for competency 5



Source: The NHS Information Centre

Average PCT performance for competency 5 sub-competencies



Source: The NHS Information Centre

Did PCTs fare equally across the sub-competencies?

No. PCTs tended to do best on 5b which is about needs assessment and worst on 5c which is about the use of benchmarks.

Which PCTs scored level 3 for each of the sub-competencies?

5(a) Analytical skills and insights: Barnsley, Milton Keynes and Somerset
 5(b) Understanding of health needs trends: Knowsley, Milton Keynes, Nottingham City, Northamptonshire and Rotherham
 5(c) Use of health needs benchmarks: Nottingham City.

When is the next round of WCC panel assessments?

PCTs will be expected to begin preparations in September and give their submissions to their strategic health authority by mid-December. As part of the process, assessment panels will spend a day with each PCT during April and May 2010.

World class commissioning assessment timeline



Ongoing follow-up

Source: Department of Health

PERFORMANCE

TWELVE STEPS TO PERFECT COMPETENCE

The NHS Information Centre's director of commissioning Sandra Hills on the key characteristics of strong PCTs

Competency 5 of the world class commissioning framework is about harnessing high quality, timely information to develop the best services for patients. While performance in the competency varied markedly between primary care trusts, it was clear that the high achievers shared some common features which others need to emulate in the next assessment round. They were:

1 Working in partnership

The joint strategic needs assessment is a crucial element of competency 5 and indicates how well a PCT is using knowledge to assess current and future need. In the best instances, the needs assessment forms part of a live relationship in which local bodies continually share information so that decisions – irrespective of who makes them – are based on a common understanding of need.

Milton Keynes provides a good example. The Milton Keynes Observatory, a constantly updated repository of local information, is jointly run by Milton Keynes PCT and Milton Keynes council. The PCT chief executive Nick Hicks is also the city's director of public health, a joint appointment with the local authority, and many services are jointly commissioned.

2 Sharing knowledge

Gathering and analysing information is crucial, but disseminating it is important too if it is to lead to action. Nottingham City's needs assessment is on a partnership website and the local NHS meets with bodies such as the police and local charities to help them understand its value and act on its information.

To support patients, Islington PCT has used quality and outcomes framework, patient experience and referrals into secondary care data to produce a sophisticated online scorecard to help people choose a GP practice.

But sharing knowledge often needs to start at home. Rotherham's director of public health Robin Carlisle says data analyses only lead to change if they are

properly understood by board members. His team produces an annual strategic intelligence review which summarises data from a range of sources and is given to board members as well as partners. It also produces summary data at neighbourhood level for seven local assemblies.

3 Securing high quality resource

The best performing PCTs produce data analyses that are compelling enough to stimulate change. To do this, they rely on senior analytical staff to construct from the raw data challenging questions about service provision.

With a shortage of analytical staff across the NHS, PCTs use different approaches to secure enough skilled resource.

Bristol PCT shares access to the Avon IM&T (information management and technology) Consortium. In Western Cheshire, much analysis is done in-house but a large primary care analytics project is contracted out to an independent provider.

While Milton Keynes PCT's in-house team models different scenarios when planning for the future, other PCTs are constrained by limited resources. Rotherham recognises it may never be able to employ a full-time health economist. However, for some analyses, it uses local universities and, together with other PCTs, it commissions programmes from Yorkshire and Humber Public Health Observatory.

4 Getting a total picture of need

To commission services effectively, PCTs need to understand that non-health data such as crime levels, educational attainment and housing quality are important proxy indicators of health need. Because of this, the PCTs who did best on competency 5 looked beyond NHS data to get a total picture of need.

Rotherham's work to tackle teenage pregnancy, for example, identifies girls most at risk by examining a range of social risk factors such as educational attendance and ward of residence.

However, the panel assessments showed some PCTs were not as familiar as others



with core data sources or where to access them. For these PCTs, increasing their knowledge of data sources needs to be a priority and, to support them, The NHS Information Centre is developing its website to help them find the data they require.

5 Identifying unmet need

Identifying unmet need is vital to tackling health inequalities.

In a review of its dental services, Bristol PCT drew on local data sources to compare the number of people accessing services with the number its analysis suggested should be expected to be accessing them. The difference indicated the level of unmet need and commissioners were able to break this figure down for different parts of the city to decide where new services should be located.

In Rotherham, identifying unmet need is part of its strategy to improve the effectiveness of GP practices. The PCT provides benchmarking information which enables practices to compare actual prevalence levels with indicative prevalence levels. From this, they can identify conditions for which they are failing to identify patients and take steps to address the problem.

6 Using up-to-date information

Lincolnshire PCT's chief executive John McIvor gets daily data from his accident and emergency providers, something he believes is essential to tracking trends and potential problems.

However, many PCTs fail to get the basic facts they need quickly enough to commission effectively. They need to address this by working with providers to get data in a timely way.

Where there are gaps in nationally available data, for example in community



Choose wisely: the River Place health centre, Islington, where the local PCT has developed an online scorecard to help people choose a GP; far left, The NHS Information Centre's commissioning director Sandra Hills

services, proactive PCTs have developed local systems for getting regular and timely data flows. PCTs without such systems have no means of monitoring the effectiveness of large parts of NHS spend.

7 Understanding difference
PCTs of all sizes have a large range of population groups within their patches, often with wide variation in life expectancy. The PCTs that did best on competency 5 recognised that blanket solutions do not make financial sense or tackle inequalities.

In a recent initiative to tackle teen pregnancies, Nottingham City used MOSAIC segmentation to improve its understanding of the characteristics of the girls most at risk of pregnancy. This insight helped it to tailor appropriate interventions.

In separate work, the PCT carried out market research to develop insight into residents' smoking and used the information to develop a stop smoking social marketing campaign.

8 Benchmarking
Benchmarking is an ongoing process that challenges commissioners to scrutinise their approach and make sure they have reached the best possible solution.

On teenage pregnancy, for example, Nottingham City benchmarks itself against Liverpool – a city with a similar demographic profile that has a strong record on tackling teenage pregnancy.

However, it is also prepared to look further afield and on cardiovascular disease wants to position itself internationally so that its work is exposed to greater scrutiny.

Within a locality, benchmarking is also important. For example, Rotherham PCT produces a disease-specific comparative

benchmarking tool that analyses the care delivered by its 39 practices. This is to raise questions about clinical practice to ensure GPs are challenged to deliver the best quality care.

9 Using the third sector
The third sector has extensive experience of working with specific, often hard to reach cohorts. They not only serve as a valuable source of information but also as a potentially effective provider of services.

In Bristol, for example, the charity Barnardo's has been appointed to deliver outreach elements of the city's new child and adolescent mental health service. This recognises the fact that many of the target user group are non-attenders at school and are often looked after by the local authority.

Traditional models of service have struggled to reach this group in the past so the involvement of Barnardo's is part of a new approach aimed at meeting currently unmet need.

10 Stratifying risk
People whose condition puts them at medium or high risk of admission into secondary care consume 60 per cent of services, according to Jim Hughes, director of knowledge management and performance at Western Cheshire PCT.

