Making a step change in health and health outcomes, (and productivity) in East of England - Building world class commissioning capabilities

Penny Dash
10 September, 2009
Aims for today

• Re-cap on WCC competences, and likely changes for this year

• Build shared view as to what good would look like for a few select areas

• Consider how PCTs will need to align their activities to the QIPP agenda

• Discuss how these skills and capabilities can be built in East of England
<table>
<thead>
<tr>
<th>Competency</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are recognised as the local leader of the NHS</td>
<td>• Reputation as the ‘local leader of the NHS’</td>
</tr>
<tr>
<td>• Reputation as a change leader for local organisations</td>
<td></td>
</tr>
<tr>
<td>• Position as the local healthcare employer of choice</td>
<td></td>
</tr>
<tr>
<td>Work collaboratively with community partners to commission services that</td>
<td>• Creation of Local Area Agreement based on joint needs</td>
</tr>
<tr>
<td>optimise health gains and reduce health inequalities</td>
<td>• Ability to conduct constructive partnerships</td>
</tr>
<tr>
<td>• Reputation as an active and effective partner</td>
<td></td>
</tr>
<tr>
<td>Proactively build continuous and meaningful engagement with the public</td>
<td>• Influence on local health opinions and aspirations</td>
</tr>
<tr>
<td>and patients to shape services and improve health</td>
<td>• Public and patient engagement</td>
</tr>
<tr>
<td>• Delivery of patient satisfaction</td>
<td></td>
</tr>
<tr>
<td>Lead continuous and meaningful engagement of all clinicians to inform</td>
<td>• Clinical engagement</td>
</tr>
<tr>
<td>strategy and drive quality, service design and resource utilisation</td>
<td>• Dissemination of information to support clinical decision making</td>
</tr>
<tr>
<td>• Reputation as an active and effective partner</td>
<td>• Use of health needs benchmarks</td>
</tr>
<tr>
<td>Manage knowledge and undertake robust and regular needs assessments that</td>
<td>• Analytical skills and insights</td>
</tr>
<tr>
<td>establish a full understanding of current and future local health needs</td>
<td>• Understanding of health needs trends</td>
</tr>
<tr>
<td>and requirements</td>
<td></td>
</tr>
</tbody>
</table>
## Reminder of Competencies (2)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Measure</th>
</tr>
</thead>
</table>
| **Prioritise investment according to local needs, service requirements and the values of the NHS** | • Predictive modelling skills and insights  
• Prioritisation of investment to improve population’s health  
• Incorporation of priorities into strategic investment plan |
| **Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes** | • Knowledge of current and future provider capacity  
• Alignment of provider capacity with health needs projections  
• Creation of effective choices for patients |
| **Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration** | • Identification of improvement opportunities’  
• Implementation of improvement initiatives  
• Collection of real time quality and outcome information |
| **Secure procurement skills that ensure robust and viable contracts**       | • Understanding of providers economics  
• Negotiation of contracts around defined variables  
• Creation of robust contracts based on outcomes |
| **Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money** | • Use of real time performance information  
• Implementation of regular provider performance discussions  
• Resolution of ongoing contractual issues |
Aims for today

• Re-cap on WCC competences, and likely changes for this year

• **Build shared view as to what good would look like for a few select areas**

• Consider how PCTs will need to align their activities to the QIPP agenda

• Discuss how these skills and capabilities can be built in East of England
Areas for detailed review

• Prioritisation of resource allocation, strategic priorities, key outcomes to focus on

• Care pathway redesign, using clinical evidence base, prioritisation within a care pathway

• Market management
Different types of priorities!

Strategic priorities for the PCT
(To meet overall objectives of PCT)

Prioritisation within a care pathway
(To maximise gain in health and health outcomes per £ spent)

Prioritisation of areas for development
(To ensure we can deliver our strategic plan)
Overall objectives for PCTs

Role of a PCT

- Improve health
- Ensure high quality care
- Maintain financial balance
- Meet national targets
A structured approach to improve performance in health and health outcomes while maintaining financial balance

1. Select disease area
   - Select disease areas to focus on based on
     - Potential impact (e.g., disease burden, avoidable mortality)
     - Feasibility (e.g., availability of cost-effective interventions)

2. Describe the pathway
   - Identify evidence-based best-practice pathway for that disease
     - Describe pathway and specific interventions along the pathway
     - Assess clinical and cost effectiveness of each intervention

3. Develop performance metrics
   - Develop a set of appropriate metrics
     - Prioritize interventions based on scientific evidence of clinical benefit and cost of each intervention in pathway

4. Measure performance gaps
   - Measure gaps in payor performance vs. best-practice for each intervention

5. Assess cost and impact
   - Calculate the payor’s cost of closing each gap, and construct a cost curve to determine the maximum improvement in quality possible for a given spend

6. Prioritize interventions
   - Prioritise / sequence interventions by assessing realistic improvement vs. feasibility
Factors influencing prioritisation

Criteria | Description | Data sources
--- | --- | ---
A | Current performance and potential impact<br>• Relative size and impact of health needs, quality gaps etc<br>• Potential impact on health | • WCC data packs<br>• Public health report<br>• Analysis of clinical evidence base
B | PCT vision<br>• Degree of alignment with existing vision and goals of the PCT | • Existing PCT vision
C | National priorities<br>• Degree of alignment with:<br>  – National and regional targets<br>  – Key development priorities for PCTs (WCC, provider arm separation) | • DH white papers<br>• Vital signs<br>• HCC targets
D | Community preferences<br>• Degree of alignment with feedback on service priorities and preferences from:<br>  – Public and patients<br>  – Local partners | • JSNA<br>• Facing the future<br>• Patient public engagement<br>• Provider feedback
Select disease area to focus on based on potential impact and feasibility

**Increasing feasibility**
- Existence of effective interventions
- Cost effectiveness of interventions
- Ease of implementation

**Increasing impact**
- Avoidable mortality
- Social impact

1 CHD and Stroke
Identify evidence-based best-practice pathway

Outcome metrics

- CHD prevalence rate
- Incidence of primary AMI
- Death rate within 30 days
- In-hospital death rate of AMI
- AMI readmission rate within 30 days
- Incidence of recurrent AMI
Identify best practice interventions along the pathway

Primary prevention

- **Active lifestyle management**
  1. Reducing salt intake (target: <6g/day)
  2. Reducing saturated and trans fats in diets
  3. Reducing prevalence of binge drinking
  4. Regularly maintained physical exercise

