NHS

worldclasscommissioning

adding life to years and years to life

assurance handbook

Year 2

2009/10 - 2010/11

DH information reader box

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Clinical	Social Care / Partnership Working

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For Recipient's Use	

handbook **contents**

foreword from **David Nicholson**

World class commissioning is about improving health outcomes and reducing health inequalities. At the heart of this is the need for PCTs to commission outcomes that deliver high quality healthcare and give value for money. Whilst we do not yet know the outcome of the next spending review, we do know that the NHS will be faced with significant challenges. The need for excellent commissioners and a step change in productivity has never been greater.

Delivering quality care whilst improving productivity will be an essential component of meeting this economic challenge and there is good evidence to demonstrate that quality and productivity go hand in hand. I am clear that commissioners will also need to focus more on prevention so that illness is avoided or delayed. The catalyst for delivering quality, productivity and prevention is innovation and the NHS has a long history of delivering innovative services. Commissioners will need to work closely with providers to deliver this objective. World class commissioning assurance Year 2 has been refined, based on your comments, to include a more explicit focus on quality and productivity. I particularly encourage commissioners to use the current growth in allocations to put in place pathways that will deliver the long-term benefits we all desire; to invest now to save later.

Clinical leadership and engagement are essential if PCTs are to become world class commissioners. We need to have clinicians from all sectors engaged in care pathway redesign and leading change. PCTs as local leaders of the health system must continue to build on the good work already in hand to develop dynamic partnerships with clinicians, local authorities and communities to deliver high quality services with high levels of productivity. This may mean services are provided from different settings and it is important that you take your local communities and stakeholders with you when undertaking such change.

The results from the first year of WCC assurance demonstrate that PCTs are rising to the challenge of commissioning for health gain. The refinements to Year 2 will help you focus on the key priorities that you need to undertake to deliver improved health for your local population. I have been delighted with the energy and commitment PCTs have demonstrated to become world class commissioners. I look forward to working with you as you rise to the challenges set in the second year of WCC.

I have been delighted with the energy and commitment PCTs have demonstrated to becoming world class commissioners.

World class commissioning assurance handbook Year 2

The WCC assurance handbook for this year is designed to focus on the key changes to the world class commissioning assurance framework, content and process.

While it does not repeat all the details of last year's handbook (particularly where content remains the same), it provides sufficient overview to stand alone, and crucially, provides details of the changes for this year.

who is the handbook for?

- PCTs.
- SHAs.
- Panel members.

what does the handbook provide?

- A detailed explanation of the content of WCC assurance Year 2, including changes made to the system following the evaluation of last year.
- A practical guide on how to understand the requirements of WCC assurance.

what is not included in the handbook?

- Guidance on how to write documents submitted as part of the assessment such as the strategic plan, financial plan and organisational development plan.
- Additional information on WCC assurance for SHAs, panel review members and SHA analysts.

Other guidance documents can be accessed by logging on to the assurance toolkit. Please follow the link at www.wccassurance.dh.gov.uk

1. Year 2 – **what is different?**

Following the evaluation of last year and having worked closely with PCTs and SHAs over the past months, WCC assurance has been refined, slimmed down and improved. This is with the aim of helping PCTs focus their time and efforts on the core activities that underpin WCC assurance, such as strategic planning and embedding capabilities and skills, rather than on WCC assurance itself.

To support this aim, the following improvements have been made:

- the description of competencies, and in particular the sub-competencies, are clearer;
- competency 11, ensuring efficiency and effectiveness of spend, is now being assessed as part of the core competencies;
- the criteria used to assess PCTs in all three aspects of governance, i.e. board, finance and strategy, will be published;
- there is a greater distinction between each rating in all aspects of governance;
- there are improved metrics for outcomes;
- the datapacks are now online and more comprehensive;
- the Audit Commission, Care Quality Commission and the Department of Health have agreed a clear, transparent and aligned approach between their three regulatory systems;
- PCT chief executives and chairs will be involved in the wider panel discussions as well as having separate interviews;
- the panel process will benefit from panels who are better trained and more prepared;
- the web-based assurance toolkit is more user-friendly and informative;
- PCTs are asked to sign-post the evidence for analysts, and analysts will in turn provide more focused information for panels to reduce the burden across the system.

2. overview of **world class commissioning assurance**

Wider context

High Quality Care for All set out an ambition to put quality at the heart of everything the NHS does. As described in the NHS chief executive's annual report for 2008/9, the task now is how to deliver on that commitment through a period of significant financial challenge.

PCTs need to ensure they are planning for and ensuring sufficient flexibility in their commissioning arrangements to respond to three different scenarios, including one of zero growth from 2011/12 onwards. This scenario planning should directly involve both managers and clinicians and be undertaken in discussion with all local partners. This work should identify specific efficiency gains and the steps that will be taken to deliver those gains.

The world class commissioning agenda is designed to give PCTs the skills to be at the forefront of delivering improvements to all parts of their local population, with the principles of quality, innovation, productivity and prevention the cornerstones of what world class commissioning and assurance have set out to achieve. PCTs should see WCC as a critical means of *embedding* the skills, capabilities and competencies at local level that will be required to respond to future challenges.

World class commissioning assurance is a nationally consistent system that:

- supports and develops PCTs towards world class performance, the achievement of better health outcomes and the reduction of health inequalities;
- holds PCTs to account for performance improvements in commissioning capabilities and outcome improvements;
- rewards success;
- provides a common basis for agreeing further development and enables reliable comparison of performance across all PCTs.

At the end of WCC assurance Year 2, each PCT's results will be published nationally by the Department of Health (DH).

Better health and well-being for all, better care for all, better value for all.

Principles of WCC assurance

WCC assurance has been designed to be:

Transparent: a clear assessment methodology

Standardised: one nationally consistent system managed locally by the SHAs

Relative: recognising the starting point of different organisations and focusing on improvement

Flexible: so that the framework can adjust over time as PCTs improve, and to support local innovation

Challenging: matching or exceeding the rigour Monitor applies to Foundation Trusts

Developmental: focusing on supporting improvement as PCTs move towards world class

Incentivised: with clear incentives for PCTs that show improvement and consequences for those that do not

Proportionate: focusing on the key indicators of commissioning performance and capabilities rather than being an all encompassing audit

Consistent: with the developing NHS Performance framework and aligned with the work of regulators

World class commissioning will deliver…

…better health and well-being for all

- People live healthier and longer lives.
- Health inequalities are dramatically reduced.

…better care for all

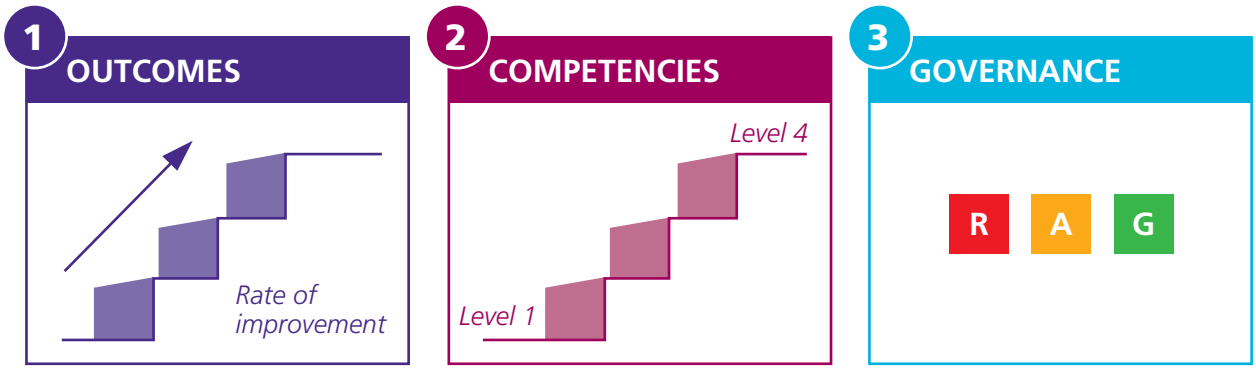
- Services will be evidence-based and of the best quality, encompassing safety, effectiveness and patient experience.
- People will have choice and control over the services that they use, so they become more personalised.

…better value for all

- Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources.
- PCTs will work with others to optimise efficient and effective care.

The WCC assurance framework

PCTs will continue to be assessed across three elements:



The three elements will continue to be assessed using a combination of approaches used in the first year including self-assessment, feedback from partners, evidence gathering and review of data. PCTs will be responsible for completing online forms through the assurance toolkit. PCTs will also upload documentation produced to support their assessment.

World class commissioning assurance aims to place as little extra burden on PCTs as possible, while ensuring a robust process for challenge and development. As WCC assurance becomes increasingly embedded in routine business, PCTs should expect the resources required to complete the process to reduce over time. On pages 43 and 44, there is an indication of the resources required to complete the process. It is important that world class commissioning and WCC assurance are embedded as part of SHAs' and PCTs' wider programmes of delivery.

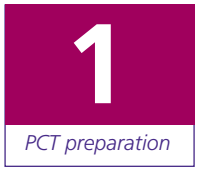
SHAs will continue to manage WCC assurance locally, and will be responsible for running the process, supporting PCTs in evidence gathering, co-ordinating the panel review day, providing follow up and supporting ongoing development. SHAs will also be responsible for providing analytical resource to support the panel review process.

The role of the DH will be to oversee WCC assurance. The DH has set this common framework, based on feedback from the first year and subsequent discussions with SHAs, PCTs and other partners. It will work with SHAs to ensure that they have the right capacity and capabilities to implement this framework effectively. The DH will act as moderator for any changes to the process, including running the national calibration process, and will be responsible for publishing annual results for Year 2 onwards.

The WCC assurance process

WCC assurance has five stages

The five stages are summarised below and outlined in more detail in chapter four.



Preparation by PCTs takes place this year from September with final submission of all material by mid-January. Submission dates will be staggered and SHAs will provide details to their individual PCTs. As last year, the material for submission includes the strategic plan (with the underpinning financial and organisational development plans). The PCT is required to complete self-assessments for both competencies and governance, submit their outcomes priorities and aspirations, nominate partners to provide input to feedback surveys and collate documentation.

Submission of all material takes place through the assurance toolkit accessed at www.wccassurance.dh.gov.uk

Each SHA has identified a nominated super-user who will serve as the first port of call for support and advice to PCTs during the submissions process. This is in addition to the central WCC support desk.

Analysts from the central team and each SHA will support the process of WCC assurance. Prior to the panel review days, the analyst's role is to create a briefing for the panel using the documentation submitted by the PCT and SHA insights, according to a nationally consistent methodology.

The panel briefing:

- benchmarks the PCT against national indicators on their priority outcomes;
- analyses the submitted information;
- highlights where criteria have been met;
- highlights where improvements have been made;
- suggests areas for discussion at the panel day.

The analysts will receive additional guidance and an analytical framework to directly support them in their role, and to ensure that the criteria for assessing evidence and briefing the panel are consistent.

3
Panel day

The panel days are the focal point of WCC assurance, and will take place between the beginning of March and the middle of May 2010. The panels provide an opportunity for a two-way discussion between the panel members and the PCT board, and PCTs should approach them as an opportunity for challenge and development.

Following the panel review day, the PCT will receive a panel report. The panel report will include a scorecard indicating performance across the three elements of outcomes, competencies and governance; a commentary on potential for improvement; and further narrative reflecting discussions at the panel review day.

4
Calibration

Ratings will continue to be calibrated at a regional and national level, to ensure consistency ahead of national publication of each PCT's ratings in summer 2010. Both regional and national calibration will be strengthened from Year 2 given that the results will be nationally published.

5
Follow up

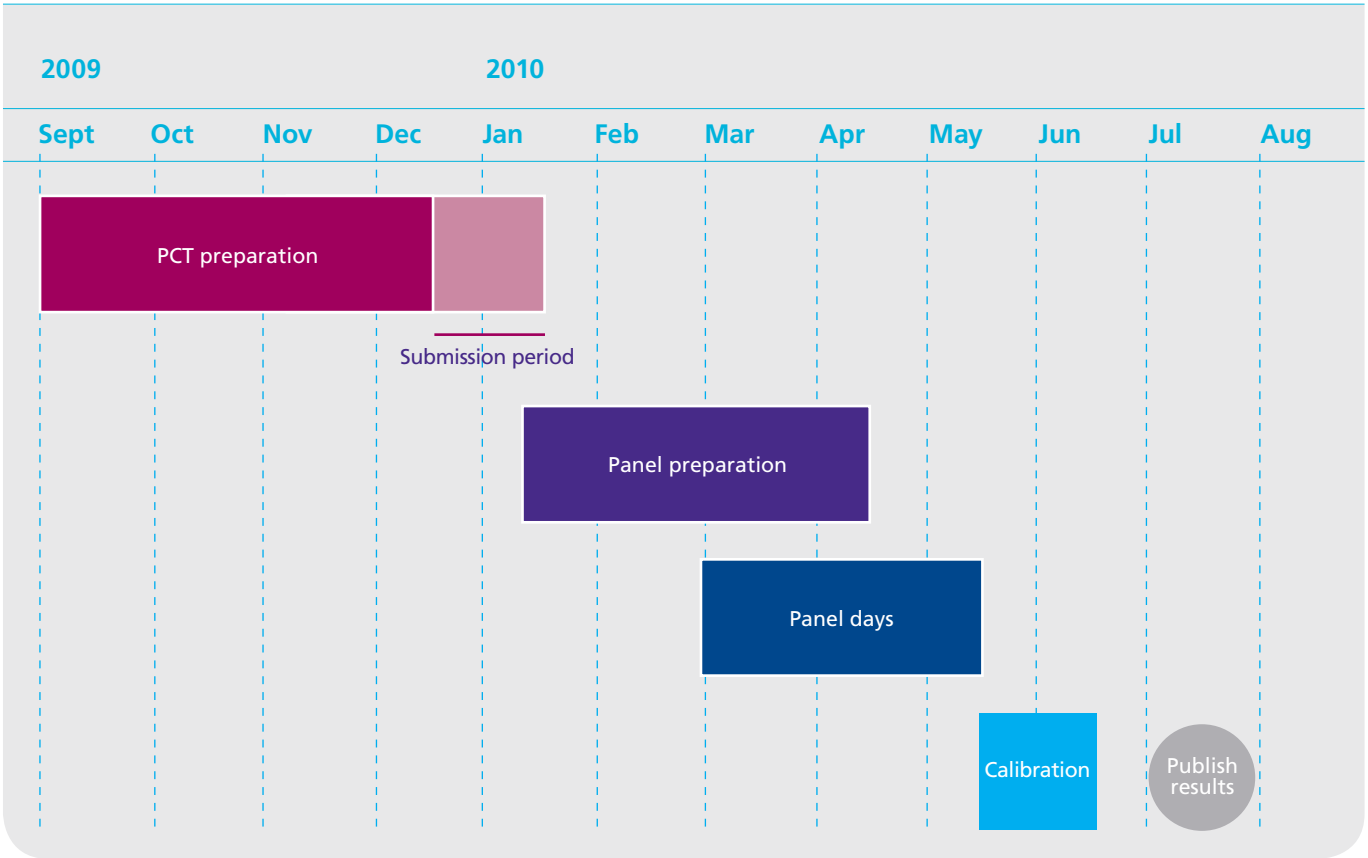
Whilst the panel days are the focal point of WCC assurance, the challenge and development of commissioners is ongoing. The SHA and PCT will meet again after the panel day to review the panel report and agree actions. Following this, the SHA and PCT will work together throughout the year to ensure commissioners are moving towards world class.

Resources and tools to support PCTs in their development towards world class are wide-ranging. Further information on support and development can be found at http://wcc.networks.nhs.uk

Timetable

The WCC assurance timetable has been adjusted for Year 2 as outlined below:

Overall timeline for WCC assurance Year 2



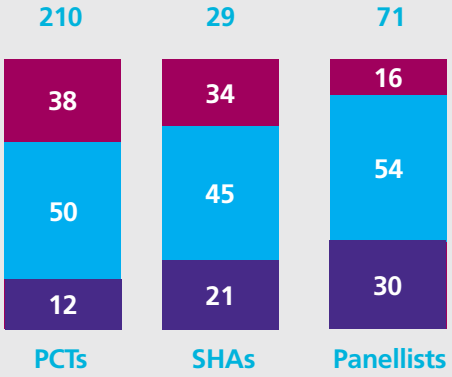
A summary of changes for Year 2

As stated last year, the definition of world class will continuously evolve, and WCC assurance will develop in response. Last year, WCC assurance was a learning and development process for PCTs, SHAs and the DH. The lessons learned have helped to improve and strengthen the process for Year 2 and beyond.

Following last year's process, the DH completed a comprehensive evaluation of WCC assurance, including a national evaluation event, interviews and an online survey with over 300 participants from PCTs, SHAs and panellists. Overall, WCC assurance was judged a success – it was seen to be rigorous and stretching, but fair and valuable.

Over 80% of the evaluation survey respondents believe WCC will drive a marked improvement in PCTs' performance

What is the likely overall impact of the programme? (%)



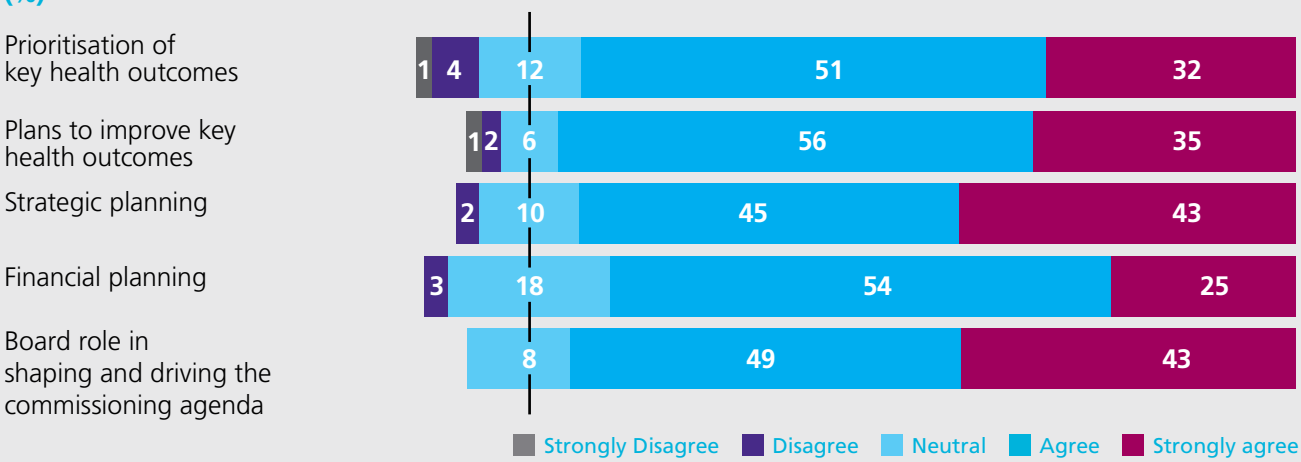
"The process has made NEDs think like commissioners... This process has allowed us to grow in a different way – people are more vocal and it is now a more cohesive group. Thank you for what you've done today. My board is buzzing."

- Major long-term improvement
- Marked improvement
- Some incremental improvement

Source: WCC evaluation survey, result from Jan 2009

Nearly 90% of participants agree WCC is leading to an improvement in PCTs' commissioning capabilities and governance

WCC assurance is leading to an improvement in PCTs: (%)



* Results aggregated across PCT, SHA and panel surveys
Source: WCC evaluation survey, results from Jan 2009

The key points arising from the evaluation were that:

- overall, only fine tuning of the framework was required;
- Year 2 should focus on improving performance against the 2008/9 position;
- better metrics were needed for some of the national outcomes, such as mental health and health inequalities;
- some sub-competency criteria needed to be clearer about how the levels equate to different standards of performance;
- competency 11 to assess efficiency and effectiveness of spend should be assessed as part of the core competencies;
- governance assessments should be strengthened to differentiate more clearly between red, amber and green ratings;
- there needed to be clearer alignment with the Audit Commission's process of assessment.

The refinements that have been made to the assurance framework (outcomes, competencies, and governance) and process for Year 2 are a reflection of:

- the evaluation and feedback, supplemented by extensive consultation across the NHS on the proposed changes for Year 2;
- the wider contextual challenges that PCTs are facing, particularly the challenge of improving quality in the current and future economic climates;
- the expected changes in commissioning skills and behaviours as the definition of world class continues to develop.

The key changes to Year 2 are set out in the table below and are described in more detail in chapters three and four:

Key changes to WCC assurance for Year 2

Outcomes

- Improving health outcomes and reducing health inequalities remain the focus and overall goals of WCC assurance. In Year 2, PCTs will be asked to describe how they will demonstrate improvements to date and to set year-on-year aspirations for the next five years.
- The outcome metrics list has been revised in response to evaluation. This change should not lead to PCTs substantially changing their health outcome areas. Panels would only expect to see such changes where:
  - feedback from the panel process indicated the need for change;
  - there has been a significant change in local strategy following the refresh/redevelopment process;
  - there has been a major improvement in performance (meaning that the outcome is no longer a key priority);
  - the new metrics list for Year 2 provides a better metric than was available last year for a priority outcome area.

Competencies

- In addition to taking into account feedback, all competencies have been revised to increase clarity, and ensure relevance to the current context and what is required of PCTs to deliver in these challenging times. The criteria for all the sub-competencies provide greater clarity on the specific skills, knowledge and processes that are required, and ensure there is a greater differentiation between each level.
- Competency 11, focusing on efficiency and effectiveness, is now being assessed as part of the core competencies. Competency 6 has been revised in the light of this and also requires PCTs to prioritise investment in different financial scenarios.

Governance

- The board self-certification has been developed so that PCTs will now self-assess against all three aspects of governance to allow a more informed debate with the panel.
- Consideration was given to the relative merits of the existing three-point red/amber/green (RAG) scale versus the adoption of a four-point scale (similar to that used to assess the competencies). To ensure consistency year-on-year, the existing three-point RAG scale will continue to be used.
- The strategy section has been strengthened this year to reflect feedback from last year and the increasing challenges that PCTs are facing. There is an increased focus on ensuring that PCTs are scenario planning for, and ready to respond to, uncertainties while still delivering against their strategic priorities.
- Within finance, the focus will continue to be on demonstrating the link between strategy and finance, rather than a full financial assessment and audit.
- The board element has been enhanced with greater emphasis on board ownership and responsibility for managing risk, and for strategic development and delivery.

Process

- The process this year has been streamlined and simplified wherever possible. For example, PCTs are asked to signpost the evidence for analysts and analysts will provide greater direction to panels to reduce the burden for all participants.
- A glossary has been added to this handbook. The terms set out the definitions against which PCTs will be assessed.

The fit of WCC with other regulatory regimes

Whilst the DH holds the final line of accountability for PCTs, regulatory bodies have statutory obligations to assess PCTs for different purposes.

The purpose of WCC is specifically to understand whether PCTs are improving their capabilities as commissioners, and whether they understand and meet the health needs of their population. It will assess a distinct set of skills and behaviours and the impact of these on the health of their local population. It therefore encourages and supports ambition, for example, encouraging PCTs to achieve improved health outcomes in their prioritised areas possibly at a level higher than their Vital Sign trajectory, or by reducing inequality of health outcomes within a PCT population.

In advance of Year 2, the Audit Commission, the Care Quality Commission (CQC) and DH have agreed a clear, transparent and aligned approach between the three regulatory systems for sharing and using ratings and evidence from each to inform the others. The agreed approach:

- ensures consistency across the regimes;
- avoids duplication and any possible circularity;
- creates a coherent overall story about PCT performance;
- enables timely use of evidence and ratings (following the shift in timing of the WCC process for Year 2);
- makes use of the distinct expertise of each system.

WCC uses insights drawn from these other regulatory assessments as part of the supporting evidence considered by the panels. Ratings from the Audit Commission will inform panels in the finance and board section of governance and the Comprehensive Area Assessment will be used as a contextual input into competency 2.

Correspondingly, both the Audit Commission (AC) and the CQC will use inputs from WCC assurance. As part of their assessment of PCTs for 2009/10, the CQC intend to publish an extract of scores from Year 2 which are relevant to Standards for Better Health. This will not form part of the rating by CQC but will demonstrate, along with information from Vital Signs and the Audit Commission, that PCTs continue to be held to account for delivery against agreed standards of care within the regulatory and performance management system.

While the Audit Commission will not separately assess KLOE 2.1 (Commissioning) as part of the Use of Resources assessment, appointed auditors will use the WCC rating given to the strategic plan (and progress towards its delivery as concluded in their review of the operating plan) to form their judgement on that element of their value for money conclusion for the PCT. The AC are finalising their guidance for auditors on how these factors should be taken into account in concluding that the PCT's arrangements are satisfactory. This will be shared by the AC with PCTs.

A summary of the approach in relation to the Audit Commission is set out in the table opposite. The inputs that will be used by the Audit Commission and WCC are distinct, in order to eliminate circularity of scores.

The proposed approach is clear, transparent and aligned, and eliminates circularity in scores

WCC will use Audit Commission KLOEs...

- 1.3 (Financial reporting)
- 2.4 (Internal control)
- 2.2 (Data)

...as inputs into WCC elements

- Finance – Robust financial management
- Board – Risk
- Competency 10

Audit Commission (UoR) will use WCC elements...

- Finance – Sustainable financial position (base case and scenarios), Robustness of planning assumptions
- Strategy – Consistency with financial plan
- Competency 11 (*not for Year 2 of WCC*)
- Board – Organisation, Information, Performance, Delegation, Board interaction

...as inputs into KLOEs

- 1.1 (Financial plan)
- 1.2 (Costs)
- 2.3 (Good governance)

Audit Commission (VFM) will use WCC elements...

- Overall strategy rating

...as inputs into KLOEs

- VFM conclusion on KLOE 2.1

WCC will use Comprehensive Area Assessment...

- Local area assessment

...as inputs into WCC elements

- Competency 2

Collaborative commissioning arrangements

The DH, working with specialised commissioning groups (SCGs), PCTs, SHAs and other key stakeholders have developed a tool for use by PCTs and SHAs to help identify both the strengths and development needs of SCGs. SHAs and PCTs will work with their specialised commissioning teams to implement the tool with the details of timetables and processes being agreed locally. Although the detail of its implementation may vary nationally, and it will not therefore provide robust comparative outcomes, it will provide a comprehensive insight into the commissioning of specialised services and how this may need to be developed across each region.

In addition to the WCC assurance process for PCTs and the locally led SCG development tool, SHAs will also be subject to an assurance process from 2009/10. As part of this process, one of the key elements of assessment will be the SHA's role in supporting PCTs as commissioners.

However, PCTs as the statutory accountable body for the activity that is commissioned, either directly by them or indirectly by others on their behalf, will continue to be the focus of WCC assurance. As collaborative commissioning arrangements evolve, assessment of their commissioning performance will become an increasingly significant input into the PCT assessment, where relevant.

Collaborative commissioning arrangements are becoming increasingly important for PCTs and the refinement of WCC assurance for Year 2 takes this into account.

3. world class commissioning assurance **framework and content**

This chapter outlines the expectations, criteria and metrics used to assess PCTs in each of the three elements of outcomes, competencies and governance. The aim of world class commissioning, and therefore the ultimate test of its success, will be an improvement in health outcomes and a reduction in health inequalities.

