NHS

operational plans 2008/09 - 2010/11

(Implementing the 2008/09 Operating Framework)

National Planning Guidance and "vital signs"

DH Department of Health

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Document purpose	Action
ROCR ref:	**Gateway ref:** 9413
Title	Operational plans 2008/09–2010/11
Author	DH/NHS Finance Performance & Operations
Publication date	31 Jan 2008
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Local Authority CEs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communications Leads
Circulation list	Voluntary Organisations/NDPBs
Description	This document explains how organisations can use the Vital Signs to develop local operational plans to deliver against national priorities and how to select and create local priorities.
Cross ref	N/A
Superseded docs	N/A
Action required	N/A
Timing	N/A
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For recipient's use	

Dear Colleague,

At the end of last year we published the Operating Framework for 2008/09 – clearly setting owut what we need to achieve within the NHS for the forthcoming year and beyond.

As a part of that Operating Framework we have introduced a new approach to planning and managing our priorities both nationally and locally – the "*vital signs*".

The planning guidance published in this document explains how your organisation can use the *"vital signs"* to develop local operational plans to deliver against national priorities and inform your decisions on local targets.

I have already been clear that I want to see more and more autonomy over how the NHS makes decisions given to local organisations: that's why in devolving a further £1.7 billion of central funds, the Operating Framework gives a greater control of the NHS budget to PCTs than ever before.

But just as important as setting the framework in which greater local decision making can take place, is the need to change the way we do business within the system to reflect this shift. This document sets out how we will manage performance against each of the three tiers of the *"vital signs"*, limiting central performance management to the *tier one* national priorities and, beyond that, only to those areas or organisations where performance is weak.

And in further underpinning this approach through behaviour at the centre, I am pleased that the Healthcare Commission has proposed that its Annual Health Check for 2008/09 will focus on national priorities when it assesses the performance of NHS organisations, so as not to be second guessing PCT decisions on priorities for local action.

But let me be clear: greater local focus does not mean decision making being undertaken by a handful of people within a PCT. All PCTs are expected to engage with their local communities, staff and stakeholders in an open and informed discussion about priorities and performance.

When we published the Operating Framework in December 2007 – and introduced the concept of the *"vital signs"* – we made it clear that it was setting a three-year direction. Because of this, we do not expect the Operating Framework to be such a substantial document in future years. Instead, we will build on the current framework and *"vital signs"* and refine them in discussion with the service and key stakeholders, taking account of the direction of travel set by Lord Darzi's *NHS Next Stage Review*.

I want to see the NHS playing a dynamic role in shaping local partnerships to address the health needs of local communities. And I want to create an environment where clinicians and managers have greater freedom to exercise their judgement and skill at a local level. This direction of travel has been decided upon – not in order to be fashionable – but because this is the best way to deliver real change and continued improvement.

Our challenge is not just to embrace this way of working, but also to ensure we deliver against it.

David Flory
Director General – NHS Finance, Performance & Operations
Department of Health

31 January 2008

Introduction

1 The Operating Framework for 2008/09 describes in outline form the business processes required throughout the system to support delivery against the national priorities, ensure local accountability and drive transformation for the benefit of patients.

2 The key elements of the business process for 2008/09 include:

- **"vital signs"**: clarification on measures of progress against the national priorities and helping PCTs to make local choices and set local priorities;
- an initial focus for 2008/09 on an annual **operational plan** for each PCT
- **strategic plans** for the medium term, developed by each PCT by autumn 2008 and signed off by SHAs;
- **talent plan and leadership development plan** at SHA level for 2008/09. From 2009/10 onwards PCTs will also have these in place.

3 This guidance provides further detail on the requirements of PCT operational plans and, in particular, on the information that will be required nationally to support the planning process for 2008/09.