His team have introduced a service that stratifies the population by risk of hospital admission. When a person moves from medium to high risk, the PCT and the person's GP practice is alerted – creating the opportunity to put in place interventions to keep the patient well.

Stratification of the patient population has also helped in deciding the caseload of community matrons, ensuring they are

deployed in a way that has maximum impact in stemming the rate of increase in hospital admissions.

11 Embracing new service models
Western Cheshire PCT has also introduced a new health coaching scheme which people can call to discuss health issues. A key aim is that it will attract people with a long-term condition who do not use GP services and instead call "999" when crisis hits. The PCT estimates the service could reduce the rise in hospital admissions by 6 per cent by the end of its first year.

Bristol PCT has put Brook sexual health advisers in every school in a bid to reduce teenage pregnancy rates and evaluations of the scheme show it is a particularly useful way of reaching young men.

12 Programme budgeting
Programme budgeting information from the Department of Health maps all PCT and SHA spending to 23 programmes of care based on medical conditions such as mental health, cardiovascular disease and cancer.

It helps commissioners check if they are spending enough on particular diseases or getting good enough outcomes for their investment. Programme budgeting information linked to clinical and health indicators is now available as an atlas on the National Centre for Health Outcomes Development website (www.nchod.nhs.uk), a service managed on behalf of The NHS Information Centre.

At Milton Keynes PCT, commissioners used programme budgeting data to identify that spending on diabetes services was high while standards of care were poor. This helped them decide to carry out a full review of diabetes care that has led to improvements in community services. ● Sandra Hills is The NHS Information Centre's director of commissioning.

For more on examples of good practice, see the PCT profiles on pages 12-21, or go to The NHS Information Centre website at www.ic.nhs.uk

ASSESSORS' VIEWS

HEALTH DATA IS

Experts who sat on the world class commissioning assessment panels share their views on how primary care trusts are performing – and their top tips

HAROLD BODMER

Director of adult social services,
Norfolk county council

The panel interviewed board members from each of the PCTs it was assessing and this was a vital part of the assurance process.

We were briefed in advance by a team of independent analysts and strategic health authority managers, who had already studied each submission. They provided us with a summary of the key points from each PCT's supporting documentation.

The joint strategic needs assessments were clearly a core element of competency 5 and, as a local authority manager, I was keen to see a rigorous process in place for developing them and embedding their use across local organisations.

The PCTs I saw had established enviable partnership arrangements with other local bodies. They had put in place excellent infrastructures and governance procedures to support effective working. However when it came to information it appeared that, despite having the levers in place, PCTs were not necessarily pulling them in order to bring about tangible change.

I felt the PCTs I saw showed a high level of skill. On benchmarking, in particular, they displayed good methodologies which will stand them in good stead in the forthcoming round of assessments.

They were weakest in the range of information sources they used, which I felt was far too narrow. They focused far too much on NHS data at the expense of local government data on issues such as education and social care or, indeed, central government statistics on crime. This meant they did not necessarily achieve a truly complete picture of their population's need.

As a general point which applies to social care as much as health, I felt the assessments showed there is a general need to put in place robust processes for ensuring needs assessments are acted upon and that they

On the panel (from left):
Simon Williams, Harold
Bodmer, Rosamond Roughton
and John McIvor



TOP TIP

Needs assessments should look well beyond health data to ensure a total picture of community need

NOT ENOUGH



become the basis of decision making. While I am hopeful this does happen in practice, during the assessment days it was not clear to what extent commissioning decisions could be tracked back to the needs assessment.

I was struck by the importance every PCT board member attached to information and that bodes well for the second round of assessments. Every board member had a strong understanding of the importance of establishing need and how that underpinned strategy. But on the day, they were not able to demonstrate the extent to which their own strategies were based on actual analysis.

I would have liked to see strong joint analyses supporting whole-community services. Needs assessments are supposed to be shared resources which can be used by every local organisation. That should lead to joint investment and commissioning of projects promoting wellbeing and health equalities. This requires joint planning and a shared understanding of need.

JOHN McIVOR

**Chief executive,
Lincolnshire PCT**

The PCTs I saw were acutely aware of the importance of information and the need for timely, comprehensive data.

However, they failed to show how they were analysing data in a way which transformed it into compelling questions which were powerful enough to stimulate change.

I think that was partly down to a lack of senior analytical capacity and that is something most PCTs will need to address if they are to improve the way they use information to support world class commissioning.

It was clear both acute sector and community services providers were →10

TOP TIP
Invest in senior analytical staff able to construct the kind of challenging questions that stimulate positive service changes

LOCAL PROFILE: MILTON KEYNES

I CAN SEE CLEARLY NOW

Milton Keynes Observatory delivers rich information on everything from crime to smoking, right down to ward level, in a model example of joined-up working

The Milton Keynes Observatory is a constantly updated repository of information about every aspect of life in the city. It covers crime, education and health, providing a detailed socio-economic map of each part of the city – right down to estate and ward level.

Jointly run by Milton Keynes primary care trust and Milton Keynes council, the observatory is a key part of the local bodies' efforts to track the changing demographics of a rapidly expanding population.

It ensures that decisions, irrespective of which organisation makes them, are based on a common understanding of the local area. It is also the principal resource from which the city's joint strategic needs assessment derives, and that, in turn, informs the local plan.

The existence of the observatory indicates how joint planning between local bodies is embedded in the city – a practice aided by the virtually identical area each body serves.

Joint appointment

Indeed, Milton Keynes PCT's chief executive and director of public health Nick Hicks is a joint appointment with Milton Keynes council. His team of 100 or so staff cover two vital areas:

- strategy, planning and public health, including needs assessment and service specification; and
- contracting and market development, including developing tenders and encouraging the existence of new providers.

"Our job is simple to



Dr Nick Hicks: joint public health role between PCT and council

describe," says Dr Hicks. "It's about turning taxpayers' money into better health, fewer inequalities and ensuring good access to really great services."

The strategy and planning team uses core information sources as a radar which constantly scans services, searching out clues that suggest closer review may be needed.

One service recently picked out for in-depth review was maternity. "Data such as birth rates, infant mortality, levels of smoking in pregnancy and patient complaints were alerting us to the fact that all was not well," says Dr Hicks. "We carried out a detailed analysis drawing on information such as staff surveys and user group panels and what emerged was a picture of a service under considerable pressure due to rising birth rates and too few midwives.

"As a result, we've put a strategy in place which will see us investing more money to ensure women get a better experience of maternity care."

Dr Hicks wants to see a clear



Testing times: checking blood sugar with a finger prick test in Milton Keynes, where community diabetes services have been overhauled

Competency 5: Panel assessment

PCT's Self Assessment
 Panel Assessment

Competency	Measure	Level 1	Level 2	Level 3	Level 4
Manage knowledge and undertake robust and regular needs assessment. Overall level: 3	• Analytical skills and insights	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
	• Understanding of health needs trends	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
	• Use of health needs benchmarks	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

WHAT THE PANEL SAID

The PCT should consider developing geographical area-based performance reports to drive improvements in health inequalities.