A change in outcomes, particularly those that focus on public health and well-being, takes time to become apparent. Therefore WCC assurance includes an assessment of both health outcomes and the programmes of change being developed and implemented to deliver those outcomes. The three elements of WCC assurance: outcomes, competencies and governance, reflect this combined approach:

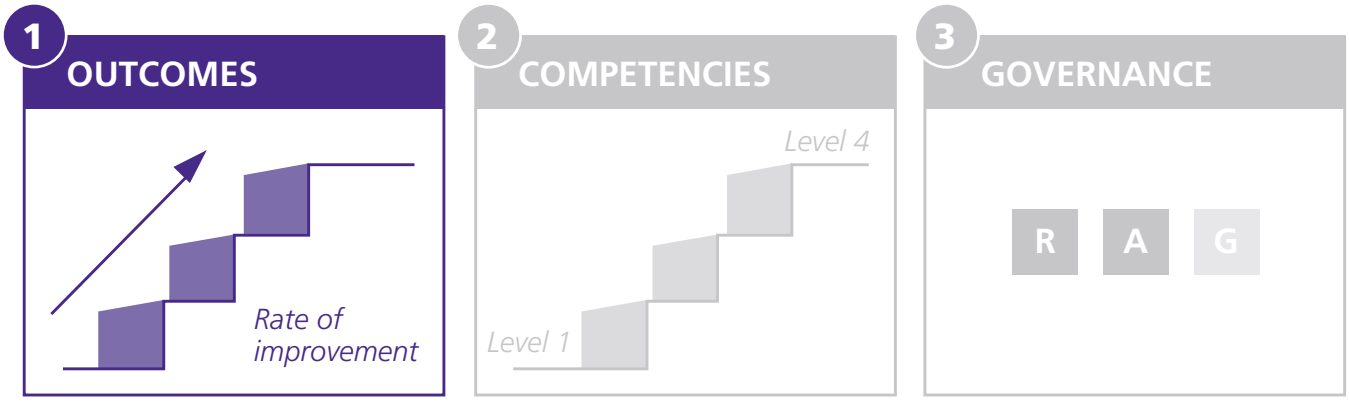
Outcomes reflect the overall improvement in health and well-being of the population and reduction in health inequalities.

Competencies reflect improvements in the PCTs skills and behaviours as commissioners.

Governance reflects the underlying grip that the board and the organisation have on their core business.

In addition, the assessment will review the PCT's potential for improvement. In this section, the panel will take account of the stage the PCT is at in its journey, and the current direction of travel.

Outcomes



Changes in Year 2 for outcomes:

Improving health outcomes and reducing inequalities remain the focus and overall goal of WCC assurance. In Year 2, PCTs will be asked to describe how they will demonstrate improvements to date and to set year-on-year aspirations for the next five years.

Through world class commissioning, PCTs align their strategic priorities with the key health needs and health outcomes that they will deliver for their population. These have a longer-term focus than the delivery of operational targets. As WCC continues to evolve, the focus of WCC assurance on outcomes will change:

- **Year 1** was focused on selecting measurable outcomes against which improvement could be tracked to align with strategic aims, local needs and Local Area Agreements targets;
- **Year 2** is focused on reviewing initial improvements in the chosen outcomes and ensuring that robust plans are in place to ensure measurable, demonstrable and ambitious levels of improvement for each of the next five years;
- **Year 3** and beyond will focus on reviewing ongoing performance and whether the PCT is on track to deliver against its aspirations.

Setting priority outcomes and aspirations

As last year, PCTs will have up to ten outcomes for assessment and review. To ensure a degree of national consistency, and because they are core to the business of all commissioners, two of these outcomes – improving life expectancy and reducing health inequalities – will continue to be included for all PCTs. As last year, PCTs will supplement these nationally defined outcomes with up to eight locally determined outcomes, which should reflect the identified health needs of the population, reflect their strategic plan priorities and be agreed with partners.

For Year 2, the majority of PCTs will use the same priority outcomes for WCC assurance. Although PCTs may review, and in some cases change their chosen outcomes, the DH expects this number to be small.

PCTs who change their priority outcomes will be asked to provide rationale and justification for the change. Panels will also review performance against last year's selected outcomes.

The outcomes chosen will need to be underpinned by quantifiable data in order to provide a basis against which improvement can be tracked. Appendix I provides a list of metrics that quantify health and patient-reported outcomes and priorities. Each of these metrics has a robust national data set available to all PCTs. The list has been updated to reflect feedback from last year's assurance process with major changes including:

- variance in life expectancy between IMD deciles has replaced IMD as the national metric for health inequalities. (This allows PCTs to demonstrate a reduction in health inequalities within a PCT in a way that last year's metric did not.);
- new mental health metrics have been introduced;
- child obesity metrics have been included.

As last year, PCTs are able to submit up to three locally defined outcomes metrics, outside the nationally defined list. This year it will be the PCT's responsibility to provide a robust dataset for these outcome metrics to support analysis and benchmarking. The dataset should:

- provide national coverage of all PCTs;
- be available for at least 12 months to enable rate of improvement to be analysed;
- be accessible by the SHA directly from source (in addition to the dataset directly supplied by the PCT).

Why set aspirations?

- **Definition of an objective measure can improve performance by:**
  - providing a motivation to strive to outperform the existing level of ambition on priority areas;
  - stimulating dialogue between the SHA and the PCT to better deliver strategic goals;
  - increasing focus and improving assessment on the delivery of successful commissioning.
- **The process of setting aspirations can drive better performance through:**
  - critical review of performance compared with peers, best performing PCTs and international benchmarks where available;
  - identification and synthesis of best practice elements seen elsewhere;
  - assessment of internal capability and capacity to drive performance.

In Year 2, PCTs will be asked to set an aspiration for improvement, aligned to their strategic goals, over the next five years against each of the priority outcomes they have chosen including the two national outcomes. Where appropriate, the PCT's level of ambition should reflect the targets, including stretch targets, in Local Area Agreements. Aspirations for outcomes which have been locally defined and are not on the national list of metrics will be set in the same way.

The purpose of setting aspirations is to encourage locally determined ambition reflecting local needs, priorities and baseline performance. PCTs are encouraged to aim high and should see aspirations as a means of stimulating and encouraging increased levels of improvement in health for their populations.

Aspirations should be set by the PCT through evaluation of best practice, their own ability to deliver and critical reflection with SHAs

Critically review local needs and performance against benchmarks	Set aspirations based on strategic aims, capabilities and capacity	Critical dialogue with SHA on underlying assumptions
• Review local needs. • Review own performance compared with peers: national peers, ONS cluster and others. • Understand the performance of peers (using both national and international benchmarks): – analyse recent performance; – evaluate the reasons for differential performance. • Identify drivers of success for both self and benchmarks identified.	• Align aspirations with strategic aims: – aspirations are driven by strategic objectives; – high importance strategic priorities should have more challenging aspirations. • Understand the implications of achieving aspirations: – clinical outcomes (e.g. lives saved); – resource implications (e.g. £, skills, staff). • Reflect on ability (spend, capability and capacity) to achieve all priority aspirations.	• Discuss rationale for benchmarks used, and why they are most applicable. • Provide rationale for why the aspiration is ambitious, compared with past performance of benchmarks. • Provide rationale for the achievability of aspirations, given any capabilities and capacity limitations.

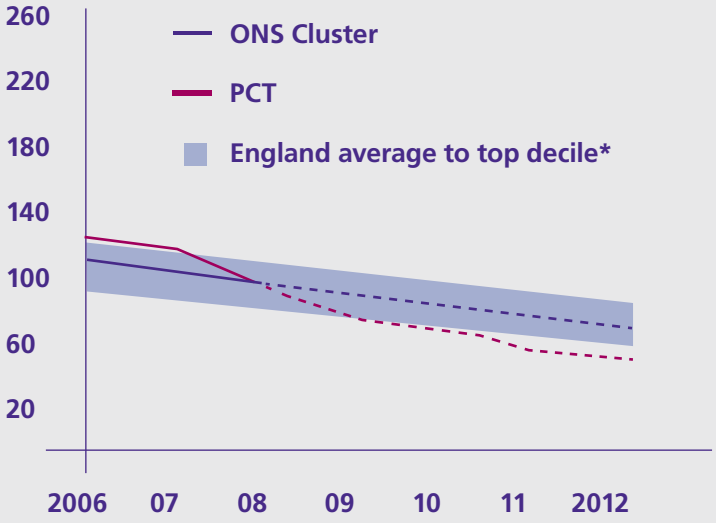
PCTs will work with their SHA to develop these aspirations having discussed and aligned them with relevant partners, including patients and the public. Aspirations should be aligned to the PCT's strategic goals and take into account the potential impact of external factors such as differing financial scenarios.

Panels will look for evidence that the level of aspiration described is both ambitious and achievable against national and international benchmarks, where available, and taking into account different financial scenarios. Panels will compare the levels of ambition to historical peer performance and other PCTs' aspirations, where available, to ensure ambition and challenge. They will discuss how the levels of ambition will be supported by the PCT's strategy and provide constructive challenge on whether the levels of ambition are sufficiently robust and credible based on local capabilities and capacity. To support these discussions, PCTs will be asked to provide the rationale for the rate of improvement that they are expecting in their outcomes, both in their outcomes submissions and in their strategic plans. The focus of a PCT's aspiration may not solely be about achieving a higher level of performance overall but may be about reducing inequalities in performance within its population.

Aspirations will be compared to historic performance

Example: the high level of aspiration set out by the PCT would be tested in context of their strategic plan

CVD Mortality comparison with PCTs nationally



Growth comparison	CAGR**, (%)
• Historic	
– PCT	-8.2
– Top relative decile*	-7.8
– ONS	-7.2
– England average	-6.5
• PCT aspiration	-9.4

* Top decile is defined as 'top 10% of PCTs in absolute terms'; top relative decile will be defined as 'top 10% most improved PCTs'
** Compound Annual Growth Rate

To support PCTs in setting their aspirations, national benchmarking data is available via the NHS Information Centre's online Data Packs. In addition, PCTs may wish to supplement this data with local knowledge and information, including that from partners.

For their identified priority outcomes, PCTs may choose to set a level of ambition which is more stretching than that for Vital Signs. The decision is for PCTs to make locally. The panels will consider performance relative to the scale of the challenge that a PCT has set itself, even if it fails to meet those ambitious aspirations. Ambition and drive to improve are important factors in progressing towards becoming world class – it is preferable that PCTs set ambitious aspirations and slightly miss, rather than meeting or overachieving on unambitious goals that present little or no challenge.

Measuring improvements against outcomes

Improvement in priority outcomes will be considered on a relative rather than an absolute basis. The detailed outcomes scorecard has been refined this year to show the PCT's absolute performance and rate of improvement relative to the national median, top decile, and the relevant Office for National Statistics (ONS) cluster. In the future, PCTs will also be shown their improvement against the aspirations that they have set.

It is recognised that it takes time to drive tangible change in outcomes and WCC assurance takes account of this. PCTs should choose metrics that reflect their strategic priorities, rather than choose metrics likely to improve by the next assessment. The link with the strategic plan, the rationale for choosing each of the priorities, and the means by which the PCT intends to drive tangible change will be central to the panel review.

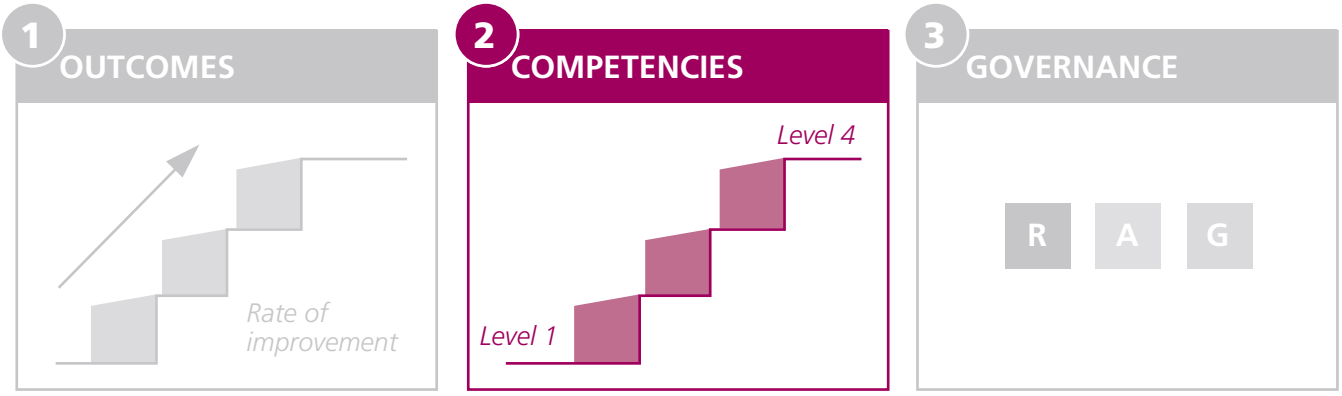
Assessment of outcomes

In WCC assurance Year 2, PCTs will not be formally rated against their outcomes. Instead, the panel's assessment of outcomes will focus on:

- improvement in the chosen outcomes relative to peers (ONS cluster, national average and top decile), including both the change in absolute performance and the rate of improvement between and within PCTs;
- the ambition and challenge of the PCT's aspirations for improvement and whether they are backed up by a credible and robust strategy for delivery;
- the fit of the priority outcomes with the strategic plan where there have been changes to the priority outcomes chosen. This will include the context, rationale and evidence for any changes being made to demonstrate how and why the outcomes reflect the strategic priorities and supporting initiatives of the PCT.

PCTs should focus on understanding the factors influencing their historic performance and how these have affected each of their priority outcomes. In the future, priority outcome performance will be reviewed using the rate of improvement that PCTs are making relative to their peers and compared to the levels of ambition PCTs set themselves. These will be used to identify whether PCTs are making progress and have the right actions in place to drive improvements in their population's health and well-being.

Competencies



Changes in Year 2 for competencies

In addition to taking into account feedback, all competencies have been revised to increase clarity, and ensure relevance to the current context and what is required of PCTs to deliver in these challenging times. The criteria for all the sub-competencies provide greater clarity on the specific skills, knowledge and processes that are required, and ensure there is a significant differentiation between each level.

Competency 11, focusing on efficiency and effectiveness, is now being assessed as part of the core competencies. Competency 6 has been revised in the light of this and also requires PCTs to prioritise investment under different financial scenarios.

The competencies element of WCC assurance focuses on how far the PCT has developed towards world class in each of the world class commissioning competencies.

The organisational competencies for WCC were published in December 2007. Alongside the vision for WCC, they set out the knowledge, skills, behaviours and characteristics expected of WCC.

The competencies describe the commissioning processes and capabilities that, when developed to a high level, will deliver improvements in health outcomes over time. Achievement of the competencies is not an end in itself, but a part of the process that drives towards transforming people's health and well-being at a local level.

By Year 4, the expectation is that the competencies will be fully embedded, with assessment focused on how successfully PCTs are using them to deliver improved health outcomes and reduced health inequalities. In Year 2, the primary focus will be assessing where and how PCTs are developing their competencies and the impact this has had over the last year.

The 11 competencies

01 locally lead the NHS

02 work with community partners

03 engage with public and patients

04 collaborate with clinicians

05 manage knowledge and assess needs

06 prioritise investment of all spend

07 stimulate the market

08 promote improvement and innovation

09 secure procurement skills

10 manage the local health system

11 efficiency and effectiveness of spend

As in the first year of assurance, each sub-competency will be assessed against a four point scale and each of the levels for the sub-competencies will be measured on an additive basis. The PCT will therefore have to meet all of the criteria for the sub-competencies at level two to progress to level three, and will have met all of the criteria for levels two and three to progress to level four. The full criteria for levels one to four on each indicator of the competencies can be found in appendix II. PCTs will use these criteria to assess themselves against each sub-competency, and they will be used by the panel to determine the PCTs' final rating.

The assessment of each competency will start with the self-assessment and associated commentary that the PCT provides. This year, the self-assessment is more targeted, asking PCTs to highlight the actions they have taken over the last year to improve in each competency, how they would demonstrate that progress and the impact it has had, and specifically to sign-post where evidence can be found in their submitted documents.

Sub-competencies for each competency

	Sub-competency a	Sub-competency b	Sub-competency c
Competency 1	Reputation as the local leader of the NHS	Reputation as a change leader for local organisations	Position as an employer of choice
Competency 2	Creation of Local Area Agreement based on joint needs	Ability to conduct constructive partnerships	Reputation as an active and effective partner
Competency 3	Influence on local health opinions and aspirations	Public and patient engagement	Improvement in patient experience
Competency 4	Clinical engagement	Dissemination of information to support clinical decision making	Reputation as leader of clinical engagement
Competency 5	Analytical skills and insights	Understanding of health needs trends	Use of health needs benchmarks
Competency 6	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
Competency 7	Knowledge of current and future provider capacity and capability	Alignment of provider capacity with health needs projections	Creation of effective choices for patients
Competency 8	Identification of improvement opportunities	Implementation of improvement initiatives	Collection of quality and outcome information
Competency 9	Understanding of provider economics	Negotiation of contracts around defined variables	Creation of robust contracts based on outcomes
Competency 10	Use of performance information	Implementation of regular provider performance discussions	Resolution of ongoing contractual issues
Competency 11	Measuring and understanding efficiency and effectiveness of spend	Identifying opportunities to maximise efficiency and effectiveness of spend	Delivering sustainable efficiency and effectiveness of spend

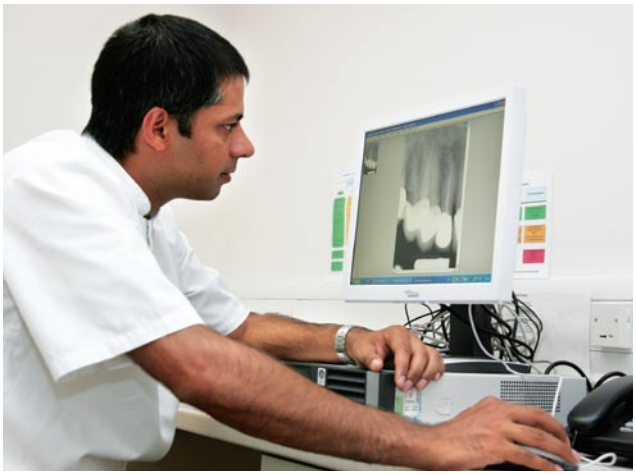
Using a consistent methodology, a number of key materials will then be reviewed by a team of analysts, along with metrics from nationally defined datasets and results from surveys including the feedback survey and public perception survey. The list of documents and data sources used has been refreshed for Year 2 and is limited to those which will provide most value. The supporting evidence and subsequent analysis will be used to provide a briefing to the panel, in advance of the panel day, highlighting where criteria have been met and suggesting key areas of questioning or points of enquiry.

Although the analysts will highlight whether criteria have been met based on the submitted evidence, the panel will take the overall decision on the rating for each PCT for each competency. The final rating for each competency will be reached by a combination of review of the PCT self-assessment, review of evidence, and the interviews with the PCT at the panel review day.

An individual rating on the four point scale will be given for each sub-competency. The rating for each competency will be an aggregated mean average rating of the levels across the three sub-competencies. The overall competency score will be reflected on the scorecard – this year shown to one decimal point – and in the panel report provided to the PCT.

The panel will assess each competency independently from the other competencies. However, it is recognised that there are interdependencies between the different competencies, which panels will take into account. For example, PCTs that have taken tough decisions on the latter competencies – for example, changing the profile of their spend to improve effectiveness and efficiency – may see lower stakeholder survey results in the short to medium term. Lower survey results should not in themselves be seen as a negative development and may be a reflection of the development of a more open and constructive working relationship with partners that will help better inform future plans.

The levels for each competency are challenging and reflect the developmental nature of world class commissioning assurance. As anticipated, the majority of PCTs achieved levels one or two in the first year of WCC assurance. In Year 2, we anticipate that PCTs will be making demonstrable improvements in the majority of the competency areas.



Governance

Changes in Year 2 for governance

- **The strategy section has been strengthened this year to reflect feedback from last year and the increasing challenges that PCTs are facing. There is an increased focus on ensuring that PCTs are scenario planning for and ready to respond to uncertainties.**
- **Within finance, the focus will continue to be on demonstrating the link between strategy and finance, rather than a full financial assessment and audit.**
- **The board element has been enhanced with greater emphasis on board ownership, responsibility for strategic development and delivery, and managing risk.**
- **The board self-certification has been developed so that PCTs will now self-assess against all three aspects of governance to allow a more informed debate with the panel.**

Good governance is at the core of a robust organisation. Within world class commissioning it is expected that the whole board is able to take control of the commissioning agenda and that all board members understand their role, have the skills that they need and are empowered to act corporately and collectively.

The governance element of WCC assurance has three components (strategy, finance and board) and focuses on whether the board has taken ownership of and developed a meaningful strategy supported by a robust financial plan. It looks at the five-year strategic, financial, and organisation development plans, as well as board controls and processes. The governance element will consider historic performance where this is relevant to the current position. It will include a summary assessment of whether the organisation is meeting current operational targets as well as whether it is planning for the future.

As last year, governance is rated using a traffic-light system: red, amber and green . Green indicates no concerns and red indicates serious concerns. Ratings will be provided for the sub-components of each of strategy, finance and board as well as overall for each. The individual ratings for each of the three components (strategy, finance and board) will appear on the scorecard and in the panel report.

This year, the criteria for assessment of each element has been published and is detailed in appendix III.

PCT governance

Strategy

Is there a coherent strategy in place that will achieve

- Health gains?
- Reduced inequalities?
- Improved quality of care?

R A G

Finance

Is the strategy underpinned by a robust long-term financial plan?

Is there a sustainable financial position?

R A G

Board

Is the board aligned on the organisation's priorities?

Has the board ensured that the organisation is geared for success?

Does the organisation have controls in place to know what is going on?

R A G

In line with other areas of the WCC framework, the governance criteria have evolved to take into account evaluation and create greater distinction between each rating level. Given this, it is expected that there will be a broader distinction of performance against the ratings levels in Year 2.

PCTs should self-assess against each defined criteria line to determine their overall self-assessment rating for the sub-component. The red-amber-green levels are not additive in the same way that the levels are in the competencies. PCTs will need to use their own judgement in determining the relative importance of each criteria line, and therefore their overall self-assessed rating. The PCT should also provide a commentary and sign-post evidence to support its self-assessment rating.

Strategy component

PCTs are required to produce robust and high quality strategic plans for their organisations reflecting their priorities over a five-year timescale. Strategic planning to achieve improved health outcomes is at the core of the business of the PCT, and as a result, at the core of WCC assurance.

Strategic plans should be revised along a spectrum from refresh to rewrite for Year 2 taking into account:

- the extent of feedback from last year;
- major national and local contextual changes;
- the PCT's and partners' learnings over the last year.

A key driver for revision will be the challenges of the current economic climate and the extent to which a PCT's strategic plan will require revising will depend on how robust and comprehensive that plan was last year.

For the purpose of WCC assurance; strategic plans will be underpinned by a five-year financial plan and an organisational development plan. In response to the current economic climate, PCTs will need to ensure that their strategic plans and financial plans allow for three financial scenarios. Further guidance and templates to support PCTs in strategic plan development are available at www.wccassurance.dh.gov.uk

For the strategy component of governance, the panel will undertake a detailed review of the strategic plan and supporting financial plan focusing on the vision, goals and initiatives included, whether these reflect the priorities of the PCT as agreed with its population and partners, and how the PCT is responding to different financial scenarios. In particular, the following areas will be considered (with more detail on the specific criteria outlined in appendix III):

Vision and goals

- The vision should be clear and supported by strategic goals which drive the achievement of improved health gains, reduced inequalities and improved quality of care.
- The vision should be a concise description of the strategic change programme that the PCT is aiming to achieve in the next five years that can be used to engage its stakeholders.
- The vision and goals should align with the pyramid structure, be specific and measurable as detailed in the strategic planning guide.
- The local population's health needs should be covered, with the vision informed by the local and national context.

Initiatives to ensure delivery of strategic goals

- The initiatives should support delivery of goals in the context of their strategic programme of change, and in turn, the PCT vision.
- There should be clear criteria on how initiatives were selected and prioritised.
- The strategic plan should describe the anticipated impact of initiatives on health outcomes, inequalities and quality of care, with a timeline for this impact.
- The impact on activity and finance should be outlined, as well as any investment or disinvestment requirements that will support delivery of the initiatives, under three financial scenarios.

Consistency of financial plan with the strategy

- The link between investment and disinvestment decisions and health outcomes, reduced inequalities, and efficiency and effectiveness of services should be both clear and robust.
- Activity and financial forecasts should reflect the initiatives outlined in the strategic plan, the anticipated impact that they will have and how this impact will be achieved.

Board challenge, ownership and monitoring of strategic plan delivery

- The board should be actively engaged in strategic development, providing robust challenge in the evolution of the strategic plan to ensure it focuses on priority health needs across different population groups, is ambitious, but is also realistic and achievable.
- The strategy should outline how the board monitors and ensures delivery of the strategic plan.

Achievement of milestones to date

- The PCT should have a comprehensive understanding of its past delivery performance and the delivery of its strategy over the past year to demonstrate its ability to set appropriate milestones, monitor achievement and identify improvements.

The strategic plan should describe the impact on health outcomes, inequalities and quality of care, with a timeline for this impact.

Finance component

The finance assessment assures the alignment of the PCT's financial position with its strategic priorities, rather than being a full financial audit.

The financial assessment, supported by a refined and more focused financial template, will now consider five factors, with robust financial management and sustainability of financial position under different financial scenarios being added in Year 2.

Historical financial management

- The PCT should demonstrate its historical ability to accurately plan its financial position so it will break even.

Robust financial management

- The PCT should have the capability to monitor financial performance, invoice auditing, debt and asset management.

Robustness of planning assumptions

- The PCT's planning assumptions and financial scenarios should be credible and aligned with guidance from the SHA.

Sustainable financial position as base case

- The PCT should have the skills to accurately manage and forecast its financial position, so it can break even in each of the next five years.
- The PCT's break even position should be supported by a credible plan, identifying financial challenges and risks over the period.

Sustainable financial position under different financial scenarios

- The PCT should be able to evidence how it will adapt to different financial scenarios.

The finance assessment assures the alignment of the PCT's financial position with its strategic priorities.

Board component

The principle functions of the PCT board are to set the strategic direction for the PCT and to exercise effective oversight and management. At all times the board members are accountable to the NHS and their local population for how they oversee investment and prioritisation and manage clinical, operational and service performance to drive better health outcomes, improve quality and reduce inequalities. The overriding objective of the board assessment is to understand the board and its sub-committees' grip on the organisation, and their ownership and control of the commissioning agenda. In particular, the following components will be considered:

Organisation

- The clarity and robustness of the PCT's organisational structure, the articulation of its values, and its development priorities to deliver their strategic vision and programme of change.
- The supporting culture and values of the organisation and how these support the implementation of priorities.
- The capacity and capability of the organisation to deliver its strategic agenda and programme of change.

Risk

- The board processes to identify, prioritise and manage risks.

Information

- The PCT's ability to provide performance information in a timely and accurate manner.

Performance

- The PCT's tracking and use of quality, clinical, operational and financial performance.
- The board's review of performance and actions to address disparities.

The principle functions are to set the strategic direction of the PCT and to exercise effective oversight and management.

Delegation

- The PCT's governance arrangements and delegation processes for joint, collaborative and specialist commissioning arrangements[1].

Board interaction

- The board's alignment on the priorities of the PCT and how members work together to ensure successful delivery.

In addition to the PCT's self-assessment of governance, SHA insights will be considered as an informal contextual input into the process (e.g. from board observations), however these will not be officially captured either in the panel briefing or panel report. On the panel day itself the board, non-executives and executive team, including the chief executive and chair, will be interviewed. In addition, the full panel will interview the chief executive and chair separately. Both of these elements of the panel day will provide insights into the functioning and alignment of the board as a group.

1 Joint, collaborative and specialised commissioning arrangements include, but are not limited to, Practice Based Commissioning, Specialist Commissioning Groups (SCGs) and collaborative commissioning units

Potential for improvement

While *organisational performance* is what the organisation delivers to its stakeholders in operational and financial terms today, *organisational health* is defined as the qualities, attributes, and actions today that help sustain performance in the future.

In addition to the PCT's ratings for outcomes, competencies and governance, the final scorecard includes a section entitled 'Potential for improvement'. This will consist of a commentary on the PCT's status and current direction of travel, and its development needs, focusing on organisational health issues.

The description of the PCT's status allows the panel to differentiate between PCTs which receive identical ratings, but are moving in different directions. For example, two PCTs could receive the same competency and governance ratings and be performing similarly on their outcomes, but one could have improved significantly from the first year while the other is unchanged.

The potential for improvement commentary describes the PCT's ability to address its challenges in order to move towards world class, and has two main sections:

- the first is a brief assessment of the PCT's journey towards world class, commenting on the current position reached and the anticipated speed and direction of travel in the short to medium term;
- the second highlights areas for organisational development. This has a different focus from the other developmental commentary provided in the panel report on outcomes, competencies and governance, which focus on tactical actions in those specific areas. Instead, the potential for improvement commentary focuses on overall organisational development issues and the organisation, capacity and capability to deliver.

