Developing the NHS Performance Regime

Commissioning Assurance Handbook

DH - World Class Commissioning

04 June 2008

PCT CEs, SHA CEs

The assurance process will hold PCTs to account and reward performance as they move towards world class. This handbook provides a detailed explanation of the content of commissioning assurance, with a practical guide on how to follow the process.

World Class Commissioning Vision and Competencies
Developing the NHS Performance Regime

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Improving commissioning is at the heart of delivering the NHS’s health agenda for the future. We have a unique opportunity today to develop world class commissioning, investing NHS funds to secure the maximum improvement in health and well-being outcomes.

The world class commissioning programme is designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way anywhere in the world.

World class commissioning is about delivering better health and well-being for the population, improving health outcomes and reducing health inequalities. In partnership with local government, practice based commissioners and others, Primary Care Trusts (PCTs), supported by Strategic Health Authorities (SHAs), will lead the NHS in turning the world class commissioning vision into a reality, adding life to years and years to life.

The assurance system for world class commissioning (“commissioning assurance”) is linked to the vision and competencies published in December 2007 and to resources for support and development available both nationally and locally. Together these provide a coherent programme aimed at supporting commissioners in delivering their health agenda.
who is it for?
PCTs; SHAs; Panel members

what does it provide?
– A detailed explanation of the content of commissioning assurance
– A practical guide about how to follow the process, with checklists for PCTs

what is not included?
– Guidance on how to write documents submitted as part of the assessment: e.g. strategic plan, financial plan, organisational development plan
– Additional information on commissioning assurance for SHAs, panel review members and SHA analysts: e.g. panel guidance for panel review members.

These guidance documents can be accessed by logging on to the assurance toolkit. Please follow the link at www.dh.gov.uk/worldclasscommissioning
Commissioning assurance will enable PCTs and SHAs to understand commissioning performance across health services, and to strive for improvements.

Commissioning assurance holds PCTs to account and rewards performance and development as they move towards world class. There is one nationally consistent system managed by the SHAs. As set out in the Operating Framework 2008/09, commissioning assurance applies to all SHAs and PCTs. Within the established annual cycle it will be a consistent assurance system to review PCT progress towards world class performance and achievement of better health outcomes and provide a common basis for agreeing further development. Nationally consistent methodology will enable reliable comparison of performance across all PCTs.

Commissioning assurance has been developed in collaboration with the NHS and other partners, including a test with PCTs in the North West SHA.

“**The purpose of commissioning assurance is specifically to understand whether PCTs are improving as commissioners of better health outcomes and for this purpose it assesses a new set of organisational skills and behaviours.**”
world class commissioning will deliver:

... better health and well-being for all
  ■ People will live healthier and longer lives
  ■ Health inequalities will be dramatically reduced

... better care for all
  ■ Services will be evidence-based and of the best quality
  ■ 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 effective care
Principles of the commissioning assurance process

The process has been designed to be:

- **Transparent**: a clear assessment methodology with clear descriptions of incentives and interventions and how these can be applied
- **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 interventions for those that do not
- **Proportionate**: focusing on the key indicators of performance and capabilities rather than being an all-encompassing audit
- **Consistent**: with the developing NHS Performance Regime
PCTs will be assessed across three elements.

The three elements will be assessed using a combination of approaches including self-assessment, self-certification, feedback from partners, evidence gathering and review of data. PCTs will be responsible for completing online templates through the assurance toolkit to provide input into these areas and will upload documentation already collected or produced by the PCT to support assessment. Commissioning assurance aims to place as little extra burden on PCTs as possible while ensuring a robust process for challenge and development.

SHAs will manage commissioning assurance locally, and will be responsible for running the process, ensuring the PCT has gathered the appropriate evidence, coordinating the panel review day, and providing follow-up, including both rating PCTs and supporting ongoing development. SHAs will also be responsible for providing analytical resource to support the panel review process.

The role of the Department of Health (DH) will be one of oversight. The DH will set a common framework, and work with SHAs to ensure that they have the right capabilities to implement this framework effectively. The DH will act as moderator for any changes to the process, and will be responsible for publishing nationally calibrated ratings from 2009/2010.

The definition of world class will continuously evolve, and commissioning assurance will develop in response. In particular, this will affect the competencies expected of world class commissioners. It is expected that the criteria used to measure the competencies and to define levels of improvement will rise in line with overall improvements in commissioning skills and behaviours.
The definition of world class will continuously evolve, and commissioning assurance will develop in response.

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 commissioning assurance is specifically to understand whether PCTs are improving as commissioners of better health outcomes and for this purpose it assesses a new set of organisational skills and behaviours. It is primarily for use by PCTs and SHAs, seeking to understand how PCTs are developing, and providing a basis for future improvement.

Insights drawn from current regulatory assessments will be part of the supporting evidence considered by the panels, and will form an integral part of the Governance assessment. In particular, ratings from both the Audit Commission (Auditors Local Evaluation and Use of Resources) and the Healthcare Commission (Annual Health Check) will inform ratings for the Board section of Governance. This will ensure consistency across the regimes, and will create a coherent overall story about PCT performance.

From 2008, the Annual Health Check performed by the Healthcare Commission will cover PCTs’ roles as providers and commissioners in two separate parts of the overall assessment. Assessment of PCTs as providers will include their compliance with healthcare and quality standards, and ongoing clinical quality investigations as appropriate. Looking at PCTs as commissioners, the Healthcare Commission will identify whether PCTs are achieving core standards and their performance against national priorities in their commissioning functions.

From 2009, the Care Quality Commission will be a new integrated regulator for health and adult social care, ensuring that quality and safety standards are maintained. In addition, the Comprehensive Area Assessment (CAA) will assess outcomes delivered by councils working alone or in partnership. The DH will ensure that these two systems are aligned with commissioning assurance.
Commissioning assurance has five stages.

1. PCT preparation
Preparation by the PCT takes place in the period leading up to the panel day with final submission of all material by the end of October. The material for submission includes the strategic plan (with underpinning financial, organisational development and annual operating plans). The PCT is required to complete self-assessment and self-certification, nominate partners to provide input to feedback surveys, and collate documentation. Submission of all material, including the strategic and financial plans, takes place through the assurance toolkit accessed via [www.dh.gov.uk/worldclasscommissioning](http://www.dh.gov.uk/worldclasscommissioning)

2. Panel preparation
Each SHA will supply an analyst to support the process of commissioning assurance. The analyst’s role is to create a briefing for the panel. This should be carried out in conjunction with a senior lead within the SHA.

Prior to the panel review days, the analyst will create a fact base using nationally-available data, the documentation submitted by the PCT, and SHA insights. Using nationally-consistent methodology, the analyst and SHA lead will create a panel briefing, benchmarking the PCT against national indicators on outcomes, providing an analysis of submitted information, and suggesting areas for discussion at the panel day.

The analyst will receive additional guidance to support them in their role, and to ensure that the criteria for assessing evidence and briefing the panel are consistent. The analyst guide will be available to download from the assurance toolkit.
3. Panel day
The panel days are the focal point of commissioning assurance, and will take place in November and December. They will be a two-way discussion between the panel members and the PCT Board and PCTs should approach them as an opportunity for challenge and development.

The panel members, informed by the panel briefing, will undertake structured interviews with members of the PCT Board. This will be followed by a feedback discussion including an assessment of the PCT and recommendations for ongoing development.

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

4. Calibration
Ratings will be regionally and nationally calibrated to ensure consistency. Nationally-calibrated ratings for each PCT will be published from 2009/2010.

5. Follow-up
Whilst the panel days are the focal point of commissioning assurance, the challenge and development of commissioners should be ongoing. The SHA and PCT Board will meet again after the panel review day to discuss the panel’s recommendations, review the panel report and agree actions. This may include access to incentives for improving PCTs or the application of interventions to underperforming PCTs. Following this, the SHA and PCT will work together throughout the year to ensure commissioners are moving towards world class.

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

SHAs will take overall responsibility for support and development of PCTs to achieve world class commissioning. Resources and tools to support PCTs in their development towards world class are wide-ranging.

SHAs have requested a national PCT support programme on Board development. Further details will be available from August 2008 at:
www.dh.gov.uk/worldclasscommissioning
Timetable
Commissioning assurance is an integral part of the planning cycle for PCTs and, as such, it is structured around the strategic planning process including the underpinning financial, annual operational and organisational development plans.

The timings given here are the latest possible dates for the completion of documents and activities. Exact timings will vary across SHAs and will be communicated to PCTs by their SHA.

**PCT PLANS**

<table>
<thead>
<tr>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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*Strategic plan*

*Five year financial plan*

Publication of Next Stages Review (2008)

PCT preparation

Ongoing follow-up

**COMMISSIONING ASSURANCE**
<table>
<thead>
<tr>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
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<tbody>
<tr>
<td>Strategic plans complete</td>
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<td>Ratings published (2009/10 onwards)</td>
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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 commissioning assurance includes an assessment of both outcomes and processes. The three elements of commissioning assurance: outcomes, competencies and governance, reflect this combined approach.

- Outcomes reflect the overall improvement in the health and well-being of the population.
- Competencies reflect improvements in the PCT’s 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.
Through world class commissioning, PCTs will align their strategic priorities with the key health outcomes that they will deliver for their population. These will have a longer-term focus than delivery against operational targets which reflect the interim milestones towards these overall health and well-being aspirations.

PCTs will locally choose a small number of priority outcomes that will be assessed as part of commissioning assurance. PCTs will choose outcomes that are reflected in their strategic plan priorities and that have been agreed with their partners, including the public and patients, community partners and clinicians.

For the purposes of commissioning assurance 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 – life expectancy and health inequalities – will be included for all PCTs. PCTs will supplement these outcomes with up to eight additional outcomes determined locally. When choosing these outcomes they should reflect their strategic plan priorities. It is recognised that there is a significant time required to drive tangible change in outcomes. This has been factored into the assessment and PCTs should feel encouraged to ensure those metrics chosen reflect their strategic priorities, rather than present opportunities for improvement by the next assessment.

The link with the strategic plan and the rationale for choosing each of the priorities, as well as the means by which the PCT intends to drive tangible change, will be central to the panel review.
The outcomes chosen will need to be underpinned by quantifiable data in order to provide a basis against which improvement can be tracked.

PCTs will be provided with a list of metrics that quantify health and patient-reported outcomes and priorities. Each of these metrics has a nationally-available data set, and a full list is shown in the appendix. The metrics reflect the Vital Signs indicator set published on the DH website (www.dh.gov.uk) in January 2008, and have been aligned with the NHS Next Stage Review areas of care, to facilitate consistency between PCT strategic priorities and SHA clinical visions.

PCTs should not restrict their choice of outcomes to this list where it does not reflect the strategic priorities agreed with their population and partners. PCTs should be innovative in how they quantify and monitor their chosen long-term health objectives; where no data is available nationally they can provide metrics they will collect locally and against which they will measure improvement. Where appropriate, up to three of the outcomes metrics provided by the PCT can be locally-defined in this way rather than from the list provided. Under these circumstances, where data is collected by the PCT, it will be submitted to the SHA prior to the panel review process in order to support analysis and benchmarking.
Improvement in outcomes will be a relative rather than an absolute assessment. For each PCT, a scorecard will be created to demonstrate current performance relative to the national average for each outcome, rate of improvement relative to the national improvement rate and key benchmarks, including SHA average, Office of National Statistics (ONS) cluster and ONS twin performance. PCTs will also be shown their performance adjusted for health deprivation. Behind each of the metrics will be a distribution chart.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>National average</th>
<th>Rate of change relative to national average</th>
<th>Time period</th>
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<tbody>
<tr>
<td>Healthy life expectancy</td>
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<tr>
<td>Health inequalities</td>
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<td>CVD mortality</td>
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<td>Cancer mortality</td>
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<td>Stroke mortality</td>
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<td>Long term health in</td>
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<td>Obesity</td>
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<td>Teenage pregnancy</td>
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<tr>
<td>Emotional wellbeing</td>
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Each PCT’s score is determined by its deviation from national average.