HOW MILTON KEYNES IS RESPONDING

Tackling inequalities is our priority and we want to turn all the things we already know into improved services for residents.



link between need and spend. "There is a very straight line read-through from our needs assessment to our strategic commissioning plan. We want to improve life expectancy and that means preventing more premature deaths, principally from the three main killers: cardiovascular disease, cancer and respiratory disease.

"Our accounts are a clear statement of where our priorities lie and we use Department of Health programme budgeting figures to help us examine expenditure on each disease group. That's helped us understand where we're getting poor value for money and, when combined with information on outcomes, gives us a set of priority areas."

His team uses a huge variety of information sources in their analyses of local health. "We start by examining the core data sources, most of which is nationally held data such as

mortality data, National Centre for Health Outcomes Development data, Hospital Episode Statistics and NHS Comparators data to get a picture of where our outliers are and to prompt questions about service delivery," he says.

"When we are examining health, we look from a variety of angles to get the most comprehensive picture of need."

Prepared for budget cuts

A priority is to ensure the NHS is able to deliver residents a good standard of care whatever the future holds. For this reason, the PCT models healthcare provision up to three years ahead, assuming differing levels of resources. "The strategic health authority originally told us to assume the NHS would be allocated 5.5 per cent growth this year and next and 4.5 per cent for the following three years," says Dr Hicks. "But we modelled for a range of finance scenarios, including the possibility there will be no growth or even cuts in budgets."

He is mindful of the approach to information use set out in the world class commissioning framework and, while pleased with his team's performance on competency 5, he adds: "We don't want to hit a target and miss the point. Our real aspiration is to be excellent sustainably." ●

→ www.miltonkeynes.nhs.uk
National Centre for Health Outcomes Development

→ www.nchod.nhs.uk
Hospital Episodes Statistics

→ www.hesonline.nhs.uk
NHS Comparators

→ www.ic.nhs.uk/nhscomparators

PATIENTS 'THRILLED BY IMPROVEMENT IN CARE'

Community diabetes services in Milton Keynes were overhauled six months ago after a review which included an analysis of quality and outcomes framework data.

This showed diabetic care offered by GPs in the city was worse than that delivered regionally and nationally. Yet the city was spending more on diabetes than other similar areas.

"We cross-referred diabetes data with data for obesity. That showed practices with the highest levels of obesity were also those with the worst QOF results for diabetes care," says Milton Keynes' primary care trust director of strategy and planning Diane Gray.

The retirement of a diabetologist created a chance to reshape services and review the care pathway. Key changes included training for GPs; two new consultants to support community-based care; initiatives to encourage patients to be involved in care; and an online resource for patients.

Six months into implementation "anecdotally we've had positive feedback", says Dr Gray. "And patients have been thrilled by the improvement in care."

QOF results at www.qof.ic.nhs.uk

TALE OF TWO CITIES

How Nottingham City is tackling problems such as teen pregnancy with creative methods – notably benchmarking against a comparable city, Liverpool

In Nottingham, the girls most at risk of falling pregnant in their teens come from families with low and uncertain incomes. They live in social housing, typically in just a few small areas of the city. “These details may sound unimportant, but they are vital elements in helping us get an in-depth understanding of the small group we need to target,” says Nottingham City primary care trust chief executive Andrew Kenworthy.

The trust uses a range of approaches, including MOSAIC market segmentation, to better characterise the girls most at risk. It uses this insight, together with other principles of social marketing, to develop more targeted interventions.

Its examination of variation and trends helps it to pinpoint the cohorts it needs to target for its four most intractable health issues: cardiovascular disease, sexually transmitted diseases, smoking and teenage pregnancy.

Most recently, its locally specific profile of the teens most at risk of pregnancy has enabled it to draw up a strategy that it hopes will lead to a range of successful interventions.

“Teenage pregnancy has been a long-standing problem in Nottingham,” says Mr Kenworthy. “The traditional, best practice approaches haven’t worked so we’ve been spurred by necessity to look for new ways forward which are specifically tailored to local circumstance.”

As England’s thirteenth most deprived local authority area, Nottingham has looked to Liverpool, which has similar demographic characteristics and a strong record on teenage



Andrew Kenworthy: “Traditional approaches haven’t worked”

pregnancy, as the most relevant comparator against which to benchmark its performance.

“Benchmarking helps us make sure we have done everything possible to tackle an issue,” says Mr Kenworthy. “We see it as an ongoing process, not something to be done at the beginning or end of a project.”

How to deploy resources

The importance of information to commissioning is ingrained at the PCT, with knowledge management led by a consultant in public health.

“There’s a tendency in the NHS to think that money spent on public health expertise is money not being spent on service delivery,” says Mr Kenworthy. “But understanding population need is the key to deploying resources discerningly. Blanket solutions don’t make financial sense or tackle health inequalities. Instead, what’s needed are targeted approaches focused on very specific population groups.”

The PCT has a well developed



Sparking a response: Jo Hopkin, an adviser at the New Leaf stop smoking service. Calls to New Leaf surged after a successful marketing drive

Competency 5: Panel assessment

PCT's Self Assessment
 Panel Assessment

Competency	Measure	Level 1	Level 2	Level 3	Level 4
Manage knowledge and undertake robust and regular needs assessments. Overall level: 3	Analytical skills and insights	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
	Understanding of health needs trends	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
	Use of health needs benchmarks	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

WHAT THE PANEL SAID	HOW NOTTINGHAM CITY PCT IS RESPONDING
PCT needs to do more work to embed population segmentation using social marketing techniques.	Up until now we have applied social marketing techniques to our priority health areas. We are now working to embed them across everything we do.
Health needs and inequalities have been detailed down to the level of wards.	We strive to get an in-depth local picture of need so we can devise solutions tailor-made for small cohorts.
Panel were impressed by the use of benchmarking to test local performance.	Benchmarking is critical and we want to develop it further by profiling our work internationally so it is exposed to even greater scrutiny and challenge.



SMOKERS FINALLY GET THE MESSAGE

A campaign developed using social marketing techniques helped Nottingham City primary care trust meet its 2008-09 smoking cessation target a month ahead of schedule.

In its first month, the campaign prompted more than 238 extra calls to the city's New Leaf stop smoking service. That increased demand meant the PCT met its smoking cessation target early for the first time ever.

"We already knew the distribution of smokers by using MOSAIC segmentation techniques," says Indu Hari, Nottingham's tobacco control strategic manager. "But we built on this by carrying

out focus groups to find out attitudes to smoking among them.

"This told us that common reasons for quitting were to have more years with grandchildren and to be fit enough to play football with a son.

"These were messages which rang a strong chord locally and became the themes of our campaign.

"We pre-tested the campaign ahead of its launch so we were confident it would be effective."

At 38 per cent, smoking rates in Nottingham are well above the national average – something the PCT links to local deprivation and a history of cigarette manufacturing.

joint strategic needs assessment, accessible through a partnership internet site, NOMAD+ (www.nomadplus.org.uk), to support managers to commission according to need and identified evidence base. "We want data to be used," says Mr Kenworthy. "For example, a pharmacist wanting to set up a new pharmacy could look at our needs assessment to see which areas have highest need for that type of service."