Potential for improvement will be reviewed across three dimensions: the extent to which the organisation is aligned ('alignment'), its ability to execute strategy ('execution') and its ability to renew itself in response to changed circumstances ('renewal').

Under these headings, the panel will ask questions such as:

Alignment: Where is the organisation headed, what is its purpose and strategy, and how supportive is its internal environment?

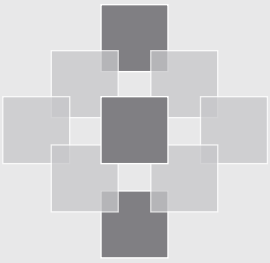
Execution: How does the organisation execute against its strategy and deliver its services?

Renewal: How does the organisation understand, interact, respond, and adapt to its situation and external environment?

The panel will assess the PCT's potential for improvement using the elements of organisational health detailed on the next page.

Elements of organisational health

alignment



Are people at all levels aligned around the organisation's vision, strategy, culture, and values?

execution

How does the organisation execute in accordance with its strategy? Can the organisation perform essential tasks with its current capabilities and motivation level?

renewal

How does the organisation understand, interact, respond, and adapt to its situation and external environment?

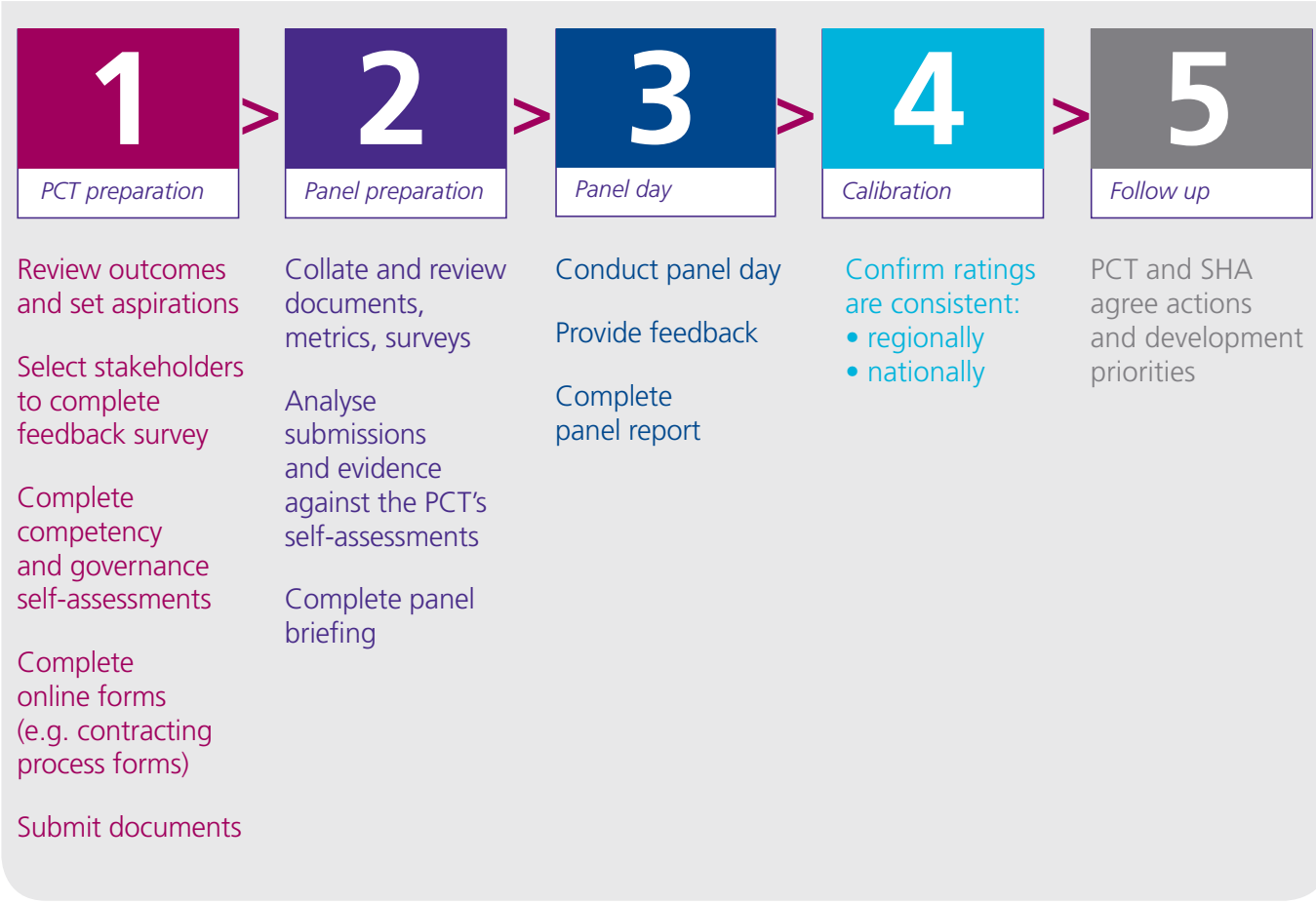
The nine dimensions address key areas of organisational health

Dimension	How effective, and in what ways does the organisation…
leadership	ensure that leaders shape and inspire the actions of other organisational members to drive better performance?
direction	articulate where the organisation is heading, how to get there, and align people around the vision?
environment and values	shape the quality of staff interactions (e.g. culture) and foster a shared understanding of core values?
accountability	design its structure and reporting relationships and evaluate individual performance to ensure that people are accountable and take responsibility for results?
coordination & control	measure and evaluate performance and risk?
capability	ensure that the requisite internal skills and talent exist to support the organisation's strategy?
motivation	inspire and encourage staff to perform and stay with the organisation?
external orientation	engage in constant two-way interactions with providers, patients, public, partners, or other external groups?
innovation	generate flow of ideas and change so that the organisation can sustain itself, develop over time, and improve the services it commissions?

The panel's advice on organisational development is intended to enhance the ongoing development discussion between PCTs and SHAs, and the PCT's own actions by providing an external perspective from the panel members. Unlike the local government assessment of 'Potential for Improvement', WCC assurance for PCTs will not provide a rating. This is to ensure continued focus on development.

4. world class commissioning assurance **process**

WCC assurance has five stages – PCT preparation, panel preparation, panel day, calibration and follow up. This section goes through each of these stages. In addition, there are examples and descriptions of how to use the tools and templates in the assurance toolkit.

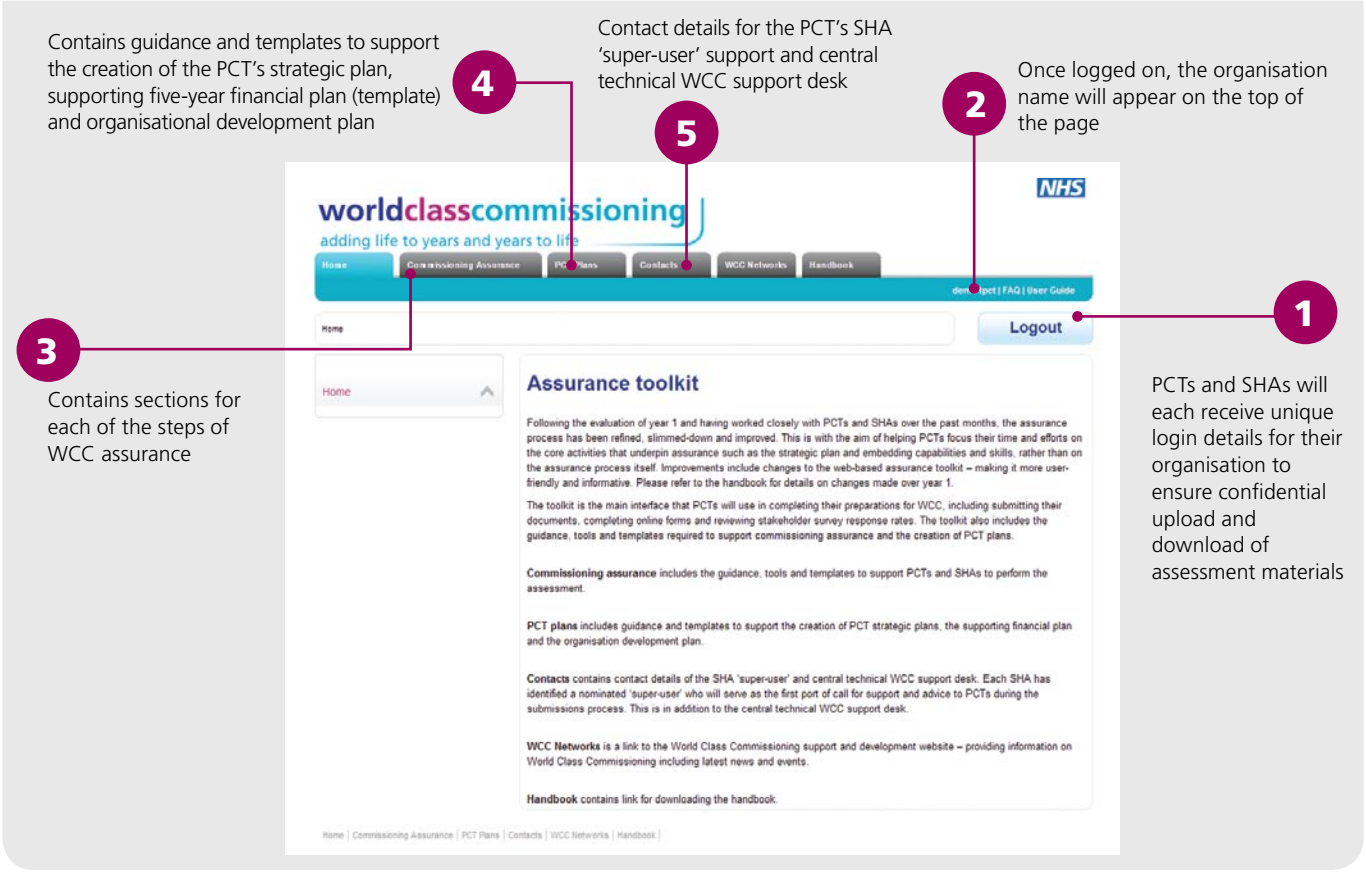


World class commissioning assurance toolkit

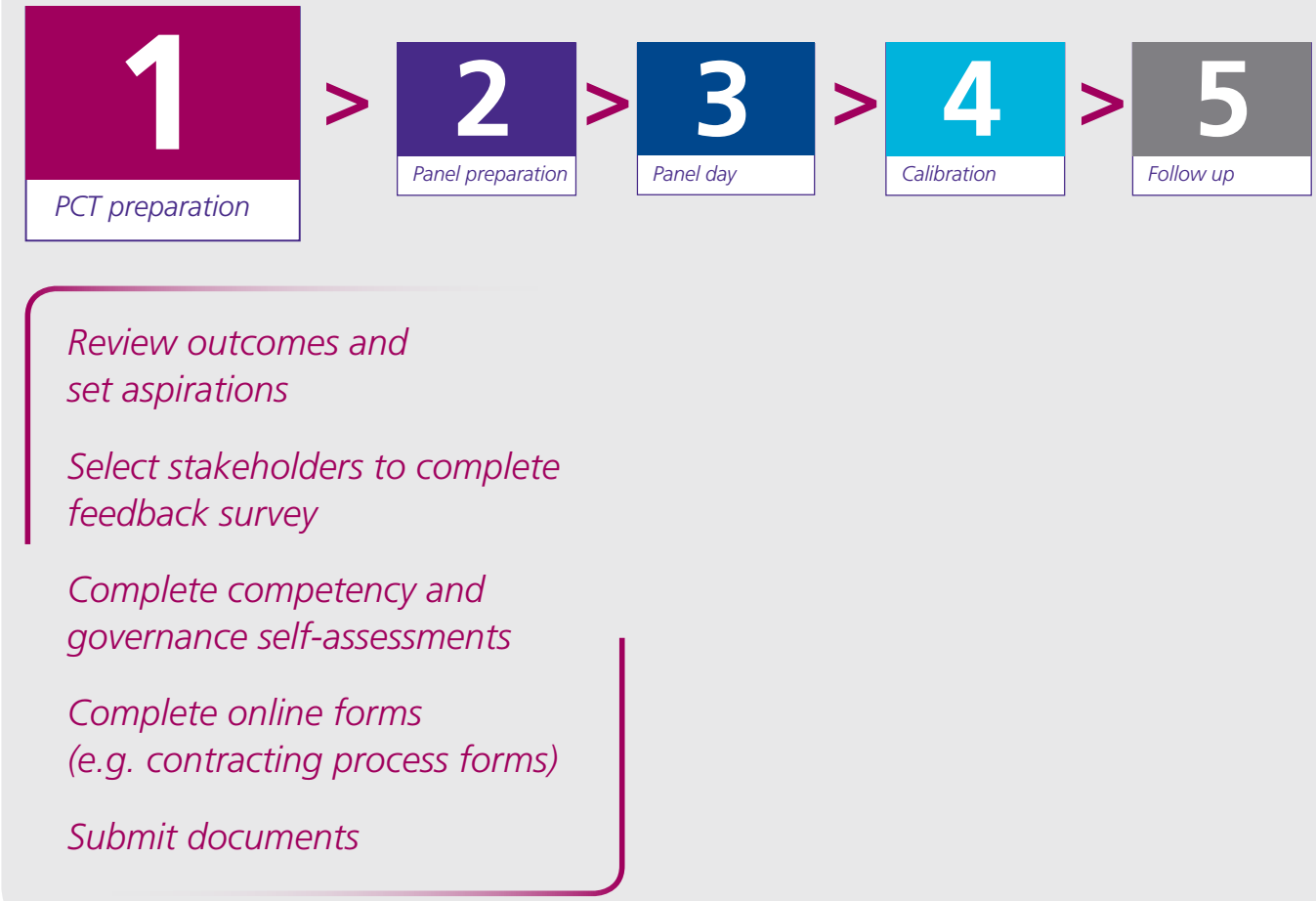
All the materials required by PCTs and SHAs can be found as part of the assurance toolkit, available electronically at www.wccassurance.dh.gov.uk Each PCT and SHA will have a unique login to the assurance toolkit.

The toolkit is the main interface that PCTs will use in completing their preparations for WCC, including submitting their documents, completing online forms and reviewing stakeholder survey response rates. Following feedback from last year, the toolkit has been enhanced to:

- replace Excel forms with web-based forms (for example, outcomes selection, stakeholder survey nominees);
- introduce new online forms for contracting, replacing the submission of contracts;
- provide a new online form for governance self-assessment;
- save partially filled forms and confirmation on all saves/submits;
- allow PCTs to select a second set of stakeholder survey nominees and SHAs, on behalf of their PCTs, to correct/resend emails if details were incorrectly supplied;
- enable PCTs and SHAs to view progress reports, such as stakeholder survey response rates;
- provide a more structured document submission process with PCTs defining the document type on upload.



PCT preparation



PCTs will prepare for the panel day in two ways. They will:

- reflect on their starting point and progress since last year and provide the panel with a reflection on where they believe they are today. This will include self-assessments across the commissioning competencies and governance components, and details of their priority outcomes and aspirations;
- provide core documents and upload online forms so that analysts can apply a consistent assessment methodology across PCTs.

To guide PCTs as to the anticipated resource required to undertake the assurance process itself, the following tables provide an indication of the amount of time and resource required to complete the individual stages of the actual assurance process – distinct from the core activities that underpin WCC assurance, such as embedding capabilities and skills.

Indicative timings for completing the individual stages of the assurance process

Key elements of submissions	Approach in Year 2	Indicative timing
Competency self-assessment	• Build off year 1 WCC panel feedback and review: – What have been the developments since year 1 – Whether this means for a given competency that the PCT now meets the next criteria level ◆ If no, limit response to major areas for development that the PCT is putting in place and/or PCT's activities against any new Year 2 criteria ◆ If yes, focus response on changes over the last year against next criteria level and/or new criteria for Year 2	• Two days of Director of Commissioning or AD equivalent
Governance self-assessment	• As per competency self-assessment: focusing on new and amended areas of WCC for Year 2 (for example, strategy refresh/redevelopment and introduction of three financial scenarios)	• Two days of Director of Commissioning/ Director of Finance or AD equivalent
Strategic plan	• Refresh/redevelopment depending on: – PCT's feedback from last year; – implications of contextual changes over the last year compared to the previous strategic plan.	• Variable depending on extent of refresh – likely to be part-time over 2-8 weeks
Financial template	• Iterative process with refresh/redevelopment of strategic plan	• Part-time over 3-6 week period
Outcomes form	• Review outcomes chosen last year, complete aspirations and provide information on any locally defined outcomes (including providing dataset)	• Included as part of strategic plan refresh/ redevelopment
OD plan	• Refresh as required to reflect: – any changes to the PCT's refreshed/redeveloped strategic plan; – requirements of the changed national context; – feedback from last year where this has not already been completed.	• Limited
Pathway descriptions	• Highlight key areas of three priority pathways with particular focus on relevant criteria in competencies 3, 4, 8, 10, 11	• One day per pathway to summarise existing materials

Key elements of submissions	Approach in Year 2	Indicative timing
• Contracting process forms	• Highlight key areas of PCT's contracting process from negotiations to contract performance management, focusing on relevant criteria in competencies 3,4,7-10	• One day of AD of Commissioning and/or Performance and/or Finance
• LAA and PCT cover pages	• Brief one-page overview of process for reconfirming the LAA (including clinical engagement) and any changes to the LAA in the last year (where relevant)	• One - two hours by Director of Commissioning for cover page • None for LAA – previously agreed document
• Joint Strategic Needs Assessment (JSNA)	• Executive summary and 1-2 chapters (those most relevant to the PCT's chosen outcomes and, in addition, providing evidence for the relevant competencies where the JSNA has been cited as a key evidence source)	• None – part of BAU* for PCTs
• Communications strategy	• Minor updates where required	• None – part of BAU* for PCTs
• LAA performance report	• Typical PCT/LA/local strategic partnership report	• None – part of BAU* for PCTs
• Refreshed practice based commissioning (PBC) governance arrangements	• Refreshed governance arrangements to reflect new PBC policy guidance	• None – part of BAU* for PCTs
• Provider performance report	• Typical PCT provider performance report	• None – part of BAU* for PCTs
• Board risk governance report	• Typical board risk report	• None – part of BAU* for PCTs
• Other schemes of delegation	• Including specialised commissioning and any collaborative commissioning arrangements	• None – part of BAU* for PCTs

* Business as usual

Reviewing outcomes and setting outcome aspirations

The outcomes assessment in Year 2 will review PCTs' initial improvements in their outcomes priorities chosen in year 1 and assess the ambition and challenge of the aspirations set.

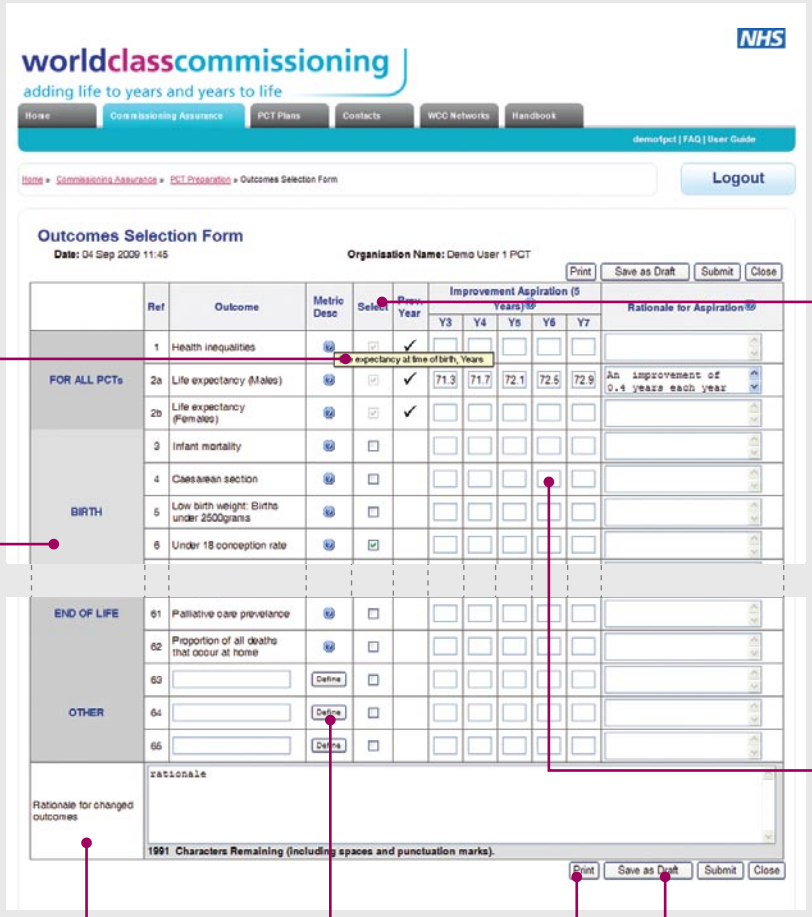
In preparing for Year 2, PCTs will complete an online form within the assurance toolkit and will be asked to:

- **Review the outcome priorities chosen in year 1:** The online form will display the outcomes chosen by the PCT in year 1 and the full list of outcomes available for Year 2. It is expected that the majority of PCTs will continue to work towards the same outcomes chosen last year. A small number of PCTs may choose to change one or more of their outcomes. The PCT board should agree any changes to the local outcomes and PCTs will be asked to provide a rationale on the outcomes form for any changes made.

- **Set outcome aspirations:** This year, PCTs are required to set aspirations for all their priority outcomes for each of the next five years – including the nationally defined assurance outcome metrics relating to life expectancy and health inequalities. The PCT should enter these on the online outcomes form, along with rationale for each of their aspiration levels reflecting the PCT's analysis of national and international benchmarks and how they are planning to deliver the improvement.

- **Complete an additional locally defined outcomes form** and upload a national dataset for benchmarking (if the PCT has chosen an outcome priority metric that is outside of the nationally provided list): In these cases, the PCT will be prompted to fill in an additional form. The PCT is required to provide a robust, nationally consistent dataset (which can be independently sourced), which it uploads as part of the submission. It is the PCT's responsibility to both source and provide the dataset against which their performance is assessed. If no robust dataset exists, the PCT should not select the outcome. Locally defined aspirations should be set in a similar manner to the nationally defined outcomes. PCTs will not be able to submit their overall outcomes form unless this supplementary form has been completed for all 'locally defined' outcomes.

Online outcomes form



The definition for each metric is provided. All metrics are sourced from national datasets

3

2

The metrics are organised around the 8 areas of care used in the NHS Next Stage Review

1

PCTs should review the outcomes chosen last year and, in the small number of cases where required, revise outcomes (up to eight metrics that most accurately reflect their strategic plan priorities)

PCTs should provide improvement aspirations for selected outcomes for next five years

4

If any outcome selection is changed, PCTs will need to provide rationale for all changes

8

5

Metrics for any locally defined outcomes will need to be defined in separate form

6

Printable view of selected outcomes

7

Partially filled form can be saved as draft for completing later

Locally defined outcomes form

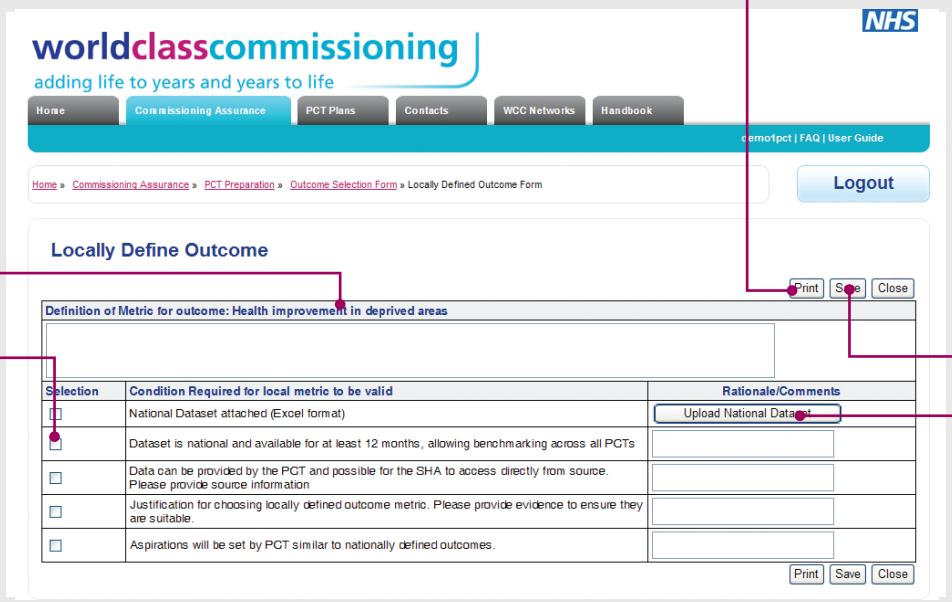
4 Printable view of locally defined outcomes form

Name of the locally defined outcome as entered by the PCT on the main outcomes form

1

2

PCTs must be able to tick all conditions required for a valid, locally defined outcome (and to complete the main outcomes form)



Saves locally defined outcome definition and form to the main outcomes form. Full details are only saved when the main outcomes form is saved

5

3

National dataset needs to be attached in Excel format

PCT feedback survey

The PCT feedback survey allows local stakeholders to provide anonymised feedback on the PCT's commissioning capabilities. The purpose of this feedback is to support PCT development, and to provide part of the evidence base for the competency assessment.

To support PCT development, each respondent is asked to provide input to the following two questions:

- what does the PCT do well that they should keep doing?
- what should the PCT do differently?

To provide input into PCT competencies, stakeholders nominated by the PCT are asked to rate the PCT, on a scale of one (strongly disagree) to six (strongly agree) against the following six statements:

- we recognise the PCT as the local leader of the NHS (Competency 1);
- the PCT has a significant influence on our decisions and actions (Competency 1);
- the PCT proactively engages my organisation to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources (Competency 2);
- the PCT is an effective partner in delivering health and well-being improvements for the local population (Competency 2);
- the PCT proactively shapes the health opinions and aspirations of the local population (e.g. through social marketing) (Competency 3);
- the PCT proactively engages clinicians (including through PBC) to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources (Competency 4).

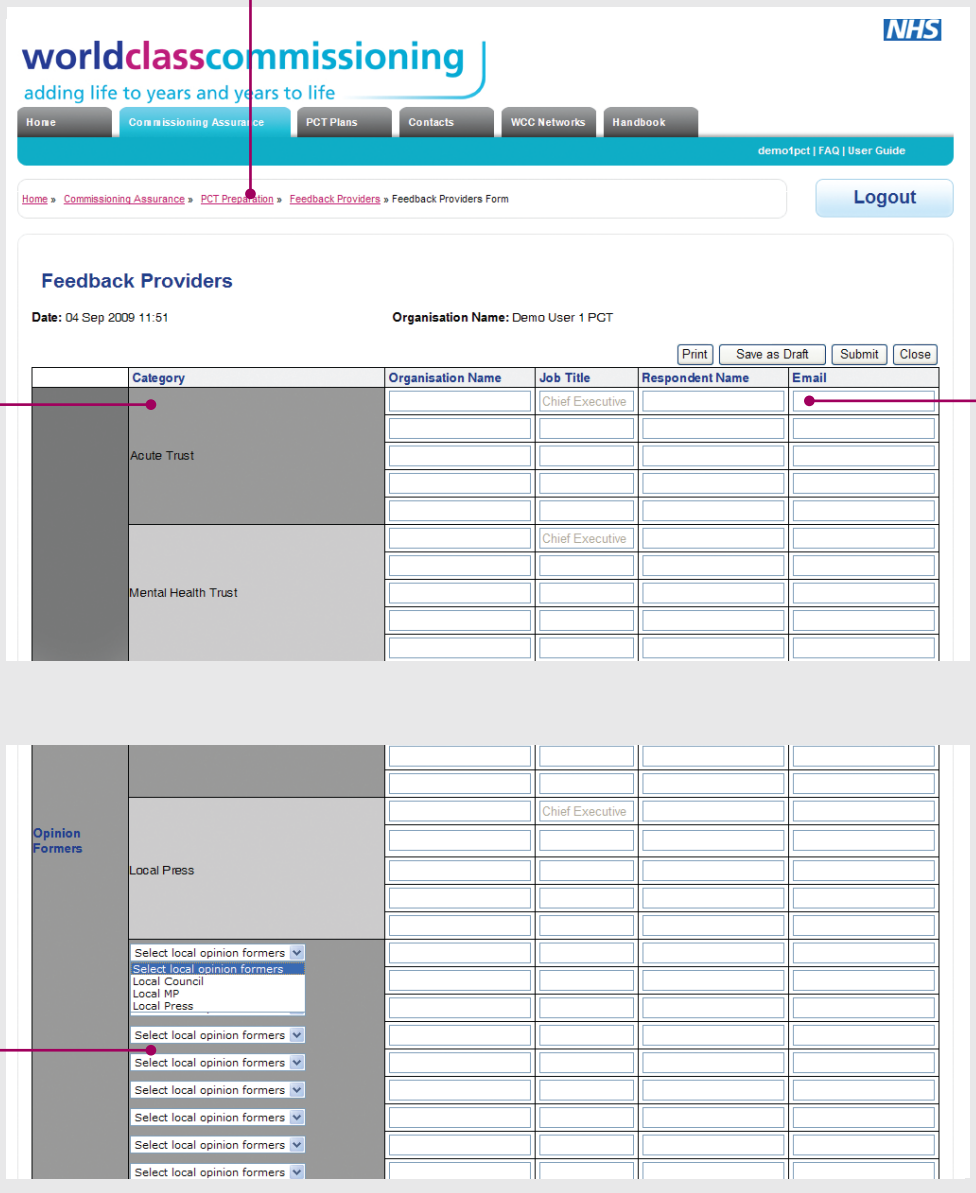
Using the online form on the assurance toolkit, PCTs should nominate and provide email addresses for proposed survey respondents. The individual nominated to complete the survey for each stakeholder organisation should be the chief executive, the leader of the organisation or a senior director. The survey will request the individual selected to provide the organisation's perspective on the PCT.