Rate of improvement over time relative to the national rate of improvement.

* Use of standard deviation from average methodology can occasionally lead to unusual distribution with none scoring zero or ten. This happens if the highest or lowest are not greater than 2.5 standard deviations from the UK average.
The assessment of outcomes will consider four areas:

- The fit of the outcomes with the strategic plan. This will include context, rationale and evidence to demonstrate how and why the outcomes reflect the strategic priorities of the PCT and its population and partners. In addition, it will include the alignment of goals and initiatives to drive improvements in the chosen outcomes.

- The PCT position on each of the metrics relative to national performance and other PCTs (e.g. ONS Cluster, ONS twin)

- Improvement over time relative to the national improvement rate

- Improvement against stretch targets, agreed locally between the PCT and the SHA (from 2009/10)

The panel report will include the outcomes scorecard and a narrative from the panel on the four areas outlined above.
The competencies element of the commissioning assurance system focuses on how far the PCT has developed towards world class in each of the world class commissioning competencies.

The 11 organisational competencies for world class commissioning were published in December 2007. Alongside the vision for world class commissioning, they set out the knowledge, skills, behaviours and characteristics expected of world class commissioners.

The competencies describe the commissioning processes 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.

Of the 11 commissioning competencies, the first ten are assessed within the competencies element of commissioning assurance. The eleventh competency, making sound financial investments, is assessed within the governance element.

For each of the ten competencies assessed by the ‘competencies’ assessment, there are three key indicators which will be used to assess them. These indicators reflect a summary of skills, processes and outputs, and focus on outputs where possible.
Each indicator will be assessed against a four point scale: level one, level two, level three, level four (where one is the first level and four is world class). Each of the levels for the competencies is measured on an additive basis. The PCT will therefore have to meet all of the criteria at level one to progress to level two, and will have met the criteria for levels one and two to progress to level three.

The full criteria for levels one to four on each indicator of the competencies can be found in the appendix. PCTs will use these criteria to assess themselves against each competency, and they will be used by the panel to determine the PCT’s final rating.
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 1st stop for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health matters.

**LEVEL 1**
- Does not meet Level 2 requirements

**LEVEL 2**
- Key stakeholders somewhat agree that the PCT is the local leader of the NHS
- The PCT has an understanding of its current and intended 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

**LEVEL 3**
- 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

**LEVEL 4**
- 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

Sample from appendices, page 75

An assessment of each competency will start with the self-assessment and associated commentary that a PCT will provide. A number of key documents will then be reviewed consistently by an SHA based analyst, along with metrics from national data sets and results from surveys including the feedback survey and public perception survey. The list of documents and data sources used is limited to those that will provide most value. This supporting evidence gathered for the competencies will be used to provide briefing to the panel in advance of the panel day, and will inform the panel about key areas of questioning or points of enquiry raised through analysis of the supporting evidence. The evidence collected is used to support the panel in identifying lines of questioning rather than to take a decision on the rating for a competency.
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 through a combination of review of the PCT self-assessment, review of evidence, and the interviews with the PCT Board at the panel review day.

An individual rating on the four point scale will be given for each competency and this will be reflected on the scorecard and in the panel report provided to the PCT. The rating for each competency will be an aggregated rating of the levels across the three key indicators.

The levels for each competency are challenging and reflect the aspirational nature of the overall world class commissioning programme. Given the journey that PCTs are on, the expectation is for the majority of PCTs to achieve levels one or two in the first year of commissioning assurance. Over time, as capabilities improve, commissioning assurance will respond by reviewing the criteria for each of the levels and adjusting and raising them as appropriate to ensure continuous improvement.

<table>
<thead>
<tr>
<th>Documents</th>
<th>Metrics</th>
<th>Surveys</th>
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<tbody>
<tr>
<td>Reputation as the 'local leader of the NHS'</td>
<td>Media evaluation (nationally consistent methodology)</td>
<td>Feedback survey, “We recognise the PCT as the local leader of the NHS”</td>
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<tr>
<td>Reputation as a change leader for local organisations</td>
<td></td>
<td>Public perception survey, “My local NHS is improving services for people like me”</td>
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<tr>
<td>Position as an employer of choice</td>
<td>Vacancy days per year</td>
<td>Feedback survey, “The PCT has a significant influence on our decisions and actions”</td>
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<tr>
<td></td>
<td>Staff retention and turnover rates</td>
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<td>Staff sickness rate</td>
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<td></td>
<td>% of bank, agency, temporary or contract workers</td>
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<td></td>
<td></td>
<td>Staff survey; Q7 – Personal development plans; Q14 – Intentions to leave; Q15 – Job satisfaction</td>
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Sample from appendices, page 85
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 commissioning assurance 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 plan, financial, organisation development and annual operating plans, as well as Board controls and processes. Governance 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.

For the purpose of this process, three components of governance will be considered: Strategy, Finance and Board.

Governance will be rated using a traffic-light system, green – amber – red, where green indicates no concerns and red indicates serious concerns. The assumption will be that PCTs are green unless there is evidence or cause for concern. The individual ratings for each of the three components of governance (strategy, finance and Board) will appear on the scorecard and in the panel report.
Strategy

PCTs are required to produce robust and high quality strategic plans for their organisations reflecting their priorities over a five year timescale. These plans will be refreshed annually and rewritten every three years. Strategic plans are required by the end of October and are at the core of the business of the PCT, and as a result, at the core of commissioning assurance.

Strategic plans will be underpinned by a five year financial plan, an organisational development plan and an annual operating plan. Further guidance and templates to support PCTs in their strategic planning is available at www.dh.gov.uk/worldclasscommissioning
The strategy component of governance will undertake a detailed review of the strategic plan focusing on the vision, goals and initiatives included and whether these reflect the priorities of the PCT as agreed with its population and partners. In particular, the following areas will be considered:

- **Vision and objectives:** The PCT should have a clear vision that is supported by strategic objectives or goals that drive towards delivery of improved health outcomes for their population. The vision should be a concise description of the changes the PCT is trying to achieve in the medium to long term. In addition, there should be an explanation of how these changes address the local population’s health needs and how they are informed by the local and national context.

- **Initiatives to ensure delivery of strategic objectives:** The initiatives should support delivery of the strategic objectives, and in turn the PCT vision. There should be a clear description of the impact on health outcomes and inequalities, with a timeline for this impact. The impact on activity and finance should also be outlined, as well as any investment or disinvestment requirements that will support delivery of the initiatives.

- **Consistency of financial plan with the strategy:** Underpinning the strategic plan, there should be a robust and consistent five year financial plan that demonstrates how the PCT is investing to improve health outcomes. Activity and financial forecasts should reflect the initiatives outlined in the strategic plan and the anticipated impact that they will have.

- **Board challenge and ownership of the strategic plan:** The strategic plan will outline the core focus of the PCT for the next five years and the changes it hopes to achieve for its population. It is therefore at the heart of the local health agenda and central to the PCT as an organisation. The Board needs to be actively involved in ensuring the vision is appropriate for the PCT, that the priorities focus on the appropriate areas for the local population and that the initiatives will ensure delivery of the vision. The Board should review and challenge the strategy at regular intervals before signing off the final document.

- **Achievement of milestones to date:** The PCT’s ability to successfully implement initiatives and its monitoring and achievement of interim milestones will provide insight as to whether the PCT is likely to achieve its strategic objectives and ultimately its vision.

The ratings will be informed by the output of the review of the strategic plan. For example, a PCT that has a strategic plan which outlines a vision that is consistent with both the findings from its Joint Strategic Needs Assessment and the context of its population, and that is supported by initiatives that will ensure tangible change in health outcomes, and that is consistent with its financial plan will be rated as ‘Green’.
Finance

The finance assessment will consider three factors: the sustainability of the PCT’s financial position, the quality of its ongoing financial management and the accuracy of its planning and projections.

- **Sustainable financial position:** The PCT will be expected to maintain a sustainable financial position. This will be determined by reviewing both the in year and the underlying financial position reported across each of the five years of the financial plan.

- **Ongoing financial management:** The finance assessment will consider how closely the PCT has performed against its plan in the previous year and will assess the scale of any variance between key plan parameters and the previous year’s actuals.

- **Accuracy of planning:** The PCT’s financial projections, with anticipated surpluses over the five year financial planning period will be reviewed. Financial assumptions and key spend categories will be benchmarked against national and regional finances in order to test the credibility of the projections.

The five year financial plans supporting the strategic plan will be used as the core source of information for the assessment.

If it is deemed that a PCT’s financial plan sets out a sustainable financial position, and that the PCT’s variance against the previous year’s actuals on key parameters is within a realistic range and its future projections are appropriate, then the PCT will be rated as ‘Green’.
Board

The principal 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 both the NHS and their local population for how they oversee investment and manage performance to drive better health outcomes. The overriding objective of the Board assessment is to understand the Board’s grip on the organisation and their ownership and control of the commissioning agenda. In particular, the following components will be considered:

- Board interaction: the Board’s alignment on the priorities of the PCT
- Organisation: the appropriateness of the organisation’s structure, capability and culture
- Processes: performance, risk and information management, as well as management of delegated authority.

PCT Boards will be responsible for providing a self-certification on each of these areas. This is intended to ensure that the Board reflects on these three components.

For each of the statements in the self-certification, the analyst and panel will review supporting evidence to verify whether or not the Board statement is appropriate. This will include a review of the PCT’s track record of performance, e.g. achievement of key operational targets, (including 18 weeks), and the ratings of other regulatory groups, e.g. the Audit Commission’s ALE score and use of resources.

SHA insights will be considered, particularly where the SHA has conducted a Board diagnostic, or observed the Board in practice, to support assessment of the functionality of the Board. On the panel day itself the Board, non-executives and the executive team, will be interviewed. In addition the Chair and the Chief Executive will be interviewed by the full panel separately. Both of these elements on the panel day will drive insights on the functioning and alignment of the Board as a group.

A PCT may be rated amber if, in its Board statements, it is unable to self-certify in areas for which self-certification is required, or if it is deemed that evidence and other regulatory assessments raise cause for concern. Where there is significant difference between the PCT’s self-certification and the evidence, the PCT’s basis for self-certification will be explored in more detail.
**Potential for improvement**

In addition to the PCT’s ratings for outcomes, competencies and governance, as described above, the final scorecard will include 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.

This commentary has two purposes: first, it describes the stage the PCT has reached on its journey towards world class and the anticipated speed and direction of future development; secondly, it gives initial advice on organisational development to accelerate the current pace of development.

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 below baseline ratings on outcomes and competencies, and an amber rating for governance, but one could be improving rapidly, while the other is unchanged since the previous year. To assess this in a way that is valuable for the PCT, the assessment panel will look at both past performance and likely future performance.

The advice on organisational development is intended to begin the ongoing development discussion between PCTs and SHAs. This section is designed to use the external perspective offered by the panel members to help SHAs to guide each PCT according to its needs. Unlike the Local Government assessment of ‘Potential for Improvement’, the commissioning assurance process for PCTs will not provide a rating. This is to ensure focus on development.

The potential for improvement commentary is based on the panel’s collective assessment of the PCT’s status, direction and organisational health over the course of the day. The final commentary will be agreed by both the PCT and the SHA before it is published as part of the final scorecard with the final decision on content being taken by the SHA (representing the panel).

The first section of the commentary will be 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 developmental element of ‘potential for improvement’ will differ from the other developmental advice given in the panel report. Where the advice given in the commentaries on outcomes, competencies and governance will focus on tactical actions in those specific areas, the potential for improvement commentary will focus on overall organisational development issues.
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 itself the following high-level questions:

- **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?