- **Management of risk factors**
  1. Reducing prevalence of obesity (target BMI <25)
  2. Using anti-obesity drugs on top of lifestyle management
  3. Preventing and treating hypertension (target BP: ≤140/90 mmHg)
  4. Preventing and treating diabetes (target: HbA1c ≤7.0%)
  5. Preventing and treating hypercholesterolaemia (target CHD: ≤200mg/dL), e.g., with statins

Early management of CHD

- **Regular medication and monitoring from primary care**
  1. Treating SA patients who have hypertension (target BP: ≤130/80 mmHg)
  2. Treating SA patients who have diabetes (target: HbA1c ≤6.5%)
  3. Treating SA patients with stable angina on a long term basis
  4. Using sublingual nitroglycerin for immediate relief of angina
  5. Treating SA patients with beta-blockers on a long term basis
  6. Treating SA patients with low-dose aspirin (75–100mg) on a long-term basis
  7. Immunising every CHD patients with flu vaccines
  8. Annual GP review for SA patients even when they are in stable condition

- **Further assessment and treatment from specialist care**
  1. Referring newly diagnosed angina patients to specialist for further assessment within 2 weeks
  2. Exercise Tolerance Testing (i.e., stress ECG) for patients with suspected CHD
  3. Angiography (if PCI) for high-risk patients identified by non-invasive diagnostics
  4. CABG for angina patients with LM (left main stem) or 3VD (triple-vessel disease)

Management of Acute coronary syndrome ACS

- **Rapid and proper ambulance support**
  1. Quick ambulance transfer of suspected ACS to A&E
  2. Aspirin 300mg for suspected ACS from ambulance staff immediately

- **Immediate diagnosis by cardiologist at A&E**
  1. Cardiac specialist care starting upon presentation to A&E
  2. Immediate 12-lead ECG at A&E
  3. Troponin tests at presentation and then at 12 hours from symptom onset

- **Proper medical therapy at A&E**
  1. Aspirin 300mg for ACS patients immediately, if not given by ambulance staff
  2. Opiate analgesia, esp. morphine, administered with antiemetics
  3. Nitrates (nitroglycerin or isosorbide mononitrate) titrated to chest pain and blood pressure

- **Proper setting of care: CCU**
  1. Transfer STEMI to CCU
  2. Comprehensive rehab program comprising supervised exercise, lifestyle education, psychosocial counselling, etc.

  **STEMI**
  1. Increasing proportion of STEMI patients who receive PPCI as means of revascularisation
  2. Reducing DIB time for patients eligible for PPCI (target: 90 mins)
  3. Immediate thrombolysis for patients ineligible for PPCI, e.g., due to contraindication or prolonged DIB time
  4. Reducing CIN time for patients eligible for thrombolysis (target: 30-60 mins)
  5. Rescue PCI for STEMI patients within 6 hours of symptom onset, after failed thrombolysis
  6. Coronary angiography (a angioplasty) for STEMI patients treated with thrombolytic therapy

  **NSTEMI/UA**
  1. Beta-blockers for STEMI
  2. LMWH for STEMI
  3. Glycoprotein IIb/IIIa inhibitor for STEMI patients undergoing PCI
  4. Emergency CABG for patients with mechanical complications or coronary rupture
  5. Leaving CCU when haemodynamically stable and 12–24 hours after symptom onset

- **Continued medical therapy and others**
  1. Beta-blockers for NSTEMI/UA
  2. LMWH for NSTEMI/UA
  3. Glycoprotein IIb/IIIa inhibitor for NSTEMI/UA patients undergoing PCI

- **Further assessment to identify high-risk patients**
  1. Coronary angiography (a angioplasty) for NSTEMI/UA patients at medium to high risk of recurrent coronary events
  2. Measure LV function with echo-cardiogram, if not assessed in angiography

Rehab & secondary prevention

- **Comprehensive rehab program comprising supervised exercise, lifestyle education, psychosocial counselling, etc.**
- **Starting long term statin therapy prior to hospital discharge**
- **Starting long term aspirin (75mg daily) therapy prior to hospital discharge**
- **Using clopidogrel (75mg daily) in combination with aspirin for post-ACS patients**
- **Starting long-term beta-blocker therapy prior to hospital discharge**
- **Oral or transdermal nitrates after ACS**
- **Starting ACEI treatment within 14 days of ACS**
- **Reducing prevalence of obesity after ACS**
- **Reducing prevalence of smoking after ACS**
- **Reducing prevalence of hypertension after ACS**
- **Reducing prevalence of diabetes after ACS**
- **Reducing prevalence of hypercholesterolaemia after ACS**
- **Reducing prevalence of hypertension after ACS**
- **Reducing prevalence of smoking after ACS**
- **Reducing prevalence of diabetes after ACS**
- **Reducing prevalence of hypercholesterolaemia after ACS**
- **Reducing prevalence of hypertension after ACS**
- **Reducing prevalence of smoking after ACS**

SOURCE: Map of Medicine; guidelines; clinical articles; interviews; team analysis
<table>
<thead>
<tr>
<th>Category</th>
<th>Name of intervention</th>
<th>Detail of intervention</th>
<th>Outcome effect</th>
<th>Clinical benefits</th>
<th>Cost per QALY/LYG</th>
<th>Cost effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Binge drinking</td>
<td>• Reducing prevalence of binge drinking</td>
<td>8% ↓ events</td>
<td>○</td>
<td>Net savings</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation</td>
<td>• Reducing prevalence of smoking</td>
<td>30% ↓ mort., 37 ↓ events</td>
<td>●</td>
<td>£0.7~10.6k/QALY</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Exercise</td>
<td>• Regularly maintained physical exercise</td>
<td>20~32% ↓ mort.</td>
<td>○</td>
<td>£0.5~9.3k/QALY</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Obesity mgmt.</td>
<td>• Reducing prevalence of obesity (target BMI &lt;25)</td>
<td>40% ↓ events</td>
<td>●</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>• Preventing and treating hypertension (target BP: ≤140/90 mmHg)</td>
<td>21~24% ↓ events for 5mmHg ↓ DBP or 10mmHg ↓ SBP</td>
<td>●</td>
<td>£0.1~6.1k/QALY</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Hypercholesterolaemia</td>
<td>• Preventing and treating hypercholesterolaemia (target CHO: ≤200mg/dL), e.g., with statins</td>
<td>23~29% ↓ mort.</td>
<td>●</td>
<td>£0.3~30k/QALY</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Hypertension for SA</td>
<td>• Treating SA patients who have hypertension (target BP: ≤130/80 mmHg)</td>
<td>n/a</td>
<td>-</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Diabetes for SA</td>
<td>• Treating SA patients who have diabetes (target: HbA1c ≤6.5%)</td>
<td>n/a</td>
<td>-</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Statins for SA</td>
<td>• Treating SA patients with statins on a long term basis</td>
<td>23% ↓ events</td>
<td>●</td>
<td>£3~8k/QALY</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Beta-blockers for SA</td>
<td>• Treating SA patients with beta-blockers on a long term basis</td>
<td>34% ↓ mort.</td>
<td>●</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Aspirin for SA</td>
<td>• Treating SA patients with low-dose aspirin (75–325mg) on a long-term basis</td>
<td>30~34% ↓ composite endpoint</td>
<td>●</td>
<td>Net savings</td>
<td>++++</td>
</tr>
</tbody>
</table>