The PCT should nominate a broad range of stakeholders to provide feedback, identifying potential respondents from each of the categories within the following three groups:

- **Partners:** SHA, specialised commissioning group, practice based commissioning consortia, overview and scrutiny committee, clinical networks, clinicians, LINks (or PPI forum), voluntary organisations, collaborative commissioning group, other strategic partners;
- **Providers:** acute trusts, mental health trusts, care trusts, private sector providers, voluntary sector providers, community service providers, ambulance trust, other providers;
- **Opinion formers:** Local council, local MPs, local press, other local opinion shapers and leaders.

Stakeholder respondents nomination form

1 The form can be accessed through the PCT preparation section of the assurance toolkit

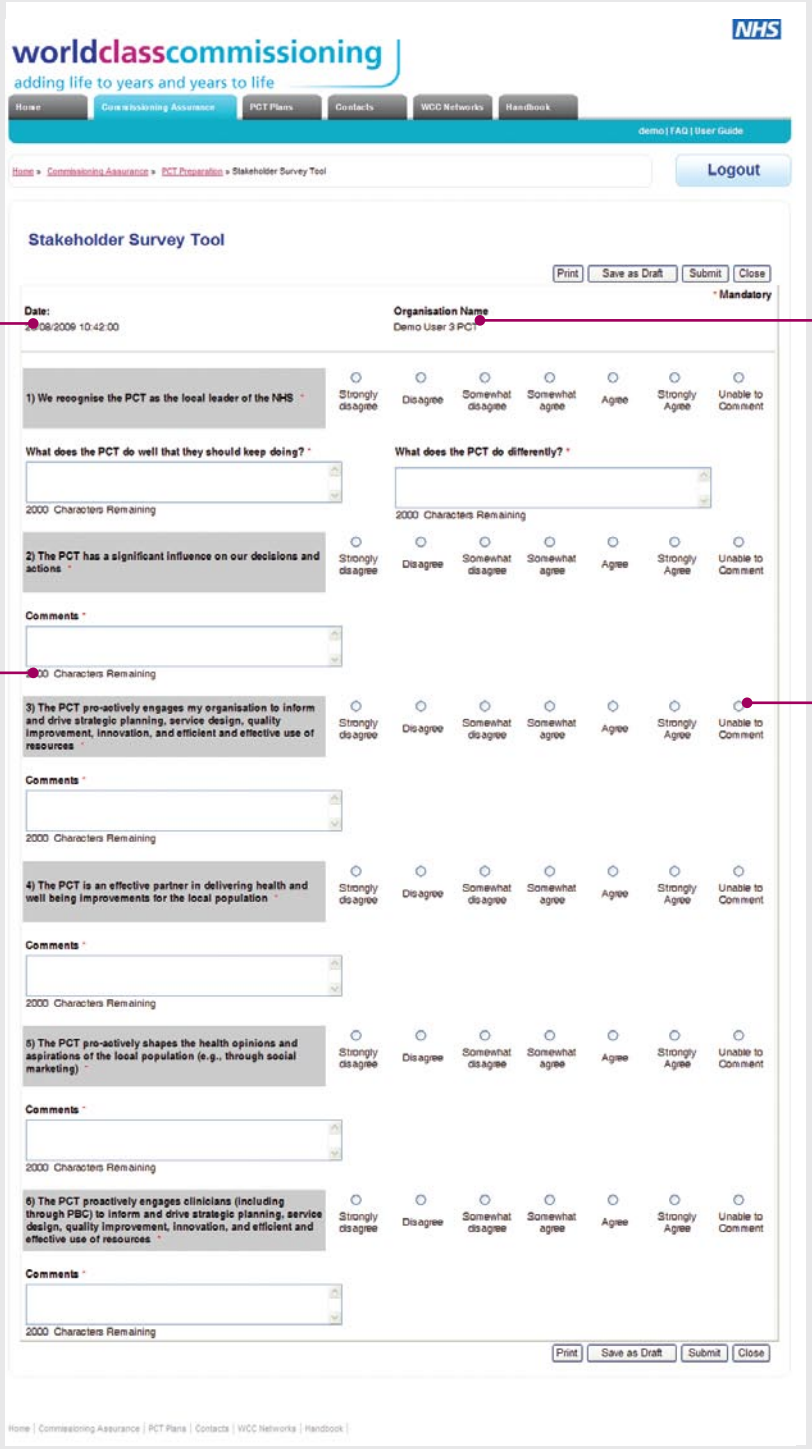


4 Up to five respondents can be selected for each category

2 PCTs should input the organisation, name and email address for the specific individual to whom the survey should be sent

3 Up to 10 additional respondents can be selected for each of providers, partners and opinion formers

Stakeholder survey tool



1

Date when form was submitted or today's date (if not yet submitted)

2

Name of PCT for whom feedback is being provided

3

Running count of additional characters still available for comments box

4

Stakeholders can 'opt' out of answering a question by stating 'unable to comment'

A minimum of 20 completed surveys will be required to ensure meaningful input into WCC assurance.

The assurance toolkit will send the link to the survey directly to each of the respondents. Respondents will be able to opt out of answering any questions they do not feel sufficiently well informed to answer by answering 'unable to comment'. The results will be automatically collated online, and provided to the SHA analysts for further analysis to support assessment of the competencies. Survey results will not be weighted by participant.

PCTs and SHAs will be able to track response rates – but not individual responses – once the initial set of respondents have been contacted with the survey. The toolkit will send out reminder emails to those respondents who have not completed the survey up until the final submission deadline for the relevent SHA region.

Up to a defined date (to be agreed with each SHA for its region), if initial response rates are low, PCTs can add a second set of nominees in addition to their first set. However, the number of nominees remains capped.

Self-assessments for competencies and governance

Self-assessment is a critical element of WCC assurance which:

- provides PCTs with an opportunity to articulate their perception of their current state and the improvements they have made over the last year;
- facilitates a more productive developmental dialogue with the panel.

The PCT's self-assessments and the evidence review will provide the input to the panel day. Areas in which the self-assessments differ from the results of the evidence gathering and data analysis will provide key areas for the panel to probe further in interviews on the day. It is important that PCTs try to give an accurate reflection of the current organisation in the self-assessment as well as details of improvements made since year 1. This will ensure that the panel day focuses on giving valuable advice to PCTs rather than telling them what they already know.

The self-assessments should be agreed by the full PCT board, with the chief executive and chair taking responsibility for the accuracy of the response. It is recommended that the board engage relevant staff in the process to ensure that the assessment is as accurate as possible.

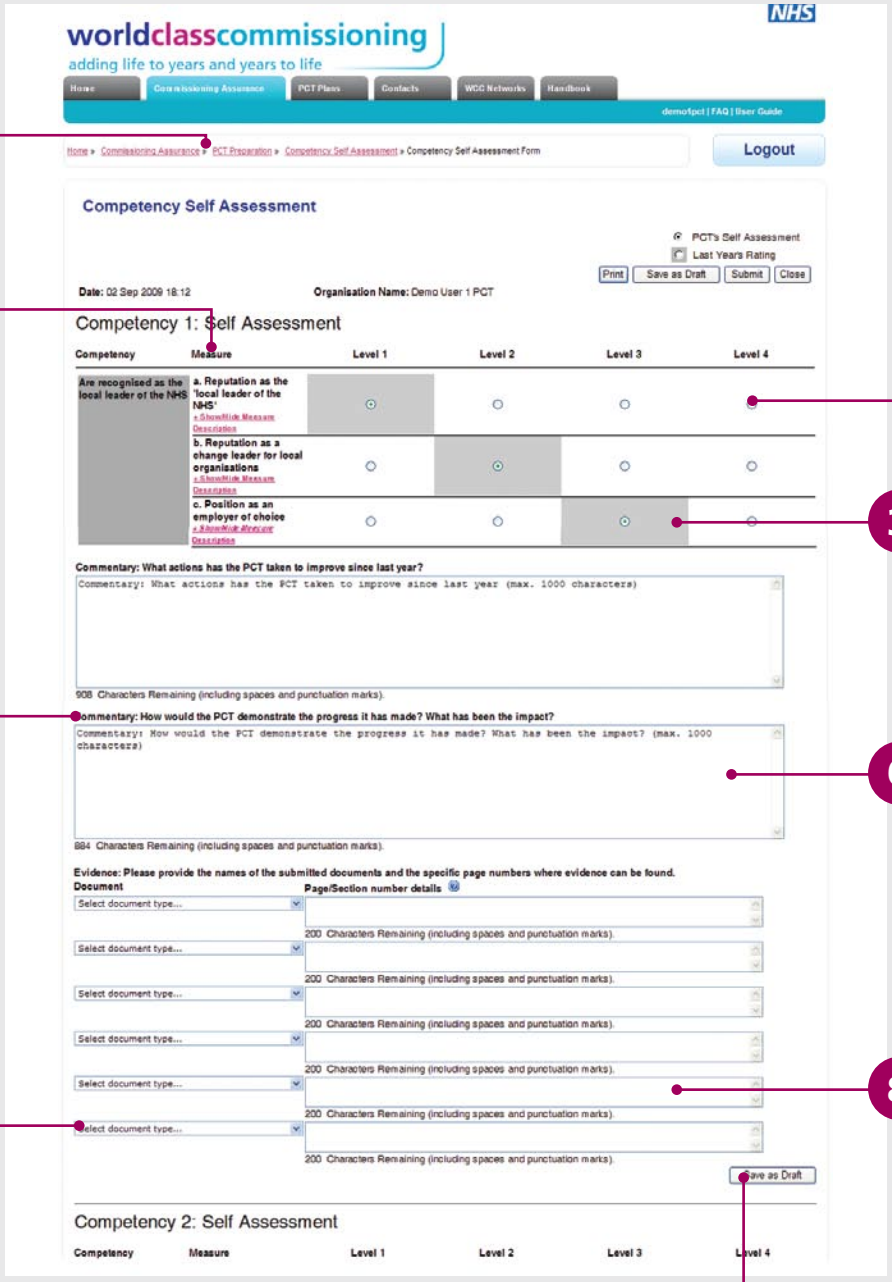
PCTs will fill in their self-assessments via online forms for competencies and governance. In order to complete the online forms, PCTs should review the descriptions of each competency and governance sub-component. The descriptions can be seen by clicking on the 'Show/Hide measure description' link on the self-assessment forms.

When filling in the self-assessment, PCTs will be asked to:

- rate themselves against each competency indicator and governance sub-component based on the detailed criteria in appendices II and III;
- provide a commentary in each area, *up to* the character limit in each form. This provides the PCT with the opportunity to inform analysts of specific initiatives or examples to support their self-rating. In the competency form, there are two commentary boxes asking PCTs to describe the actions they have taken over the last year to improve, and how they would demonstrate that progress and the impact it has had. In the governance form, there is one commentary box asking PCTs to describe their current position and the evidence they have to support their self-rating;
- signpost where evidence can be found in their submitted documents. Analysts will only review the evidence where it has been clearly sign-posted and PCTs should ensure that specific document page (and paragraph where possible) references are provided, rather than large page ranges.

Competency self-assessment form

Links on top can be used for navigation



1 Links on top can be used for navigation

2 For each of the three sub-competencies, PCTs need to provide a self-assessment of where they are today – from level one to four

3 Last year's final post-national calibration rating is provided for information

4 PCTs can access the description of each level by clicking 'Show/Hide menu description'

5 PCTs should provide a brief commentary on the actions they have taken over the last year up to the character limit specified on the form

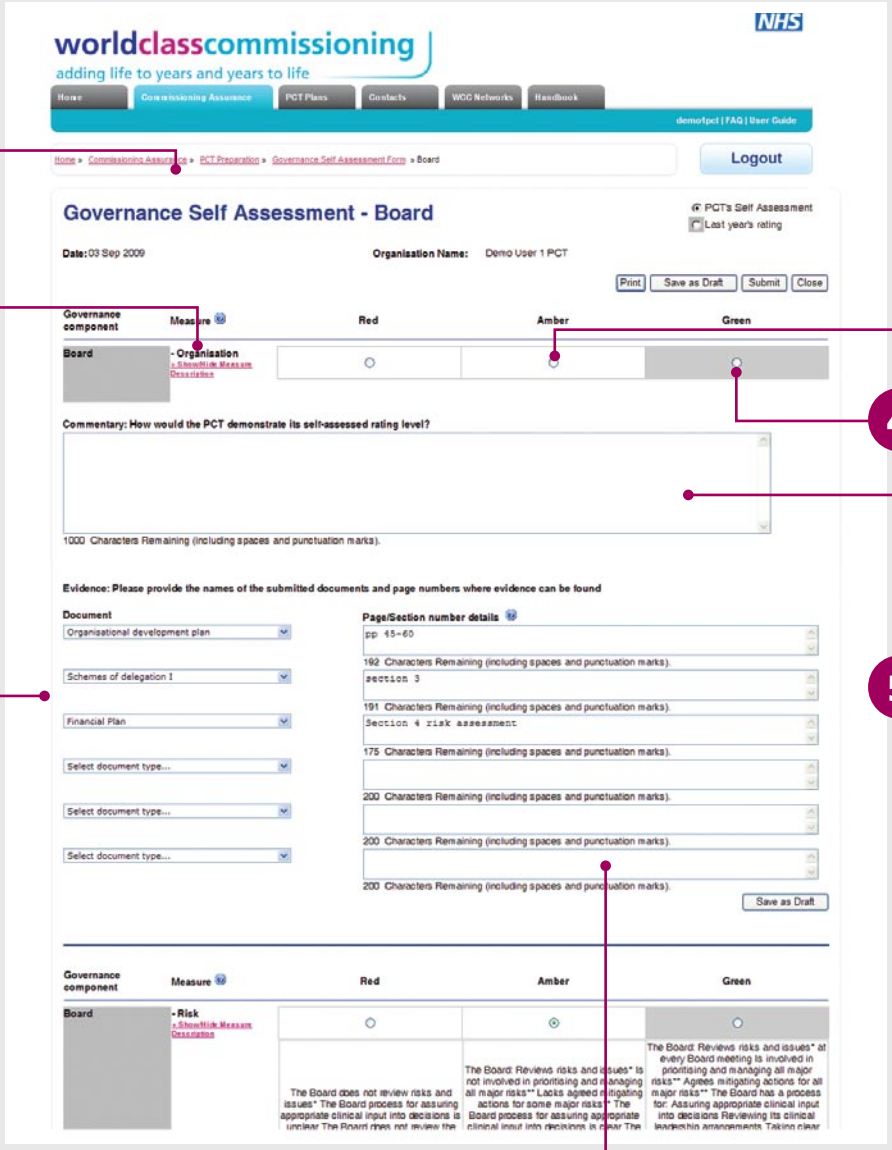
6 PCTs should also provide commentary on the impact of the actions taken and how that impact could be demonstrated

7 Up to six documents can be signposted for evidence for each competency

8 Signposting needs to be accurate and precise, specifying the exact page numbers and paragraphs where the evidence can be found rather than broad page ranges

9 'Save as draft' buttons can be used to save the form either at the end of each competency or at the very top of the form

Governance self-assessment form



1 Links on top can be used for navigation

2 PCTs can access a broad description of the governance component measure by clicking 'Show/Hide measure description'

3 For each of the sub-components of strategy, finance and board, PCTs need to provide a self-assessment of where they are today – red, amber or green

4 Last year's nationally calibrated rating is provided for information

5 PCTs should provide a brief commentary, where required, to demonstrate their self-assessed rating level (i.e. where the other submitted documentation does not provide direct evidence) up to the character limit specified on the form

6 Like the competency self-assessment, up to six documents can be signposted for evidence for each sub-component of governance

7 Signposting again needs to be accurate and precise

Submitting documents

Documents submitted by the PCT form an essential source of information for the analyst. The documents will be used to assess the PCT across each of WCC assurance domains – outcomes, competencies and governance.

The list of submission documents is prescriptive to ensure national consistency in the evidence that is reviewed so that results can be compared easily between PCTs. The number of documents has been deliberately restricted to minimise the burden on PCTs and to focus the evidence requirements on those documents which provide the greatest level of insight.

The documents defined for analysis have been reviewed for Year 2 and are outlined in appendices IV, V and VI. As last year, PCTs have the opportunity to upload three non-prescribed documents where they have particular areas of evidence that they would like to highlight. The PCT should also cross-refer to any of these documents during its 'sign-posting' in the self-assessments for competencies and governance.

Guidance showing the expected contents of the strategic plan, the organisation development plan and the new pathway descriptions documents are provided in the assurance toolkit. Use of the financial template is mandatory and a new, more focused version of the template is available for Year 2.

The assurance toolkit's preparation section contains the functionality for PCTs to upload evidence documents. Documents should be submitted by the deadline communicated by the SHA (this will vary by SHA). In submitting documents:

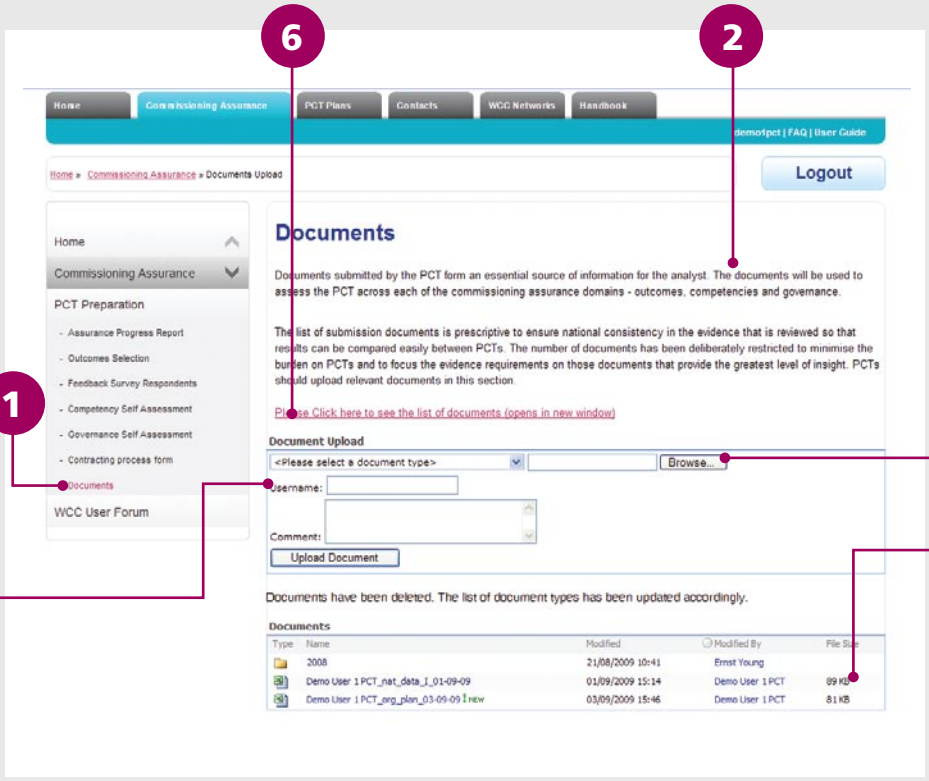
- PCTs will be asked to specify which document type they are uploading. There is a specific limit on the number of documents per type with a size limit per document as set out within the toolkit;
- the documents will be saved onto the system in a standard format (PCT Name_Document Type_Date) to help PCTs, SHAs and the central WCC team track documents that have been uploaded;
- where a non-prescribed document is uploaded, PCTs will be required to complete a comments box to specify what the document is and what evidence the analysts should be looking for within it;
- where a locally defined outcome has been chosen by the PCT, the PCT will be re-directed to the document submission area of the toolkit to upload the robust national dataset that supports that outcome. The PCT will be asked to fill in a comment box to specify which outcomes metric the dataset is for and will be unable to submit their outcomes form unless all the required data and inputs are provided.

PCTs may upload draft documents as they work on them. Previously submitted documents can be updated by deleting the old version and uploading the new version.

Documents submission process

PCTs can access a description of each document type by clicking on the link for more information

Once a document is uploaded, PCTs will be able to delete the old version if required, upload a new version and view the date of upload



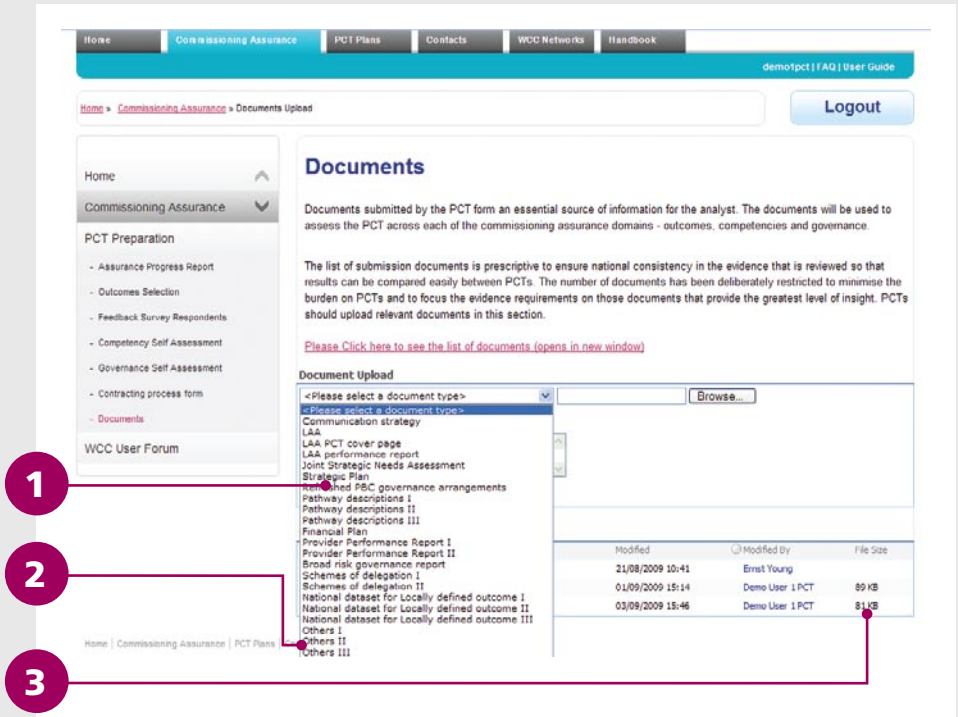
All PCT documents can be uploaded through the 'documents' section of 'PCT preparation'

PCTs can browse for the file that they want to upload. When the selected document is uploaded it will be automatically renamed as per the defined naming convention

PCTs can provide the name of the person uploading the document for tracking purposes

Only the PCT and their SHA will be able to access the uploaded documents. PCTs will not be able to view other PCTs' documents

Documents submission process (continued)



When uploading, PCTs should select the document type.
The number of documents that can be uploaded for each required document type is limited

Three additional documents, apart from those on the required list, can be uploaded

There is a size limit for uploads of documents

Contracting process forms

Following feedback, the contracting process forms are a new addition for Year 2 but replace last year's requirement for three contracts. Their purpose is to allow PCTs to describe their contracting process, from negotiations through to contractor performance management, for three key contracts – one acute, one primary care and a third one of their choosing.

The contracting process forms are available online within the PCT preparation area of the assurance toolkit. Each of the three forms has:

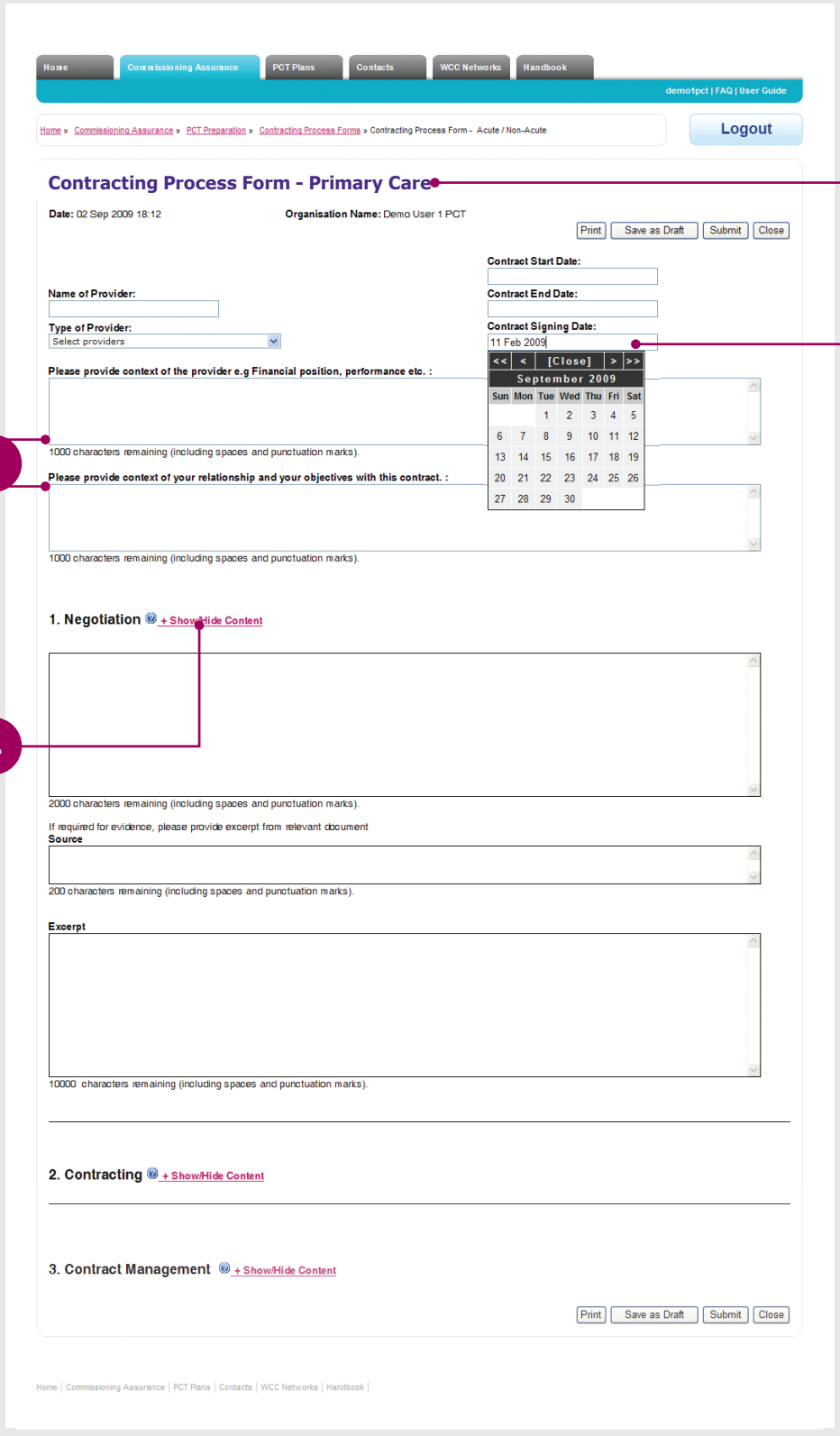
- a set of general questions about the specific contract, including name of provider, the date the contract was signed, and the start and end date of the contract;
- space for the PCT to provide contextual background on the provider and the objectives of their contract with them;
- an area for commentary in each of three areas: negotiations, contracting and contract management. The specific areas that PCTs should complete are included in the guidance for the form available on the assurance toolkit;
- space in each of the three areas (negotiations, contracting and contract management) for PCTs to add excerpts from relevant documents – such as schedules from contracts.