Each of these dimensions has a number of components, which together make up the nine components of potential for improvement.
Drawing on insights from the panel day discussions and the evidence collected for commissioning assurance, the panel will reflect on the PCT’s organisational health against each of these components. The panel’s conclusions will be used to compose a commentary on the PCT’s ability to address its challenges and move towards world class commissioning. The commentary will include a brief rationale for the panel’s conclusions. From year two of commissioning assurance evidence of progress since the previous year will also be incorporated.

**EXAMPLE COMMENTARY**

**PCT trajectory**

Although the PCT scored an average of below level 2 on the competencies and has shown no recent improvement in health outcomes, the panel believes that it has significant potential to improve these indicators over the coming year. The recent appointment of a new management team, combined with an impressive level of detail in strategic plans, leads us to believe that the pace of organisational development seen over the past two months will accelerate in the period before the next assessment.

**Areas for organisational development**

Alignment across the PCT is impressive, especially given how recently the management was appointed. However, challenges remain in the areas of execution and renewal. At many levels the PCT still lacks the skills and talent to support the execution of its strategy; the organisational development plan shows the scope of the challenge here. Rather than relying on current training programmes, as the organisation development plan suggests, the panel would advise the PCT to widen its recruitment pool and investigate the underlying reasons for the low levels of motivation noted in the commissioning staff survey recently carried out locally. In the area of renewal, the feedback survey results suggested a continued tendency not to view partners as an extension of the PCT’s own systems; this was also evident during the Board interviews on the panel day.

The commentary on the PCT’s potential for improvement should be seen as the beginning of an ongoing development conversation between the PCT and SHA. It should therefore strongly influence the post-assessment follow-up by the SHA and the PCT’s own actions. It may also need to initiate formal intervention by the SHA in line with the NHS Performance Regime.
The commissioning assurance process has five stages – PCT preparation, panel preparation, panel day, calibration and follow up. This section goes through each of these stages describing what it is, who should complete it and how this should be done. In addition there are examples and descriptions of how to use the tools and templates in the assurance toolkit which can be found at www.dh.gov.uk/worldclasscommissioning
Commissioning assurance has five stages.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCT PREPARATION</strong></td>
<td><strong>PANEL PREPARATION</strong></td>
<td><strong>PANEL DAY</strong></td>
<td><strong>CALIBRATION</strong></td>
<td><strong>FOLLOW UP</strong></td>
</tr>
<tr>
<td>■ Choose outcomes</td>
<td>■ Collate and review documents, metrics, surveys</td>
<td>■ Conduct panel day</td>
<td>■ Confirm ratings are consistent</td>
<td>■ PCT should finalise</td>
</tr>
<tr>
<td>■ Select stakeholders to complete feedback survey</td>
<td>■ Complete panel briefing</td>
<td>■ Provide feedback</td>
<td>– Regionally</td>
<td>– Development plan</td>
</tr>
<tr>
<td>■ Complete self-assessment on competencies</td>
<td></td>
<td></td>
<td></td>
<td>■ PCT and SHA agree actions</td>
</tr>
<tr>
<td>■ Complete self-certification for governance</td>
<td></td>
<td></td>
<td></td>
<td>■ SHA should confirm incentives and interventions to administer</td>
</tr>
<tr>
<td>■ Submit documents</td>
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</table>

Commissioning assurance has five stages.
world class commissioning assurance toolkit

All the materials required by PCTs, SHAs and panels can be found as part of the assurance toolkit, available electronically at www.dh.gov.uk/worldclasscommissioning. All documents required should be submitted via the website.

1. PCTs and SHAs will each receive unique log-in details for their organisation to ensure confidential upload and download of assessment materials.

2. Contains sections for each of the steps of the commissioning assurance process.

3. Contains guidance and templates to support the creation of PCT strategic plan, supporting five year financial plans and organisation development plan.

4. Once logged on, your organisation name will appear on the top of the page.
PCTs will prepare for the panel day in two ways. First, they will reflect on their starting point and provide the panel with a reflection on where they believe they are today. This will involve both self-assessment across the commissioning competencies and a Board self-certification to support the governance assessment. Secondly, they will provide core documents so that analysts can apply a consistent assessment methodology across PCTs.
Self-assessment and self-certification are important components of the world class commissioning process and give PCTs an opportunity to articulate their perception of their current state. The PCT’s self-assessment and self-certification will be set alongside the results of the evidence gathering and data analysis to provide the input to the panel day. Areas in which the self-assessment and self-certification 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.
Choosing local outcomes
The outcomes assessment measures PCTs on two national and up to eight locally-chosen health outcomes. The locally-chosen outcomes allow PCTs to reflect local health priorities. PCTs provide this information during the assessment process so that SHA based analysts can collate data on these outcomes for comparison purposes.

who?

Who chooses the local outcomes?
PCTs will choose outcomes that are reflected in their strategic plan and that have been agreed with their partners, including public and patients, community partners and clinicians. The local outcomes should be chosen by the PCT Board.

how?

How are they chosen?
The Board should choose the outcomes to reflect the health needs of the population and the priorities identified and targeted in the strategic plan. A list of outcomes from which to choose is provided in the assurance toolkit. The PCT should use the online tool to submit their choices to the SHA. Where the list does not provide an appropriate metric to reflect the PCT strategic priorities, PCTs are encouraged to provide their own metrics. In these circumstances the PCT will also be required to supply a robust data set against which their performance can be measured.
PCTs should indicate up to eight metrics they feel most accurately reflect their strategic plan priorities.

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

The definition for each metric is provided. All metrics are sourced from national data sets.
The PCT feedback survey

The PCT feedback survey allows local stakeholders to provide 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 on 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 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 (Competency 3)
- The PCT proactively engages my organisation to inform and drive strategic planning and service design (Competency 2)
- The PCT proactively engages clinicians to inform and drive strategic planning and service design (Competency 4)

Completing the list of stakeholders for the survey allows PCTs to ensure that the feedback survey is sent to the most appropriate and relevant organisations.
who?

Who selects the stakeholders?
The local stakeholders should be chosen by the PCT Board with the input of relevant staff.

how?

How should the stakeholders be selected?
Using the form on the assurance toolkit, PCTs should nominate and provide email addresses for survey respondents. The individual nominated to complete the survey for each stakeholder organisation should be the Chief Executive, or leader of the organisation. The survey will require this individual to provide the organisation’s perspective on the PCT.

The PCT should provide one to three stakeholders from each of the categories within the following three groups:

- **Partners:** Strategic Health Authority, Specialist Commissioning Group, Practice Based Commissioning Consortia, Overview and Scrutiny Committee, Clinical networks, LINks (or PPI forum), voluntary organisations, 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
The toolkit will send a survey directly to each of these respondents. Respondents will be able to opt out of answering any questions they do not feel sufficiently well informed to answer. The results will be automatically collated online, and provided to an SHA analyst for further analysis to support assessment of the competencies. Survey results will not be weighted by participant. The analyst may contact survey respondents to follow up and provide greater depth to support the comments made in the feedback survey.
Input the organisation, name and email address for each individual to whom the survey should be sent.

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

PCTs can provide up to three additional names for each provider, partner and local opinion former.
Self-assessment
The aim of self-assessment is to encourage PCTs to reflect on their starting point before the commissioning assurance assessment, resulting in greater ownership of the process and a more productive developmental dialogue with the panel. PCTs will be asked to assess themselves against the competency measures.

It is important that PCTs try to give an accurate reflection of the current organisation in the self-assessment. This will ensure that the panel day focuses on giving valuable advice to PCTs rather than telling them what they already know.

who?
Who should carry out the self-assessment?
The self-assessment should be agreed by the full PCT Board. It is recommended that the Board should engage relevant staff in the process to ensure that the assessment is as accurate as possible.

how?
How should the self-assessment be done?
Each PCT should assess itself against each of the three indicators in the competency measures (thirty indicators in total) rating the organisation at level one, two, three or four (four is the highest). The PCT will rate itself against the same criteria later used by the analyst and panel.
The template for the self-assessment is an online tool in the toolkit, in the PCT preparation section of commissioning assurance. In order to complete this, PCTs should review the descriptions of each competency and the different levels. The descriptions can be seen by clicking on the ‘show measure descriptions’ button on the self-assessment questionnaire webpage.

When filling in the self-assessment, PCTs have the opportunity to provide up to three supporting points or examples (up to 300 words for each point) which they have taken into account when assessing themselves. This gives PCTs the opportunity to make the panel aware of initiatives or examples which do not appear in the other documents they have submitted to the panel. The panel may investigate these examples further during the panel day.

The full list of competencies and the criteria used to assess them appears in the appendix.

1. Your PCT name should appear at the top of the form
2. For the three indicators for each competency, PCTs need to provide a self-assessment of where they are today - level one to four
3. PCTs should provide a commentary of up to 300 words for each competency
4. PCTs can access the description of each level by clicking ‘show measure descriptions’
Self-certification

Self-certification forms part of the assessment of governance, and specifically Board control. Like self-assessment of the competency measures, self-certification of governance is intended to encourage PCTs to reflect on their current situation. The high-level questions which the panel aims to answer are:

- Is the Board aligned across the key priorities for the PCT?
- Is the PCT developing talent and capabilities to support organisation development?
- Does the PCT have controls in place to know what is going on?

The PCT Board is asked to consider its capabilities in three areas: Board interaction, organisation and process.

- Board interaction addresses alignment and effective working
- Organisation addresses structure, capability and culture
- Process addresses performance, risk, IT and delegation.

Evidence will be used by the analyst to confirm whether or not there are any concerns against each of the statements the Board has provided as self-certification. PCTs should focus on providing an accurate reflection and are therefore encouraged to highlight any statements for which they are unable to provide a self-certification and a rationale for not doing so.

Who?

Who should agree the self-certification?
The self-assessment should be agreed by the full PCT Board. It is recommended that the Board should engage relevant staff in the process to ensure that the assessment is as accurate as possible.
How should the self-certification be carried out?
The PCT Board should download the self-certification form from the assurance toolkit and complete it. This should provide an opportunity for reflection on the core requirements of a PCT Board and should be discussed by the full Board and executive team as appropriate. The Chief Executive and Chair are required to confirm each of the statements, and to sign the self-certification. This should then be uploaded to the website as a PDF file. The full self-certification form appears in the appendix.

1. The Board should reflect on each of the statements and consider whether they are true of their PCT.

2. The commentary box allows PCTs to provide information on statements that it feels unable to self certify and / or information about their PCT as appropriate that provides further background for the panel.