Evaluate scientific evidence of clinical benefits and cost-effectiveness of each intervention (1/2)

- strong
- weak

CHD EXAMPLE
<table>
<thead>
<tr>
<th>Category</th>
<th>Name of intervention</th>
<th>Detail of intervention</th>
<th>Outcome effect</th>
<th>Clinical benefits</th>
<th>Cost per QALY/LYG</th>
<th>Cost effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of ACS</td>
<td>Aspirin for ACS</td>
<td>Aspirin 300mg for ACS patients immediately, if not given by ambulance staff</td>
<td>30~46% ↓ events</td>
<td>⚫</td>
<td>Net savings</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>PPCI</td>
<td>Increasing proportion of STEMI patients who receive PPCI as means of revascularisation</td>
<td>26~52% ↓ mort. (vs. thrombo.)</td>
<td>⚫</td>
<td>Net savings to £6.5k/QALY</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Beta-blockers for STEMI</td>
<td>Beta-blockers for STEMI</td>
<td>13<del>15% ↓ mort., 17</del>18% ↓ events</td>
<td>⚫</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>LMWH for STEMI</td>
<td>Low Molecular Weight Heparin for STEMI patients</td>
<td>28% ↓ composite endpoint</td>
<td>⚫</td>
<td>n/a</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Rehab program</td>
<td>Comprehensive rehab program comprising supervised exercise, lifestyle education, psychosocial counselling, etc.</td>
<td>50% ↓ mort.</td>
<td>⚫</td>
<td>£2.0~11k/QALY</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Post-ACS statins</td>
<td>Starting long term statin therapy prior to hospital discharge</td>
<td>16~29% ↓ events</td>
<td>⚫</td>
<td>£4.2~13k/QALY</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Post-ACS aspirin</td>
<td>Starting long term aspirin (75mg daily) therapy prior to hospital discharge</td>
<td>15% ↓ mort., 28% ↓ events</td>
<td>⚫</td>
<td>£0.9k/LYG</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Post-ACS beta-blockers</td>
<td>Starting long-term beta-blocker therapy prior to hospital discharge</td>
<td>23~32% ↓ mort.</td>
<td>⚫</td>
<td>£0.5k/LYG</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Post-ACS ACEI</td>
<td>Starting long-term ACEI treatment within 14 days of ACS</td>
<td>17~20% ↓ mort.</td>
<td>⚫</td>
<td>£4.1~13.6k/QALY</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation after ACS</td>
<td>Reducing prevalence of smoking after ACS</td>
<td>32 ↓ events, 36% ↓ mort.</td>
<td>⚫</td>
<td>£0.1~11k/QALY</td>
<td>++++</td>
</tr>
<tr>
<td></td>
<td>Flu vaccines</td>
<td>Immunising CHD patients with flu vaccines</td>
<td>40% ↓ events</td>
<td>⚫</td>
<td>n/a</td>
<td>-</td>
</tr>
</tbody>
</table>
### A shortlist of the most important metrics along CHD pathway

**Key interventions**

<table>
<thead>
<tr>
<th>Primary prevention</th>
<th>Early management of CHD</th>
<th>Management of ACS</th>
<th>Rehab &amp; secondary prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of adult daily smokers</td>
<td>% of CHD patients with BP ( \leq 130/80 \text{mmHg} )</td>
<td>% of ACS patients given aspirin with 60 minutes of call for ambulance</td>
<td>% of ACS patients who receive comprehensive cardiac rehabilitation program after discharge</td>
</tr>
<tr>
<td>% adults with regular exercise</td>
<td>% of diabetic CHD patients whose HbA1c ( \leq 6.5% )</td>
<td>% of STEMI patients who receive PCI for revascularisation</td>
<td>% of patients with ACS history who are on long-term statin therapy</td>
</tr>
<tr>
<td>% of adults with BMI &gt; 30</td>
<td>% CHD patients with total cholesterol &lt; 5mmol/L</td>
<td>% of AMI patients who receive PCI within 90 minutes, among patients receiving PCI</td>
<td>% of patients with ACS history who are on long-term aspirin therapy</td>
</tr>
<tr>
<td>% adults with BP &lt;140/90 mmHg</td>
<td>% of CHD patients using beta-blockers</td>
<td>% of STEMI patients who receive beta-blocker in the 24 hours after ACS onset</td>
<td>% of patients with ACS history who are on long-term beta-blocker therapy</td>
</tr>
<tr>
<td>% adults with normal cholesterol i.e. LDL &lt;160 mg/dL</td>
<td>% of CHD patients using aspirin</td>
<td>% of STEMI patients who receive LMWH during the hospitalisation</td>
<td>% of patients with ACS history who are non-smokers</td>
</tr>
<tr>
<td>% adults with alcohol consumption under 6L/year</td>
<td></td>
<td></td>
<td>% of CHD patients immunised with flu vaccine</td>
</tr>
</tbody>
</table>

The most important interventions along the CHD pathway can be captured with 23 metrics

**Source:** Team analysis
Measure performance gaps in the identified metrics, and calculate the payor-specific cost of closing gaps