The primary care contract form should describe the overall approval of the PCT to managing all primary care contracts.

The PCT board should agree the specific contracts against which forms will be completed with input from relevant staff.

Contracting process form

PCTs fill in three forms – one acute, one primary care and one of their choice



1

2

Dates can be selected from the date picker

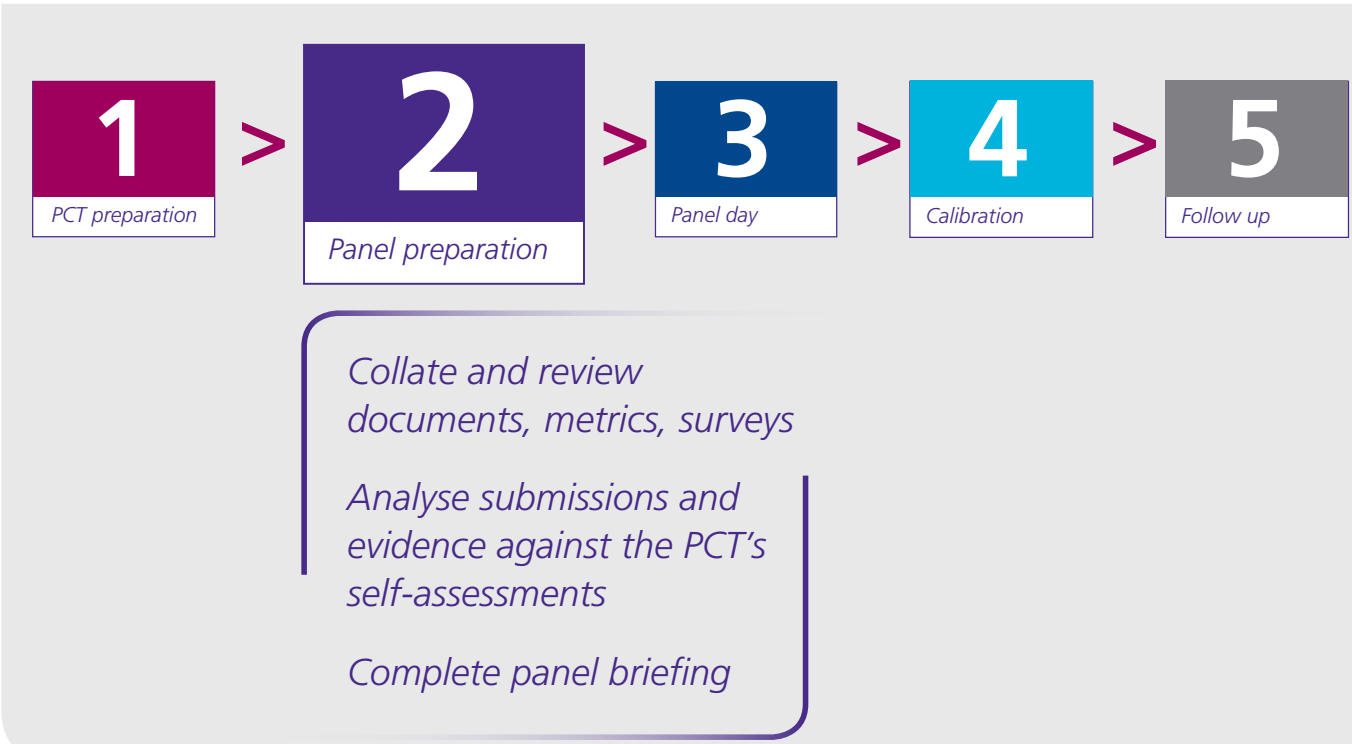
PCTs have space to provide contextual background on the provider, their relationship, and the objectives of contract – as input and context for the analysts

3

4

Show/Hide content can be used to show or hide sections of the contracting process

Panel preparation



The SHA will be responsible for collating and analysing the submitted documents, nationally defined surveys and metrics, and providing information about the PCT to create a briefing document for the panel.

It is expected that much of the work will be performed by analysts based at the SHA, with an SHA senior lead responsible for ensuring that the panel briefing is appropriate and reflects SHA insights about the PCT. The role of the analysts will be to support the panel before, during and after the panel review day and they will follow national guidance on how to support the panel at each stage. This will include a consistent methodology for collating the insights gathered through the evidence review into the panel briefing document.

The panel briefing is designed to provide insights for the panel in advance of the panel day. This is to ensure the day focuses on areas most appropriate and important for that PCT. Specifically it will contain:

- background information on the PCT to provide context to the panel;
- initial assessment of whether the evidence meets the criteria for the PCT's self-assessed levels;
- key areas of focus for the panel – particularly where there is a gap between the PCT's self-assessment and what the evidence suggests. In addition, the panel briefing will highlight areas where:
  - the PCT has made significant improvement that the panel may want to review;
  - limited progress has been made and where there may be opportunities for the panellists to provide developmental input.

Documents

The documents submitted by the PCT will inform assessment of all three elements of WCC assurance: outcomes, competencies and governance. These will be analysed (based on the signposting provided by the PCT in its self-assessments) to assess whether the specific evidence provided supports the PCT's self-assessment.

Metrics

Each of the PCT's chosen outcomes priorities, from both last year and Year 2 (where there have been changes) will be compared with peers and with the PCT's previous year's performance, to assess initial relative improvement. In addition, the PCT's aspirations will be reviewed against benchmarks.

To support the competency and governance assessments, the analysts will use metrics that look at the PCT's position relative to peers, including those:

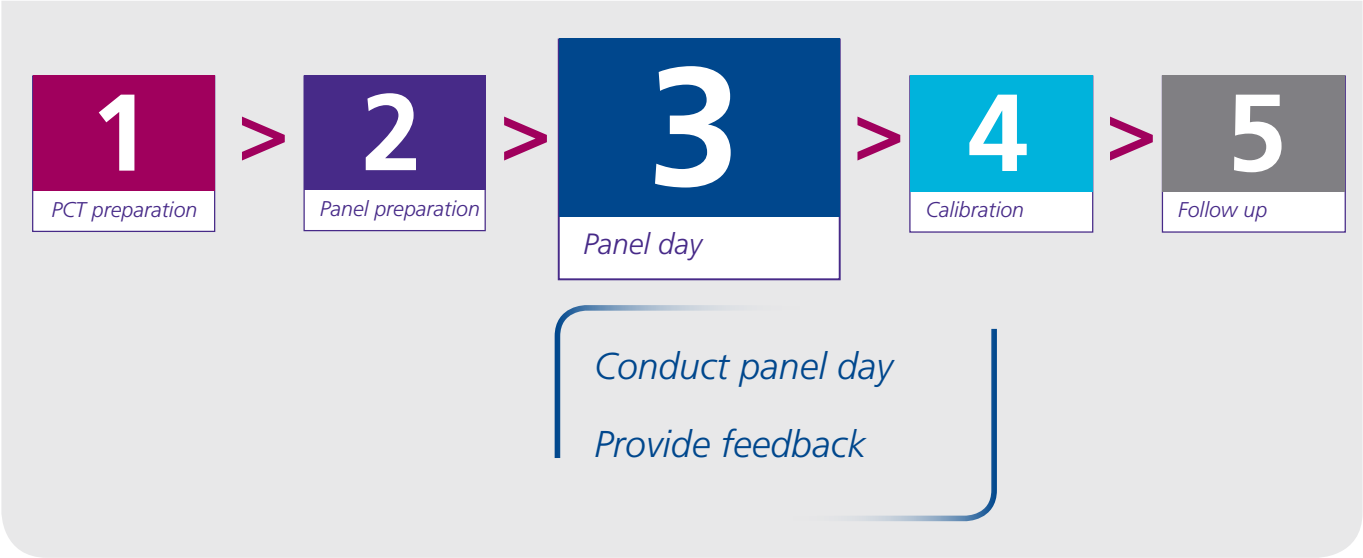
- defined nationally as evidence inputs for the competencies and governance;
- derived from the PCT's financial submission.

Surveys

In addition to the PCT feedback survey, the analyst will use selected data, including the Public Perception Survey, the PBC Survey, the NHS Staff Survey, the Patient Choice Survey and the NHS Patient Survey.

The evidence reviewed by the analyst will take three forms: documents, metrics and surveys.

The PCT's panel day



The panel day is the focal point in WCC assurance. The panel has two functions:

- first, it performs an assessment of the PCT across outcomes, competencies and governance – this year increasingly focusing on reviewing the rate of improvement the PCT has made over the last year;
- second, it provides developmental advice to PCTs to support ongoing improvement.

The panel day is designed to be challenging, but fair. For the PCT, the panel day is a chance to discuss its challenges and to receive external input and development advice to help it on the journey to becoming world class. To get maximum value from the panel, PCTs should be encouraged to have a dialogue with the panel and use the day for learning and ongoing development. PCTs should neither see it nor approach it as an audit.

The day takes the form of a series of interviews designed to elicit a detailed understanding of the PCT's current position, what changes there have been over the last year, and the ways in which the SHA can assist the PCT in its development. The day is designed to balance detailed discussions on areas of focus – for example, where there are gaps between the PCT's self-assessments and the evidence submitted or where progress has been more limited – with more broad-ranging debate about the organisational issues or key strategic challenges facing the PCT, particularly given the current financial climate. Given this, PCT board members should expect to be asked about the:

- actions the PCT has taken over the last year and the progress this has generated;
- PCT's relative improvement in their outcomes, priorities and aspirations;
- implications of the changes to the strategic plan and how the PCT is planning to respond to different financial scenarios.

The review panel members

The review panel will continue to have five mandatory members from a variety of backgrounds, each bringing a unique, complementary perspective. The panel will be chaired by the SHA director of commissioning and some SHAs may choose to have an additional SHA director on the panel.

	description	role
1 SHA	Director(s) (from the local SHA)	Provide oversight of the process and support identification of development requirements of the PCT for future follow up. One SHA Director to chair the day
2 CLINICIAN	Clinician from another PCT	Provide challenge from a clinical perspective and ensure continued focus on outcomes and quality
3 LOCAL GOVERNMENT	Director of Adult Services or Children's Services, or other LA representative at Director level who fit criteria from another PCT area	Provide local government expertise and partnership perspective
4 INDEPENDENT EXPERT	Executive Director from an international organisation or another industry*	Provide insight into international best practice
5 PCT	PCT Chief Executive from another SHA area	Provide sense check from a PCT perspective

* Representatives from Kaiser Permanent Medical Group will undertake this role in Year 2

All panel members will be expected to ask questions and provide input throughout the panel review.

From the PCT, a range of board members (including non-executive directors and the executive team) and other individuals that the PCT considers appropriate should attend.

The structure of the panel week and day

Typically, each panel will serve for at least one week, and ideally two weeks, with the broad weekly structure encompassing:

- Monday: panel briefing where panellists will prepare for the PCT panel days over the coming week(s) with the SHA analyst team;
- Tuesday to Thursday: PCT panels typically held at the PCT (this may vary by SHA/PCT);
- Friday: either a panel review to finalise panel reports or a fourth PCT panel day (the exact timetable will vary by SHA and by week).

The panel day itself is divided into three sections: introduction, interviews and feedback.

The panel day is designed to be challenging, but fair.

The panel day

		Who should be there from the PCT?	Comments/Key content
08:45	**Panel brief**		• Refresh brief on PCT
09:15	**'Pitch on your patch'**	PCT board	• 15 minute presentation from PCT CE outlining: – background of the PCT; – strategic objectives; – key development gaps/challenges and progress over last year.
09:45	**Panel stock take**	.....	• Panel discuss presentation, agree key questions and how to structure interviews
10:00 10:30 11:30	**Outcomes** O1 O2 **Competencies** C1 C2 **Governance** G1 G2	Sub-groups of the PCT board as agreed before the panel day	• Two parallel interview sessions with the panel interviewing members of the PCT board across the three elements of commissioning assurance (PCT members may change in between, so the panel are able to meet a broad range of PCT attendees) • Indicative interview timings which may be flexed depending on areas of focus for each PCT
12:15	**Panel stock take**	.....	• Panel review findings from interviews and agree themes and questions for the CE and Chair interviews
13:00 13:30	**CE and Chair discussions**	CE and Chair	• Clarification on key themes from interviews – CE/Chair discussions may be held together or separately at the panel's discretion with same questions/topics for discussion for each
14:00	**Panel stock take**	.....	• Panel agree ratings and feedback
15:00	**Feedback and Q&A**	PCT board	• Panel feed back overall impressions and recommendations; PCT opportunity to discuss and learn from panel (no ratings)
15:45 17:45	**Debrief**		• Panel debrief for panel report and panel dynamics

The panel day

The introduction to the panel day gives the PCT chief executive the opportunity to brief the panel on the PCT. This should take the form of a short 15 minute presentation, covering the background of the PCT, its strategic objectives, key development gaps or challenges, and developments since last year. Following this presentation, the panel will agree key questions to ask over the course of the day, building on their preparation.

The majority of the day involves running interviews in parallel on outcomes, competencies and governance. Not every member of the PCT Board will need to attend all of the interviews. The precise combination of attendees will be agreed between the PCT and the SHA prior to the panel day based on national guidelines.

In Year 2, the PCT chief executive and PCT chair will attend all the panel interviews with the wider PCT board. It will be the role of the panel to ensure that everyone attending from the PCT has the opportunity to contribute as appropriate with a view to establishing the most comprehensive overview of the PCT's position.

The interviews focus on both the areas highlighted in the preparation phase, and on questions arising from the opening presentation. Following the interviews, the panel will discuss their impressions, before clarifying key themes in discussions with the chief executive and chair.

The third section of the day begins with the panel preparing their feedback. This is then discussed with the PCT board. There will be time available for the PCT to ask questions and receive guidance from the panel, ensuring the panel day remains a two-way process.

The output of the panel day

The output of the panel day will be a completed panel report. This will form the basis of follow-up conversations between the PCT and SHA to determine ongoing dialogue, support and development, and relevant incentives and interventions for the PCT.

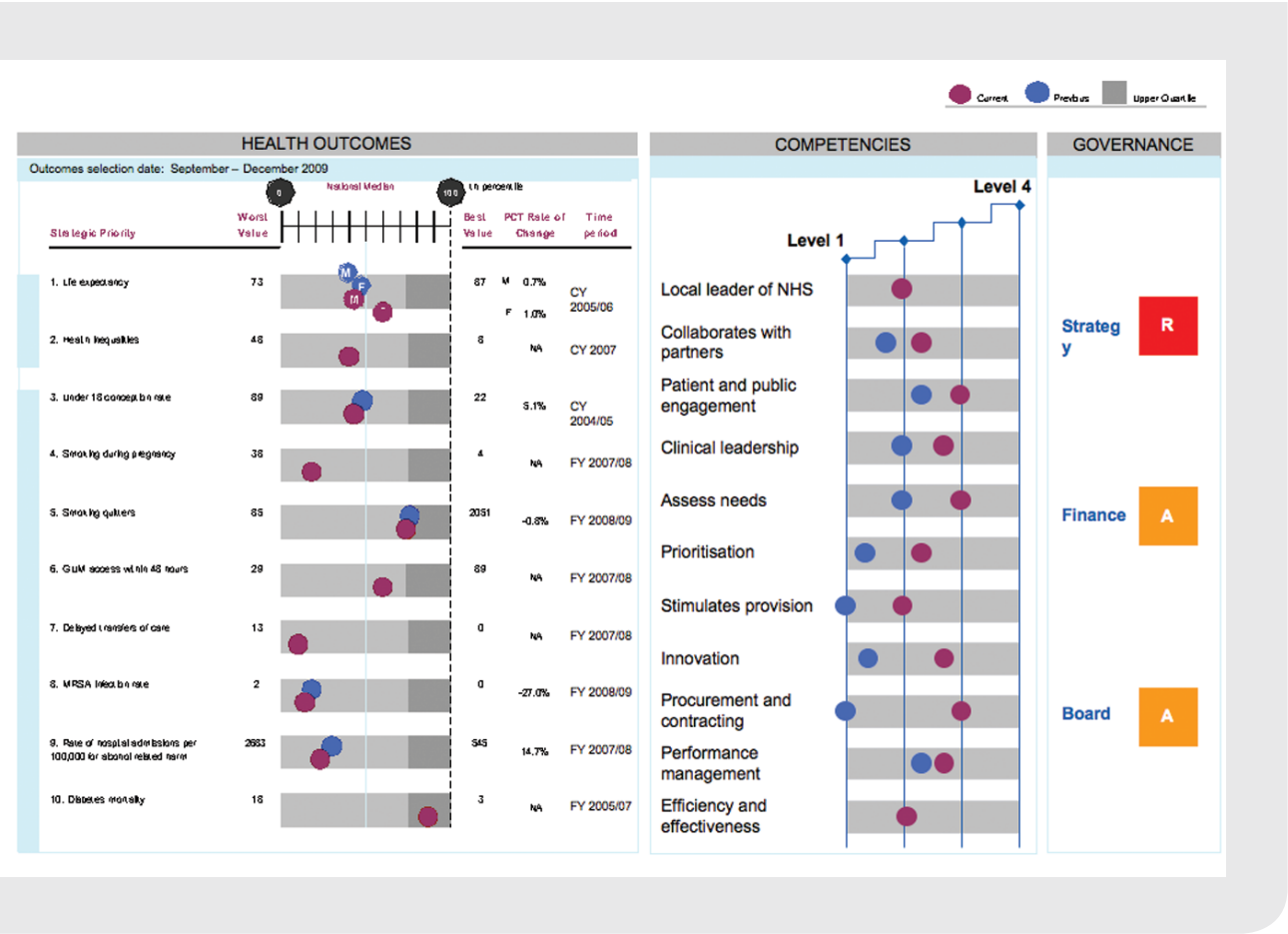
The panel report will include the summary scorecard, which covers the three areas of outcomes, governance and competencies. A sample summary scorecard, updated for Year 2, is on page 66.

The panel report will provide further detail on the areas covered by the summary scorecard, including:

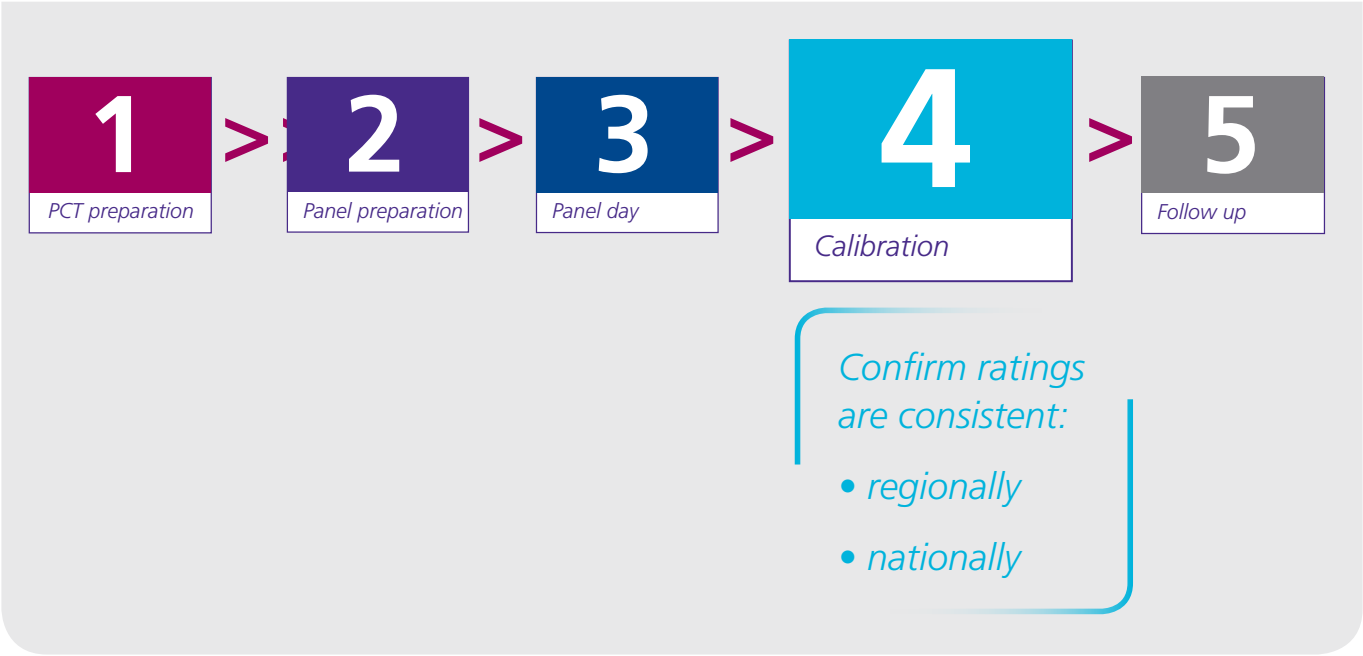
- **Summary:** summary of the report, including immediate tactical actions to be implemented by the PCT and developmental advice for consideration;
- **Outcomes:** full outcomes scorecard, including commentary on the PCT's initial rate of improvement and the ambition and realism of the aspirations that have been chosen;
- **Competencies:** the rating given to the PCT on each indicator of each of the eleven competencies, with deviations from the self-assessment clearly marked. The report includes a commentary on the panel's assessment of each competency, particularly regarding the rationale for rating the PCT differently from their self-assessment.

- **Governance:** the rating given to the PCT in each of the three areas of governance (strategy, finance and board) and their respective sub-components, with commentary on the panel's rationale for each rating;
- **Potential for improvement:** a review of the direction of travel of the PCT and longer-term developmental feedback from the panel.

The panel report will include the summary scorecard which covers the three areas of outcomes, governance and competencies. A sample summary scorecard, updated for Year 2, is shown here:



Calibration



Before ratings on outcomes, competencies and governance are published, they will, as last year, be regionally and nationally calibrated using a strengthened calibration process.

The 'potential for improvement' commentary will not be formally calibrated, but will be considered where relevant in the national review. The text of the commentary will be agreed between the PCT and SHA before publication of the scorecards.

Regional calibration will be led by the SHAs. Regional calibration will be at two levels:

- calibration by the panel for the PCTs that they have assessed;
- regional calibration panels attended by panel chairs, other panellists (where possible), and the analysts supporting the panels.

The national calibration panel will include representatives from all 10 SHAs, and external experts selected from those who have served on panels. The objectives of national calibration are to:

- ensure consistency in results/scores across SHAs;
- provide quality assurance for the process overall;
- highlight, where required, issues that need to feed into evaluation of the WCC assurance process in the future;
- agree any re-scoring of competencies or governance required.

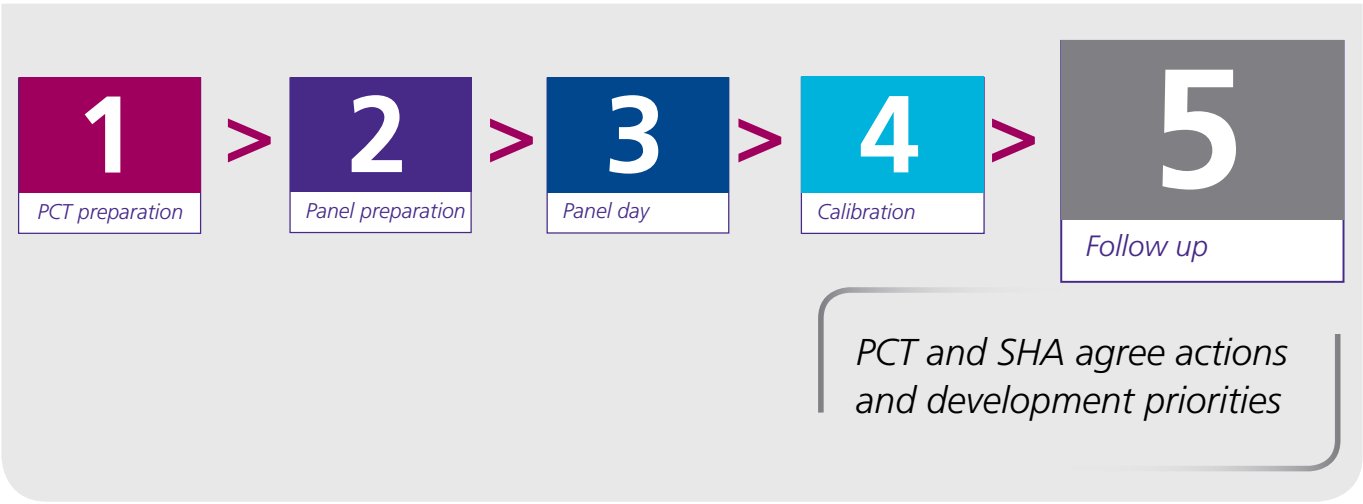
The final, formal ratings will be signed off by the national calibration panel.

Publishing results

Following regional calibration, SHAs will make the provisional ratings and scorecard available to PCTs along with the panel report. The 'potential for improvement' commentary should be agreed at this point and appear in its final form on the scorecard.

However, PCTs should be aware that results will not be considered final until after the completion of national calibration when they will be updated as required. Ratings will only be formally published following national calibration.

Follow up



Whilst WCC assurance has a focal point at the panel days, the challenge and development of commissioners is an ongoing process. The SHA and PCT have an ongoing relationship throughout the year to ensure commissioners are moving towards world class.

Following the panel day, the PCT will reflect on the process and the discussion with the panel, and will drive their own development, revising their organisational development plan, and seeking out resources and tools to support them as they move towards world class.

The SHA and PCT senior management and board will meet again after the panel review day to discuss the panel's recommendations, review the panel report and agree actions.

Following the formal assessment of the PCT, the SHA and PCT will continue to work together throughout the year with WCC assurance as part of the annual development cycle, which is aligned with local performance management arrangements.

5. incentives and interventions

Rewarding success and intervening where there is cause for concern

In July 2010, following the second year of WCC assurance, the panel reports for each PCT will be published nationally. The panel report and scorecard for Year 2 will be used to determine the PCTs whose performance will be rewarded and those which will be under greater scrutiny. Results from last year will not be taken into account.

PCTs that are at the upper end of performance will be rewarded with a range of incentives. This is in keeping with the commitment made in *High Quality Care for All*. The measure of success will be based on a combination of outcomes, competency and governance. We recognise determining the criteria by which relative performance will be measured is complex.

However, we are committed to working with the NHS to finalise this by the end of October 2009.

The incentives that high-performing PCTs will gain will include:

(a) Financial
- Support in managing financial risk over more than one year.
- Access to national and regional development funds.
- Flexibilities over non-executive appointments.

(b) Non-financial
- Kudos of being within a high-performing group.
- Lighter touch performance management.
- Creation of a franchising model to facilitate high-performing PCTs to take over commissioning functions of underperforming PCTs.
- Direct input into national policy formulation.

PCTs which are at the lower end of performance will be subject to increased SHA intervention. This will be in line with the principles set out in the NHS Performance Framework and the NHS Transactions Manual. The NHS Performance Framework will be applied to PCT commissioners from April 2010. The Framework will set clear thresholds for intervention in underperforming organisations and a rules-based process for escalation, including defined timescales for demonstrating performance improvements to ensure the NHS is consistently delivering high quality care. The DH will work with the NHS to develop the framework over the autumn.

6. appendices

I. Outcome metrics

Please select up to eight measures. PCTs should choose outcomes that are reflected in their strategic plan priorities and that have been agreed with their partners, including public and patients, community partners and clinicians.