Board self certification

<table>
<thead>
<tr>
<th>BOARD INTERACTION</th>
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</thead>
<tbody>
<tr>
<td>– The Board and the wider PCT executive team are aligned on the execution, talent management, performance, and governance</td>
</tr>
<tr>
<td>– The Board helps shape and challenge the PCT’s strategy</td>
</tr>
<tr>
<td>– The Board divides its time appropriately between strategic and operational matters</td>
</tr>
<tr>
<td>– Board members constructively challenge each other to ensure the PCT is focused on doing the right things</td>
</tr>
<tr>
<td>– Board members work together effectively, and stay connected by monitoring the progress of the PCT’s strategy</td>
</tr>
</tbody>
</table>

Comments box
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 the commissioning assurance domains - outcomes, competencies and governance.

who?
Who should select the documents?
The majority of the documents for submission are mandatory. Where there are options (e.g., when selecting which provider contracts to submit) the documents should be chosen by the relevant staff and confirmed by the PCT Board.

how?
How should the documents be submitted?
The assurance toolkit’s preparation section contains a facility for PCTs to upload evidence documents. The list 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 restricted in order to avoid placing a heavy burden on PCTs and to focus the evidence requirements on those documents that provide the greatest level of insight.
The documents defined for submission are:

- **Strategic plan** – a five year plan containing the PCT strategic goals and initiatives to achieve them.
- **Financial plan** – the five year financial plan that supports the strategic plan and outlines the impact of initiatives on finance and activity.
- **Organisational development plan** – a live document and therefore the plan that PCTs are currently implementing. It is expected that this plan will be revised following the panel assessment.
- **Annual operating plan** – the plan for the current year, i.e. the year which the PCT is part-way through.
- **Local Area Agreement** – as agreed at the beginning of the summer with the PCT’s Local Authority(ies).
- **Joint Strategic Needs Assessment** – the examination of aggregated assessment of need as conducted with the Local Authority(ies) and used to provide context to inform the strategic plan.
- **Communication strategy** – a live document and therefore the plan that the PCT is currently implementing.
- **PBC governance arrangements** – the document outlining the governance arrangements between the PCT and its PBC consortia.
- **Provider contracts (3 examples)** – the contracts held with providers. Ideally the examples should provide an illustration of the breadth of the contracts used, from major acute to community care. The appendices are the critical component as, for example, the key performance indicators outlined will inform assessment of the competencies.
- **Pathway redesign (3 examples)** – a review of all aspects of a patient’s journey through the health system for a particular condition from the start of their journey until the finish. The documents should outline changes necessary to improve efficiency, safety, patient experience and patient outcomes for the condition and include the action plan to implement the changes. These can be historic initiatives that have been implemented, or current initiatives that are prior to or mid-way through implementation.
- **Provider performance report** – an example of a provider performance document used to support ongoing management discussions with providers, and containing information against key performance indicators.
Guidance showing the expected contents of strategic plans and organisation development plans is provided in the assurance toolkit. There is also a template for these two plans. Use of the financial template is mandatory. The other templates are optional unless your local SHA advises otherwise.

Documents should be submitted by the deadline set by the SHA (this will vary between SHAs). They should be uploaded to the preparation section of the toolkit. PCTs may upload draft documents as they work on them. When they submit their final version of each document they should tick the box confirming that this is the final version. A prompt email will be sent out if final versions of all required documents have not been received shortly before the SHA deadline.
All PCT documents can be uploaded through the 'documents' section of 'PCT preparation'.

Once uploaded, PCTs will be able to add new versions if required and view the date of upload.

Only the PCT and their SHA will be able to access the uploaded documents. PCTs will not be able to view other PCT documents.
The SHA will be responsible for collating and analysing the documents, 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 an analyst 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 analyst will be to support the panel before, during and after the panel review day. They will be part of the SHA, and are required to follow national guidance on how to support the panel as set out in the analyst guide. The analyst guide will contain the steps the analyst will take, national guidance on how to perform each step, and a consistent methodology for collating the insights gathered through evidence review into a panel briefing document.

The analyst does not provide absolute ratings on any of the assessment areas. The role of the panel briefing is to provide background information and insights to the panel in advance of the panel day to ensure the day focuses on areas appropriate for that PCT. The evidence will also be used to inform the panel’s assessment.
The evidence reviewed by the analyst will take three forms:

- **Documents**
- **Metrics**
- **Surveys**

**Documents**

The documents submitted by the PCT will inform assessment of all three elements of commissioning assurance: outcomes, competencies and governance. These will be analysed to assess the PCT’s consistency of planning and evidence of change. On rare occasions, the analyst may request additional follow-up data from the PCT if needed to support this analysis.

**Metrics**

Each of the PCT’s chosen outcomes metrics will be compared with SHA and national averages, and with the PCT’s previous year’s performance.

To support the competency and governance assessments, the analyst will use national data sets and the PCT’s financial submission to calculate metrics. These metrics will look at the PCT’s position relative to peers.

In addition, the analyst will review national metrics (available for 2008 in the SHA data packs) to identify those metrics for which the PCT is a particular outlier. These charts from the data packs will be added to the panel briefing and used to advise the panel on lines of questioning as appropriate.

**Surveys**

In addition to the PCT feedback survey, the analyst will use selected data from: the Public Perception Survey; the PBC Survey; the NHS Staff Survey; and the Patient Choice Survey.
Panel day

The panel day is the focal point in commissioning assurance. The panel has two functions. First, it performs an assessment of the PCT across outcomes, competencies and governance. Secondly, it provides developmental advice to PCTs to support ongoing improvement. The panel day will be challenging, but fair. It takes the form of a series of interviews designed to elicit a detailed understanding of the PCT’s current position and the ways in which the SHA can assist the PCT in its development.

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 world class commissioning. To ensure they 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.

PCT Board members should expect to be asked about their self-assessment and self-certification, as well as discussing the outcomes metrics selection and documents submitted. Discussion will cover outcomes, competencies and governance. Over the course of the day the panel will seek to surface important organisational issues which will feed into the developmental section of the commentary on ‘potential for improvement’. PCTs should expect to discuss some or all of the nine components of potential for improvement.
The review panel will have five mandatory members from a variety of backgrounds. It will be chaired by the SHA Director.

The review panel will consist of five individuals

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Director from the local SHA</td>
<td>• Provide oversight of the process and support identification of development requirements of the PCT for future follow up. Chair the day</td>
</tr>
<tr>
<td>2</td>
<td>PEC chair, or Medical Director from another PCT</td>
<td>• Provide challenge from a clinical perspective and ensure continued focus on outcomes and quality</td>
</tr>
<tr>
<td>3</td>
<td>Director of Adult Services or Director of Children’s Services from another PCT</td>
<td>• Provide local government expertise and partnership perspective</td>
</tr>
<tr>
<td>4</td>
<td>Executive Director from an international organisation or another industry</td>
<td>• Provide insight into international best practice</td>
</tr>
<tr>
<td>5</td>
<td>PCT Chief Executive from another SHA area</td>
<td>• Provide sense check from a PCT perspective</td>
</tr>
</tbody>
</table>

Some SHAs may wish to have additional representatives on the panel. Where this is the case the SHA should seek approval by following the assurance system’s change control procedures, described in the appendix.

All panel members will be able to ask questions and provide input throughout the panel review.
# How will the panel day be run?

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

## Introduction

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Who should be there from the PCT?</th>
<th>Comments / key content</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:15</td>
<td>‘Pitch on your patch’</td>
<td>PCT Board</td>
<td>• 15 minute presentation from Chief Executive outlining</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Background of the PCT</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>– Strategic objectives</td>
</tr>
<tr>
<td>09:45</td>
<td>Panel stock take</td>
<td></td>
<td>• Panel discuss presentation and agree key questions</td>
</tr>
</tbody>
</table>

## Interviews

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Who should be there from the PCT?</th>
<th>Comments / key content</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00</td>
<td>Outcomes</td>
<td></td>
<td>• Sub groups of the PCT Board as agreed with the SHA</td>
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<td></td>
<td></td>
<td></td>
<td>• Two parallel sessions with the panel interviewing members of the PCT Board across</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>the three elements of commissioning assurance</td>
</tr>
<tr>
<td>10:45</td>
<td>Competencies</td>
<td></td>
<td>• Panel review findings from interviews and agree key</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>themes and questions for the CE and Chair interviews</td>
</tr>
<tr>
<td>11:30</td>
<td>Governance</td>
<td></td>
<td>• Clarification on key themes from interviews – same</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>questions / topics for discussion for each</td>
</tr>
<tr>
<td>12:15</td>
<td>Panel stock take</td>
<td></td>
<td>• Panel stock take on content from morning and</td>
</tr>
<tr>
<td>13:00</td>
<td>Overview 1: CE and Panel</td>
<td></td>
<td>prepare feedback</td>
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<tr>
<td>13:30</td>
<td>Overview 2: Chair and Panel</td>
<td></td>
<td>• Panel feedback overall impressions and</td>
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<td></td>
<td></td>
<td></td>
<td>recommendations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• PCT opportunity to learn from the panel on key</td>
</tr>
<tr>
<td>14:00</td>
<td></td>
<td></td>
<td>questions /challenges they would like to discuss</td>
</tr>
</tbody>
</table>

## Feedback

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Who should be there from the PCT?</th>
<th>Comments / key content</th>
</tr>
</thead>
<tbody>
<tr>
<td>14:00</td>
<td>Panel stock take</td>
<td></td>
<td>• Panel feedback overall impressions and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>recommendations</td>
</tr>
<tr>
<td>15:00</td>
<td>Feedback and Q&amp;A</td>
<td>PCT Board</td>
<td>• PCT opportunity to learn from the panel on key</td>
</tr>
<tr>
<td>16:30</td>
<td></td>
<td></td>
<td>questions /challenges they would like to discuss</td>
</tr>
</tbody>
</table>
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 15 minute presentation, covering the background of the PCT, its strategic objectives and key development gaps or challenges. Following this presentation the panel will agree key questions to ask over the course of the day.

The majority of the day involves interviews 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. The sample agenda provides an example. These interviews will focus on both the areas highlighted in the panel briefing, and on questions arising from the opening presentation. Following the interviews, the panel will discuss their impressions, before clarifying key themes in separate 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.

It is recommended that the panel day be held at the PCT. PCTs should ensure that the relevant people have time reserved in their diaries to meet the review panel and that a number of suitable rooms are booked for the day.

**Who will attend the panel day?**
The panel day should be attended by the PCT Board, including non-executive directors and the executive team, and other individuals that the PCT considers appropriate.
What is the output of the panel day?
The output of the panel day will be a completed summary scorecard and a panel report, both sent to the PCT. Taken together, these will form the basis of follow-up conversations between the PCT and SHA to determine ongoing dialogue, management and the application of relevant incentives and interventions for the PCT.

The summary scorecard will cover the three areas of outcomes, competencies and governance, and also include the agreed commentary on the PCT’s potential for improvement. A sample summary scorecard is shown here:
The panel report will provide further detail on the areas covered by the summary scorecard. The contents of the panel report will be:

- **Summary**: summary of the report including immediate tactical actions to be implemented by the PCT and developmental advice for consideration.
- **Outcomes**: full outcomes scorecard, with a commentary on the PCT’s choice of outcomes and degree of success in improving them.
- **Competencies**: rating given to the PCT on each indicator of each of the ten competencies with deviations from the self-assessment clearly marked. 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**: rating given to the PCT in each of the three areas of governance (strategy, finance and Board), with commentary on the panel’s rationale for each rating.
- **Potential for improvement**: more detailed version of the ‘potential for improvement’ commentary to that on the scorecard, focusing particularly on the evidence underlying the panel’s conclusions.
Before ratings on outcomes, competencies and governance are published, they will be regionally and nationally calibrated. This will ensure that standards and rating levels are consistent across the country. The ‘potential for improvement’ commentary will not be formally calibrated, but will be considered in the national review. The text of the commentary will be agreed between the PCT and SHA before publication of the scorecards.
When will the results be available?

Following regional calibration the SHAs will make the provisional ratings and scorecard available to PCTs along with the panel report. The ‘potential for improvement’ commentary should be agreed by this point and appear in its final form on the scorecard. PCTs should be aware that ratings will not be considered final until after the completion of national calibration. Ratings will only be published following national calibration and only from 2010.

At the SHA’s discretion, ratings may be revised between annual assessments. However, revised ratings will not be published nationally.
Follow-up

1. PCT Preparation
2. Panel Preparation
3. Panel Day
4. Calibration
5. Follow Up

- PCT should finalise
  - Strategic plan
  - Development plan
- PCT and SHA agree actions
- SHA should confirm incentives and interventions to administer

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

Following the panel day, the PCT will revise its strategic plan to take account of the panel discussion and recommendations. This may also have an impact on any underpinning plans where updates will also need to be reflected. The final strategic plan will then be resubmitted to the SHA for final sign off. Exact timescales will be agreed locally with the SHA.

In addition, PCTs 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. This may include access to incentives for improving PCTs or application of interventions to underperforming PCTs.