Promoting needs analysis

One of the PCT's priorities is to ensure that information about its needs analysis is routinely used by community organisations. To promote this, it is conducting presentations to bodies such as the police and local council to ensure the depth and potential of the information is properly understood.

"We did well on competency 5 and the panel assessment gave us a reasonable sense of how we are expected to move forward," says Mr Kenworthy.

"We want to take the techniques we use to analyse and then tackle our priority health issues and apply them systematically and consistently across all our work.

"We also want to invest more resources in sharing good practice and raising our profile internationally for the work we have done in, for example, cardiovascular disease. That will expose what we are doing to greater scrutiny and challenge which will in turn drive further improvement." ●

→ www.nottinghamcity.nhs.uk

9 ← not supplying the PCTs I saw with timely, up-to-date data on the basic facts such as the number of people they were seeing, what treatments they were having and so on. In the case of secondary care, this made it difficult for PCTs to plan and commission effectively.

In the case of community services, the dearth of information made for an extremely difficult working environment for commissioners. I know from experience that nationally there is a shortage of information about community services.

With community services accounting for a significant proportion of the NHS budget, this has to be a real cause for concern. However, there is still a lot PCTs can do locally to help the situation.

Despite the constraints facing them, I felt the PCTs I saw needed to be far more demanding of providers in order to get the data they needed.

While there are clearly national contracts to work with, PCTs should still be developing relationships with their providers that enable them to get the data they need quickly enough so that they can monitor performance and activity.

During the assessments, I was impressed by the amount of working and analysis that took place between the PCTs and their local authorities to understand need. It was clear all the PCTs were achieving an excellent depth of analysis around health inequalities and targeting specific population groups on particular health issues.

I also saw an excellent example of the way information can be used and presented in a way that supports patient choice.

Islington PCT had taken a range of sources – including quality and outcomes framework, referrals into secondary care and patient experience data – and developed a sophisticated balanced scorecard to help people choose a GP practice. It gave a very rounded view of the level of care a patient was likely to receive and was easy to understand and use online.

ROSAMOND ROUGHTON

Director of strategy and system reform, NHS Yorkshire and the Humber

The panel days in Yorkshire and the Humber, combined with material provided in advance by PCTs, taught us a lot about strengths and development areas.

For some PCTs, last year's joint strategic needs assessment was their first and they were still in the process of finalising it with their local authority when the panel visited. But others, such as Sheffield PCT, had been co-producing the needs assessment with their local authority for several years.

We found that there was a really deep

understanding at board level of the health needs of the population of Sheffield, both overall and at disaggregated level. This has driven the

TOP TIP
Concrete case studies demonstrate clearly how commissioners are using information to improve health provision

'Reporting back to residents will also become more important. This was something PCTs scored poorly on in competency 5. Yet it is a vital part of enabling public accountability'

development of Sheffield's strategy to tackle health inequalities across the city, where the difference in life expectancy between areas is as much as 14 years.

Some of the strongest evidence for the power of being good at competency 5 came from concrete case studies, where PCTs could demonstrate how information had influenced the way they commissioned services. And in turn, some PCTs demonstrated how this had made a significant impact on the health of their target population.

One story that has stayed with me since the assurance process last winter was a project in Rotherham around teenage pregnancy.

Rotherham PCT, working with its partners, had brought together different information sources to identify the cohort of young women most at risk of teenage pregnancy in one particularly deprived area. On the back of this, it commissioned two support workers to work with that cohort. This has led to a dramatic reduction – nearly 80 per cent – in the number of girls falling pregnant while teenagers. As we know, this in turn has an impact on the long term life chances and opportunities for young women, and the health of their families and themselves.

This is an excellent illustration of how good information can enable PCTs to target their finite resources to maximum effect. And as we enter a much tighter financial climate, having the right information to support the prioritisation of need and resource is going to be critical.

SIMON WILLIAMS

Director of community and housing, Merton council

What distinguished the best PCTs from the rest was the way they translated their joint needs assessments into shared action plans and, ultimately, improved services.

All the PCTs I saw had partnerships in place and reasonable working relationships with other local organisations.

But among the highest performing PCTs, the needs assessment was much more than an annual set-piece that was put aside to gather dust once complete. Instead, it was a dynamic tool that enabled the NHS and local council to adjust their direction of travel collaboratively as issues emerged.

It fostered a live relationship in which organisations continually pooled

information so that if one partner had a critical issue – struggles to meet the 18-week referral to treatment target, for example – the other would have a shared understanding of it and could respond supportively.

The needs assessment was inevitably an important element when we looked at competency 5 performance, largely because it highlighted the extent to which a PCT had a grip on strategic planning.

Our first questions were around whether the needs assessment was in-depth and comprehensive and whether it had been developed collaboratively.

Then we wanted to be clear that it had enabled local partners to draw up a shared set of priorities and to develop an appropriate strategy.

I was struck, for example, by the way Nottingham City PCT worked with its local authority to develop a ward-specific approach to assessing residents' needs. Through this, they were able to focus interventions such as smoking cessation and teenage pregnancy initiatives in the most targeted and effective way.

A weakness on competency 5 was when needs assessments failed to provide a holistic picture of need, drawing upon "total knowledge" from a wide range of sources – not just NHS data.

Some failed to draw upon a sufficient range of data sources. Many relied upon a few core censuses and failed to supplement them with fresh, in-year data from sources such as the quality and outcomes framework, crime statistics and residents' perception surveys.

It was clear that most PCTs were still developing a comprehensive grasp of the information sources available to them and organisations that can provide them. For many PCTs, the first task needs to be to get a fuller understanding of data sources.

Once they have done that they need to put together a strategy for using them systematically. This is a joint endeavour with local authority partners.

Information can still be seen as the narrow preserve of "techies". But as world class commissioning matures, we will be looking to PCTs to use a whole range of information and to demonstrate a shared approach to performance management and action planning.

Reporting back to residents will also become more important. This was something PCTs scored poorly on in competency 5. Yet it is a vital part of enabling public accountability and something they need to work on – again in partnership with local authorities.

PCTs tended to self-assess themselves realistically on competency 5. That points to a self-awareness among PCTs, which in itself is an encouraging sign. ●

TOP TIP
The starting point is getting to know the wide range of data sources available and the organisations that can provide them

LOCAL PROFILE: WESTERN CHESHIRE

RISK AND REWARD

Western Cheshire has developed a sophisticated understanding of which patients are most at risk, enabling it to act pre-emptively to cut emergency admissions

In most primary care trusts knowledge management is carried out by a team principally dedicated to finance or commissioning. In Western Cheshire PCT the function commands a directorate of its own – ensuring that it gets attention at the highest levels.

“The vision was to bring together under a single directorate the core intelligence and information services needed to drive commissioning,” says its director of knowledge management and performance Jim Hughes. “The model we’ve created has enabled us to introduce predictive modelling and risk stratification to a much greater degree.

“Our approach to analytics has already led to new services such as a health coaching scheme, which particularly supports those with long term conditions – a group our data shows to be high impact users of our services. Increasingly, our analytic services will enable GP practices to micromanage their caseload, ensuring patients most at risk of secondary care admission get the optimum support they need to remain healthy and at home.”