		Year 2 outcome	Year 2 outcome definition
For all PCTs	1a	Health inequalities (Males)	Slope index of inequality for life expectancy at birth at LSOA
	1b	Health inequalities (Females)	Slope index of inequality for life expectancy at birth at LSOA
	2a	Life expectancy (Males)	Life expectancy at time of birth, years
	2b	Life expectancy (Females)	Life expectancy at time of birth, years
Birth	3	Infant mortality	Mortality rate per 1,000 live births, under one year old
	4	Caesarean section	Percentage of live births delivered by caesarean section
	5	Low birth weight: (under 2500 grams)	Number of live and still births where babies have weighed less than 2500 grams
	6	Under 18 conception rate	Teenage conception rate per 1000 females, aged 15-17
	7	Infants breastfed	Percentage of infants breastfed at 6-8 weeks
	8	Smoking during pregnancy	Actual percentage of women known to be smokers at the time of delivery
Children	9	Hospital admissions caused by unintended and deliberate injuries	Proportion of deliberate or unintended injuries to children or young people (per 10,000 aged under 19)
	10	Proportion of children who complete MMR immunisation by their 2nd birthday	Proportion of children aged 2 who complete immunisation for Measles, Mumps and Rubella (MMR)
	11	Proportion of children who complete MMR immunisation (1st and 2nd dose) by their 5th Birthday	Proportion of children aged 5 who complete immunisation for MMR (1st and 2nd doses)
	12	Proportion of children who complete DTP immunisation by their 5th Birthday	Proportion of children aged 5 who complete immunisation for Diptheria, Polio, Tetanus (DTP)
	13	Prevalence of obesity in Reception children	Prevalence of obesity in Reception children, as measured by the National Child Measurement Programme
	14	Prevalence of obesity in Year 6 children	Prevalence of obesity in Year 6 children, as measured by the National Child Measurement Programme

		Year 2 outcome	Year 2 outcome definition
Staying healthy	15	Deaths from Chronic liver disease	Directly standardised rates from chronic liver disease, including cirrhosis (ICD-10 K70, K73-K74) per 100,000, all ages
	16	HIV prevalence	Rate per 100,000 of diagnosed HIV infected patients
	17	Smoking quitters	Rate per 100,000 population aged 16 and over
	18	Hypertension prevalence	Unadjusted hypertension prevalence
	19	Uptake of pnemococcus vaccinations by over 65s	PPV uptake in the 65 years and over and GP response rate by PCT for 2006/07 presented as total percentage uptake
	20	Uptake of influenza vaccinations by over 65s	Percentage uptake of influenza vaccinations by over 65s
	21	GUM access within 48 hours	Percentage of all patients seen at a GUM clinic who were seen within 48 hours of contacting the service
	22	Chlamydia prevalence (screening)	Percentage of the population aged 15-24 screened or tested for chlamydia
Planned care	23	Cancer mortality rate	Directly standardised rates from all malignant neoplasms (ICD-10 C00-C97) Premature mortality (under 75 years)
	24	Proportion of women aged 53-70 screened for breast cancer within the last three years	The proportion of women aged 53-70 screened for breast cancer within the last three years
	25	Proportion of women aged 25-49 who have received cervical screening	Proportion of women aged 25-49 who have received cervical screening in the last 3.5 years
	26	Proportion of women aged 50-64 who have received cervical screening	Proportion of women aged 50-64 who have received cervical screening within the last 5 years
	27	Percentage of patients first seen by a specialist within two weeks when urgently referred	Percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer
	28	Proportion of patients waiting no more than 31 days for cancer treatment	Percentage of patients with diagnosis to treatment time less than or equal to one month
	29	Percentage of patients receiving their first definitive treatment for cancer within two months of urgent referral for suspected cancer	The number of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer
	30	Percentage of patients seen within 18 weeks for admitted pathways	RTT admitted pathways
	31	Percentage of patients seen within 18 weeks for non-admitted pathways	RTT non-admitted pathways

		Year 2 outcome	Year 2 outcome definition
	32	Self-reported experience of patients and users	Patient/user experience defined by five key dimensions: • Access and waiting; • Safe, high quality co-ordinated care; • Building closer relationships; • Clean, friendly, comfortable place to be; • Better information, more choice.
	33	Measure of public confidence in local NHS	Public confidence defined by three key dimensions: • focus on the person; • focus on dignity and respect; • focus on improving as an organisation.
Acute	34	Mortality rate from causes considered amenable to healthcare	Directly age-standardised rates (DSR) per 100,000 European Standard population
	35	Stroke deaths within 30 days	Deaths in hospital and after discharge between 0 and 29 days (inclusive) of an emergency admission to hospital with a stroke. Indirectly age and sex standardised rates per 100,000 persons
	36	Percentage of stroke admissions given a brain scan within 24 hours	Percentage of stroke admissions given a brain scan within 24 hours
	37	Percentage of stroke admissions given a physiotherapist assessment within 72 hours	Percentage of stroke admissions given a physiotherapist assessment within 72 hours
	38	Delayed transfers of care	Percentage of cases of delayed transfers of care per 100,000 population (age 18 and over)
	39	Four-hour A&E waiting time target	Percentage of patients who spent less than four hours in A&E
	40	MRSA infection rate	MRSA rate per 10,000 bed days
	41	Clostridium Difficile infection rate	Clostridium Difficile rate per 1000 bed days in patients aged 2 and over

		Year 2 outcome	Year 2 outcome definition
Mental health	42	Drug treatment waiting times	The percentage of clients that have to wait under three weeks to start their first intervention after presentation to treatment
	43	Percentage of drug users recorded as being in effective treatment	Percentage of drug misusers sustained in treatment
	44	Rate of hospital admissions per 100,000 for alcohol-related harm	Rate of alcohol-related admissions per 100,000 population (EASR)
	45	Adults receiving secondary mental health services in employment	Percentage of specialist MH service users on new Care Programme Approach who are employed (PSA 16)
	46	Adults receiving secondary mental health services in settled accommodation	Percentage of specialist MH service users on new Care Programme Approach who are in settled accommodation (PSA 16)
	47	For IAPT services the number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological treatment	For IAPT services the number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological treatment
	48	For IAPT services the number of people entering IAPT treatment	For IAPT services the number of people entering IAPT treatment
	49	The proportion of those discharged from inpatient care and on the new Care Programme approach who are followed (by face-to-face or phone contact) within 7 days (IC Omnibus collection)	The proportion of those discharged from inpatient care and on the new Care Programme approach who are followed (by face-to-face or phone contact) within 7 days (IC Omnibus collection)
	50	The proportion of users on new Care Programme Approach who have had a HoNOS assessment in the last 12 months	The proportion of users on new Care Programme Approach who have had a HoNOS assessment in the last 12 months
	51	The percentage of patients (cared for by GPs) with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status (QOF)	The percentage of patients (cared for by GPs) with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status (QOF)
	52	Users' involvement with decisions about their own care	Users' involvement with decisions about their own care (Patient Survey)

		Year 2 outcome	Year 2 outcome definition
Long-term conditions	53	Mortality rate per 100,000	Mortality from all ages and all causes presented as DSR per 100,000 European Standard population
	54	COPD mortality	Directly standardised rates per 100,000 European standard population from bronchitis, emphysema and other chronic obstructive pulmonary disease (ICD10 J40-J44), all ages
	55	CVD mortality	Directly standardised rates per 100,000 standard European population for all CVD mortality, (ICD10 I00-I99). Premature mortality (under 75 years)
	56	CHD mortality	Directly standardised rates per 100,000 standard European population for all CHD mortality, (ICD10 I20-I25), all ages
	57	COPD prevalence	Percentage of all patients with COPD in a GP registered population
	58	Diabetes controlled blood sugar	The percentage of patients with diabetes who have an HbA1c of 7.5 or less
	59	CHD controlled blood pressure	The percentage of patients with coronary heart disease, in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less
	60	CHD controlled cholesterol	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the last 15 months) is 5 mmol/l or less
	61	Percentage of people screened for diabetic retinopathy	Percentage of diabetics screened for diabetic retinopathy
End of life care	62	Palliative care prevalence	Palliative care, unadjusted prevalence percentage
	63	Proportion of all deaths that occur at home	Proportion of all deaths that occur at home

II. Competencies – sub-competencies and criteria for each level

Competency 1 Are recognised as the local leader of the NHS

PCTs should lead and steer the local health agenda in their community. PCTs will be the natural point of contact for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health and well-being matters.

A Reputation as the local leader of the NHS

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• Key stakeholders somewhat agree that the PCT is the local leader of the NHS • The PCT has an understanding of its current and intended local leadership reputation, with strategies in place to address this • The PCT participates in the local health agenda • The local population agree to some extent that the local NHS is improving services • The PCT monitors patient experience levels	• Key stakeholders agree that the PCT is the local leader of the NHS • The PCT actively participates in and leads the local health agenda • The local population agree that the local NHS is improving services • The PCT understands and acts upon patient experience and reputation levels	• Key stakeholders strongly agree that the PCT is the local leader of the NHS • The PCT actively participates in and leads the local health agenda, effectively participating in multi-agency and NHS wide agendas • The local population strongly agree that the local NHS is improving services • The PCT understands and acts upon its patient experience and reputation levels by different population and partnership groups

B Reputation as a change leader for local organisations

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• Key stakeholders somewhat agree that the PCT significantly influences their decisions and actions • The PCT actively works with other local commissioners and other partners to influence their actions	• Key stakeholders agree that the PCT significantly influences their decisions and actions • The PCT has led and implemented change, influencing and impacting other local commissioners and local partners (e.g. leading region wide improvements in quality, effectiveness and efficiency)	• Key stakeholders strongly agree that the PCT significantly influences their decisions and actions • The PCT has: – Led and implemented system-wide change – Impacted and informed other local commissioners and local partners

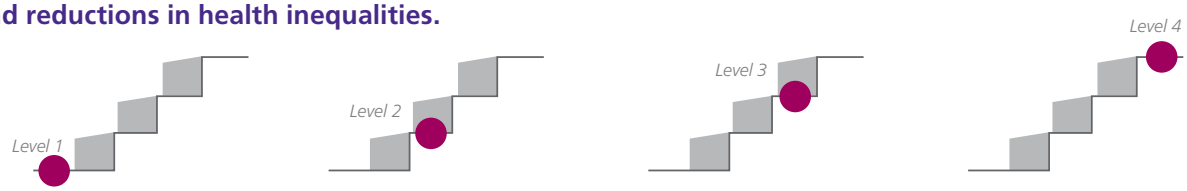
C Position as an employer of choice

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT presents an employment offer to its commissioning staff that is attractive to current staff and potential recruits, with clear training, support and development programmes • The PCT ensures ongoing environment supports commissioning staff satisfaction	• The PCT provides meaningful commissioning training and development programmes to support staff development, attract new staff and increase the quality of the staff employed • The PCT fosters an environment of ongoing commissioning staff development and satisfaction	• The PCT is able to recruit high quality staff for all positions in commissioning • PCT commissioning staff are motivated and excited with the roles that they adopt

Competency 2

Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities and deliver increased productivity

PCTs should not commission services in isolation. In addition to commissioning healthcare services, they will need to consider the wider determinants of health and the role of other partners in improving the health outcomes of their local population. PCTs also share responsibility for undertaking a Joint Strategic Needs Assessment (JSNA) with local authorities. Partners include local government, Children's Trusts, healthcare providers, third sector organisations and clinical partners, such as practice based commissioners (PBCs) and specialist consortia. Working collaboratively with partners, PCTs will stimulate innovation, improvements in quality, efficiency and service design, increasing the impact of the services they commission to optimise health gains and reductions in health inequalities.

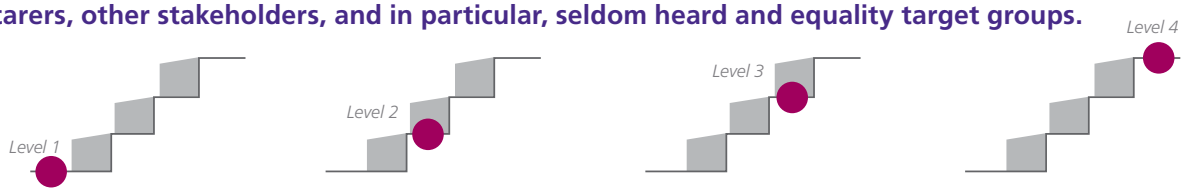


	Level 1	Level 2	Level 3	Level 4
A Creation of Local Area Agreement based on joint needs	• Does not meet Level 2 requirements	• The PCT and the local strategic partners agree in a timely way, on Local Area Agreement (LAA) priorities • LAA targets: – Directly address the needs highlighted in the JSNA – Are regularly reconfirmed to reflect delivery and changing needs • The PCT and the local authority are both jointly accountable for LAA targets • There is broad clinical engagement (PBCs, other clinicians etc.) in reconfirming LAA priorities	• The PCT and local strategic partners have worked together to agree and reconfirm LAA priorities • LAA priorities are based on joint needs as assessed though the JSNA • The PCT is clearly engaged in the LAA negotiation, ongoing monitoring, delivery and performance management	• The PCT creates joint accountability and agrees clear arrangements for delegated responsibility with local strategic partners for all key targets • The PCT has developed a partnership way of working with active participation • There is clear clinical leadership (PBCs, secondary clinicians etc.) in creating, reconfirming and delivering the LAA • The PCT can demonstrate health gains and reductions in health inequalities through achieving LAA priorities
B Ability to conduct constructive partnerships	• Does not meet Level 2 requirements	• Key stakeholders somewhat agree that the PCT proactively engages their organisation to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources • The PCT has worked with partners to produce a JSNA which assesses the health needs of the population • The role of the PCT in the LAA is clear and delivery is effective both independently and as a partner • The PCT co-ordinates commissioning priorities, plans, information and data with other local commissioners (including other PCTs and collaborative commissioning arrangements) • Shared posts are in place where appropriate	• Key stakeholders agree that the PCT proactively engages their organisation to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources • The PCT has worked constructively and effectively with partners to: – Produce a high quality JSNA, which identifies the health needs of the population – Evaluate partnership effectiveness (e.g. as part of CAA) • Shared posts have effective governance and joint accountability • The PCT takes ownership of the specialised commissioning agenda with other local commissioners (e.g. PCTs, collaborative commissioning arrangements)	• Key stakeholders strongly agree that the PCT proactively engages their organisation to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources • The PCT has worked with partners to: – Apply best practice across a range of collaborations – Assess the impact on health outcomes • Multiple partnerships are in place across a broad range of settings to support and deliver the health and well-being agenda
C Reputation as an active and effective partner	• Does not meet Level 2 requirements	• Key stakeholders somewhat agree that the PCT is an effective partner in delivering health and well-being improvements for the local population • The PCT has set out clear milestones with partners, on key initiatives and has a track record of delivery • The PCT works with leads of other local commissioners to agree commissioning plans, priorities and ensure delivery	• Key stakeholders agree that the PCT is an effective partner in delivering health and well-being improvements for the local population • The PCT has clear success stories of delivery through partnerships (e.g. in CAA, Strategic Partnership priorities)	• Key stakeholders strongly agree that the PCT is an effective partner in delivering health and well-being improvements for the local population

Competency 3

Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health

PCTs are responsible through the commissioning process for investing public funds on behalf of their patients and communities. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the public and patients, PCTs will have to engage the public in a variety of ways (e.g. through EIAs) openly and honestly. They will need to be proactive in seeking out and using the views and experiences of the public, patients, their carers, other stakeholders, and in particular, seldom heard and equality target groups.



A Influence on local health opinions and aspirations

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT has effective strategies for communicating with the public and patients (including seldom heard groups) that are informed by Equality Impact Assessments • Key stakeholders somewhat agree that the PCT proactively shapes health opinions and aspirations of the public and patients (e.g. through social marketing) • The PCT actively promotes independence, health, well-being, and personalisation of services	• Key stakeholders agree that the PCT proactively shapes health opinions and aspirations of the public and patient (e.g. through social marketing) • The PCT has clear success stories of delivery	• Key stakeholders strongly agree that the PCT proactively shapes health opinions and aspirations of the public and patients (e.g. through social marketing)

B Public and patient engagement

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT has a strategy in place that actively and continuously engages patients and public in PCT business • The PCT actively listens to, understands and responds to public and patients, including seldom heard and equality target groups • The PCT can demonstrate how: – Public and patients are made aware of the channels and processes through which they can raise concerns – Local engagement, including regular two-way dialogue with Local Involvement Networks (LINks) or equivalent patient forums, has influenced some aspects of commissioning • The PCT proactively disseminates information to the public and patients • The public and patients somewhat agree that the local NHS listens to the views of local people and acts in their interest	• The PCT can demonstrate: – They know the impact of public and patient involvement and engagement – How public and patient involvement and engagement has led to improved health and service experience • The PCT formally and regularly involves patients and the public, including seldom heard and equality target groups, in review of services • Information from patients and the public, including 'soft' or informal data: – Is actively investigated – Is used in provider performance management discussions – Has a direct impact on improving quality and health outcomes • The PCT can demonstrate how they work with LINks or equivalent patient forums and voluntary groups to capture patient/public views which have affected commissioning plans • The public and patients agree that the local NHS listens to the views of local people and acts in their interest	• The PCT has successfully deployed innovative approaches to engagement which have: – Been shared with other PCTs and partners – Led to high levels of engagement with seldom heard and equality target groups – Accessed non-traditional partners (e.g. criminal justice system) • The PCT systematically collects, collates and uses individual patient and carer insights (e.g. individual feedback) • The PCT can demonstrate how proactive engagement and partnership arrangements with the local community, including LINks, is embedded in all commissioning processes and drives decision making • The public and patients strongly agree that the local NHS listens to the views of local people and acts in their interest

C Improvement in patient experience

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT actively reviews trends in patient and carer feedback, including complaints, PALs (Patient Advice & Liaison Service) and patient survey data sent to providers and initiates improvements as a result • The public and patients agree that the NHS is helping to manage and improve the health and well-being of the population	• The PCT is timely and regular in seeking feedback and following up on impact as required • The PCT demonstrates how patient and carer feedback, survey data, complaints and PALs queries have systematically driven commissioning decisions and led to improvements in quality of care	• The PCT demonstrates and shares with the public and patients: – How ongoing integrated patient experience data systematically drives commissioning decisions and has led to improvements in quality of care – Measurable improvements in patient experience as a result of its commissioning decisions

Competency 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

Clinicians are best placed to advise and lead on transformational change relating to clinical quality and effectiveness. They are the local care pathway experts who work closely with local people understanding clinical needs. PCTs should ensure that through the involvement of clinicians in strategic planning and service design (for example in meeting the expectations of Transforming Community Services (TCS)), services commissioned build on the current evidence base, maximise local care pathways and utilise resources effectively. Professional Executive Committees (PECs) have a crucial role to play in building and strengthening clinical leadership in the strategic commissioning process. Practice based commissioning (PBC) is the key formal route for driving innovative and transformational change and the PCT demonstrates fulfilment of the roles set out in *'Clinical commissioning: our vision for Practice Based Commissioning'*.

A Clinical engagement

- Does not meet Level 2 requirements

- The PCT can identify several non-PEC clinicians that have made substantive contributions to PCT strategy and service redesign
- Clinicians are regularly present and actively participate in PEC meetings
- The PCT seeks views of a broad range of clinical groups, including through PBC, to gain support and alignment with the PCT's strategic priorities
- The PCT has delegated authority to clinicians as required to drive the agenda

- PCT engagement includes clinicians that represent all healthcare and well-being delivery methods (e.g. local social care, and allied health practitioners)
- The PCT ensures active clinical leadership across the PCT agenda
- The PCT demonstrates that priorities for local quality and efficiency improvement are supported by relevant clinicians
- The PCT regularly and continuously facilitates links between primary (e.g. PBC) and secondary care clinicians to support commissioning

- All engagement groups actively drive PCT planning and service development and support the setting of the strategic direction for the PCT
- Clinical engagement supports ongoing improvement of patient health outcomes
- The PCT demonstrates that local clinicians have played a central role in the identification and delivery of local quality and efficiency improvement priorities

B Dissemination of information to support clinical decision making

- Does not meet Level 2 requirements

- Quality of care information is regularly shared
- The PCT proactively solicits and disseminates status updates and quality improvement ideas from a broad range of clinicians on a regular basis
- The quality, format and frequency of information on health outcomes, activity, finance, quality and patient experience is used and perceived as appropriate by PBCs
- The PCT supports PBC and ensures all PBCs receive:
  - Management and financial information/support
  - Agreement on local incentive schemes
  - Agreement of indicative budgets

- Quality reports are routinely produced, and:
  - Include recent clinical evidence and benchmarks
  - Are systematically reviewed by a broad range of clinicians
  - Link quality and efficiency
- The PCT has taken steps to reduce unacceptable clinical variations

- Quality reports include recent clinical evidence, benchmarks, and changes in clinical practice
- The PCT actively considers and can demonstrate devolution of health budgets to practice based commissioners

C Reputation as leader of clinical engagement

- Does not meet Level 2 requirements

- Key stakeholders somewhat agree that the PCT proactively engages clinicians (including through PBC) to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources
- The PCT has a track record of implementing initiatives to redesign care
- The PCT has robust processes in place to ensure:
  - Decisions on PBC plans and business cases are communicated within 8 weeks
  - Perceived 'conflict of interest' issues are addressed

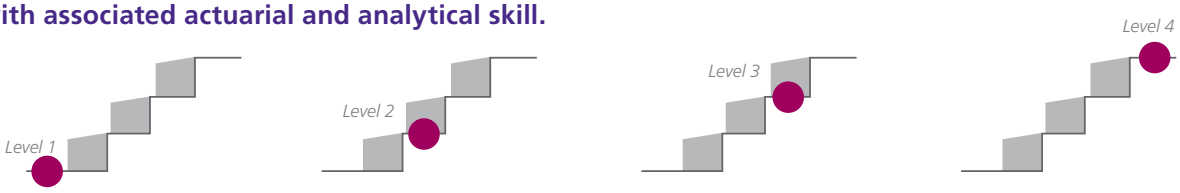
- Key stakeholders agree that the PCT proactively engages clinicians (including through PBC) to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources
- The PCT has a track record of clinicians leading initiatives to improve quality and productivity

- Key stakeholders strongly agree that the PCT proactively engages clinicians (including through PBC) to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources
- The PCT can demonstrate benefits delivered by clinician-led innovations, in terms of both quality and productivity

Competency 5

Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements

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 the 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 within the proposed duty of a JSNA. Fulfilling this competency will require a high level of knowledge management with associated actuarial and analytical skill.



A

Analytical skills and insights

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT, working in partnership with the Local Authority, conducts regular needs assessments and can demonstrate clear outputs and conclusions • A consistent methodology is used to identify gaps in care (including health inequalities) and drivers of performance in addressing these gaps • The PCT prioritises major health needs for its local population • The JSNA assesses current and future needs, both met and unmet	• The PCT has a consistent and validated methodology, using insights from a range of stakeholders and both quantitative and qualitative data, for contributing to the JSNA • The PCT analyses progress towards reducing gaps (including health inequalities) and identifies the key causes of variance from expectations • The PCT has clear, robust segmentation of population by healthcare needs	• The PCT analyses the effectiveness of past interventions to drive tangible improvements in health • The PCT analyses progress and any gaps (including health inequalities), identifies the key drivers of variance from expectations and develops solutions • The PCT has proactive population risk stratification to identify populations at risk and to intervene at the earliest possible point

B

Understanding of health needs trends

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT has a fact-based list of the major health risks and priorities facing its local population by demographic and disease group, as identified in the JSNA • The PCT can identify over time trends in major health and well-being issues • The PCT has gathered key insights from public, patients, clinicians and other stakeholders in JSNA findings	• The PCT has a view of unmet needs for its local population and can disaggregate to locality/ward level • The PCT analyses progress and identifies any gaps towards achieving improvement targets	• The PCT has a view of unmet needs for disadvantaged subgroups, and identifies gaps in care and opportunities to improve services for these populations on an ongoing basis • For prioritised areas, the PCT: – Uses predictive modelling and analytical tools to project future needs, incorporating them into patient level profiles – Reviews needs projections against previous forecasts and accounts for variance from expectations – Creates a programme to best address future needs

C

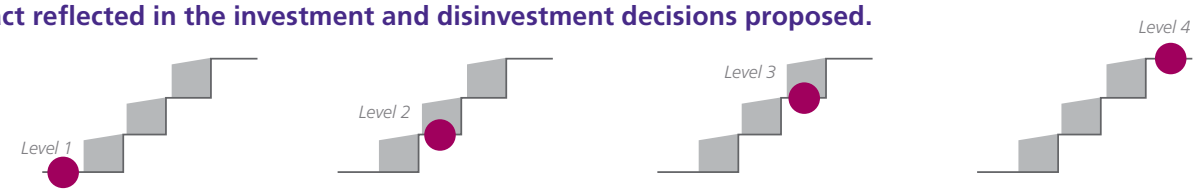
Use of health needs benchmarks

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT benchmarks itself against national targets and peer PCTs on: – Local health needs status – Priority health outcomes • The PCT has developed plans to improve its performance to meet health outcome aspirations and benchmarks • The PCT effectively disseminates reports (e.g. to providers, partners, the public)	• The PCT regularly benchmarks itself against national targets and peer PCTs on: – Local health needs status – Priority health outcomes	• The PCT benchmarks itself continuously, to create ambitious improvement aspirations, against similar populations, national and international targets on: – Local health needs status – Priority health outcomes • The PCT has developed plans to match the top performers on each benchmark and identifies the key capabilities it will need to develop to match their performance

Competency 6

Prioritise investment of all spend in line with different financial scenarios and according to local needs, service requirements and the values of the NHS

By having a clear understanding of the needs of different sections of the local population, PCTs, with their partners, will set strategic priorities and make investment and disinvestment decisions, focused on the achievement of key clinical and other outcomes. This will include investment and disinvestment plans to achieve health gains and address areas of greatest health inequality. Three financial scenarios are considered and their impact reflected in the investment and disinvestment decisions proposed.



	Level 1	Level 2	Level 3	Level 4
A Predictive modelling skills and insights to understand impact of changing needs on demand	• Does not meet Level 2 requirements	• The PCT demonstrates simple best and worst case scenario analysis, across a range of areas including: – Activity – Patient quality – Financial activity • PCT scenarios for predictive modelling are by disease area or care pathway	• The PCT's model conducts sensitivity analysis to project probable ranges by altering inputs to determine impact on scenario • PCT scenarios are on an individual/case basis, identifying specific treatments or interactions required (particularly for high cost or high usage individuals or groups)	• PCT staff can lead knowledgeable discussion and defence of all predictive models, including evidence to support modelling techniques, assumptions used, and links to clinical expertise • The PCT has, and effectively uses, predictive modelling to support its ability to target required interventions with precision • PCT forecasting is based on a full understanding of all relevant root causes, and is linked with other public forecasts
B Prioritisation of investment and disinvestment to improve population's health	• Does not meet Level 2 requirements	• The PCT has defined criteria for evaluating and prioritising investment and disinvestment including: – Quality – Local needs – Impact on health outcome gains and inequalities – NICE technology appraisals – Cost – Productivity • Strategic investment and disinvestment initiatives are generated through insights from: – Public and patient engagement – Local needs (e.g. JSNA) – Clinical evidence – Programme budgeting or equivalent • Investment and disinvestment proposals contain predicted improvement in health outcomes and impacts on health inequalities • The PCT board consults with PCT clinicians, local GPs and key stakeholders when evaluating strategic initiatives	• The PCT has a robust process to: – Use its criteria to evaluate and prioritise investment and disinvestment – Conduct a full annual impact review of all investments and disinvestments • The PCT actively monitors what has happened as a result of past investment and disinvestment	• The PCT understands the return on past investment (and disinvestment) and: – Compares this to national and international benchmarks – Uses this to inform future investment and disinvestment decisions • The PCT board works with clinicians, local GPs, key stakeholders and the public to develop, implement and evaluate investment and disinvestment proposals
C Incorporation of priorities into strategic investment plan to reflect different financial scenarios	• Does not meet Level 2 requirements	• There is some alignment between identified gaps, current initiatives to address those gaps, and strategic investment plan • Priorities include investment and disinvestment as appropriate • Investment and disinvestment decisions are evaluated and re-prioritised based on three different financial scenarios • Financial scenarios are based on clear and robust assumptions which are regularly updated to reflect evolving economic and contextual factors • Cross cutting and enabling initiatives (e.g. IT) that do not directly map to a health need, have been identified, evaluated for their overall impact and included in the prioritisation as appropriate	• There is clear and consistent alignment between identified gaps, current initiatives to address those gaps, and strategic investment plan • Financial scenario planning is undertaken regularly (6–12 months) and there is clear rationale for changes in investment and disinvestment decisions by financial scenario (based upon degree of health outcome gain) • Investment and disinvestment priorities are articulated and delivered as part of the strategic plan • The PCT, local authority, other allied commissioning bodies (e.g. SCG, joint commissioning arrangements) and other stakeholders have identified clear responsibility for financing • The PCT develops programme budgeting or equivalent methodology demonstrating a whole system approach to investment and disinvestment	• Projects and initiatives are evaluated against defined prioritisation criteria with effective targeting of resources • Planning and budgeting cycles are aligned to facilitate coordination and joint financing arrangements • Mature programme budgeting or equivalent methodology for all key priority care pathways/disease groups with integrated investment and disinvestment plans of up to ~10 years are in place • The PCT invests for longer-term health outcome gains and can quantify impact

Competency 7

Effectively stimulate the market to meet demand and secure required clinical and health and well-being outcomes

PCTs will need to have in place a range of responsive providers that they can choose from. They must understand the current and future market and provider requirements. Employing their knowledge of future priorities, needs and community aspirations, PCTs will use their investment power to influence improvement, choice and service design (including through TCS) through new or existing providers to secure the desired outcomes and quality, effectively shaping their market and increasing local choice of provision. This will include building upon local social capital and encouraging provision via third sector organisations. Where adequate provider choice does not exist, PCTs will need clear strategies to address this need, especially in areas of relatively poor health experience, access or outcome.