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

**PCT-led follow up**

- Revise strategic plan and submit to SHA for final sign off
- Revise organisational development plan and agree actions with SHA
- Seek out resources to support development
- Align with in-year performance management cycle

**SHA-led follow up:**

- Agree potential for improvement commentary with PCT
- Sign off final strategic plans
- Agree revised organisational development plans and actions to take
- Support PCTs to access resources for their development
- Align with in-year performance management cycle
- Consider and apply incentives and interventions in line with the requirements set out in the NHS Performance Regime
At the upper end of performance, PCTs will be rewarded for improvement and achievement. This will focus on celebrating success and enhanced reputation at a national level. PCTs performing at the top level of success will achieve status as a World Class PCT and a package of complementary incentives which will be articulated further in the *NHS Next Stage Review*. 

Commissioning assurance is one nationally consistent system, managed locally by the SHAs.
For 2009/10, the upper end of performance, at which a PCT would become ‘world class’, will be:

- Improvement in all the locally-chosen health outcomes, with at least half of these showing above-average rates of improvement compared to the national average; and,
- Level three in all the competencies, with at least half of the competencies also rated at level four; and,
- Green in all three areas of governance; and,
- An overall positive commentary on potential for improvement

At the lower end, where there is cause for concern about the commissioning performance of PCTs, interventions may need to be applied by the SHA as described in our vision for Developing the NHS Performance Regime.

In taking this forward, we will work with colleagues in the service to develop a ‘performance framework’ for SHAs, as performance managers of PCTs, for implementation under the 2009/10 Operating Framework. The performance framework will complement the commissioning assurance process and will include criteria-based thresholds for intervention to address underperformance.

Where a PCT fails to address serious or persistent underperformance over time, the organisation may be publicly designated as ‘challenged’ and subject to intervention at Board-level, aimed initially at supporting recovery.

For further details, see Developing the NHS Performance Regime (Department of Health; June 2008).
The performance framework will complement the commissioning assurance process and will include criteria-based thresholds for intervention to address underperformance.
appendices

I. timeline template
II. outcomes measures
III. document checklist for PCTs
IV. competencies
   - indicators and criteria for each level
V. competencies
   - supporting evidence
VI. feedback survey respondents form
VII. feedback survey
VIII. governance
   – Board self-certification
IX. change control process
## I. Timeline template

SHAs will need to communicate the deadlines for each step of the process to their PCTs

<table>
<thead>
<tr>
<th>PCT preparation</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Choose outcomes</td>
<td></td>
</tr>
<tr>
<td>• Select stakeholders to complete feedback survey</td>
<td></td>
</tr>
<tr>
<td>Surveys will be sent to stakeholders the next working day, with 2 weeks for completion</td>
<td></td>
</tr>
<tr>
<td>Respondents will be sent reminder emails if they have not completed the survey 3 days before the completion date</td>
<td></td>
</tr>
<tr>
<td>• Complete self-assessment on competencies</td>
<td></td>
</tr>
<tr>
<td>• Complete self-certification for governance</td>
<td></td>
</tr>
<tr>
<td>• Submit documents</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Panel preparation</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Panel briefing circulated to panel</td>
<td></td>
</tr>
<tr>
<td>At least 5 working days before panel day</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Panel day</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Panel dates</td>
<td></td>
</tr>
<tr>
<td>Four PCT panel days per week</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calibration</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Regional calibration</td>
<td></td>
</tr>
<tr>
<td>• Initial report sent to PCTs</td>
<td></td>
</tr>
<tr>
<td>• National calibration</td>
<td></td>
</tr>
<tr>
<td>• Final scorecards sent to PCTs</td>
<td></td>
</tr>
</tbody>
</table>
## II. Outcomes measures

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. The local outcomes should be chosen by the PCT board.

### Instructions
1. Select measures from the list by typing 1 to 8 next to metrics you would like to include in your list. Only 8 measures in total can be chosen.
2. To submit the form, go to the toolbar, and click on "Data / Lists / Synchronise List". Then click on "Save" to submit the list and close the window.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Selection</th>
<th>Metric definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For all PCTs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health inequalities</td>
<td>ALL PCTs</td>
<td>Average IMD (deprivation index) score</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>ALL PCTs</td>
<td>Life expectancy at time of birth, Years</td>
</tr>
<tr>
<td><strong>Birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Infant mortality</td>
<td></td>
<td>Mortality rate per 1,000 live births, under one years old</td>
</tr>
<tr>
<td>2 Caesarean section</td>
<td></td>
<td>Percentage of live births delivered by caesarean section</td>
</tr>
<tr>
<td>3 Low birth weight: Births under 2500 grams</td>
<td></td>
<td>Number of live and still births where babies have weighed less than 2500 grams</td>
</tr>
<tr>
<td>4 Under 18 conception rate</td>
<td></td>
<td>Teenage conception rate per 1000 females, aged 15-17</td>
</tr>
<tr>
<td>5 Infants breastfed</td>
<td></td>
<td>Percentage of infants breastfed at 6-8 weeks</td>
</tr>
<tr>
<td>6 Smoking during pregnancy</td>
<td></td>
<td>Actual percentage of women known to be smokers at the time of delivery</td>
</tr>
<tr>
<td>7 Downs syndrome screening</td>
<td></td>
<td>Percentage of parents who chose to have Downs Syndrome screening</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Hospital admissions caused by unintended and deliberate injuries</td>
<td></td>
<td>Proportion of deliberate or unintended injuries to children or young people (per 10,000 aged under 19)</td>
</tr>
<tr>
<td>9 Proportion of children who complete MMR immunisation by 2nd Birthday</td>
<td></td>
<td>Proportion of children aged 2 who complete immunisation for Measles, Mumps and Rubella (MMR)</td>
</tr>
<tr>
<td>10 Proportion of children who complete MMR immunisation (1st and 2nd dose) by their 5th Birthday</td>
<td></td>
<td>Proportion of children aged 5 who complete immunisation for MMR (1st and 2nd doses)</td>
</tr>
<tr>
<td>11 Proportion of children who complete DTP immunisation by their 5th Birthday</td>
<td></td>
<td>Proportion of children aged 5 who complete immunisation for Diptheria, Polo, Tetanus (DTP)</td>
</tr>
<tr>
<td><strong>Staying Healthy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Life expectancy: Males</td>
<td></td>
<td>Life expectancy at time of birth, Years</td>
</tr>
<tr>
<td>13 Life expectancy: Females</td>
<td></td>
<td>Life expectancy at time of birth, Years</td>
</tr>
<tr>
<td>14 Deaths from Chronic liver disease</td>
<td></td>
<td>Directly standardised rates from chronic liver disease, including cirrhosis (ICD-10 K70, K73-K74) per 100,000, all ages</td>
</tr>
<tr>
<td>15 HIV prevalence</td>
<td></td>
<td>Rate per 100,000 of Diagnosed HIV infected patients</td>
</tr>
<tr>
<td>16 Smoking quitters</td>
<td></td>
<td>Rate per 100,000 population aged 16 and over</td>
</tr>
<tr>
<td>17 Hypertension prevalence</td>
<td></td>
<td>Unadjusted hypertension prevalence</td>
</tr>
<tr>
<td>18 Uptake of pneumococcus vaccinations by over 65s</td>
<td></td>
<td>PPV Uptake in the 65 years and over and GP response rate by PCT for 2006/07 presented as total % uptake</td>
</tr>
<tr>
<td>19 Uptake of influenza vaccinations by over 65s</td>
<td></td>
<td>Percentage uptake of influenza vaccinations by over 65s</td>
</tr>
<tr>
<td>20 GUM access within 48 hours</td>
<td></td>
<td>% of all patients seen at a GUM clinic who were seen within 48 hours of contacting the service</td>
</tr>
<tr>
<td><strong>Planned Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Cancer mortality rate</td>
<td></td>
<td>Directly standardised rates from all malignant neoplasms (ICD-10 C00-C97) Premature mortality (under 75 years)</td>
</tr>
<tr>
<td>22 Proportion of women aged 53-64 offered screening for breast cancer</td>
<td></td>
<td>Coverage of women aged 53-64 by PCO (less than 3 years since last test)</td>
</tr>
<tr>
<td>23 Proportion of women aged 25-64 screened for cervical cancer</td>
<td></td>
<td>Coverage of women aged 25-64 (less than 3.5 years since last adequate test)</td>
</tr>
<tr>
<td>24 Percentage of patients first seen by a specialist within two weeks when urgently referred</td>
<td></td>
<td>Percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer</td>
</tr>
<tr>
<td>25 Proportion of patients waiting no more than 31 days for cancer treatment</td>
<td></td>
<td>Percentage of patients with diagnosis to treatment time less than or equals to one month</td>
</tr>
<tr>
<td>26 Percentage of patients receiving their first definitive treatment for cancer within two months of urgent referral for suspected cancer</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>27 Percentage of patients seen within 18 weeks for admitted pathways</td>
<td></td>
<td>RTT admitted pathways</td>
</tr>
<tr>
<td>28 Percentage of patients seen within 18 weeks for non-admitted pathways</td>
<td></td>
<td>RTT non admitted pathways</td>
</tr>
<tr>
<td>29 Self reported experience of patients &amp; users</td>
<td></td>
<td>Quality of care received</td>
</tr>
<tr>
<td>30 Patient and user reported measure of respect and dignity in their treatment</td>
<td></td>
<td>Percentage of patients who felt they were treated with respect and dignity while in the hospital</td>
</tr>
<tr>
<td>Metric</td>
<td>Selection</td>
<td>Metric definition</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>31 Mortality rate from causes considered amenable to healthcare</td>
<td></td>
<td>Directly age-standardised rates (DSR) per 100,000 European Standard population</td>
</tr>
<tr>
<td>32 Stroke deaths within 30 days</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>33 Percentage of stroke admissions given a brain scan within 24 hours</td>
<td></td>
<td>Percentage of stroke admissions given a brain scan within 24 hours</td>
</tr>
<tr>
<td>34 Percentage of stroke admissions given a physiotherapist assessment within 72 hours</td>
<td></td>
<td>Percentage of stroke admissions given a physiotherapist assessment within 72 hours</td>
</tr>
<tr>
<td>35 Delayed transfers of care</td>
<td></td>
<td>Percent of cases delayed of delayed transfer of care per 100,000 population (age 18 and over)</td>
</tr>
<tr>
<td>36 4-hour A&amp;E waiting time target</td>
<td></td>
<td>Percentage of patients who spent less than 4 hours in A&amp;E</td>
</tr>
<tr>
<td>37 MRSA infection rate</td>
<td></td>
<td>MRSA rate per 10,000 bed days</td>
</tr>
<tr>
<td>38 Clostridium Difficile infection rate</td>
<td></td>
<td>Clostridium difficile rate per 1000 for patients aged over 65 years</td>
</tr>
<tr>
<td>39 Suicide &amp; Injury Undetermined Intent Mortality Rate</td>
<td></td>
<td>Directly standardised rates per 100,000 European standard population from intentional self-harm and injury undetermined whether accidentally or purposely inflicted (ICD-10 X60-X84, Y10-Y34 excl: Y33.9)</td>
</tr>
<tr>
<td>40 Drug treatment waiting times</td>
<td></td>
<td>Drug treatment average waiting times in weeks of all treatments eg. Rehab, GP specialist, outpatient etc.</td>
</tr>
<tr>
<td>41 Percent drug users recorded as being in effective treatment</td>
<td></td>
<td>Percent of drug misusers sustained in treatment</td>
</tr>
<tr>
<td>42 Rate of hospital admissions per 100,000 for alcohol related harm</td>
<td></td>
<td>Rate of alcohol-related admissions per 100,000 population (EASR)</td>
</tr>
<tr>
<td>43 Mortality rate per 100,000</td>
<td></td>
<td>Mortality from all ages and all causes presented as DSR per 100,000 European Standard population</td>
</tr>
<tr>
<td>44 COPD mortality</td>
<td></td>
<td>Directly standardised rates per 100,000 European standard population from bronchitis, emphysema and other chronic obstructive pulmonary disease (ICD10 J40-J44), all ages</td>
</tr>
<tr>
<td>45 Diabetes mortality</td>
<td></td>
<td>Directly standardised rates per 100,000 standard European population for diabetes (ICD-10 E10-E14), all ages</td>
</tr>
<tr>
<td>46 CVD mortality</td>
<td></td>
<td>Directly standardised rates per 100,000 standard European population for all CVD mortality, (ICD10 I00-I99). Premature mortality (under 75 years)</td>
</tr>
<tr>
<td>47 CHD mortality</td>
<td></td>
<td>Directly standardised rates per 100,000 standard European population for all CHD mortality, (ICD10 I20-I25), all ages</td>
</tr>
<tr>
<td>48 COPD prevalence</td>
<td></td>
<td>Percentage of all patients with COPD in a GP registered population</td>
</tr>
<tr>
<td>49 Diabetes controlled blood sugar</td>
<td></td>
<td>The percentage of patients with diabetes in who have an HbA1c of 7.5 or less</td>
</tr>
<tr>
<td>50 CHD controlled blood pressure</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>51 CHD controlled cholesterol</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>52 Percentage of people screened for diabetic retinopathy</td>
<td></td>
<td>Percentage of diabetics screened for diabetic retinopathy</td>
</tr>
<tr>
<td>53 Palliative care prevalence</td>
<td></td>
<td>Palliative care, unadjusted prevalence percent</td>
</tr>
<tr>
<td>54 Percentage of all deaths that occur at home</td>
<td></td>
<td>Percentage of all deaths that occur at home as reported by Primary Care Organisation</td>
</tr>
<tr>
<td>55 Other &lt;please specify&gt;</td>
<td></td>
<td>&lt;please provide definition&gt;</td>
</tr>
<tr>
<td>56 Other &lt;please specify&gt;</td>
<td></td>
<td>&lt;please provide definition&gt;</td>
</tr>
<tr>
<td>57 Other &lt;please specify&gt;</td>
<td></td>
<td>&lt;please provide definition&gt;</td>
</tr>
</tbody>
</table>
III. Document checklist for PCTs