The programme for risk stratification and predictive modelling is jointly sponsored with the practice based commissioning group West Cheshire Health Consortium. Called “Staying Healthy for Longer”, it includes a health coaching service called “YourHealthCoach”.

Under the scheme, the PCT supplies monthly updated data about every patient in the initiative to health analytics



Jim Hughes: “Our approach has already led to new services”

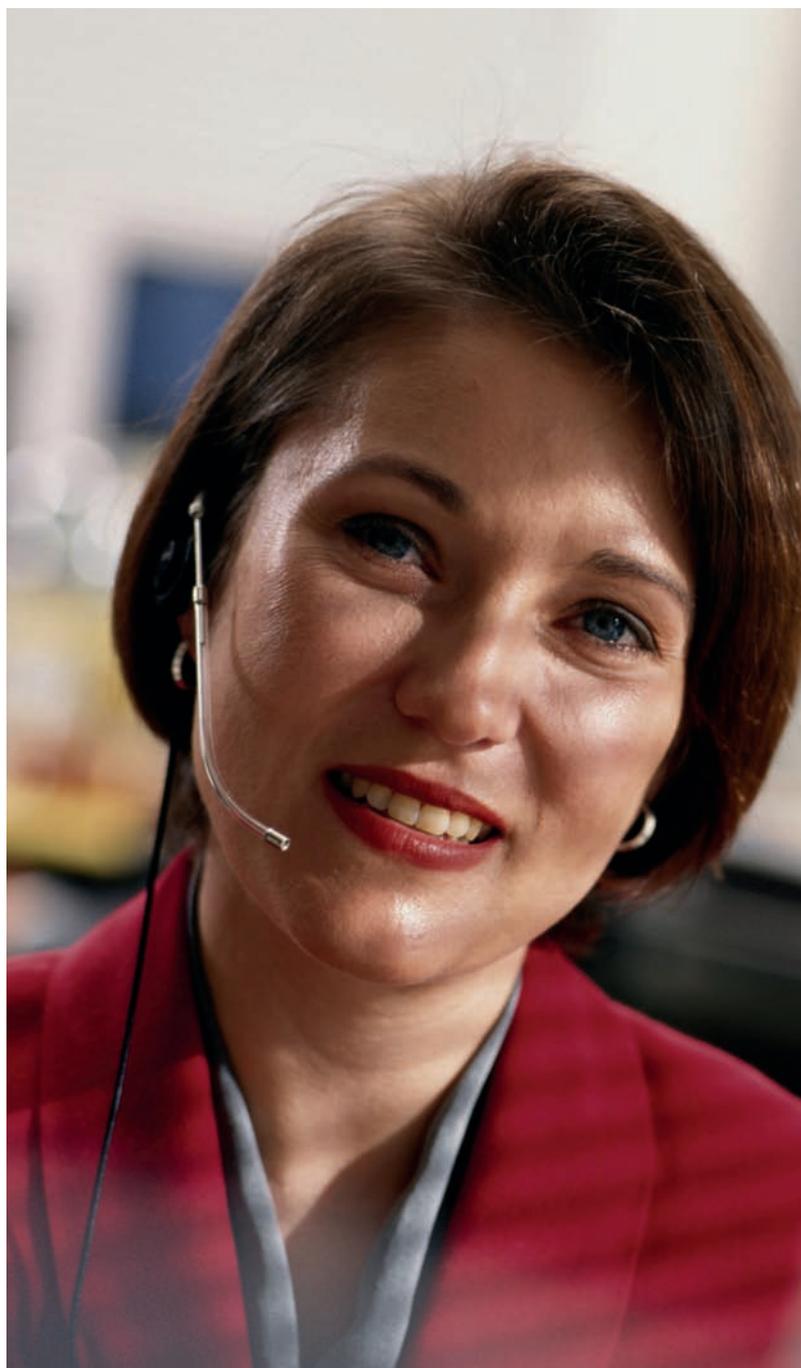
company Bupa Health Dialog. The company applies a sophisticated algorithm which enables it to stratify the population in terms of risk of future hospital admission.

Patient alerts

Typically those most at risk have long-term conditions. Bupa Health Dialog’s analysis generates an alert to the PCT – and 18 GP pilot practices in the scheme – whenever a patient moves from the medium to high risk category. This enables the PCT to intervene with support designed to keep the patient’s condition under control and avoid unplanned hospital stays.

“Patients categorised as high or medium risk consume 60 per cent of all services and their use of services is typically unplanned and event-driven,” says Mr Hughes. “Our data is analysed in a way which allows us to pre-empt a patient’s condition and to put in targeted support – such as a telephone call or community matron – at an earlier stage.”

The PCT places considerable



Competency 5: Panel assessment

PCT's Self Assessment
 Panel Assessment

Competency	Measure	Level 1	Level 2	Level 3	Level 4
Manage knowledge and undertake robust and regular needs assessments. Overall level: 2	• Analytical skills and insights			<input type="radio"/>	<input type="radio"/>
	• Understanding of health needs trends	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
	• Use of health needs benchmarks	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

WHAT THE PANEL SAID	HOW WESTERN CHESHIRE IS RESPONDING
The PCT mentioned an “intelligent commissioning toolset” but the panel were unable to understand its remit, scope and output.	Time in front of the panel can be short so in the next assessments we will aim to outline our work with even sharper focus.
The panel could not find clear evidence of the assessment of future/unmet needs in the joint strategic needs assessment.	We plan to use GP practice data to assess future and unmet need. We will also use the NHS Institute's toolkits around scenario generation.
The PCT should think how it can move from benchmarking for the identification of gaps to benchmarking for excellence.	We plan to use actuarial techniques not only to identify gaps in respect of national or cluster performance but to go further and establish thresholds for quality outcomes.

‘Our data allows us to pre-empt a patient’s condition and to put in targeted support – such as a telephone call – at an earlier stage’

emphasis on analysis but Mr Hughes feels the assessment panel was fair in awarding the organisation a level 1 for the analytics sub-competency of competency 5. “We scored at level 1 in the area where we feel we are strong: analytics,” he says.

“However our work is innovative and was at an embryonic stage at the time of the last assessment. A lesson we learned is that time in front of the panel can be short and we will have an even sharper focus in covering all the key points about each competency during the next assessment round.”

The panel praised the PCT for its work in communicating its joint strategic needs assessment (JSNA) to the local population. “We took the view it wouldn’t be effective to produce a paper report called JSNA so we did an early bird report of highlights instead,” says Mr Hughes. “We

also developed an online resource which the panel felt was the most accessible needs assessment feedback tool they had seen.”

Mr Hughes says a shortage of actuarial and health economics skills poses one of the greatest threats to PCTs achieving world class commissioning. Western Cheshire’s short-term solution has been to outsource these functions. But looking ahead it may consider doing them in partnership with other PCTs.

The PCT aims to roll out its data analyses to all 39 of its GP practices so they can benefit from the insights they provide into improving care for even the smallest cohorts of patients.

It sees huge potential in using GP practice systems, which provide overnight refreshed data, to produce a clearer assessment of future and unmet health needs. ●

→ www.wcheshirepct.nhs.uk

COACHES DRIVE DOWN HOSPITAL ADMISSIONS

Western Cheshire primary care trust’s analysis of health needs prompted it to launch a health coaching service last October.