<table>
<thead>
<tr>
<th>Most Effective Interventions</th>
<th>Eligible population</th>
<th>Health-Tracker metric</th>
<th>Current perf., %</th>
<th>Target perf., %</th>
<th>LYG</th>
<th>Cost to PCT £k</th>
<th>Calculated cost/LYG, £</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol control for SA</td>
<td>30,847</td>
<td>P13</td>
<td>85</td>
<td>95</td>
<td>108</td>
<td>85</td>
<td>787</td>
<td>3</td>
</tr>
<tr>
<td>Aspirin for SA</td>
<td>30,847</td>
<td>P16</td>
<td>95</td>
<td>100</td>
<td>80</td>
<td>42</td>
<td>525</td>
<td>4</td>
</tr>
<tr>
<td>Referral to specialist in 2 weeks</td>
<td>4,239</td>
<td>P20</td>
<td>95</td>
<td>98</td>
<td>51</td>
<td>-19</td>
<td>01</td>
<td>0</td>
</tr>
<tr>
<td>Increasing PPCI rate</td>
<td>1,174</td>
<td>P33</td>
<td>35</td>
<td>80</td>
<td>820</td>
<td>127</td>
<td>155</td>
<td>5</td>
</tr>
<tr>
<td>Beta-blocker in 24 hours</td>
<td>1,174</td>
<td>P40</td>
<td>75</td>
<td>100</td>
<td>138</td>
<td>97</td>
<td>703</td>
<td>3</td>
</tr>
<tr>
<td>Post-event aspirin</td>
<td>1,174</td>
<td>P52</td>
<td>94</td>
<td>100</td>
<td>21</td>
<td>9</td>
<td>429</td>
<td>2</td>
</tr>
<tr>
<td>Post-event beta-blocker</td>
<td>1,174</td>
<td>P54</td>
<td>91</td>
<td>100</td>
<td>60</td>
<td>66</td>
<td>1,100</td>
<td>6</td>
</tr>
<tr>
<td>Post-event ACEI for LVSD</td>
<td>470</td>
<td>P56</td>
<td>90</td>
<td>95</td>
<td>8</td>
<td>45</td>
<td>5,625</td>
<td>7</td>
</tr>
</tbody>
</table>

1 Net saving due to reduced hospitalizations
Construct a cost curve to determine maximum improvement achievable for a given increase in spend

ILLUSTRATIVE CORONARY HEART DISEASE EXAMPLE

Life years gained
Thousands

Expenditure
$ millions

Primary PCI
Post-event aspirin
Aspirin for SA
Beta-blocker for AMI in 24 hours
Cholesterol control
Post-event beta-blocker
Post-event ACEI

Theoretical cost curve
Identify opportunities for disinvestment and reinvestment

ILLUSTRATIVE CHD EXAMPLE

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Best practice</th>
<th>Actual spend</th>
<th>Opportunity to reinvest</th>
<th>Opportunity to disinvest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary PCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-event aspirin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin for SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beta-blocker for AMI in 24 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiate analgesia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-ACS nitrates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-ACS clopidogrel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rescue PCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Spend $
Assess realistic impact and feasibility, and prioritise improvement levers appropriately

Increasing PPCI rate

Optimizing cholesterol control

Increasing beta blocker for AMI within 24 hours

Increasing prescribing of post-event beta-blocker

Increasing prescribing of aspirin for stable angina patients

Increasing prescribing of aspirin for stable angina patients

Increasing prescribing of post-event aspirin

Increasing prescribing of post-event ACEI for LVSD

Increasing prescribing of post-event beta-blocker

SOURCE: Academic literature search; team analysis
Finally … recognise that significant changes to provider structure may be required

<table>
<thead>
<tr>
<th>New models of primary care</th>
<th>• How can multidisciplinary teams best be organised to ensure consistently high quality care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>New models of community care</td>
<td>• How should nursing staff support primary care services?</td>
</tr>
<tr>
<td>New models for social care</td>
<td>• How should social care services be organised to support the most vulnerable patients?</td>
</tr>
<tr>
<td>Changes to public health delivery structures</td>
<td>• How should public health teams commission and provide care to maximise health gain?</td>
</tr>
<tr>
<td>Changes in hospital configuration</td>
<td>• What is the optimal hospital configuration to drive improved outcomes in care?</td>
</tr>
</tbody>
</table>
Aims for today

• Re-cap on WCC competences, and likely changes for this year
• Build shared view as to what good would look like for a few select areas
• **Consider how PCTs will need to align their activities to the QIPP agenda**
• Discuss how these skills and capabilities can be built in East of England
Five ways to think about actions to be taken to address QIIPP

• Where can changes be made across and within care pathways to improve quality and reduce cost?

• How does this translate into commissioning spend – and what are the levers to drive through reduced spend?

• What does this mean for providers and how can they reduce cost and maintain/improve quality?

• What are some of the enablers to support?

• How can barriers to change be overcome, especially will?
## Care pathways - but translatable into commissioning plans

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Maternity</th>
<th>Children</th>
<th>Staying healthy</th>
<th>Mental health</th>
<th>Acute care</th>
<th>Planned care</th>
<th>LTC</th>
<th>Other (etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute spend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Opportunities across care pathways e.g. 20 initiatives to improve quality and reduce cost in maternity and newborn services

- **Pre-natal care**
  - 1. Access to high quality information for women, accessible via internet, printed copies
  - 2. Co-ordinate care for high risk women between GP and specialist
  - 3. No access to GP for pregnancy testing – done via pharmacist with supporting information about diet

- **Antenatal care**
  - 4. Direct booking with midwife
  - 5. Midwives organised into teams with access to obstetricians as per protocols/if required
  - 6. Teams of midwives self employed and encouraged to work efficiently (e.g. antenatal at central location; use of IT; use of MSWs)
  - 7. 14 antenatal consultations as per NICE guidance
  - 8. 1 ultrasound scan per pregnancy as per NICE guidance
  - 9. PCT exceptions panels for variation to NICE guidance
  - 10. Antenatal admissions only as per agreed criteria

- **Birth**
  - 11. Efficient deployment of midwives to enable one to one midwife care
  - 12. Obstetric services operating at scale with networked models of consultant services to allow consultant presence and leadership on labour ward
  - 13. Reduced c section rate through clear application of protocols, one to one midwife care and consultant presence on labour ward
  - 14. Reduced error rate and improved quality through continual monitoring and publishing of process and outcome metrics e.g. apgar scores