- Strategic plan
- Five year financial plan
- Organisational development plan
- Annual operating plan
- Local Area Agreement
- Joint Strategic Needs Assessment
- Communication strategy
- PBC governance arrangements
- Provider contracts (3 examples)
- Pathway redesign (3 examples)
- Provider performance report
- Board self certification
IV. Competencies - indicators 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 1st stop for local political and community leaders. Through partnership, they seek and stimulate discussion on NHS and wider community health matters.

LEVEL 1
- Does not meet Level 2 requirements

LEVEL 2
- Key stakeholders somewhat agree that the PCT is the local leader of the NHS
- The PCT has an understanding of its current and intended 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

LEVEL 3
- 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

LEVEL 4
- 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

Reputation as the ‘local leader of the NHS’

Reputation as a change leader for local organisations

Position as an employer of choice

- Does not meet Level 2 requirements

- The PCT develops an employment offer to commissioning staff that is attractive to current and potential recruits, with clear training and support
- The PCT ensures ongoing environment supports employee satisfaction

- Does not meet Level 2 requirements

- The PCT creates meaningful commissioning training programmes to support staff development, attract new staff and increase the quality of the staff employed
- The PCT fosters an environment of ongoing employee development and excitement

- Does not meet Level 2 requirements

- The PCT is able to source and recruit high quality staff for all positions in commissioning
- PCT staff are motivated and satisfied with the roles that they adopt
COMPETENCY 2

Work collaboratively with community partners to commission services that optimise health gains and reduce health inequalities.

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, healthcare providers, third sector organisations and clinical partners such as practice based commissioners and specialist consortia. Working collaboratively with partners, PCTs will stimulate innovation, efficiency and better service design, increasing the impact of the services they commission to optimise health gains and reductions in health inequalities.

**LEVEL 1**
- Does not meet Level 2 requirements

**LEVEL 2**
- The PCT and the local authority agree in a timely way, on Local Area Agreement priorities
- Local Area Agreement targets directly address the needs highlighted in the JSNA
- The PCT and the Local Authority both independently accountable for Local Area Agreement targets

**LEVEL 3**
- The PCT and the local authority have worked with local strategic partners to agree Local Area Agreement priorities
- Local Area Agreement priorities are based on joint needs as assessed though the Joint Strategic Needs Assessment
- The PCT is clearly engaged in the Local Area Agreement negotiation and delivery

**LEVEL 4**
- The PCT creates joint accountability and clearly delegates roles with local partners for all key targets
- The PCT has developed a partnership way of working with active participation
- There is clear clinical and PBC leadership and engagement in the Local Area Agreement

**Creation of Local Area Agreement based on joint needs**
- Key stakeholders somewhat agree that the PCT proactively engages their organisation to inform and drive strategic planning and service design
- The PCT has worked with partners to produce a Joint Strategic Needs Assessment which identified the health needs of the population
- The role of the PCT in the Local Area Agreement and the delivery of targets partnership is effective
- Shared posts are in place where appropriate

**Ability to conduct constructive partnerships**
- Key stakeholders somewhat agree that the PCT proactively engages their organisation to inform and drive strategic planning and service design
- The PCT has set out clear milestones with partners, on key initiatives and has a track record of delivery
- The PCT works with PBC leads to agree commissioning plans

**Reputation as an active and effective partner**
- Key stakeholders somewhat agree that the PCT is an effective partner in delivering health objectives
- The PCT has clear success stories of delivery

**Key stakeholders strongly agree that the PCT is an effective partner in delivering health objectives**
- Multiple partnerships are in place across a broad range of settings to support health and wellbeing agenda
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 local population, PCTs will have to engage the public in a variety of ways, openly and honestly. They will need to be proactive in seeking out the views and experiences of the public, patients, their carers and other stakeholders, especially those least able to act as advocates for themselves.

### Level 1
- 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.
- The PCT can demonstrate how local engagement including regular 2-way dialogue with LiNKs or equivalent patient forums has influenced some aspects of commissioning.
- The PCT proactively disseminates information to the public and patients.
- The local population somewhat agree that the local NHS listens to the views of local people and acts in their interest.

### Level 2
- Does not meet Level 2 requirements
- The PCT has effective strategies for communicating with the local population.
- Key stakeholders somewhat agree that the PCT has pro-actively shaped the health opinions and aspirations of the local population.
- The PCT actively promotes independence, health, wellbeing, and personalisation of services.

### Level 3
- Key stakeholders agree that the PCT has pro-actively shaped the health opinions and aspirations of the local population.
- Clear evidence of successful opinions changing public health, e.g., through social marketing.

### Level 4
- Key stakeholders strongly agree that the PCT has pro-actively shaped the health opinions and aspirations of the local population.
- The PCT demonstrates that they know the impact of their involvement and engagement and know how effective it is through evaluation.
- The PCT formally involves patients and public in review of services.
- Information from patients and the public has a direct impact on quality and improvement.
- 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 local population strongly agree that the local NHS listens to the views of local people and acts in their interest.

The PCT demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions.

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**Influence on local health opinions and aspirations**

- Does not meet Level 2 requirements
- The PCT has effective strategies for communicating with the local population.
- Key stakeholders somewhat agree that the PCT has pro-actively shaped the health opinions and aspirations of the local population.
- The PCT actively promotes independence, health, wellbeing, and personalisation of services.

**Public and patient engagement**

- 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.
- The PCT can demonstrate how local engagement including regular 2-way dialogue with LiNKs or equivalent patient forums has influenced some aspects of commissioning.
- The PCT proactively disseminates information to the public and patients.
- The local population somewhat agree that the local NHS listens to the views of local people and acts in their interest.

**Improvement of patient experience**

- Does not meet Level 2 requirements
- The PCT actively reviews trends in patient feedback, including complaints, PALS and patient survey data sent to providers and initiates improvements as a result.
- The local population agrees that the NHS is helping to manage and improve the health and well being of the population.

The PCT carries out its own surveys and follows up on impact as required.
- The PCT demonstrates how patient feedback – survey data, patient complaints and PALS queries have driven commissioning decisions.

The PCT demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions.
Clinicians are best placed to advise and lead on issues 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, 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 methodology for this and should be maximised to drive innovative and transformational change.

**COMPETENCY 4**

*Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality, service design and resource utilisation*

Clinicians are best placed to advise and lead on issues 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, 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 methodology for this and should be maximised to drive innovative and transformational change.

**Clinical engagement**

- Does not meet Level 2 requirements
- The PCT can identify several non-PEC clinicians that have made substantive contributions to PCT strategy, planning and policy development
- Clinicians are regularly present and actively participate in PEC meetings
- The PCT seeks views of a broad range of clinical groups
- The PCT has delegated authority to clinicians as required to drive the agenda

**Dissemination of information to support clinical decision making**

- Does not meet Level 2 requirements
- Quality of care and quality information is regularly shared
- The PCT proactively solicits and disseminates status updates and quality improvement ideas from all clinicians on a regular basis
- The quality, format and frequency of information is perceived as appropriate by PBCs
- Quality reports include recent clinical evidence and benchmarks
- The PCT has taken steps to reduce unacceptable clinical variations
- Quality reports include recent clinical evidence, benchmarks, and changes in clinical practice
- The PCT can calculate PBC return on investment

**Reputation as leader of clinical engagement**

- Does not meet Level 2 requirements
- Key stakeholders slightly agree that the PCT pro-actively engages clinicians to inform and drive strategic planning and service design
- The PCT has a track record of implementing initiatives to redesign care
- Key stakeholders agree that the PCT pro-actively engages clinicians to inform and drive strategic planning and service design
- Key stakeholders strongly agree that the PCT pro-actively engages clinicians to inform and drive strategic planning and service design
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.

- LEVEL 1
  - Does not meet Level 2 requirements

- LEVEL 2
  - The PCT conducts regular needs assessments and can collect clear outputs and conclusions
  - A consistent methodology is used to identify gaps in care and drivers of performance
  - The PCT prioritises major health needs for its local population
  - JSNA assesses current and future needs, both met and unmet

- LEVEL 3
  - The PCT has a consistent and validated methodology for contributing to the JSNA
  - The PCT analyses progress towards reducing gaps and identifies the key causes of variance from expectations
  - The PCT has clear, robust segmentation of population by healthcare needs

- LEVEL 4
  - The PCT analyses the effectiveness of past interventions to drive tangible change for health needs
  - The PCT analyses progress and any gaps, identifies the key drivers of variance from expectations and develops solutions
  - The PCT has proactive population risk stratification in order to identify populations at risk and to intervene at the earliest possible point

Analytical skills and insights

- LEVEL 1
  - Does not meet Level 2 requirements

- LEVEL 2
  - 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 and clinicians to supplement JSNA findings

- LEVEL 3
  - 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

- LEVEL 4
  - 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
  - The PCT uses predictive modelling and analytical tools to discuss and describe trends in needs, create future projects and identify variants from expectations

Understanding of health needs trends

- LEVEL 1
  - Does not meet Level 2 requirements

- LEVEL 2
  - The PCT benchmarks itself against national targets and other PCTs on local health needs status
  - The PCT has developed plans to improve its performance on each benchmark
  - The PCT effectively disseminates reports – e.g., to providers and the public

- LEVEL 3
  - The PCT regularly benchmarks itself against national targets and other PCTs on local health needs status
  - The PCT has developed plans to improve its performance to meet stretch targets and benchmarks

- LEVEL 4
  - The PCT benchmarks itself continuously against similar populations, national and international targets on local health needs status, to create ambitious improvement trajectories
  - 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
  - The PCT has identified key health needs gaps

Use of health needs benchmarks
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 decisions, focused on the achievement of key clinical and other outcomes. This will include investment plans that address areas of greatest health inequality.