YourHealthCoach appeals particularly to those with long term conditions but enables those in the scheme to call one of its team of specially trained nurses to discuss a health issue.

Some 60 per cent of the PCT’s acute services are used by patients at medium or high risk of unplanned admission. Typically, these are people with a long term

condition; many of them do not use GP services when a crisis hits but prefer to dial “999”. For this group, the telephone coaching service gives the PCT an alternative way of supporting them to stay well and avoid health crises and emergency admissions.

The number of people using the YourHealthCoach service rose from 700 to 1,600 a month in its first six months. The PCT estimates the service should reduce the rise in hospital admissions by 6 per cent by the end of its first year.

LOCAL PROFILE: BRISTOL

BIGGER AND BETTER

Bristol has joined three other PCTs to create an information consortium – giving it access to a team of 25 dedicated data experts, and totally new approaches to analysis

When Bristol primary care trust was developing a new community service for children and young people, it knew from analyses that a large proportion of potential users would be hard to reach.

“We have a rapidly growing population of children and young people, with diverse and changing needs,” says Bristol PCT chief executive Deborah Evans. “From our knowledge of the target cohort, we realised that traditional models of service were unlikely to work and we needed a new approach.

As a result, it awarded the contract to a partnership of North Bristol acute trust and the highly regarded voluntary sector provider Barnardo’s, which has experience of working with the target group. “We felt Barnardo’s experience in outreach work combined with its knowledge of the target cohort locally made it a good partner in delivering a new model of service,” says Ms Evans.

“The service launched in April 2009 and we will assess it on its effectiveness in tackling inequalities and meeting the distinct range of needs presented by the children and young people we’re aiming at. Every child, young person or carer in touch with the service will be invited to give feedback.”

In Bristol, the views of local people play an important role in commissioning decisions.

For example, the trust recently used the city’s Citizen Panel – a 2,000-strong body consulted quarterly on a range of local issues – to gauge residents’ attitudes to independent sector providers and maximum travel



Bristol PCT chief Deborah Evans:
“Sensitive to differing needs”

times for treatment. This revealed that residents were prepared to travel further for minor treatments than for more serious surgery. The exercise also tested which types of provider people preferred (NHS or private) and which factors influenced their choice.

“This type of information provides a very valuable perspective as we work to model future need and capacity and increase diversity within the independent sector,” says Ms Evans.

Trusts united

Bristol is one of four neighbouring PCTs that have opted for economies of scale and invested in a joint information resource called Avon Information Management and Technology Consortium.

With a team of 97 staff, 25 of whom deliver knowledge management, analytical predictive modelling and forecasting services, the consortium gives the PCTs access to a far wider range of



Competency 5: Panel assessment

PCT's Self Assessment
 Panel Assessment

Competency	Measure	Level 1	Level 2	Level 3	Level 4
Manage knowledge and undertake robust and regular needs assessments. Overall level: 2	• Analytical skills and insights	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
	• Understanding of health needs trends	<input type="radio"/>			<input type="radio"/>
	• Use of health needs benchmarks	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

WHAT THE PANEL SAID	HOW BRISTOL PCT IS RESPONDING
The PCT should consider benchmarks beyond "core cities".	As the only major city in the region, we feel we need to look beyond the South West for statistical neighbours. We routinely benchmark ourselves against statistical neighbours, core cities and best practice in the UK and beyond.
The PCT should develop its best practice in health impact assessment and evaluation to all major health needs.	Could this be made more directly relevant to health impact assessment rather than just equality impact assessments?



Bristol PCT is working with Barnado's to reach out to young people. From left: Tim Mortimore, Bristol south head of children's occupational therapy, Barnado's childrens services manager for Bristol south Jenny Lewis, and Bristol south children's physiotherapy department head Dawn Ravenhill

skills and resources than they could afford individually.

For example, the shared resource means the PCTs have access to geographic information and mapping services. It also means they can call on the skills of an analyst with a specific expertise in prescribing data.

Better picture

The consortium is also piloting a primary care data reporting service across Bristol, Bath and North Somerset and South Gloucestershire. The service extracts data from participating practices and produces dashboards of population information around conditions such as heart disease and diabetes. This ensures the PCTs have a richer picture of activity in primary care, without being able to see any patients' individual medical records.

The service also stratifies the population by risk of admission to secondary care, so that practices can identify high-risk patients, enabling the practice and the PCT to put in place pre-emptive health interventions.

"Because we're a shared resource we can offer a more extensive analytical service than PCTs would otherwise have and that means they can explore new approaches which would be impractical as an individual organisation," says Avon IM&T Consortium head Andy Kinnear.

Bristol has a diverse population of 450,000 and the difference in health terms between its wealthiest and most disadvantaged residents is huge.

For this reason, the trust places considerable emphasis on health improvement and, according to Ms Evans, the world class commissioning framework has helped it improve its approach in areas such as smoking cessation, cardiovascular disease, cancer and teenage pregnancy.

"We are becoming increasingly sensitive to the differing population needs within the city and more effective at making primary care perform at its best for the areas we want to target such as cardiovascular disease," she says.

"As we head into difficult economic circumstances, one priority we must hold on to is health improvement for the most disadvantaged. We want to strengthen how we look across the population and introduce case management to support those with complex needs and long term conditions." ●

FILLING THE DENTAL GAPS

Bristol primary care trust pinpointed the five areas of the city most in need of extra dentistry services using geographic information and data mapping techniques.

These showed that NHS dentistry was most available in affluent areas and least available in deprived ones. Over the past two years the PCT has increased access to dentists in deprived areas and commissioned two new dental practices in communities that previously had no NHS dentist.

A further procurement exercise is now under way and the organisation intends that the new services will be up and running in

this financial year. "We had all the raw data such as population numbers, level of expected demand and how many people already had access to dental services, all at city and ward level," says dental commissioning officer Mel Byrne.

"The GIS and data mapping services were able to take the data and translate it into a map of the city which detailed precisely where need was greatest in a clear visual format using different sized and coloured circles."

Under the procurement plan, the five new dental services will provide access to over 40,000 patients.

➔ www.bristolpct.nhs.uk

LOCAL PROFILE: ROTHERHAM

PINPOINT ACCURACY

Rotherham PCT is leading the way in understanding precisely where and with whom it should be intervening – and where GP services are falling short

People living in Rotherham's most deprived ward can expect to die seven years earlier than those living in the most affluent.

The scale of this inequality highlights the extent to which health needs can vary in just one small area – Rotherham primary care trust serves only 250,000 people – as well as the scale of the challenge local bodies face in providing well-targeted services.

PCT consultant in public health medicine Robin Carlisle believes the town's long history of tackling inequalities meant it was well placed to score highly in the part of competency 5 that focused on understanding health need.

"The difference in life expectancy in Rotherham is major and is mirrored by widely varying rates in other things such as smoking," says Dr Carlisle. "In our better off wards, for example, only 11 per cent of the population smokes, compared to 50 per cent in the most deprived.

"These variations mean our commissioning decisions need to be informed by a detailed understanding of different health needs right down to the smallest geographical areas."