A

Knowledge of current and future provider capacity and capability

- Does not meet Level 2 requirements

- The PCT works with the local authority, other local PCTs and commissioners to:
  - Develop a robust market analysis on all segments of the market
  - Identify a full range of core (current and future) providers (including NHS providers, independent and third sector providers) by speciality, pathway and setting of care
  - Assess the relative cost, quality and patient feedback of providers and the services they deliver

- The PCT works with the local authority, other local PCTs and commissioners to:
  - Prioritise market segments for targeted improvement action
  - Identify potential costs and benefits of changing or managing providers in priority segments

- The PCT has identified cost and quality for each procedure in each area of care and in each setting of care (where incomplete, the PCT collects robust local data)
- The PCT has developed a clear specification for each setting of care (acute, primary, community, mental health etc) including quality, access, productivity and cost which reflects national and international best practice
- The PCT has the necessary resource and the necessary strategic partnerships with the right expertise and experience to support:
  - Robust market analysis
  - Market management
  - Provider capability development

B

Alignment of provider capacity with health needs projections

- Does not meet Level 2 requirements

- The PCT uses demand projections, demand management assumptions and population need to project required capacity by speciality; and matches provider capacity with this and adjusts commissioning and decommissioning accordingly
- The PCT has identified gaps in market supply and has mitigation plans for risks in supply structure
- The PCT can demonstrate it has appropriately used different forms of market management

- The PCT identifies specific changes to provider capacity to optimise provision to address health needs
- The PCT models demand and supply scenarios that can be varied and tested with risk assessment
- The PCT is forecasting potential as well as current risks and has adequate mitigation plans, particularly where the impact is broader than the PCT
- The PCT identifies barriers to entry and exit in priority markets for all types of providers and considers how to minimise these barriers
- The PCT has commissioned higher quality care at increased efficiency and effectiveness in its priority segments

- The PCT takes demand projections and incorporates demand management assumptions from strategic plan (e.g. pathway redesign) to identify required capacity by provider type, by speciality and by care/patient pathway
- The PCT implements specific changes to provider capacity driven by provider market analysis, needs modelling, including long-term structural changes, and forecasts based on actual risk analysis
- The PCT has successfully reduced or removed barriers to entry and exit for providers where appropriate
- The PCT has managed the market so that higher quality care is delivered at increased efficiency and effectiveness across all service areas

C

Creation of effective choices for patients

- Does not meet Level 2 requirements

- By provider, pathway and care setting, the PCT:
  - Regularly reviews the healthcare provision market place and the choice patients have
  - Has a clear strategy for creating more choice, particularly when specific services lack alternatives
- The PCT works with GPs and other referrers to develop an effective strategy to improve uptake of choice at a practice level
- The PCT offers patients choice of location, content, care setting, provider type and style of services
- The PCT involves patients in creating the choice offer, particularly those with long-term conditions, and makes information available to enable patients to exercise choice
- The PCT is fulfilling its legal responsibility for choice of elective care

- The PCT uses its understanding of the market, and patient feedback and input to make decisions on investment and disinvestment to create more effective choice

- The PCT has clear investment and disinvestment processes which lead to a mix of providers based on clinically defined cost/quality trade-off
- The PCT explicitly and regularly:
  - Tests with patients the acceptability of the choice available
  - Identifies and shares best practice for developing and communicating the choice offer
- The PCT has co-developed with local authorities a coherent strategy for increasing personalisation of care including choice, addressing joint health and care needs

Competency 8

Promote and specify continuous improvements in quality (e.g. CQUIN, IQI) and outcomes through clinical and provider innovation and configuration

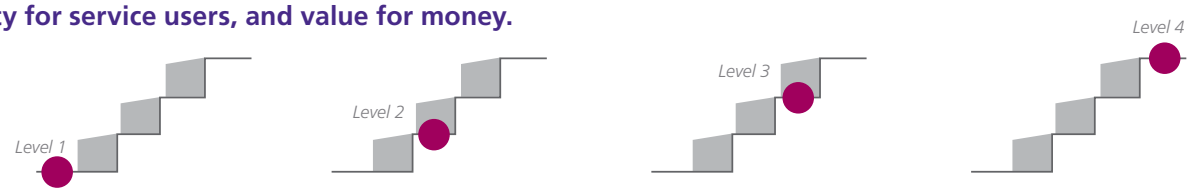
PCTs are the driver of a continually improving NHS. They must ensure that they develop the necessary capabilities and capacity to drive continuing improvements in quality. PCTs seek innovation, knowledge and best practice, applying this locally to demonstrate the improvements in the quality and outcomes of commissioned services. In partnership with local clinicians (e.g. PBCs), and providers, they will specify required quality and outcomes, facilitating supplier and contractor innovation that delivers at best value. Through open and effective commissioning and decommissioning decisions, PCTs transform clinical and service configuration, meeting local needs and securing world class improvements in outcomes and quality.

	Level 1	Level 2	Level 3	Level 4
A Identification of improvement opportunities	• Does not meet Level 2 requirements	• The PCT benchmarks their current performance in pathways related to priority outcomes against: regional and national definitions of best practice in the Next Stage Review, SHA clinical visions, NICE guidelines, other available data (e.g. through NHS Evidence) • The PCT demonstrates some recent examples of clinical pathway improvement where a need has been identified for groups/individuals • The PCT examines the specific interventions that are required at each point in the pathway from prevention to rehabilitation • Patients are involved in pathway redesign	• The PCT and its providers proactively and regularly: – Agree and review clinical pathways – Identify opportunities for improvement and innovation, based on national/international best practice of the pathways • For each pathway initiative, the PCT has outlined the specific interventions that are required at each point in the pathway and clear criteria for moving patients along the pathway • The PCT aggregates GP system data to run patient risk analysis and target patients	• For each pathway initiative, the PCT has outlined: – The specific interventions that are required at each point in the pathway and clear criteria for moving patients along the pathway (from prevention to rehabilitation) – Clinical guidelines (from prevention to rehabilitation) sourced from international best practice – Clear plans for ensuring services across settings are coordinated and integrated to provide seamless care
B Implementation of improvement initiatives	• Does not meet Level 2 requirements	• The PCT has a clear model of quality improvement which is well understood by staff • The PCT has applied improvement techniques in service or pathway redesign and: – Understood the implications on provider quality, productivity and workforce – Worked with providers and partners across the local health economy to mitigate risks associated with these – Measured progress against objectives (e.g. improved quality)	The PCT has: – A clear approach to quality improvement – Staff who are capable of applying the approach • Changes in clinical pathways have led to demonstrable results (e.g. shift in spend, improved cost effectiveness, quality, access, and lifestyle choices of those most at risk) • These improvement priorities span a range of services and geographical networks (e.g. local, regional and national)	• The PCT has: – A clearly embedded approach to change throughout its organisation – A significant number of staff who are highly capable of and committed to applying the approach • Milestones of clinical pathway change and quality improvement programmes are actively tracked • The PCT demonstrates actions on the basis of monitoring findings
C Collection of quality and outcome information	• Does not meet Level 2 requirements	• There is clear identification of quality and outcome metrics to monitor (both national contract and locally agreed) • The metrics chosen are developed with the relevant stakeholders • Monitoring frequency and reporting arrangements with major providers occur at regular intervals	• Information provides sufficient detail to support identification of drivers of performance and quality • There is near real time monitoring on measures where the PCT could have influence and act to address problems as they arise (e.g. out of hours access affecting A&E attendances) • Information links quality and efficiency	• The PCT has developed strategies for monitoring the impacts of specific initiatives on clinical health and well-being outcomes and quality • Reporting arrangements process and transmit data directly to key decision-makers and throughout the NHS (e.g. SHA, DH) • The PCT actively seeks out clinical evidence (from prevention to rehabilitation) for comparison with international best practice

Competency 9

Secure procurement skills that ensure robust and viable contracts

Procurement and contracting processes ensure that agreements with all sectors of providers (acute, primary, community, mental health, third sector, independent sector etc) are set out clearly and accurately with both commissioner and provider clear about what is expected. By putting in place excellent procurement and contracting processes, PCTs can specify quality requirements and outcomes (e.g. CQUIN, PROMs), incentivise development of innovative new service models and ensure good working relationships with their providers, ensuring quality for service users, and value for money.



A

Understanding of provider economics

- Does not meet Level 2 requirements

- For each category of provider (acute, primary, community, mental health, etc.) the PCT has an understanding of
  - Provider economics, e.g. scale, finances, performance
  - Provider market dynamics
- The PCT monitors and considers a broad range of available patient experience, quality of care and productivity metrics for all key providers
- Procurement approach and recent procurement exercises show compliance with Principles and Rules of Cooperation and Competition

- The PCT has a clear understanding of the economics of existing and potential providers and performs analyses on all key commissioned or in-house providers' economics
- The PCT generates insights about its key providers (e.g. benchmarking to understand causes of poor productivity, patient experience or quality care)
- The PCT understands the economic impact of changing provider activity volumes and service specification
- The PCT has an ongoing process for challenging, disseminating and refreshing the fact base of providers

- The PCT can use its clear understanding of provider economics to sort and extract a variety of metrics and benchmarks by providers and by disease group (e.g. capacity, average and marginal cost, financial results, quality of care)
- The PCT uses target costing, i.e. forecasting service cost before providers supply estimates

B

Negotiation of contracts around defined variables

- Does not meet Level 2 requirements

- There is clear identification of locally defined negotiation variables, including cost, quality, outcomes (e.g. PROMS), service targets (e.g. patient experience), which align to the PCT's strategic priorities
- The PCT rigorously prepares for all contract negotiations establishing:
  - A service specification and price
  - The best alternative to a negotiated agreement (BATNA)
  - A negotiation strategy
  - Negotiation team roles

- The PCT explicitly uses negotiation variables
- The PCT works with providers to develop outcome based service specifications
- All negotiations have defined improvements in service quality and value for money, reinforced where appropriate in CQUIN schemes
- Providers carry a significant proportion of risk to deliver on agreed improvements
- The PCT has a sophisticated approach for negotiating risk, including risk sharing where appropriate

- Negotiation has successfully delivered changes to variables and significant improvements in productivity, patient experience and quality of care
- Negotiation of contracts has delivered a positive position for the PCT and providers, that reinforces strong strategic relationships between the two

C

Creation of robust contracts based on outcomes

- Does not meet Level 2 requirements

- All contracts and other spend include clearly specified:
  - PCT defined outcomes
  - Quality and service metrics
  - Cost, productivity and activity expectations
  - Arbitration process
- The PCT employs national and PCT defined outcome and quality metrics to negotiate new contracts with defined performance improvement targets and improvements to patient pathways
- Contracts, in all care settings, are agreed and signed in advance of activity commencing

- PCT defined outcome, quality and service targets and improvements to patient pathways are an explicit part of all negotiations and are incorporated in all contracts in all care settings in line with priorities in the strategic plan
- Services are procured and contracted for in a way that incentivises good patient experience and clinical quality with the PCT using indicators and incentives for quality improvement in contracts
- Clinical leadership are involved in review of finalisation of contracts
- Contracts, in all care settings, have clearly defined break clauses, linking to quality variables where appropriate

- All contracts include clearly specified, measurable, and practical outcomes and quality metrics, with a transparent arbitration process
- Specific measurable performance improvement targets are jointly agreed
- Contract incentives drive desired provider performance which results in health improvements

Competency 10

Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money

Commissioners will need to manage their relationships and contracts with providers in order to ensure that they deliver the highest possible quality of service and value for money. This will involve working closely with providers to sustain and improve provision, and engaging in constructive performance discussions to ensure continuous improvement. Commissioners will need to ensure that their providers understand and promote the values of the NHS.

A

Use of performance information

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• Data is accessible and used to monitor the performance of all providers • Data from providers is analysed at least monthly and should be no more than two months old • Data is shared with providers when requested • Data collected supports key performance indicators, including quality and outcomes, defined in contracts	• Contract agreements: – Support collection of performance data, including quality and outcomes where national data is not available – Clearly define ownership and management control of data • Data is no more than six weeks old and is proactively discussed with providers • Data supports key performance indicators across all domains (e.g. quality, access, workforce) • Performance information is available for and accessible to the public, partners and stakeholders where relevant • There is near real time monitoring on measures where the PCT could have influence and ensure actions to address problems as they arise	• The PCT obtains real time feedback from users on services • The PCT maintains a 'live' dashboard of information on key performance indicators, including quality and outcomes, and ensures it is readily available to support performance management • The PCT can demonstrate data is used to drive fact-based continuous improvement in quality and outcomes

B

Implementation of regular provider performance discussions

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• The PCT generates regular reports (at least monthly) addressing performance of major providers within acute, primary, community and social care etc for internal and external use • The PCT has regular performance discussions with key providers to agree and review actions at a frequency determined by the scale of the provider and the potential risk • The PCT performs risk analysis of, and manages, data on quality (e.g. CQUIN, PROMs), access, patient feedback, operational workforce and workforce planning issues	• The PCT holds regular performance improvement discussions with key providers • The PCT tracks performance for all providers, segmented by type and care setting • The PCT works with providers to address issues by focusing on root causes, to enable sustainable improvements	• Continuous performance improvement discussions occur, leading to demonstrable change • There is ongoing provider capability building through sharing of international best practice

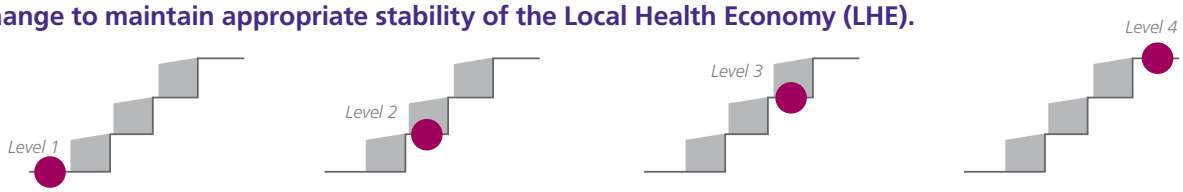
C

Resolution of ongoing contractual issues

Level 1	Level 2	Level 3	Level 4
• Does not meet Level 2 requirements	• Contracts indicate when intervention is required • Contract terms are not breached without appropriate investigation and remedial action • Contract compliance management is in place with all key providers	• The PCT has proactive contract compliance management, tailored to major providers • Actionable next steps for improvement are agreed, with assigned leads, time frames and milestones • Improvement plans are actively monitored and tracked with strong record of delivery	• The PCT has proactive contract compliance management, tailored to all providers • Required improvements are always delivered • There is a track record of innovative and effective resolution of conflict • The PCT has clear track record of: – Not tolerating poor performance (from providers in any sector), particularly in patient care – Acting swiftly to ensure change

Competency 11 Ensuring efficiency and effectiveness of spend

A core purpose of commissioners is to make sustainable trade off decisions and sound investments across all spend, to deliver the highest level of health benefit and quality of care* for a given level of spend along each care pathway. Robust analysis of spend and its impact on health benefit enables PCTs to make well-informed investment decisions. By identifying and unlocking efficiency and productivity improvements across all commissioned activity, PCTs will deliver both better health outcomes and greater value for money. PCTs manage change to maintain appropriate stability of the Local Health Economy (LHE).



	Level 1	Level 2	Level 3	Level 4
A Measuring and understanding efficiency and effectiveness of spend	• Does not meet Level 2 requirements	• For its commissioned activity, the PCT collects and analyses for pathways relating to priority outcomes: – Outputs – Spend level – Output efficiency (output per £ spent) – Relevant outcomes • Output efficiency and relevant outcomes by pathway are benchmarked against national best practice • The PCT has a clear understanding of the optimal economics of provision for major care settings	• For its commissioned activity, the PCT collects and analyses at the intervention level for pathways r elating to key priorities: – Outputs – Spend level – Output efficiency (output per £ spent) – Relevant outcomes – Health benefits per £ spent • Output efficiency and relevant outcomes are benchmarked against international best practice • Health benefits per £ spent for interventions in pathways relating to priority outcomes are benchmarked against national best practice • The PCT has a clear and detailed understanding of the optimal economics of provision for each care setting	• For its commissioned activity, the PCT collects and analyses for its own region, ward and provider level: – Health benefits per intervention – Health benefits per £ spent for each intervention • Health benefits per intervention and health benefits per £ spent for each intervention are benchmarked against national and international best practice • The PCT has a clear and detailed understanding of the optimal economics of provision for each type of service in each care setting
B Identifying opportunities to maximise efficiency and effectiveness of spend	• Does not meet Level 2 requirements	• The PCT identifies opportunities in pathways relating to priority outcomes for: – Improving efficiency and effectiveness of spend (e.g. shifting to other settings) – Maximising impact into targeted local population – Minimising duplicate and non-value add interventions based on NICE and other clinical guidelines – Provision efficiencies (e.g. switching providers) • Within its own cost base, the PCT identifies opportunities for improved: – Operational efficiency – Capital efficiency (e.g. fixed assets) – Spend efficiency (e.g. procurement)	• The PCT identifies opportunities at the intervention level for pathways relating to key priorities: – Improving efficiency and effectiveness of spend (e.g. shifting to other settings) – Maximising impact into targeted local population – Minimising duplicate and non-value add interventions through health benefits analysis in the PCT's priority outcome areas • The PCT uses its understanding of provider economics and efficiency and effectiveness drivers, to work with its major providers to identify opportunities to improve efficiency and effectiveness	• The PCT improves efficiency and effectiveness of spend whilst delivering greater health benefits and improved quality • The PCT identifies opportunities at the intervention level in all pathways for: – Improving efficiency and effectiveness of spend based upon health benefit per £ spent for each intervention – Maximising impact into targeted local population – Minimising duplicate and non-value add interventions
C Delivering sustainable efficiency and effectiveness of spend	• Does not meet Level 2 requirements	• The PCT defines a set of initiatives to deliver the identified efficiency and effectiveness opportunities • In delivering efficiency and effectiveness initiatives, the PCT: – Engages a broad range of clinicians – Works with its partners, providers and other local commissioners to agree clear responsibilities and means of delivery – Considers key delivery risks and creates mitigation plans – Measures impact – Performance manages providers – Ensures progress is tracked and responsible persons are held to account	• In delivering efficiency and effectiveness initiatives, the PCT: – Sets milestones relative to national and international best practice – Reviews performance and redirects initiatives to capture the greatest level of efficiency and effectiveness • The PCT reviews the impact of previous initiatives	• The PCT and other commissioners ensure appropriate stability of provision in the LHE by managing change • The PCT has effective structures and incentives in place to ensure that initiatives will be maintained and improved over time • The PCT: – Demonstrates that all retained initiatives continue to have impact – Demonstrates improvement in efficiency and effectiveness of spend over time

* For example QALYs

III. Governance – sub-components and criteria for each level

Governance – Strategy

	Red	Amber	Green
Vision and goals	• The vision: – References PCT and national context – Does not devote sufficient attention to individual localities and their particular health needs • The vision is not underpinned by analytical research into needs/ priorities (e.g. disease incidence rates) • The vision for health outcome improvements: – Is unambitious or unrealistic – Lacks measurable health improvement commitments – Is not backed up by credible timelines • The pyramid structure of vision, goals, initiatives and enabling initiatives, as explained in the WCC Year 2 strategy guidance, is poorly articulated and unfocused • The vision and goals do not provide confidence that the PCT will deliver all of: – The local NSR vision – The national priorities – The PCT's top strategic priorities	• The vision clearly: – References PCT and national context – Articulates individual locality needs and implications for PCT level strategy • The vision is underpinned by some analytical research into needs/priorities (e.g. disease incidence rates) • The vision for health outcome improvements: – Is somewhat ambitious and realistic – Has measureable health improvement commitments, but – Is not backed up by credible timelines	• The vision: – Is firmly grounded in the PCT and national context – Makes explicit links between priority health needs of localities, the implications for PCT level vision and how the strategy addresses these needs • The vision is underpinned by thorough analytical research into needs/priorities (e.g. disease incidence rates) • The vision for health outcome improvements: – Is ambitious and realistic – Has measurable health improvement commitments – Is backed up with credible timelines • The pyramid structure of vision, goals, initiatives and enabling initiatives, as explained in the WCC Year 2 strategy guidance, is clearly articulated and focused • The vision and goals provide confidence that the PCT will deliver all of: – The local NSR vision – The national priorities – The PCT's top strategic priorities

	Red	Amber	Green
Initiatives to ensure delivery of strategic goals and the PCT's programme of change	• A significant number of initiatives do not address the overall vision of the PCT	• Initiatives: – Address the overall vision – Lack sufficient prioritisation, resulting in a large number of small programmes	• Initiatives: – Address the overall PCT vision – Are focused, limited in number and prioritised
	• Initiative investment or disinvestment requirements are: – Not explicit – Not selected using clear and articulated criteria – Insufficiently detailed	• Initiative investment or disinvestment requirements are: – Explicit – Selected using clear and articulated criteria, but – Insufficiently detailed	• Initiative investment or disinvestment requirements are: – Explicit – Selected using clear and articulated criteria – Sufficiently developed
	• The PCT does not articulate how priority investments and disinvestments will change in multiple financial scenarios	• The PCT articulates how investments and disinvestments will change in multiple financial scenarios; however, without clear rationale or consideration of wider implications (e.g. for services provided)	• The PCT articulates how investments and disinvestments will change in multiple financial scenarios with clear rationale considering and stating wider implications (e.g. for services provided)
	• The impact of the initiatives on health outcomes and inequalities is not: – Explicit – Credible – Measurable	• The impact of the initiatives on health outcomes and inequalities is: – Explicit – Credible, but – Not measurable	• The impact of the initiatives on health outcomes and inequalities is: – Explicit – Credible – Measurable
	• The timeline for impact on health outcomes and inequalities is: – Missing or not explicit – Unrealistic – Insufficiently detailed	• The timeline for impact on health outcomes and inequalities is: – Explicit, and – Realistic, but – Insufficiently detailed	• The timeline for impact on health outcomes and inequalities is: – Explicit, and – Realistic, and – Detailed with milestones, potential bottlenecks and mitigation plans
	• External risks and required internal capacity, capabilities and responsibilities are not: – Identified – Managed appropriately	• External risks and required internal capacity, capabilities and responsibilities are: – Identified – Without a sufficiently robust plan to manage them	• External risks and required internal capacity, capabilities and responsibilities are: – Identified – Appropriately and robustly managed
	• There has not been appropriate engagement with all stakeholders, including: – Local population – Patients – Clinicians – Local partners – Providers	• There has been appropriate engagement with all stakeholders, including: – Local population – Patients – Clinicians – Local partners – Providers	• There has been full and ongoing engagement with all stakeholders, including: – Local population – Patients – Clinicians – Local partners – Providers

	Red	Amber	Green
Consistency of financial plan with the strategy	• The link between investment/ disinvestment decisions and health outcomes, reduced inequalities, and efficiency and effectiveness of health services is unclear • The financial plan: – Is incomplete, and – Lacks sufficient detail • Investment or disinvestment against each initiative is: – Not explicit by year – Not modelled • Timelines for investment or disinvestment are unclear • There is significant additional expenditure that is not accounted for by the strategic initiatives • Surpluses are not reinvested against strategic priorities	• The link between investment/ disinvestment decisions and health outcomes, reduced inequalities, and efficiency and effectiveness of health services: – Is clear, but – Could be more robust • The financial plan: – Is complete, and – Addresses multiple financial scenarios, but – Lacks sufficient detail • Investment or disinvestment against each initiative: – Is explicit, but – Lacks annual financial impact over the next five years – Does not describe how this impact will be achieved* • Timelines for investment or disinvestment are clear but either: – Overambitious, or – Under-ambitious • There is some additional expenditure that is not accounted for by the strategic initiatives	• The link between investment/ disinvestment decisions and health outcomes, reduced inequalities, and efficiency and effectiveness of health services: – Clear – Robust • The financial plan: – Is complete – Addresses multiple financial scenarios – Is sufficiently detailed with clear shifts in investment and disinvestment by year • Investment or disinvestment against each initiative: – Is explicit – Details annual financial impact over the next five years – Describes how this impact will be achieved* • Timelines for investment or disinvestment are: – Clear – Realistic – Detailed with milestones, potential bottlenecks and mitigation plans • There is little additional expenditure that is not accounted for by the strategic initiatives • Surpluses are reinvested against strategic priorities

* E.g. shifting providers, shifting settings of care, CIPs

	Red	Amber	Green
Board challenge, ownership and monitoring of strategic plan delivery	• There is insufficient evidence that the board was actively involved in robustly challenging the strategic plan as it was being reviewed and refreshed	• The board: – Can demonstrate its engagement in strategic development – Provided regular, somewhat robust challenges as the strategic plans were being reviewed and refreshed – Signed off the strategic plan	• There is evidence that the board provided: – Engagement in strategic development – Regular and robust challenges in the development of the strategic plan to identify health improvement priorities – Input which is clearly reflected in the strategic plan
	• The Chair and NEDs cannot – Name and explain the PCT's vision, goals and initiatives – Explain how the vision addresses the highest priority health needs of the local population	• The Chair and NEDs can: – Name and explain the PCT's vision, goals and initiatives – Explain how the vision addresses the highest priority health needs of the local population – Explain how initiatives should deliver the vision	• The Chair and NEDs can: – Name and explain the PCT's vision, goals and initiatives – Explain how the vision addresses the highest priority health needs of the local population – Explain how initiatives should deliver the vision – Articulate individual responsibilities and actions taken in governance and delivery of the strategic plan
	• The board is not aligned on the PCT's: – Vision – Goals – Initiatives	• The board is somewhat aligned on the PCT's: – Vision – Goals – Initiatives	• The entire board is aligned on the PCT's: – Vision – Goals – Initiatives
	• Performance scorecards for strategic initiatives and goals are, at only a few board meetings: – Presented – Reviewed – Challenged – Followed up with appropriate action	• Performance scorecards for strategic initiatives and goals are, at some board meetings: – Presented – Reviewed – Challenged – Followed up with appropriate action	• Performance scorecards for strategic initiatives and goals are, at all board meetings: – Presented – Reviewed – Challenged – Followed up with appropriate action
Achievement of milestones to date	• The PCT has a history of: – Setting inappropriate milestones – Failing to achieve milestones	• The PCT has a history of: – Setting appropriate milestones – Achieving most of its milestones	• The PCT has a history of: – Setting appropriate milestones – Achieving most of its milestones
	• The PCT has not: – Reviewed past performance against milestones – Developed robust plans to address delivery issues	• The PCT has: – Thoroughly reviewed past performance against milestones – Identified the causes of non-delivery – Developed a robust plan to achieve future milestones	• The PCT has: – Thoroughly reviewed past performance against milestones – Identified the causes of non-delivery – Identified drivers of success – Developed a robust plan which leads to achieving or exceeding more milestones
	• The PCT has not articulated the impact of missing milestones on achieving the PCT's goals and vision		• The PCT has articulated the impact of achieving/exceeding milestones on achieving the PCT goals and vision

Governance – Finance

	Red	Amber	Green
Historical financial management	• In 08/09, the PCT's end-of-year outturn was: – An operating deficit, or – An operating surplus more than 1.0%* different from SHA expectations • For 06/07 and 07/08, the PCT's end-of-year outturn was >1.0%* different from SHA expectations	• In 08/09, the PCT's end-of-year outturn was: – No operating deficit, and – A position within 0.5% - 1.0%* of SHA expectations • For 06/07 and 07/08, the PCT's end-of-year outturn was within 0.5% - 1.0%* of SHA expectations	• In 08/09, the PCT's end-of-year outturn was: – No operating deficit, and – A position within 0.5%* of SHA expectations • For 06/07 and 07/08, the PCT's end-of-year outturn was within 0.5%* of SHA expectations
Robust financial management	• The PCT has some but not all of: – A set of key metrics to measure progress – Robust monitoring in place – Board agreement on the frequency of reporting by metric • For invoice auditing, the PCT has either: – No process in place, or – A process that is not clear and robust • For debt and asset management, the PCT has either: – No process in place, or – A process that is not clear and robust	• The PCT has: – A set of key metrics to measure progress – Robust monitoring in place – Board agreement on the frequency of reporting by metric	• The PCT: – Has a set of key metrics to measure progress – Has robust monitoring in place – Ensures board review and challenges performance against key financial metrics at every board meeting • For invoice auditing, the PCT has a clear and robust process in place • For debt and asset management, the PCT has a clear and robust process in place

*The 0.5% and 1.0% in the criteria refer to the percentage of income, not the percentage of the outturn/operating surplus. For example, if there was an outturn of 0.9% and the SHA expectation was of 1.1%, then the PCT is within the tolerance for a Green rating as there is only 0.2 percentage points variance.