- **Post natal care**
  - 15. Centralised post natal care rather than at home
  - 16. Clear criteria for prioritisation of visits and adherence to NICE guidance
  - 17. Strong incentives and performance measurement for breastfeeding (mothers and midwives)
  - 18. Clear handover to health visitors with criteria for prioritisation
  - 19. Tariff for health visiting service
  - 20. Efficient deployment of health visitors e.g. through better scheduling
<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decommission</strong></td>
</tr>
<tr>
<td>• Reduce spend on low value added interventions through active decommissioning</td>
</tr>
<tr>
<td>• Focus spend on most cost effective interventions</td>
</tr>
<tr>
<td>• Reduce spend on unnecessary prescribing</td>
</tr>
<tr>
<td><strong>Improve Prevention</strong></td>
</tr>
<tr>
<td>• Primary prevention to reduce smoking, improve diet and exercise levels**</td>
</tr>
<tr>
<td>• Increased uptake of immunisation and screening programmes</td>
</tr>
<tr>
<td><strong>LTC management</strong></td>
</tr>
<tr>
<td>• Improve management of people with LTC through proactive delivery of best practice care</td>
</tr>
<tr>
<td>• Focus spend on most cost effective interventions</td>
</tr>
<tr>
<td><strong>Case management</strong></td>
</tr>
<tr>
<td>• Provide care proactively for people with complex health needs outside of hospital to prevent hospital admission</td>
</tr>
<tr>
<td><strong>Shift care to lowest cost setting</strong></td>
</tr>
<tr>
<td>• Reduce unit price for those services that can be safely and more cost effectively provided through a different pathway in another location e.g. out of the hospital and closer to home</td>
</tr>
<tr>
<td><strong>Reduce unit cost of activity</strong></td>
</tr>
<tr>
<td>• Reduce unit price of non-acute services</td>
</tr>
<tr>
<td>• Eliminate service overlaps (e.g., out-of-hours, extended hours, urgent care, A&amp;E)</td>
</tr>
<tr>
<td>• Reduce unit cost of acute services through reduced tariff</td>
</tr>
<tr>
<td>• Reduce prescribing unit cost</td>
</tr>
</tbody>
</table>

* Feasibility includes time to impact and likelihood of implementation
** Note secondary prevention – i.e. tackling health behaviours in people with disease is covered in improved management of LTC
<table>
<thead>
<tr>
<th>Description</th>
<th>Impact</th>
<th>Feasibility*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decommission</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce spend on low value added interventions through active decommissioning</td>
<td>L/M</td>
<td>M</td>
</tr>
<tr>
<td>• Focus spend on most cost effective interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improve Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary prevention to reduce smoking, improve diet and exercise levels**</td>
<td>M</td>
<td>L</td>
</tr>
<tr>
<td>• Increased uptake of immunisation and screening programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LTC management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improve management of people with LTC through proactive delivery of best practice care</td>
<td>M</td>
<td>M/H</td>
</tr>
<tr>
<td>• Focus spend on most cost effective interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide care proactively for people with complex health needs outside of hospital to prevent hospital admission</td>
<td>M</td>
<td>M/H</td>
</tr>
<tr>
<td><strong>Shift care to lowest cost setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce unit price for those services that can be safely and more cost effectively provided through a different pathway in another location e.g. out of the hospital and closer to home</td>
<td>M</td>
<td>M/H</td>
</tr>
<tr>
<td><strong>Reduce unit cost of activity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce unit price of non-acute services</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>• Eliminate service overlaps (e.g., out-of-hours, extended hours, urgent care, A&amp;E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce unit cost of acute services through reduced tariff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Feasibility includes time to impact and likelihood of implementation
** Note secondary prevention – i.e. tackling health behaviours in people with disease is covered in improved management of LTC
Some healthcare activity can be shifted out of hospitals and delivered through lower cost models of care

<table>
<thead>
<tr>
<th>Example</th>
<th>Unit cost of service (2016/17, £)</th>
<th>% suitable to shift</th>
<th>Net saving (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before shift</td>
<td>After shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination and assessment</td>
<td>1,474</td>
<td>106</td>
<td>20</td>
</tr>
<tr>
<td>Non Elective Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney or urinary tract infection</td>
<td>2,614</td>
<td>96</td>
<td>8</td>
</tr>
<tr>
<td>Elective Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor skin procedures</td>
<td>1,805</td>
<td>112</td>
<td>7</td>
</tr>
<tr>
<td>Non Elective Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor skin procedures</td>
<td>2,588</td>
<td>95</td>
<td>2</td>
</tr>
<tr>
<td>Regular Attender</td>
<td>Renal replacement therapy</td>
<td>154</td>
<td>116</td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td>115</td>
<td>92</td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td>61</td>
<td>49</td>
</tr>
</tbody>
</table>

Note: increase spend of £635m (in a more efficient out of hospital delivery system) reduce hospital care by £1,143m

1 Weighted average activity shift. Only includes activity shifted to polysystem, does not include activity that is decommissioned
Long Term Condition mgt., case mgt. and prevention can deliver c. £250m savings if delivered through a different model of care

<table>
<thead>
<tr>
<th>Example Intervention</th>
<th>Costs to deliver</th>
<th>Reduction in acute spend</th>
<th>Increase in non acute spend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LTC management</strong></td>
<td>• Pro-active care for patients with LTC</td>
<td>202</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>• Includes diabetes, COPD, coronary heart disease, heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assumes investments/ set up costs minimal and part of project mgt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assumes 4 x outpatient visits per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case management</strong></td>
<td>• Proactive care for people with complex health needs and frail elderly</td>
<td>31</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>• Assumes investments/ set up costs minimal and part of project mgt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assumes 4 x outpatient visits per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>• Improved provision of preventative services e.g. vascular checks</td>
<td>71</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>• Assumes investments/ set up costs minimal and part of project mgt.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assumes 4 x GP visits per year in polysystem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

£258m savings
Decision aids have been used in US and here to support de-commissioning care

Percentage of patients deciding to have a procedure after use of decision aid

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Standard Care</th>
<th>D-Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA-Prostatectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAOrchiectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>coronary bypass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hysterectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mastectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>back surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bphprostatectomy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: O’Connor et al., Cochrane Library, 2007
Reduced unit cost for out of hospital care may impact both primary care and community care up to £1bn each

<table>
<thead>
<tr>
<th>Service</th>
<th>Unit cost of service (2016/17, £)</th>
<th>Reduction in non acute spend, £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Before shift 71</td>
<td>After shift 51</td>
</tr>
<tr>
<td>Community Care</td>
<td>Before shift 132</td>
<td>After shift 58</td>
</tr>
</tbody>
</table>

£2,008m
Examples of changes required to deliver £2.0bn cost savings in primary and community care