Its work to reduce teenage pregnancy exemplifies the PCT's targeted approach. While rates had reduced in line with the national overall reduction, the PCT wanted to accelerate the reduction in pregnancies among under-16s.

So it launched a project in Maltby – a "hotspot" area that has a higher rate of teenage pregnancy than the town's average. Girls assessed as most at risk are referred for targeted



Dr Robin Carlisle: "The difference in life expectancy is major"

support such as one-to-one sessions, group work or peer support – whichever suits their individual needs.

Since its launch, the project has virtually eliminated pregnancy among those taking part. It has also resulted in improved mental health and smoking cessation, reductions in drinking and antisocial behaviour and fewer participants not in education, employment or training. The project is now being rolled out to other areas of Rotherham.

Keep boards informed

Dr Carlisle says that communication is an important element in ensuring information is properly understood and acted upon within an organisation.

"Most PCTs will produce quite a lot of needs analysis," he says. "The question is do their boards know about it and can those boards speak eloquently on the subject?"

"Similarly, are partners familiar with the information



...And stretch: exercise classes at the Carnegie Club for overweight children, at Rotherham Leisure Complex

Competency 5: Panel assessment

PCT's Self Assessment
 Panel Assessment

Competency	Measure	Level 1	Level 2	Level 3	Level 4
Manage knowledge and undertake robust and regular needs assessments. Overall level: 3	<ul style="list-style-type: none"> Analytical skills and insights 	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<ul style="list-style-type: none"> Understanding of health needs trends 	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
	<ul style="list-style-type: none"> Use of health needs benchmarks 	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

WHAT THE PANEL SAID	HOW NHS ROTHERHAM IS RESPONDING
The PCT should develop predictive modelling and analytical tools to describe trends in need and create future projects.	We are continuing to support a pan-regional initiative which will deliver support for predictive modelling and programme budgeting.
It should consider what other national or international benchmarks it could use to stretch its ambition.	Rotherham PCT is reviewing this together with Yorkshire and Humber Public Health Observatory.



available and is it acted upon in decision making?"

In Rotherham, communicating information and its implications for services is core. Once a year, the PCT produces a strategic intelligence review summarising key pieces of information from a disparate range of sources and makes it available to partners and providers as well as its board. It also provides summary data at ward and neighbourhood level for the area's seven local assemblies.

It produces a partnership publication *Rotherham News*, which goes to every household, and uses a third sector health network to disseminate health information to the public.

Meanwhile, a disease-specific comparative benchmarking tool analyses the care delivered by its 39 GP practices for three important pathways: chronic obstructive pulmonary disease, cardiovascular disease and diabetes. "We use it for clinical

benchmarking," says Dr Carlisle. "For example, it might show some clinicians having a low use of ACE inhibitors – the drugs which tackle heart failure – and high numbers of patients being admitted to hospital for heart failure.

"This would raise questions about clinical practice which we would need to talk through with any practices involved."

The emphasis on primary care is clear. The trust produces its world class commissioning performance indicators at practice level and these are used to analyse each practice's effectiveness in their annual review.

It also provides benchmarking information which enables the GP practices to compare their actual prevalence levels with indicative prevalence levels – to enable them to pinpoint conditions for which they are failing to pick people up.

Looking ahead, Dr Carlisle recognises the challenge in achieving a level four rating for the competency.

"We won't ever be able to employ a full-time health economist," he says. "However, we have good links with three universities in the region and Yorkshire and Humber Public Health Observatory.

"We also help fund Health Intelligence Yorkshire and Humber, which is working on a series of themes including programme budgeting and predictive modelling for cardiovascular disease.

"Because of our size, we need to explore innovative ways of moving forward." ●

→ www.rotherham.nhs.uk

TACKLING CHILD OBESITY IN YORKSHIRE

The NHS Information Centre's National Child Measurement Programme shows Rotherham's children are the heaviest in Yorkshire and Humberside, with one in three overweight or obese. Without concerted action, this could rise to two thirds by 2050.

In response, the PCT has developed a healthy weight commissioning framework specifically for children.

The framework includes work to promote breastfeeding (which is low in more deprived wards), take-up of school meals and availability of outdoor space.

Overweight children may be referred to a Carnegie Club, where they can learn new activities and better eating habits.

Obese children may be referred to a multidisciplinary team and some of those with the most significant weight problems are offered residential summer camps.

The 38 children who attended camp last year saw their body mass reduced by an average 6.6 per cent, their aerobic fitness increased by 17 per cent and waist circumference reduced by 7.1 per cent.

National Child Measurement Programme, www.ic.nhs.uk

INFORMATION SOURCES

AHEAD OF THE PACK

The new data support for world class commissioning promises to be online, interactive and more user-friendly than ever. But what does that mean for PCTs?

So you need to know the best places to benchmark yourself against? Or a quick overview of your area's health needs – including graphics? The new upgraded world class commissioning data pack could be your answer.

The data pack to support world class commissioning 2009-10 is now available to primary care trusts for testing as a live, interactive online tool.

The pack covers some 252 indicators and has been produced by The NHS Information Centre to offer greater functionality than its predecessor.

The pack is designed to help PCTs prepare for the second round of WCC panel assessments that will take place early in 2010. A final version with complete data and full functionality will be available from August.

Initially it is available to PCTs and in time

will also be made available to the wider NHS and organisations outside the NHS, such as local councils, as part of a staged roll-out in the autumn. For each indicator, the pack allows users to:

- Print off reports to illustrate and provide insight for board meetings and other forums;
- select peers outside their region for benchmarking their performance;
- manipulate data to produce bespoke peer group comparisons and favourite reports;
- produce dashboards highlighting best, worst and most improved trusts on self selected indicators;
- select a variety of graphical presentations to support ease of understanding.

Many of the indicators will be updated more regularly than the previous version as requested by the user reference group. "Users will see a big difference between this

year's and last year's data pack," says The NHS Information Centre's director of commissioning Sandra Hills.

"The new one has huge functionality and many of the indicators will be updated more regularly to make it as useful and relevant as possible to commissioning organisations.

"The publication of the data pack is an important milestone in the new round of assessments which will be taking place at the end of the financial year, with analysis and self-assessment starting in September 2009."

With capacity and capability a key issue for many commissioning bodies, Ms Hills says that the data pack will be a very welcome resource. "It will free them up to focus on the more complex, analytical aspects of their role." ●

Data to support commissioning, pages 23-24
→ www.wccdatapacks.ic.nhs.uk

FOCUS ON: NHS COMPARATORS 1

Chiltern Vale Health GP Consortium in Bedfordshire is reviewing its approach to its urgent care services, after NHS Comparators data showed it had a higher admission rate for urgent care than a neighbouring area.

Leigh Garraway, the consortium's chief officer, says: "At the click of a mouse, NHS Comparators is helping us understand levels of urgent care activity across our consortium.

"Comparators made it easy to see different rates of urgent admission among our practices and which clinical conditions were driving those. Our rates were similar to the averages for Bedfordshire, East of England and nationally but another PCT just down the road had a much lower rate. This has triggered a great deal of work around our GP urgent access, out-of-hours and district nursing services. NHS Comparators is such a simple system to use. It puts the information I need to assess local activity, costs and outcomes at my fingertips."