**LEVEL 1**
- Does not meet Level 2 requirements

**LEVEL 2**
- Across a range of analytical areas e.g. financial forecasts, activity, monitoring patient quality, the PCT demonstrates simple analysis of extremes including best and worst case outcomes scenarios
- PCT scenarios for predictive modelling are by disease area

**LEVEL 3**
- 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

**LEVEL 4**
- 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 full understanding of all relevant root causes, and linked with other public forecasts

**COMPETENCY 6**
**Prioritise investment according to local needs, service requirements and the values of the NHS**

**LEVEL 1**
- Does not meet Level 2 requirements

**LEVEL 2**
- The PCT has defined criteria for evaluating and prioritising investment including:
  - Local needs
  - Impact on health gain
  - Impact of interventions
- Prioritisation criteria is used to move from insights from public and patient, and intelligence from the joint strategic needs assessment and clinical evidence to strategic priorities
- The PCT Board consults with PCT clinicians, local GPs and key stakeholders when evaluating strategic initiatives
- Investment proposals contain predicted improvement in health outcomes and impacts on health inequality

**LEVEL 3**
- “Value” is linked directly to PCT’s key public health objectives, such as significant reductions in morbidity, or the elimination of health inequalities
- The PCT conducts an annual review of all spending so all investments are subject to full impact review
- The PCT actively monitors what has happened as a result of past investment

**LEVEL 4**
- The PCT understands the return on investment of past interventions and investments and compares this to best practice. This is used to inform future investment
- The PCT Board works with clinicians, local GPs, key stakeholders and the public to develop, implement and evaluate strategy

**Prioritisation of investment to improve population’s health**

**Incorporation of priorities into strategic investment plan**

**LEVEL 1**
- Does not meet Level 2 requirements

**LEVEL 2**
- Projects and initiatives are evaluated against prioritisation
- There is some alignment between identified gaps, current initiatives to address those gaps, and strategic investment plan
- Priorities include investment and disinvestment as appropriate

**LEVEL 3**
- There is clear and consistent alignment between identified gaps, current initiatives to address those gaps, and strategic investment plan
- The PCT, local authority and other stakeholders have identified clear responsibility for financing
- The PCT develops programme budgets demonstrating a whole system approach to investment
- Disinvestment priorities are articulated and delivered

**LEVEL 4**
- Projects and initiatives are evaluated against prioritisation with effective targeting of resources toward projects that offered the highest value for money
- Planning and budgeting cycles are aligned to facilitate coordination and joint financing arrangements
- Mature programme budgets for all key priority care pathways/disease groups with integrated investment plans of up to ~10 years are in place
- The PCT invests for longer-term health gain and can quantify impact
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 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.

### COMPETENCY 7
Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes

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<th>LEVEL 1</th>
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<tbody>
<tr>
<td>Does not meet Level 2 requirements</td>
<td>Does not meet Level 2 requirements</td>
<td>Does not meet Level 2 requirements</td>
<td>The PCT has identified cost and demand projections in each area of care and in each setting of care</td>
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</tbody>
</table>

- The PCT has analysed the market with the local authority and identified a full range of core providers for each specialty and level of care, including NHS providers, independent and third sector providers
- The PCT has conducted analysis to assess the relative cost and quality of providers to ensure services in place meet the needs of users
- The PCT uses patient feedback to gain a richer understanding of commissioned services

- The PCT uses demand projections, demand management assumptions and population need to project required capacity by specialty and matches this with provider capacity and adjusts spending accordingly (decommissioning as appropriate)
- The PCT has identified gaps in market supply and for risks in supply structure has mitigation plans

- The PCT indicates specific changes to provider capacity and addresses gaps in provision
- 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 takes demand projections and incorporates demand management assumptions from strategic plan (e.g., pathway redesign) to identify required capacity by provider type, by specialty and by care/patient pathway
- The PCT implements specific changes to provider capacity driven by needs modelling, including long-term structural changes, and forecasts based on actual risk analysis

- The PCT regularly reviews the healthcare provision marketplace and identifies potential providers
- The PCT has a strategy for creating more choice when specific services lack credible alternatives
- The PCT offers its patients choice of location, content, and style of services
- The PCT involves patients in creating the choice offer, particularly those with long term conditions

- The PCT uses patient experience data to develop specification of services and choices available
- The PCT has clear investment and disinvestment processes
- The PCT identifies a number of provider by disease area

- 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 tests the acceptability of the choice available with patients, on a regular basis
- The PCT has 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 and outcomes through clinical and provider innovation and configuration*

PCTs are the driver of a continually improving NHS. They seek innovation, knowledge and best practice, applying this locally to improve the quality and outcomes of commissioned services. In partnership with local clinicians, 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**

- **Identification of improvement opportunities**
  - Does not meet Level 2 requirements

**LEVEL 2**

- The PCT benchmarks their current performance against best practice utilising/regional and national definitions of best practice through the Next stages review and SHA clinical visions
- The PCT demonstrates some recent examples of clinical pathway improvement where a need has been identified
- The PCT has identified a process map listing the specific interventions that are required at each point in the pathway including prevention
- Patients are involved in pathway redesign
- PBCs contribute to improvement through service redesign proposals

**LEVEL 3**

- The PCT and providers review and agree clinical pathways and engage on opportunities for improvement and innovation
- For each pathway initiative, the PCT has outlined a ‘process map’ listing 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

**LEVEL 4**

- The PCT and providers regularly review and agree clinical pathways and engage on opportunities for improvement and innovation
- For each pathway initiative, the PCT has outlined
  - A ‘process map’ listing the specific interventions that are required at each point in the pathway and clear criteria for moving patients along the pathway
  - Clinical guidelines sourced from inter-national best practice
  - Plans to ensure smooth patient flow along the pathway and between different levels of care

**Milestones of clinical pathway change programmes are actively tracked**

- The PCT demonstrates actions on the basis of monitoring findings, e.g., prescribing choices and failures to collect alerted to GPs

**Collection of quality and outcome information**

- Does not meet Level 2 requirements

**LEVEL 2**

- There is clear identification of quality and outcome metrics to monitor
- Monitoring frequency and reporting arrangements with major providers occur at regular intervals

**LEVEL 3**

- Information provides sufficient detail to support identification of drivers of performance
- 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

**LEVEL 4**

- The PCT has developed strategies for monitoring the impacts of specific initiatives on clinical quality/outcomes
- Reporting arrangements process and transmit data directly to key decision-makers
- The PCT actively seeks out clinical evidence for comparison with international best practice
Secure procurement skills that ensure robust and viable contracts

Procurement and contracting processes ensure that agreements with providers 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 standards and outcomes and facilitate good working relationships with their providers, offering protection to service users and ensuring value for money.

**LEVEL 1**
- Understanding of providers economics
  - Does not meet Level 2 requirements
  - For all categories 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 considers patient experience data for each provider
    - Procurement strategy and recent procurement exercise shows compliance with Principles and Rules for Cooperation and Competition

**LEVEL 2**
- Negotiation of contracts around defined variables
  - Does not meet Level 2 requirements
  - There is clear identification of defined negotiation variables, e.g., cost, quality, clinical indicators, service targets
  - The PCT rigorously prepares for contract negotiations including
    - Establishing a service specification and price
    - Establishing the best alternative to a negotiated agreement (BATNA)
    - Defining a negotiation strategy
    - Defining negotiation team roles

**LEVEL 3**
- Creation of robust contracts based on outcomes
  - Does not meet Level 2 requirements
  - All elective and non-elective acute existing contracts include clearly specified outcomes and quality metrics, with a transparent arbitration process, including for ISTCs
  - All newly negotiated contracts are based on desired outcomes (i.e., the PCT’s strategic priorities) and service quality with defined performance improvement targets and improvements to patient pathways
  - All contracts agreed and signed by 1st April, or appropriate timescales in advance of activity commencing
  - Contracts have clearly defined break clauses, linking to quality variables where appropriate

**LEVEL 4**
- 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
- The PCT has a database on economics of existing providers and performs analyses on commissioned or in-house providers’ economics
- The PCT has data and insights about key providers e.g., benchmarking to understand causes of poor productivity or poor patient experience
- The PCT understands the cost impact of increasing activity volume through a provider and changing service specification
- The PCT also has an ongoing process for challenging and disseminating the fact base of providers

- The PCT explicitly uses negotiation variables
- The PCT works with providers to develop outcome based service specifications
- Negotiation has defined improvements in service quality and value for money
- Providers carry a significant proportion of risk to deliver on agreed improvements, e.g., demand management
- The PCT has a sophisticated approach for negotiating risk, including risk sharing where appropriate

- The PCT has taken a data-driven approach to secure the best placed providers (Principles and Rules for Cooperation and Competition, principle 1)
- Negotiation has successfully delivered changes to variables and significant improvements in service quality and value for money
- Negotiation of contracts delivers a positive position for both the PCT and providers, that reinforces strong strategic relationship with providers
- The PCT has a database on economics of existing providers and performs analyses on commissioned or in-house providers’ economics
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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, 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.

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<th>LEVEL 1</th>
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<tbody>
<tr>
<td><strong>Use of performance information</strong></td>
<td><strong>Implementation of regular provider performance discussions</strong></td>
<td><strong>Resolution of ongoing contractual issues</strong></td>
<td><strong>Does not meet Level 2 requirements</strong></td>
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<td>Does not meet Level 2 requirements</td>
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<tr>
<td>Data is accessible and used to monitor provider performance</td>
<td>Regular reports (at least monthly) addressing performance of major providers, acute care, primary and community care and social care for internal and external use</td>
<td>Contracts indicate when intervention is required</td>
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<tr>
<td>Data is collected and analysed at appropriate intervals</td>
<td>Regular performance improvement discussions</td>
<td>Contract terms are not breached without appropriate investigation and remedial action</td>
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<tr>
<td>Monthly data from providers is no more than one month old</td>
<td>Performance tracking for all providers, segmented by type</td>
<td>Contract compliance management with major providers</td>
<td></td>
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<tr>
<td>Data is shared with providers when requested</td>
<td>Real focus on uncovering root causes of issues jointly with providers that enables sustainable improvements</td>
<td>The PCT has pro-active contract compliance management with all major providers</td>
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<tr>
<td>Data collected supports key performance indicators defined in contracts</td>
<td></td>
<td>Actionable next steps for improvement are agreed, with assigned leads, time frames and milestones</td>
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<tr>
<td></td>
<td>Performance info is available for and accessible to the public where relevant</td>
<td>Improvement plans are actively monitored and tracked with strong record of delivery</td>
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<td></td>
<td>There is near real time monitoring on measures where the PCT could have influence and ensure actions to address problems as they arise</td>
<td>Required improvements are always delivered</td>
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<tr>
<td></td>
<td>The PCT obtains real time feedback from users on services</td>
<td>There is a track record of innovative and effective resolution of conflict</td>
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<tr>
<td></td>
<td>The PCT maintains a ‘live’ dashboard of information on key performance indicators, and ensures it is readily available to support performance management</td>
<td>The PCT has clear track record of not tolerating poor performance (from any type of provider), particularly in patient care, and acting swiftly to ensure change</td>
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<tr>
<td></td>
<td>Data is proactively discussed with providers</td>
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### V. Competencies - supporting evidence