<table>
<thead>
<tr>
<th>Spend category</th>
<th>Example source of saving</th>
<th>Cost savings by 2016/17 (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff productivity and scale</td>
<td>GP and nurse practitioner utilisation: GPs and nurse practitioners increase total proportion of contracted time spent with patients to reach 25h patient-facing time per week</td>
<td>615</td>
</tr>
<tr>
<td></td>
<td>Staff mix: Primary care staff adjusts skill-mix so that 50% of appointments are attended by nurse or nurse practitioner (from 33% today)</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Community staff utilisation: Nurses increase number of visits per day so as to achieve 10% above the median productivity (increase in efficiency of 15%)</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Staff mix: Community service line staff adjusts skill-mix (e.g. ensuring 70% of the current mix of activities is carried out by the minimum staff band required)</td>
<td>225</td>
</tr>
<tr>
<td></td>
<td>Admin staff: Consolidation of GPs in polysystem reduces admin from 0.8 FTE/clinical staff average to 0.3 FTE/clinical staff average</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>Time/ case: Average patient facing time decreases by 20% across primary and community care</td>
<td>570</td>
</tr>
<tr>
<td>Space and scheduling</td>
<td>Consolidation of GPs and community services in polyclinic network enables increased use of space, from 50% up to 80%</td>
<td>24-40</td>
</tr>
<tr>
<td>Drug spend</td>
<td>Reduction in drug branded price (PPRS 2009 agreement expected to deliver average savings of 5% from 2010 onwards)</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Reduction in prescribing variability by bringing average prescribing cost from £153/pop(^1) to national top quartile of £140/pop</td>
<td>120</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,010</td>
</tr>
</tbody>
</table>
Modelling work suggests high quality and efficient primary / community care needs to be integrated and delivered at scale

- Integrated diagnostics on-site or via hospital lab with rapid turnaround
- Supports LTC, planned care and urgent care services
- Proactive care for LTC and complex needs
- Doctors present for all opening hours
- Integrated with primary care (e.g. patient registers)
- Min 12x7 access
- One-stop triage centre with transfer to hospital A&E if required
- Delivery point for ambulances other than those needing emergency care

ILLUSTRATIVE
Scope to look at the medical costs of care within an intervention

<table>
<thead>
<tr>
<th>Epo CKD (n=62)</th>
<th>Control (n=74)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median days to goal = 47.5 days</strong></td>
<td><strong>Median days to goal = 62.5 days</strong></td>
</tr>
<tr>
<td><strong>% Time below goal = 13.7%</strong></td>
<td><strong>% Time below goal = 39.7%</strong></td>
</tr>
<tr>
<td><strong>% Time in goal = 69.8%</strong></td>
<td><strong>% Time in goal = 43.9%</strong></td>
</tr>
<tr>
<td><strong>% Time above goal = 16.5%</strong></td>
<td><strong>% Time above goal = 16.4%</strong></td>
</tr>
<tr>
<td><strong>Avg Epo Units/week = 6,698</strong></td>
<td><strong>Avg Epo Units/week = 12,000</strong></td>
</tr>
<tr>
<td><strong>Home/Clinic = 58.1%/41.9%</strong></td>
<td><strong>Home/Clinic = 39.2%/60.8%</strong></td>
</tr>
<tr>
<td><strong>Expanded Dose Utilization = 40%</strong></td>
<td><strong>Expanded Dose Utilization = 16%</strong></td>
</tr>
<tr>
<td><strong>Avg Hgb at start = 9.6 mg/dl</strong></td>
<td><strong>Avg Hgb at start = 10.0 mg/dl</strong></td>
</tr>
<tr>
<td><strong>Avg T-Sat at start = 18%</strong></td>
<td><strong>Avg T-Sat at start = 18%</strong></td>
</tr>
</tbody>
</table>

*Savings $3,860/pt/year @$0.014/unit of Epo (p<.001)*

Bucaloiu et. al, Managed Care Interface, June 2007.
<table>
<thead>
<tr>
<th>Understanding &amp; conviction</th>
<th>Hospital</th>
<th>Out of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Create senior group of top leaders to visibly champion and lead change with consistent, ambitious, visionary message</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Clear clinical rationale for change accessible and used across system</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reinforcement mechanism</th>
<th>Hospital</th>
<th>Out of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Incentivise clinicians to take ownership of their own hospital operations (e.g. Consultant Chambers)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Drive central designation of key specialist services</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Apply failure regime</td>
<td>Tender services, hospitals to alternative operators</td>
</tr>
<tr>
<td>6</td>
<td>Incentivise GPs to build and run polysystems</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Create tariff for CHS and break tariff for activity shifted out of hospital</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>AHSC deploy expertise to primary and community care transformation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Talent and skills</th>
<th>Hospital</th>
<th>Out of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Incentivise clinicians across primary/community care and consultant chambers via ICO with real budget</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Collect and provide information and data at each level to support the messages and drive change</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Clearly define what happens where and expertise needed &amp; improve calibre of management</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Dramatically expand and modify role of clinical pathway groups and extend to sector level</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role model</th>
<th>Hospital</th>
<th>Out of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Share examples of best practice</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Support development of innovative pilots</td>
<td></td>
</tr>
</tbody>
</table>
Aims for today