→ www.ic.nhs.uk/nhscomparators

FOCUS ON: SHARED LEARNING

Work is under way to share best practice on the joint strategic needs assessment process and to highlight the central role of assessments in planning and commissioning services.

The Department of Health has commissioned The NHS Information Centre, in partnership with the Association of Public Health Observatories, to lead a national joint strategic needs assessment dataset project which aims to make it easier for local strategic partnerships to obtain, analyse, interpret and use data in the assessment process and ensure national data products meet local requirements.

'This is about sharing good practice and inspiring others to seize the opportunities the process offers'

Nine local strategic partnerships are taking part, each exploring different methodologies to enhance and embed the value and use of data in their local assessment process. They are: Calderdale, Cambridgeshire, Gateshead, Islington, Manchester, Nottingham City, Sandwell, Surrey and Torbay.

Their progress and examples of good practice will be charted online via The Information Centre's website and a final report of the learning will be published in the autumn.

"The project is about sharing good practice and inspiring others to seize the opportunities that the joint strategic needs assessment process offers," says Dr Fay Haffenden, national joint strategic needs assessment lead at the Department of Health.

"Each of the sites taking part bring a different perspective on undertaking and using their assessment but they have all embraced the process seeing tangible improvements as a result and demonstrating some excellent practice."



Targeted help: a district nurse helps a patient at home in Bedfordshire, where the local PCT uses NHS Comparators data to focus efforts to cut urgent admissions

FOCUS ON: NHS COMPARATORS 2

Asthma sufferers are breathing easier at Dr Ian Greaves' Staffordshire practice – instead of many having to go to hospital for urgent care services, the services come to them.

The practice has developed a new strategic partnership with its local acute trust after data on NHS Comparators revealed it referred many more sufferers than average to hospital for care.

"We felt the high number of admissions could be avoided if urgent care services were better," says Dr Greaves. "So we agreed with the trust to bring those services here to the practice."

As a result, junior doctors and doctors of registrar level are now based at the practice between 6.30pm and 10.30pm every evening, including weekends and bank holidays.

They see urgent cases, including asthmatics, and also see hospital outpatient follow-ups.

→ www.ic.nhs.uk/nhscomparators

FOCUS ON: INFORMATION SKILLS

The bodies that supply information services to the NHS are working together to identify how best to support PCTs on competency 5. Together they have formed the Information Skills Co-production Group in order to clarify roles, eliminate duplication and avoid confusion. Key organisations involved and some of the services to support PCTs are outlined below:

NHS Institute for Innovation and Improvement

- The Turning Data into Information for Improvement programme helps trusts apply techniques for improvement on actual projects including breast feeding rates, cancer treatment waiting times, children's palliative care service.

→ www.institute.nhs.uk/world_class_commissioning/

- The Opportunity Locator explores the potential for shifting services from an acute hospital setting into the community at PCT and PBC cluster level.

→ www.institute.nhs.uk/opportunitylocator

- The Priority Selector facilitates objective scoring of proposals for service improvement, in order to develop a portfolio of projects that combine impact with practicality.

→ www.institute.nhs.uk/priorityselector

The Wiki Handbook lets information professionals pool their knowledge

- The library provides timely and efficient access to high quality information resources for all those involved in commissioning.

→ www.library.nhs.uk/commissioning

National Institute for Health and Clinical Excellence

Topic-specific web-based guides to commissioning evidence-based care.

→ www.nice.org.uk/CommissioningGuides

NHS Evidence

This is an online search facility that enables commissioners to locate the most appropriate information by sifting the best and most relevant commissioning search results to them. It also provides a link to the commissioning evidence collection via the "specialist searches" option.

→ www.evidence.nhs.uk

The Wiki Commissioning Handbook

This dynamic resource is being developed by information professionals, pooling their knowledge of resources and good practice.

→ <http://commissioning.pbworks.com>

Information for World Class Commissioning 2009

Data packs coming soon:
www.ic.nhs.uk/commissioning



Access these information resources at:
www.ic.nhs.uk/commissioning

The central, authoritative source of health and social care information

Strategy planning

Assessing needs

WCC Data Packs

Benchmarking for national, regional and most comparable PCT activity for the World Class Commissioning assurance process

NHS Comparators

Supports practice-based commissioning and primary care by understanding local activity, costs, and outcomes and comparisons with others

Health Poverty Index

Compare areas on factors influencing health inequalities

Compendium of Public Health Indicators

See how you're performing against over 250 public health indicators

Lifestyle publications

Insight into alcohol consumption, obesity, smoking, drug misuse, and a range of specialist surveys including those relating to young people, infant feeding, mental health and dental health

National Diabetes Audit

With the National Diabetes Information Service you can examine local population profiles, risk factors, service provision and outcomes

Reviewing service provisions

Programme Budgeting

Plan budgets using NHS Comparators and Compendium of Public Health Indicators

Social Care publications and statistics

Examine how much is being spent on social care services in your area

Deciding priorities

Joint Strategic Needs Assessment (JSNA)

JSNA core dataset focussing on a list of indicators, cross-tabulated against Vital Signs and the National Indicator Set

Procuring services

Designing services

Workforce

Resource enabling NHS workforce planning, using statistics on NHS staff numbers, earnings, turnover, and vacancies

Hospital Episode Statistics (HES)

Data on all patients admitted to NHS hospitals in England

Mental Health Minimum Data Set (MHMDS)

Data on patients accessing secondary mental health services

Shaping structure of supply

18 Weeks Reporting Tool

Informs resourcing based on tracking of patient progress through 18 week treatment pathways

Healthcare Resource Groups (HRGs)

Supports delivery of future patient care based on current patient need

Planning capacity and managing demand

WCC Data Packs

Data from multiple sources providing individual organisational profiles against national averages

NHS Comparators

Identifying patterns of referrals from primary to secondary care and comparisons with others

General Practice, dentistry and optometry

Insight into workforce; levels and types of activity; earnings and expenses

Secondary Uses Service (SUS)

Identifies the cost of provider activity against the national tariff – highlights coding activity, ensuring accuracy in provider payments

Estates and Facilities Management

Resources showing estate size, condition, energy use, food costs, parking availability and so on

Monitoring and evaluation

Supporting patient choice

National Clinical Audit Support Programme

Compare clinical conditions and treatment received for cancer, heart disease, diabetes and renal

Over 120 health and social care publications

Comprehensive insight into disability, older people, screening, eye care, dentistry and maternity

Managing and monitoring performance

WCC Data Packs

Regularly refreshed data with an organisational dashboard to monitor trends and evaluate services

NHS Comparators

Appraise local in/outpatient disease area activity, costs, outcomes, and identifying prescribing activity

Quality and Outcomes Framework

Resourcing healthcare based on practice-level prevalence data

Seeking public and patient views

Health Survey for England

Annual snapshot of the nation's health and local health needs

Social care user experience surveys

Annual surveys to get feedback from different groups of service users

Patient Reported Outcome Measures (PROMS)

Collect information on the clinical quality of care as perceived by patients themselves