<table>
<thead>
<tr>
<th>Documents</th>
<th>Metrics</th>
<th>Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Communication strategy</td>
<td>• Media evaluation (nationally consistent methodology)</td>
<td>• Feedback survey, “We recognise the PCT as the local leader of the NHS”</td>
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<tr>
<td></td>
<td></td>
<td>• Public perception survey, “My local NHS is improving services for people like me”</td>
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<tr>
<td></td>
<td></td>
<td>• Feedback survey, “The PCT has a significant influence on our decisions and actions”</td>
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<tr>
<td>• Reputation as the ‘local leader of the NHS’</td>
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<tr>
<td>• Reputation as a change leader for local organisations</td>
<td>• Vacancy days per year</td>
<td>• NHS Staff survey: Q7 – Personal development plans; Q14 – Intentions to leave; Q15 – Job satisfaction</td>
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<tr>
<td></td>
<td>• Staff retention and turnover rates</td>
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<td></td>
<td>• Staff sickness rate</td>
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<td></td>
<td>• % of bank, agency, temporary or contract workers</td>
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<tr>
<td>• Position as an employer of choice</td>
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<tr>
<td>• Creation of Local Area Agreement based on joint needs</td>
<td>• Percentage of pooled spend, e.g., for MH and LD; children and elderly care</td>
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<tr>
<td>• Joint Strategic Needs Assessment</td>
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<tr>
<td>• Local Area Agreement</td>
<td>• Number of shared posts e.g., PCT and council, 3rd sector</td>
<td>• Feedback survey, “The PCT pro-actively engages my organisation to inform and drive strategic planning and service design”</td>
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<tr>
<td>• Ability to conduct constructive partnerships</td>
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<tr>
<td>• Local Area Agreement</td>
<td></td>
<td>• Feedback survey, “The PCT is an effective partner in delivering local health objectives”</td>
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<tr>
<td>• Reputation as an active and effective partner</td>
<td></td>
<td>• PBC survey, Q5 – “Have you agreed a commissioning plan with your PCT? (%)”</td>
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<tr>
<td>COMPETENCY 3</td>
<td>COMPETENCY 4</td>
<td>COMPETENCY 5</td>
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<tr>
<td><strong>Influence on local health opinions and aspirations</strong></td>
<td><strong>Public and patient engagement</strong></td>
<td><strong>Delivery of patient satisfaction</strong></td>
</tr>
<tr>
<td>Documents</td>
<td><strong>Communication strategy</strong></td>
<td><strong>Strategic plan</strong></td>
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<tr>
<td>Metrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveys</td>
<td><strong>Patient complaint trends</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Documents**
- Feedback survey, “The PCT has pro-actively shaped the health opinions and aspirations of the local population”
- Public perception survey, “My local NHS listens to the views of local people and acts in their interests”
- PBC Survey – Q16 “How, if at all, do you engage with your local population for PBC purposes? (%)

**Metrics**
- **Communication strategy**
- **Strategic plan**

**Surveys**
- Public perception survey “My local NHS helps manage and improve the health and wellbeing of me and my family”
- Public perception survey “My local NHS is improving services for people like me”
- **Public perception survey**

**Documents**
- Feedback survey “The PCT proactively engages all clinicians to inform and drive strategic planning and service design”

**Metrics**
- **PBC governance arrangements**

**Surveys**
- PBC survey, Q15 “How would you rate the following aspects of the information provided for PBC by the PCT across quality, format and frequency?”
- Feedback survey “The PCT proactively engages all clinicians to inform and drive strategic planning and service design”

**Documents**
- Joint Strategic Needs Assessment
- **Joint Strategic Needs Assessment**
- Local Area Agreement
- Pathway redesign examples

**Metrics**
- **Joint Strategic Needs Assessment**

**Surveys**
- Feedback survey “The PCT proactively engages all clinicians to inform and drive strategic planning and service design”
- Joint Strategic Needs Assessment

**Documents**
- Local Area Agreement
- **Strategic plan**

**Metrics**
- **Strategic plan**

**Surveys**
- Feedback survey “The PCT proactively engages all clinicians to inform and drive strategic planning and service design”
<table>
<thead>
<tr>
<th>Documents</th>
<th>Metrics</th>
<th>Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of current and future provider capacity and capability</td>
<td>Strategic plan</td>
<td>% spend moved between individual providers</td>
</tr>
<tr>
<td>Alignment of provider capacity with health needs projections</td>
<td>Strategic plan</td>
<td>Patient choice survey Q2 “Were you offered a choice of hospital for your first appointment?”</td>
</tr>
<tr>
<td>Creation of effective choices for patients</td>
<td>Strategic plan</td>
<td>% spend shifted to new clinical pathways</td>
</tr>
<tr>
<td>Identification of improvement opportunities</td>
<td>Pathway redesign examples</td>
<td>PBC survey Q10 “How many, if any, of the business cases for service redesign have been accepted by your PCT (%)”</td>
</tr>
<tr>
<td>Implementation of improvement initiatives</td>
<td>Pathway redesign examples</td>
<td>PBC survey Q12 “To what extent do you agree or disagree that PBC has improved patient care (%)”</td>
</tr>
<tr>
<td>Collection of quality and outcome information</td>
<td>Pathway redesign examples</td>
<td>PBC survey Q12 “To what extent do you agree or disagree that PBC has improved patient care (%)”</td>
</tr>
<tr>
<td>Understanding of providers economics</td>
<td>Provider contracts</td>
<td></td>
</tr>
<tr>
<td>Negotiation of contracts around defined variables</td>
<td>Provider contracts</td>
<td></td>
</tr>
<tr>
<td>Creation of robust contracts based on outcomes</td>
<td>Provider contracts</td>
<td>% No. of contracts in place on time</td>
</tr>
<tr>
<td>Use of performance information</td>
<td>Provider performance report</td>
<td></td>
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<tr>
<td>Implementation of regular provider performance discussions</td>
<td>Provider performance report</td>
<td></td>
</tr>
<tr>
<td>Resolution of ongoing contractual issues</td>
<td>Provider contracts</td>
<td></td>
</tr>
</tbody>
</table>
## VI. Feedback survey respondents form

### PCT FEEDBACK SURVEY: RESPONDENTS LIST

**Instructions**
1. Please insert at least one contact for each of the categories. PCTs may choose to nominate multiple contacts within each of the categories, to a maximum of 3 organisations by category. Please provide the organisations whose feedback will be most valuable e.g., for acute trusts, PCTs should provide up to three trusts with whom they have the highest levels of activity and spend.
2. To submit the form, go to the toolbar, and click on “Data / Lists / Synchronize List”. Then click on “Save” to submit the list and close the window.

<table>
<thead>
<tr>
<th>Category</th>
<th>Organisation name</th>
<th>Job title</th>
<th>Name</th>
<th>Email</th>
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</thead>
<tbody>
<tr>
<td><strong>PARTNERS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Health Authority</td>
<td></td>
<td>Chief Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Authority</td>
<td></td>
<td>Chief Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Commissioning Group</td>
<td></td>
<td>Leader</td>
<td></td>
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<tr>
<td>Practice Based Commissioning</td>
<td></td>
<td>Leader</td>
<td></td>
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<tr>
<td>consortia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview and Scrutiny Committee</td>
<td></td>
<td>Chair</td>
<td></td>
<td></td>
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<tr>
<td><strong>CLINICAL NETWORKS</strong></td>
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<tr>
<td>Clinical networks</td>
<td></td>
<td>Local leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LINks (or PPI forum)</td>
<td></td>
<td>PPI forum leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary organisations</td>
<td></td>
<td>Chief Executive</td>
<td>Leader</td>
<td></td>
</tr>
<tr>
<td>Other strategic partners</td>
<td></td>
<td>Chief Executive</td>
<td>Leader</td>
<td></td>
</tr>
<tr>
<td><strong>ACUTE TRUSTS</strong></td>
<td></td>
<td>Chief Executive</td>
<td></td>
<td></td>
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<tr>
<td>Mental Health Trust</td>
<td></td>
<td>Chief Executive</td>
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<tr>
<td>Care Trust</td>
<td></td>
<td>Chief Executive</td>
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<tr>
<td><strong>PRIVATE SECTOR PROVIDERS</strong></td>
<td></td>
<td>Chief Executive</td>
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<tr>
<td>Voluntary sector providers</td>
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<td>Chief Executive</td>
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<tr>
<td>Community services providers</td>
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<td>Chief Executive</td>
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<tr>
<td>Ambulance Trust</td>
<td></td>
<td>Chief Executive</td>
<td></td>
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<tr>
<td>Other providers</td>
<td></td>
<td>Chief Executive</td>
<td></td>
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<tr>
<td>Local Council</td>
<td></td>
<td>Council leader</td>
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<tr>
<td>Local MP</td>
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<td>MP</td>
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<tr>
<td>Local Press</td>
<td></td>
<td>Editor</td>
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<tr>
<td>Other local opinion formers</td>
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</tr>
</tbody>
</table>
## VII. Feedback survey

### Feedback Survey Form

**Date:** 5/15/2008

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Somewhat disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Unable to comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>We recognize the PCT as the local leader of the NHS</td>
<td></td>
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<tr>
<td>What does the PCT do well that they should keep doing?</td>
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<td>What should the PCT do differently?</td>
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<tr>
<td>The PCT has a significant influence on our decisions and actions</td>
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<tr>
<td>Comments</td>
<td></td>
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<tr>
<td>The PCT is an effective partner in delivering health and well-being improvements for the local population</td>
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</tr>
<tr>
<td>Comments</td>
<td></td>
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<tr>
<td>The PCT pro-actively engages the health opinions and aspirations of the local population</td>
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<tr>
<td>Comments</td>
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<tr>
<td>The PCT pro-actively engages my organization to inform and drive strategic planning and service design</td>
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<td></td>
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<tr>
<td>Comments</td>
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<tr>
<td>The PCT pro-actively engages clinicians to inform and drive strategic planning and service design</td>
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<td>Comments</td>
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</table>
VIII. Governance - self certification

Self-certification
Instructions: Following consultation with the Board, the Chair and Chief Executive should sign this form to confirm that all of the statements below are applicable to their PCT. If a statement is not applicable, or is only partially applicable, or if the assessment panel should take particular circumstances into account when assessing this area, a clear explanation should be written in the comments box.
Board self certification

BOARD INTERACTION
- The Board and the wider PCT executive team are aligned on the overall direction of and priorities for the PCT
- The Board and the wider PCT executive team are aligned on the key challenges and opportunities the PCT faces in strategy, execution, talent management, performance, and governance
- The Board helps shape and challenge the PCT’s strategy
- The Board divides its time appropriately between strategic and operational issues, and between commissioning and provision
- Board members constructively challenge each other to ensure the Board arrives at the best outcome
- Board members work together effectively, and stay connected between formal meetings

ORGANISATION

Structure
- The structure of the organisation helps rather than hinders the work of the PCT
- Within the organisation, roles and responsibilities are well defined and appropriate

Capability
- The PCT executive team has a full understanding of both the organisation’s current capability gaps and its future needs
- The organisation is taking the right steps to build these capabilities, and these are supported by a clear plan

Culture
- The organisational culture supports both delivery of current operational priorities and longer-term development aims, and this culture is role-modelled by the Board
- Staff within the organisation understand and support the goals and values of the PCT, and understand how their work contributes to the PCT’s success

PROCESS

Performance
- Clinical, service and financial performance are tracked effectively
- The progress of key initiatives is tracked and corrective actions are implemented as required
- The Board helps to ensure that the PCT achieves national and local targets
- The Board regularly reviews performance management information and ensures appropriate actions are taken as required

Risk
- There is a process in place to identify and mitigate risks and this is both appropriate and regularly reviewed

Information
- Timely and accurate data collection and reporting processes are in place to support management on a day-to-day basis
- The Board receives the input and information it needs to support effective decision-making

Delegation
- Delegated authority is clearly performance-managed and lines of accountability are clear
- Where the Board has delegated budget and/or commissioning responsibilities to partners or other commissioning groups, it has ensured that the governance arrangements support best practice commissioning
IX. Change control process

The commissioning assurance handbook sets out guidance on the process for SHAs and PCTs in implementing the assurance 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.
adding life to years and years to life