- Re-cap on WCC competences, and likely changes for this year
- Build shared view as to what good would look like for a few select areas
- Consider how PCTs will need to align their activities to the QIPP agenda
- Discuss how these skills and capabilities can be built in East of England
## Reminder of Competencies (1)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are recognised as the local leader of the NHS</td>
<td>• Reputation as the ‘local leader of the NHS’</td>
</tr>
<tr>
<td>• Reputation as a change leader for local organisations</td>
<td>• Position as the local healthcare employer of choice</td>
</tr>
<tr>
<td>• Position as the local healthcare employer of choice</td>
<td>• Creation of Local Area Agreement based on joint needs</td>
</tr>
<tr>
<td>Work collaboratively with community partners to commission services that</td>
<td>• Ability to conduct constructive partnerships</td>
</tr>
<tr>
<td>optimise health gains and reduce health inequalities</td>
<td>• Reputation as an active and effective partner</td>
</tr>
<tr>
<td>• Creation of Local Area Agreement based on joint needs</td>
<td>• Influence on local health opinions and aspirations</td>
</tr>
<tr>
<td>• Ability to conduct constructive partnerships</td>
<td>• Public and patient engagement</td>
</tr>
<tr>
<td>• Reputation as an active and effective partner</td>
<td>• Delivery of patient satisfaction</td>
</tr>
<tr>
<td>Proactively build continuous and meaningful engagement with the public</td>
<td>• Clinical engagement</td>
</tr>
<tr>
<td>and patients to shape services and improve health</td>
<td>• Dissemination of information to support clinical decision making</td>
</tr>
<tr>
<td>• Influence on local health opinions and aspirations</td>
<td>• Reputation as an active and effective partner</td>
</tr>
<tr>
<td>Lead continuous and meaningful engagement of all clinicians to inform</td>
<td>• Analytical skills and insights</td>
</tr>
<tr>
<td>strategy and drive quality, service design and resource utilisation</td>
<td>• Understanding of health needs trends</td>
</tr>
<tr>
<td>Manage knowledge and undertake robust and regular needs assessments that</td>
<td>• Use of health needs benchmarks</td>
</tr>
<tr>
<td>establish a full understanding of current and future local health needs</td>
<td></td>
</tr>
<tr>
<td>and requirements</td>
<td></td>
</tr>
<tr>
<td>Competency</td>
<td>Measure</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Prioritise investment according to local needs, service requirements and the values of the NHS | • Predictive modelling skills and insights  
• Prioritisation of investment to improve population’s health  
• Incorporation of priorities into strategic investment plan |
| Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes | • Knowledge of current and future provider capacity  
• Alignment of provider capacity with health needs projections  
• Creation of effective choices for patients |
| Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration | • Identification of improvement opportunities  
• Implementation of improvement initiatives  
• Collection of real time quality and outcome information |
| Secure procurement skills that ensure robust and viable contracts           | • Understanding of providers economics  
• Negotiation of contracts around defined variables  
• Creation of robust contracts based on outcomes |
| Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money | • Use of real time performance information  
• Implementation of regular provider performance discussions  
• Resolution of ongoing contractual issues |
Back up pages

Unit of measure

Text
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
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 significantly influences their decisions and actions

Level 3
- Key stakeholders agree that the PCT significantly influences their decisions and actions

Level 4
- Key stakeholders strongly agree that the PCT significantly influences their decisions and actions
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.

Position as an employer of choice

Level 1
- Does not meet Level 2 requirements

Level 2
- 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

Level 3
- 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

Level 4
- 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

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
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

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
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.

Considerations for panel (including examples):

- x

Areas for further enquiry:

- x
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.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does not meet Level 2 requirements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Key stakeholders somewhat agree that the PCT is an effective partner in delivering health objectives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The PCT has set out clear milestones with partners, on key initiatives and has a track record of delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The PCT works with PBC leads to agree commissioning plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Key stakeholders agree that the PCT is an effective partner in delivering health objectives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The PCT has clear success stories of delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Key stakeholders strongly agree that the PCT is an effective partner in delivering health objectives</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Considerations for panel (including examples):
• x

Areas for further enquiry:
• x
**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

**Level 2**
- The PCT has effective strategies for communicating with the local population
- Key stakeholders somewhat agree that the PCT has proactively 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 proactively shaped the health opinions and aspirations of the local population

**Considerations for panel (including examples):**
- x

**Areas for further enquiry:**
- x
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.

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
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

Level 2
- 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

Level 3
- 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

Level 4
- The PCT demonstrates how ongoing integrated patient experience data systematically drives commissioning decisions

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
**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.

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

**Level 2**
- 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

**Level 3**
- PCT engagement includes clinicians that represent all healthcare and well-being delivery methods, e.g., local social care, and allied health practitioners
- The PCT ensures active clinical leadership across PCT agenda
- The PCT facilitates links between primary and secondary care clinicians to support commissioning

**Level 4**
- All engagement groups actively drive PCT planning and service development and support the setting of the strategic direction for the PCT
- Clinical engagement supports ongoing improvement of patient outcomes

**Considerations for panel (including examples):**
- x

**Areas for further enquiry:**
- x
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.

Level 1
- Does not meet Level 2 requirements

Level 2
- 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

Level 3
- Quality reports include recent clinical evidence and benchmarks
- The PCT has taken steps to reduce unacceptable clinical variations

Level 4
- Quality reports include recent clinical evidence, benchmarks, and changes in clinical practice
- The PCT can calculate PBC return on investment

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
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.

Considerations for panel (including examples):
- • x

Areas for further enquiry:
- • x
Competency 5
Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs & 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

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
**Competency 5**

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

**Considerations for panel (including examples):**
- x

**Areas for further enquiry:**
- x
Competency 5
Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs & 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.
Competency 6

Prioritise investment according to local needs, service requirements and the values of the NHS.

By having a clear understanding of the needs of different sections of the local population, PCTs, with their partners, will set strategic priorities and make investment 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

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
Competency 6

Prioritise investment according to local needs, service requirements and the values of the NHS.

By having a clear understanding of the needs of different sections of the local population, PCTs, with their partners, will set strategic priorities and make investment decisions, focused on the achievement of key clinical and other outcomes. This will include investment plans that address areas of greatest health inequality.

Considerations for panel (including examples):

- x

Areas for further enquiry:

- x
**Competency 6**

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

By having a clear understanding of the needs of different sections of the local population, PCTs, with their partners, will set strategic priorities and make investment 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**
- 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

---

**Considerations for panel (including examples):**
- 

**Areas for further enquiry:**
- 

---

BACKUP PCT Self-Assessment
**Competency 7**

Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes.

PCTs will need to have in place a range of responsive providers that they can choose from. They must understand the current and future market and provider requirements. Employing their knowledge of future priorities, needs and community aspirations, PCTs will use their investment power to influence improvement, choice and service design 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.

**Knowledge of current and future provider capacity and capability**

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

- **Level 2**
  - The PCT has analysed the market with the local authority and identified a full range of core providers for each speciality 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.

- **Level 3**
  - The PCT has a complete and prioritised list of providers in the region and the scope of services provided by each.
  - This list should include NHS, independent sector providers and PCT- or GP-organised diagnostic and treatment centres, third sector and social enterprise groups.

- **Level 4**
  - The PCT has identified cost and quality for each procedure in each area of care and in each setting of care.
  - The PCT has developed a clear specification for each setting of care (Primary, community, mental health) including quality, access and cost.
  - The PCT has dedicated resource containing expertise and experience to support provider capability development.
  - The PCT can demonstrate that it has established strategic relationships with providers that include the expertise and experience to support provider development.