	Red	Amber	Green
Robustness of planning assumptions	• The PCT's assumptions for inflation, activity and population growth rates deviate significantly (e.g. >10%), with no clearly articulated rationale, from those of the SHA and other local agencies • Financial scenarios either: – Do not align with SHA guidelines, or – Have deviations that are not compellingly justified • The assumptions on contingency are too high or too low in multiple areas • The assumptions on savings are not backed up by: – Justifiable evidence* – A credible delivery plan • Contracted provider capacity is not aligned to activity projections	• The PCT's assumptions for inflation, activity and population growth rates either deviate: – Moderately (e.g. up to 10%) with only partially articulated rationale, or – Significantly (e.g. >10%) with a clear rationale that is validated with external data from those of the SHA and other local agencies • The assumptions on contingency are too high or too low in one area • The assumptions on savings are backed up by either: – Justifiable evidence*, or – A credible delivery plan • Contracted provider capacity is only aligned to activity projections in some areas	• The PCT's assumptions for inflation, activity and population rates either: – Are fully aligned – Have small to moderate deviations (e.g. up to 10%) with a very clear rationale that is validated with external data from those of the SHA and other local agencies • Financial scenarios both: – Align with SHA guidelines – Have deviations that are compellingly justified • The assumptions on contingency are appropriate • The assumptions on savings are backed up by: – Justifiable evidence* – A credible delivery plan • Contracted provider capacity is aligned to activity projections
Sustainable financial position as base case	• The PCT is projecting in any year over the next five-year period: – An operating deficit, or – A position that is more than 1.0%** different from SHA expectations • The organisation lacks a credible turnaround plan	• The PCT is projecting in every year over the next five-year period: – No operating deficit and – A position that is within 0.5%-1.0%** of SHA expectations • For any year with an operating deficit projected, the PCT has put in place a credible turnaround plan with: – A timeline – Metrics – Turnaround resources identified	• The PCT is projecting in every year over the next five-year period: – No operating deficit, and – A position that is less than 0.5%** different from SHA expectations • For a PCT showing no operating deficit, there is a credible plan in place to address all significant financial challenges and major risks over the next five years
Sustainable financial position under different financial scenarios	• Under all financial scenarios, the PCT projects in any year over the next five-year period: – An operating deficit, or – A position that is more than 1.0%** different from SHA expectations • The PCT lacks a plan detailing how it will break even under all financial scenarios for each of the next five years	• Under all financial scenarios, the PCT projects in every year over the next five-year period: – No operating deficit unless explicitly agreed with the SHA – A position that is within 0.5%-1.0%** of SHA expectations • The PCT has a plan that: – Details how it will break even under all financial scenarios, unless explicity agreed with the SHA, for each of the next five years – Has insufficient detail to be credible	• Under all financial scenarios, the PCT projects in every year over the next five-year period: – No operating deficit, and – A position that is less than 0.5%** different from SHA expectations • The PCT has a plan that: – Details how it will break even under all financial scenarios for each of the next five years – Is credible

* E.g. benchmarks

** The 0.5% and 1.0% in the criteria refer to the percentage of income, not the percentage of the outturn/operating surplus. For example, if there was an outturn of 0.9% and the SHA expectation was of 1.1%, then the PCT is within the tolerance for a Green rating as there is only 0.2 percentage points, variance.

Governance – Board

	Red	Amber	Green
Organisation	• The PCT has not clearly described its organisational structure	• The PCT has described its organisational structure	• The PCT has a clear and well-defined organisational structure, which is well-understood by the board
	• Roles and accountabilities within the organisation are not clearly articulated	• Roles and lines of accountability are not entirely clear	• Roles and accountabilities are clearly articulated and delineated
	• The PCT has not outlined its capacity and capability gaps at all levels of the organisation (board, executive, rest of organisation) and there is no plan to address capability gaps	• The PCT outlined its capacity and capability gaps at all levels of the organisation (board, executive, rest of organisation), but: – They are not aligned with those identified in the self-assessment – The plan to address the capability gaps is not robust	• The PCT has outlined: – Its capacity and capability gaps at all levels of the organisation (board, executive, rest of organisation), which are aligned with those identified in the self assessment – Clear, robust actions with timelines to address these gaps
	• The PCT has not articulated or communicated a set of clear values	• The PCT has communicated values, but they are not always consistent	• The PCT has clearly articulated values that have been communicated consistently to stakeholders
	• The values and organisational requirements outlined in the strategic plan are not consistent with the OD plan	• Some of the organisational requirements to support the strategy are clear actions in the OD plan	• The organisational requirements in the strategic plan are those prioritised by the PCT in the OD plan
	• The PCT's OD plan does not reflect engagement with or input from staff	• The PCT's OD plan references the staff survey, but does not directly map to the needs identified	• The PCT's OD plan outlines actions to be taken in response to the staff survey
Risk	• The board does not review risks and issues*	• The board: – Reviews risks and issues* across all domains** – Is not involved in prioritising and managing all major risks – Lacks agreed mitigating actions for some major risks***	• The board: – Reviews risks and issues* across all domains** at every board meeting – Is involved in prioritising and managing all major risks – Agrees mitigating actions for all major risks***
	• The board process for assuring appropriate clinical input into decisions is unclear	• The board process for assuring appropriate clinical input into decisions is clear	• The board has a process for: – Assuring appropriate clinical input into decisions – Reviewing its clinical leadership arrangements – Taking clear steps to improve the effectiveness of such arrangements
	• The board does not review the effectiveness of the PEC as advisors	• The board reviews the effectiveness of the PEC as advisors	• The board: – Regularly reviews the effectiveness of the PEC as advisors – Takes clear steps for improvement

* E.g. internal risks, SUIs, provider risks and provider staff issues
** Including its own activities, those of its providers, joint activities with partners (e.g. Safeguarding Boards etc)
*** With providers where applicable

	Red	Amber	Green
Information	• PCT board reports and provider performance and quality reports do not provide actionable data of a timely and accurate nature	• PCT board reports and provider performance and quality reports do not consistently provide actionable data of a timely and accurate nature	• PCT board reports and provider performance and quality reports provide consistent and actionable data of a timely and accurate nature
Performance	• The PCT does not track quality, clinical and operational performance of its providers • The PCT does not consistently report to its board on: – Quality, clinical, service and financial performance indicators – Progress on key initiatives • The board does not act to address key disparities in performance • The PCT is not: – Delivering on all existing 'Vital Signs' commitments – On trajectory for more than three 'Vital Signs' Tier 1 indicators	• The PCT tracks quality, clinical and operational performance of its providers from time to time • The PCT reports to its board at every board meeting on: – Quality, clinical, service and financial performance indicators – Progress on key initiatives • The board sometimes acts to address key disparities in performance • The PCT is: – Delivering on all existing 'Vital Signs' commitments – On trajectory for all but one to three 'Vital Signs' Tier 1 indicators	• The PCT tracks and uses quality, clinical and operational performance of its providers on a monthly basis • The PCT reports to its board at every board meeting on: – Quality, clinical, service and financial performance indicators – Progress on key initiatives • The board plays an active role in addressing disparities in performance • The PCT is: – Delivering on all existing 'Vital Signs' commitments – On trajectory or meeting all of 'Vital Signs' Tier 1 indicators

	Red	Amber	Green
Delegation	• In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has described unclear or blurred: – Roles and responsibilities – Accountabilities • In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has no clearly agreed: – Performance metrics – Frequency of reporting • In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has not clearly described: – Evidence of a robust, transparent process for decision making and managing conflicts of interest – Points of scrutiny applied when assessing business cases and commissioning plans • The PCT does not outline how joint, collaborative and specialised* commissioning arrangements and/or local authorities will support delivery of the strategy	• In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has clearly agreed: – Performance metrics – Frequency of reporting • In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has clearly described either: – Evidence of a robust, transparent process for decision making and managing conflicts of interest – Points of scrutiny applied when assessing business cases and commissioning plans • The PCT: – Outlines how joint, collaborative and specialised* commissioning arrangements and/or local authorities will support delivery of the strategy – Discusses delegation differently across the strategic plan and the OD plan	• In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has described clear and delineated: – Roles and responsibilities – Accountabilities • The board reviews and challenges joint, collaborative and specialised* commissioning performance against key metrics at every board meeting • In its joint, collaborative and specialised* commissioning governance arrangements, the PCT has clearly described both: – Evidence of a robust, transparent process for decision making and managing conflicts of interest – Points of scrutiny applied when assessing business cases and commissioning plans • The PCT: – Outlines how joint, collaborative and specialised* commissioning arrangements and local authorities will support delivery of the strategy – Describes it consistently in both the strategic plan and the OD plan
Board interaction	• The PCT board does not appear to have played a role in: – Shaping strategy – Prioritising areas and timings of investment – Making investment trade-offs • Board members cannot identify any criteria used to define priorities and cannot name initiatives that flow from these priorities	• The PCT board does not appear to have played an active role in: – Shaping strategy – Prioritising areas and timings of investment – Making investment trade-offs • Board members can identify some of the criteria used to define priorities and can name some of the initiatives that flow from these priorities	• The entire PCT board, including executive and non-executive directors played an active role in: – Shaping strategy – Prioritising areas and timings of investment – Making investment trade-offs • The board can speak of the trade-offs made in prioritisation and the rationale for the priorities based on a consistent set of criteria

* Includes, but is not limited to, practice based commissioning, specialised commissioning groups and collaborative commissioning arrangements.

IV. Documents index

Document	Competencies											Governance		
	1	2	3	4	5	6	7	8	9	10	11	Strategy	Finance	Board
Communications strategy	●		●				●							
LAA and PCT cover page[1]		●			●	●								
LAA performance report		●			●	●								
Joint Strategic Need Assessment[2]		●			●	●	●							
Strategic plan[3]		●	●	●	●	●	●	●	●		●	●	●	●
Contracting process forms[4]			●	●			●	●	●	●	●			
Refreshed PBC governance arrangements				●						●				●
Pathway descriptions[5]				●	●		●	●		●	●			
Financial plan						●	●				●	●	●	
OD plan						●	●	●				●		●
Excerpt from accounts showing results of Public Sector Payment Policy compliance													●	
Provider performance reports[6]										●				●
Board risk governance report														●
Other schemes of delegation[7]														●
Board minutes[8]												●		●

1 Briefly details the process for reconfirming the LAA (including clinical engagement) and the changes to the LAA in the last year where relevant.
2 JSNA submission to be an executive summary and 1-2 chapters. Chosen chapter(s) should be those most relevant to the PCT's chosen outcomes while providing evidence for the relevant competencies where the JSNA is a key evidence source. Submission should be provided in document form.
3 Strategic plan includes evidence for forecasting health needs, stakeholder engagement, strategic initiatives, implications of financial scenarios and provider market analysis.
4 Three contracting process forms to be completed (one for acute, one for primary care and the third of the PCT's choice) – covering the overall contracting process, including space for relevant areas of contracts to be included.
5 Three pathways to be submitted.
6 Minimum of one, maximum of two.
7 Including SCG and collaborative commissioning arrangements delegation.
8 Provided by SHAs on behalf of their PCTs.

V. Competencies – supporting evidence

Competency 1 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Reputation as the local leader of the NHS	• Communications strategy	• Media evaluation (nationally consistent methodology)	• Stakeholder survey, 'We recognise the PCT as the local leader of the NHS' • Public perception survey, 'My local NHS is improving services for people like me'
B Reputation as a change leader for local organisations			• Stakeholder survey, 'The PCT has a significant influence on our decisions and actions'
C Position as an employer of choice		• Vacancy days per year • Staff retention and turnover rates • Staff sickness rate • Percentage of bank, agency, temporary or contract workers	• NHS Staff survey: – KF 4: percentage staff agreeing that they have an interesting job – KF 11: percentage staff feeling there are good opportunities to develop their potential at work – KF 12: percentage staff receiving job-relevant training, learning or development in last 12 months – KF 14: percentage staff having well-structured appraisals in last 12 months – KF 15: percentage staff appraised with personal development plans in last 12 months – KF 30: percentage staff agreeing that they understand their role and where it fits in – KF 33: Staff intention to leave jobs

Competency 2 Supporting documents, metrics and surveys

Sub-competency		Documents	Metrics	Surveys
A	Creation of local area agreement based on joint needs	• Local Area Agreement and PCT cover page • LAA performance report • Joint Strategic Needs Assessment • Strategic plan		
B	Ability to conduct constructive partnerships	• Local Area Agreement and PCT cover page • LAA performance report • Strategic plan	• CAA – local area assessment	• Stakeholder survey, 'The PCT proactively engages my organisation to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources'
C	Reputation as an active and effective partner	• Local Area Agreement and PCT cover page		• Stakeholder survey, 'The PCT is an effective partner in delivering health and well-being improvements for the local population'

Competency 3 Supporting documents, metrics and surveys

Sub-competency		Documents	Metrics	Surveys
A	Influence on local health opinions and aspirations	• Communications strategy • Strategic plan		• Stakeholder survey, 'The PCT proactively shapes health opinions and aspirations of the local population (e.g. through social marketing)'
B	Public and patient engagement	• Communications strategy • Strategic plan • Contracting process forms		• Public perception survey, 'My local NHS listens to the views of local people and acts in their interests' • PBC Survey
C	Improvement in patient experience		• Trend in (i.e. data for this year and last year) percentage of complaints concluded in 25 days	• Public perception survey, 'My local NHS helps manage and improve the health and well-being of me and my family' • Public perception survey, 'My local NHS is improving services for people like me' • NHS patient survey

Competency 4 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Clinical engagement	• Refreshed PBC governance arrangements • Strategic plan • Pathway descriptions • Contracting process forms		• PBC survey
B Dissemination of information to support clinical decision making	• Refreshed PBC governance arrangements		• PBC survey
C Reputation as leader of clinical engagement	• Strategic plan • Refreshed PBC governance arrangements		• Stakeholder survey, 'The PCT proactively engages clinicians (including through PBC) to inform and drive strategic planning, service design, quality improvement, innovation, and efficient and effective use of resources'

Competency 5 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Analytical skills and insights	• Joint Strategic Needs Assessment • Strategic plan		
B Understanding of health needs trends	• Joint Strategic Needs Assessment		
C Use of health needs benchmarks	• Joint Strategic Needs Assessment • Local Area Agreement and PCT cover page • LAA performance report • Pathway descriptions		

Competency 6 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Predictive modelling skills and insights to understand impact of changing needs on provision	• Joint Strategic Needs Assessment • Strategic plan • OD plan		
B Prioritisation of investment and disinvestment to improve population's health	• Local Area Agreement and PCT cover page • LAA performance report • Strategic plan • Financial plan		
C Incorporation of priorities into strategic investment plan to reflect different funding scenarios	• Strategic plan • Financial plan		

Competency 7 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Knowledge of current and future provider capacity and capability	• Strategic plan* • OD plan • Pathway descriptions		
B Alignment of provider capacity with health needs projections	• Strategic plan • Joint Strategic Needs Assessment • Contracting process forms • Financial plan	• Supply2Health**	
C Creation of effective choices for patients	• Strategic plan • Communications strategy		• Patient choice survey: – Q2 'Were you offered a choice of hospital for your first appointment?' – Q5 'Were you able to go to the hospital that you wanted to go to?'

* Outputs of Health Market Analysis and implications for the PCT's strategy, including the actions taken as a result.
** Numbers of ITTs placed on Supply2Health website.

Competency 8 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Identification of improvement opportunities	• Pathway descriptions • Strategic plan		• PBC survey
B Implementation of improvement initiatives	• Pathway descriptions • Strategic plan • OD plan		• PBC survey
C Collection of quality and outcome information	• Pathway descriptions • Contracting process forms		

Competency 9 Supporting documents, metrics and surveys

Sub-competency	Documents	Metrics	Surveys
A Understanding of provider economics	• Contracting process forms		
B Negotiation of contracts around defined variables	• Contracting process forms		
C Creation of robust contracts based on outcomes	• Contracting process forms • Strategic plan		

Competency 10 Supporting documents, metrics and surveys

Sub-competency		Documents	Metrics	Surveys
A	Use of performance information	• Provider performance reports • Contracting process forms • Refreshed PBC governance arrangements	• Better Care, Better Value workforce metrics (for PCT's main providers) • CQC Annual Health Check – Quality of Services (for PCT's main providers) • UoR KLOE 2.2 (Data)	
B	Implementation of regular provider performance discussions	• Provider performance reports • Contracting process forms • Pathway descriptions		
C	Resolution of ongoing contractual issues	• Contracting process forms		

Competency 11 Supporting documents, metrics and surveys

Sub-competency		Documents	Metrics	Surveys
A	Measuring and understanding efficiency and effectiveness of spend	• Pathway descriptions		
B	Identifying opportunities to maximise efficiency and effectiveness of spend	• Pathway descriptions • Strategic plan	• Better Care, Better Value (non-workforce) indicators	
C	Delivering sustainable efficiency and effectiveness of spend	• Pathway descriptions • Strategic plan • Financial plan • Contracting process forms		

VI. Governance – supporting evidence

Strategy – Supporting documents, metrics and surveys

Sub-area	Documents	Metrics	Surveys
Vision and goals	• Strategic plan		
Initiatives to ensure delivery of strategic goals and the PCT's programme of change	• Strategic plan • Financial plan • OD plan		
Consistency of financial plan with the strategy	• Financial plan • Strategic plan		
Board challenge, ownership and monitoring of strategic plan delivery	• Strategic plan • Board minutes		
Achievement of milestones to date	• Strategic plan		

Finance – Supporting documents, metrics and surveys

Sub-area	Documents	Metrics	Surveys
Historical financial management	• Financial plan		
Robust financial management	• Excerpt from accounts showing result of Public Sector Payment Policy compliance	• UoR KLOE 1.3 (Financial Reporting)	
Robustness of planning assumptions	• Financial plan • Strategic plan		
Sustainable financial position as base case	• Financial plan • Strategic plan		
Sustainable financial position under different financial scenarios	• Financial plan • Strategic plan		

Board – Supporting documents, metrics and surveys

Sub-area	Documents	Metrics	Surveys
Organisation	• OD plan • Strategic plan		
Risk	• Board risk governance report • Board minutes	• UoR KLOE 2.4 (Internal control)	
Information	• Board minutes • Provider performance reports		
Performance	• Board minutes • Provider performance reports	• 'Vital Signs' 12 month rolling average of – Existing commitments – Tier 1 indicators	
Delegation	• Schemes of delegation – Refreshed PBC governance arrangements – SCG governance arrangements – Collaborative commissioning governance arrangements where applicable • Strategic plan • OD plan		
Board interaction	• Strategic plan	• Evidenced through panel day	

VII. Contracting process forms and guidance

'Contracting process online form' guidance

Objectives

Provide the PCT with an opportunity to:

- Provide context on the provider, their relationship and the objectives of the contract
- Describe the contracting process
- Describe this process across a range of care settings
- Reference specific schedules / other excerpts that illustrate key elements of the contract

PCTs will insert description into an online form and include extracts from relevant schedules etc.

The PCT will be asked to complete for three contracts (one acute, one primary care and a third of their choice) narrative against the three stages of the contracting process (negotiations, contracting and contracting management), providing rationale where required

The contracting process form provides space for narrative across the following structure:

1. Negotiation:

- What data was used to establish the PCT's negotiating position for this contract?
- In what ways were patients, carers, clinicians involved in the negotiations?
- What was the negotiation strategy?
- What are the locally defined negotiation variables?
  - How are the negotiation variables used and which are prioritised?
  - What is the approach for risk negotiation?
  - What level of risk is carried by (a) the provider and (b) the PCT?
- How has the PCT developed its best alternative to a negotiated agreement (BATNA) for this contract?

(The PCT might also include extracts from schedules or other documentation illustrating negotiation variables, BATNA etc.)

2. Contracting

- What level and type of activity is set out and agreed in the contract?
- What improvement requirements have been defined?
- What KPI metrics and targets are set out in the specification? How are these aligned to providers' own KPIs? Which of these are locally defined and agreed between the provider and PCT?
- How do locally (and nationally – where relevant) agreed metrics reflect local strategic priorities?

(The PCT might also include extracts from schedules or other documentation illustrating outcome targets, KPI metrics etc.)

3. Contract management

- What is the process for involving clinicians in setting and reviewing provider direction?
- How is provider data (both 'soft' and 'hard') gathered, shared and monitored (e.g. patient experience, quality, productivity)?
- How are incentives (e.g. CQUIN) used?
- What is the intervention process (i.e. when the PCT believes the provider is not meeting the terms (e.g. in performance targets) of the contract)? When has this process been used successfully (e.g. early termination of a contract with an underperforming provider)?

(The PCT might also include extracts from schedules or other documentation illustrating data to be collected and monitored, use of incentives, intervention process etc.)

Note: For the primary care contracting process form, the PCT should describe the overall approach of the PCT to managing all primary care contracts.

VIII. Pathway descriptions guidance

Objectives

Provide the PCT with an opportunity to:

- Illustrate pathway redesign and the rationale behind it
- Explain efficiency and effectiveness initiatives
- Show impact of initiatives (including impact on workforce)

PCTs will upload three pathway description documents alongside all other uploads

The PCT will be asked to submit (for up to three care pathways – which should reflect strategic outcome priority areas)

A Maximum five page description of pathway redesign describing the

1. **Current interventions** at each step along the patient journey from prevention; through primary and community care, secondary care and tertiary and specialist care; to rehabilitation
2. **Challenges and gaps** identified by benchmarking the current set of interventions against national or international best practice along the care pathway
3. **Initiatives to redesign** the care pathway to address these challenges, including:
   - Adding, removing or changing the balance of interventions
   - Improving the effectiveness of interventions
   - Improving the efficiency of interventions (including procurement)
4. **Rationale and process** behind the redesign initiatives, detailing:
   - Expected and target impact on health outcomes, quality, choice, reach
   - Impact on efficiency and effectiveness of spend (using health benefits analysis)
   - Benchmarking against national and international best practice to set progress milestones
   - Metrics tracked (locally defined and/or drawn from national sources (e.g. *Indicators for Quality Improvement – Full indicator list*))
   - Engagement with clinicians, public, patients and other stakeholders
   - Implications for the current and future provider landscape (e.g. provision, economics, workforce, patient choice) from redesign initiatives (e.g. from switching providers, changing performance management, changes to contracts)

IX. Change control process

The WCC assurance handbook sets out guidance on the process for SHAs and PCTs in implementing the system for world class commissioning. There may be circumstances where SHAs wish to flex the system to align with local needs and existing systems. To safeguard the consistency of a national system, SHAs should agree any significant changes to the process with the DH.

X. Glossary of terms

Term	Definition	Relevant competencies
Care pathway	The aggregated stages of care provision by disease group ranging from prevention through rehabilitation to continuing care	6,11
Disease area	Health conditions and/or impairments of health that can be classified under one diagnosis, or 'disease area'	6
Equality Target Groups	Should be considered when making reference to population, staff and services provided. Includes women, women in maternity, men, black and minority ethnic (BME) people, lesbians, gay men, bisexual people, transgender people, children, young people and older people, disabled people and people from different religious or belief groups.	3
Health benefit	A quantifiable measure of improvement in health (e.g. Quality Adjusted Life Years)	11
Interventions	The patient care actions taken at stages along the care pathway	5,6,8,10,11
IQI	Indicators for Quality Improvement – an assured menu of provider-based indicators which can be benchmarked across different providers	6
KLOE	Key Line of Enquiry as defined by the Audit Commission	
Key providers	Providers accounting for greatest proportion of PCT spend or providers with the greatest opportunity for improvement (as relevant)	9,10
Market analysis	Understanding current and future structure of segmented healthcare provision markets including an understanding of cost, capacity, quality, access, productivity, effectiveness etc., of providers	7
Major care settings	Care settings accounting for the largest proportions of PCT spend	11
Market management	Proactive shaping of the provider base to deliver the best outcomes for patients at the best value to commissioners – levers include 'competition in the market', 'competition for the market' and 'improving performance of current market'	7
Optimal economics	An understanding of the resources required (capacity, workforce, costs, etc.) to meet clinical requirements	11
Other local commissioners	Includes: SCGs, PBCs, LAs, Children's Trusts, other collaborative arrangements (e.g. hubs)	1,2,11
Other referrers	Includes all non-GP referrers: consultants, dentists, nurses, opticians, AHPs, etc.	7

Term	Definition	Relevant competencies
Output efficiency	The level of output per £ spent (e.g. number of [activity currency] per £ spend)	11
Outputs	The number of procedures/treatments undertaken over a given period of time (e.g. year)	5,11
Partners	Other commissioning, strategic or governmental bodies which work with the PCT to help improve the health and well-being of its population (e.g. LAs Children's Trusts, CQC, Schools)	1,2,3,5,6,7,8,10,11
Patient level profiles	Understanding of patterns of care (frequency, settings, care packages/interventions etc.) for different groups or segments of representative patients	5
Population	PCTs should actively consider equality target groups and seldom heard groups (see above) as part of their population	1,2,3,5,6,7,11
Predictive modelling	Projection of future needs and demands by aggregated modelling of demographic shifts, changes to incidence rates and risk factors, technology etc.	5,6
Provider economics	The economic drivers of a provider's financial performance, including an understanding of capacity, profitability, fixed and variable costs levels by service line	9,11
Programmes	An ordered sequence of actions taken to deliver an initiative	5,8
Provider sectors	Includes: acute, primary, community, mental health, learning disabilities, social, third sector, independent sector	9,10
QALY	Quality Adjusted Life Year: number of years of life added by an intervention corrected for the degree of health those years are lived in – derived using NICE guidelines, clinical evidence, medical literature	11
Quality	In line with NSR's definition of quality, including clinical effectiveness, patient safety and patient experience	1,2,3,4,6,7,8,9,10,11
Real time data	Data that is collected and provided as activity happens or close to the activity happening	8,10
Risk stratification	Ability to segment patients in a very granular way on the basis of risk, especially future risk	5
Stakeholders	A wide range of groups both internal (e.g. PCT staff, board) and external (e.g. Provider Board, Local Government, Trade Unions)	1,2,3,4,5,6,8,10
TCS	Transforming Community Services	4,7

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