**Considerations for panel (including examples):**

- x

**Areas for further enquiry:**

- x
Competency 7
Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes

PCTs will need to have in place a range of responsive providers that they can choose from. They must understand the current and future market and provider requirements. Employing their knowledge of future priorities, needs and community aspirations, PCTs will use their investment power to influence improvement, choice and service design 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.

PCT Self-Assessment
• Does not meet Level 2 requirements
• The PCT uses demand projections, demand management assumptions and population need to project required capacity by speciality and matches 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 speciality 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

Considerations for panel (including examples):
• x

Areas for further enquiry:
• x
Competency 7
Effectively stimulate the market to meet demand and secure required clinical and health and wellbeing outcomes

PCTs will need to have in place a range of responsive providers that they can choose from. They must understand the current and future market and provider requirements. Employing their knowledge of future priorities, needs and community aspirations, PCTs will use their investment power to influence improvement, choice and service design 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.

Level 1
- Does not meet Level 2 requirements

Level 2
- 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

Level 3
- 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

Level 4
- 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

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
**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.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does not meet Level 2 requirements</td>
<td>• 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</td>
<td>• The PCT and providers review and agree clinical pathways and engage on opportunities for improvement and innovation</td>
<td>• The PCT and providers regularly review and agree clinical pathways and engage on opportunities for improvement and Innovation</td>
</tr>
<tr>
<td></td>
<td>• The PCT demonstrates some recent examples of clinical pathway improvement where a need has been identified</td>
<td>• 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</td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• The PCT has identified a process map listing the specific interventions that are required at each point in the pathway including prevention</td>
<td>• The PCT aggregates GP system data to run patient risk analysis and target patients</td>
<td>• Clinical guidelines sourced from international best practice</td>
</tr>
<tr>
<td></td>
<td>• Patients are involved in pathway redesign</td>
<td>• Plans to ensure smooth patient flow along the pathway and between different levels of care</td>
<td></td>
</tr>
</tbody>
</table>

**Considerations for panel (including examples):**
- x

**Areas for further enquiry:**
- x
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
- Does not meet Level 2 requirements

Level 2
- The PCT has applied improvement techniques in service or pathway redesign and measured progress against objectives (e.g. improved quality, improved patient experience)

Level 3
- Changes in clinical pathways has led to demonstrable measurable results e.g., shift in spend, improvement in access, improved patient satisfaction. These improvements span a range of services
- 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

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
**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**

- 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 effecting 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

---

**Considerations for panel (including examples):**

- x

---

**Areas for further enquiry:**

- x
Competency 9
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
- Does not meet Level 2 requirements

Level 2
- 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 3
- 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

Level 4
- The PCT can use its database to sort and extract a variety of metrics and benchmarks by providers and by disease group – e.g., capacity, average and marginal cost and financial results
- The PCT uses target costing, i.e., forecasts service cost before providers supplies estimate
- The PCT demonstrates that for all services the PCT has secured the best placed providers (Principles and Rules for Cooperation and Competition, principle 1)

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x
Competency 9

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

- Does not meet Level 2 requirements

Level 2

- There is clear identification of defined negotiation variables – e.g., cost, quality, clinical indicators, service targets
- The PCT rigorously prepares for contract negotiations including
  - Establishment a service specification and price
  - Establishment the best alternative to a negotiated agreement (BATNA)
- Defining a negotiation strategy
- Defining negotiation team roles

Level 3

- 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 mgmt
- The PCT has a sophisticated approach for negotiating risk, including risk sharing where appropriate

Level 4

- 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

Considerations for panel (including examples):

- x

Areas for further enquiry:

- x
**Competency 9**
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**
- Does not meet Level 2 requirements

**Level 2**
- 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 time-scales in advance of activity commencing
- Contracts have clearly defined break clauses, linking to quality variables where appropriate

**Level 3**
- Outcome and quality targets and improvements to patient pathways are an explicit part of all negotiations and are incorporated in contracts in line with priorities in the strategic plan
- The majority of existing contracts include clearly specified outcomes and quality metrics, with a transparent arbitration process, including ISTC
- Services are procured and contracted for in a way that incentivises good patient experience and clinical quality
- Clinical leadership are involved in review of finalisation of contracts

**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

**Considerations for panel (including examples):**
- x

**Areas for further enquiry:**
- x
**Competency 10**

Effectively manage systems and work in partnership with providers to ensure contract comp. and continuous improv. 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.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does not meet Level 2 requirements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data is accessible and used to monitor provider performance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data is collected and analysed at appropriate intervals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monthly data from providers is no more than one month old</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data is shared with providers when requested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data collected supports key performance indicators defined in contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contract agreements support collection of performance data where national data is not available, and ownership and management control of data is clearly defined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data is proactively discussed with providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Data supports key performance indicators across all domains (clinical quality, access, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performance info is available for and accessible to the public where relevant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<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></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Considerations for panel (including examples):**

• x

**Areas for further enquiry:**

• x
Competency 10

Effectively manage systems and work in partnership with providers to ensure contract comp. and continuous improv. 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.

Level 1

- Does not meet Level 2 requirements

Level 2

- Regular reports (at least monthly) addressing performance of major providers, acute care, primary and community care and social care for internal and external use
- Regular performance discussions with key providers and agree actions as required

Level 3

- Regular performance improvement discussions
- Performance tracking for all providers, segmented by type
- Real focus on uncovering root causes of issues jointly with providers that enables sustainable improvements

Level 4

- Continuous performance improvement discussions occur, leading to demonstrable change
- There is ongoing provider capability building through sharing of international best practice
- The PCT clearly defines responsibility for the performance management interface for each supplier

Considerations for panel (including examples):

- x

Areas for further enquiry:

- x
Competency 10
Effectively manage systems and work in partnership with providers to ensure contract comp. and continuous improv. 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.

Level 1
- Does not meet Level 2 requirements

Level 2
- Contracts indicate when intervention is required
- Contract terms are not breached without appropriate investigation and remedial action
- Contract compliance management with major providers

Level 3
- The PCT has pro-active contract compliance management with all major providers
- Actionable next steps for improvement are agreed, with assigned leads, time frames and milestones
- Improvement plans are actively monitored and tracked with strong record of delivery

Level 4
- Required improvements are always delivered
- There is a track record of innovative and effective resolution of conflict
- The PCT has clear track record of not tolerating poor performance (from any type of provider), particularly in patient care, and acting swiftly to ensure change

Considerations for panel (including examples):
- x

Areas for further enquiry:
- x