The Operational Plan

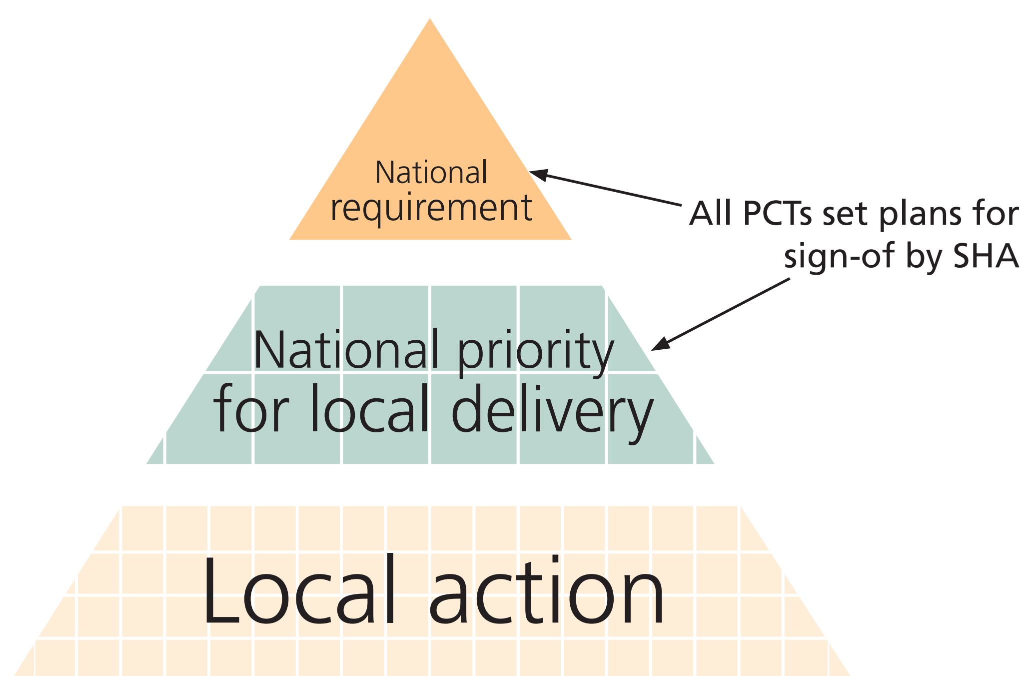
4 The Operating Framework requires PCTs to develop an operational plan by the end of March 2008 that:

- describes local targets, how they have been agreed and how they will be achieved;
- defines success;
- details milestones;
- details their proposed LAA content on health outcomes.

5 The PCT operational plan will also be expected to include nationally required information on the PCT's plans for delivering progress against national and local priorities. These are described in the paragraphs below.

6 Further content and specification of operational plans are for PCTs and SHAs to consider locally. There will be no requirement for PCTs to submit their operational plan to DH, but PCTs and SHAs will want to consider how the operational plan is shared with the local community.

National Priorities for 2008/09



PCTs need to choose – in consultation with local partners – which of these to prioritise locally

Supporting measures are required for performance management purposes

An A3 colour poster has been published alongside this guidance illustrating the overall approach and detailing the "vital signs".

7 The Operating Framework for 2008/09 describes the national priority areas where PCTs (working with providers) need to explicitly plan for delivery in 2008/09, as follows:

- Cleanliness and healthcare-associated infections
- Improving access
- Keeping adults and children well, improving their health and reducing health inequalities

- Experience, satisfaction and engagement
- Emergency preparedness

Our Approach to Performance Management

8 PCTs will monitor progress against these national priorities using the indicators set out in Tier 1 and Tier 2 of the "vital signs". Our approach to performance management aims to provide assurance of progress against those national requirements (Tier 1) that apply to all PCTs (i.e. 'must dos'). A risk-based approach to performance management against Tier 2 indicators will allow strongly performing organisations to get on and deliver without intervention from the centre.

9 Measuring performance against Tier 3 indicators will enable benchmarking and is intended to help PCTs make choices on local priorities and inform the process of engagement with the local community. The DH would not expect to be involved in performance management against Tier 3 indicators and should not be second guessing PCT decisions on local priorities. Assurance of this process must take place at local level, between the SHAs and PCTs.

10 This differential approach to performance management across the three Tiers of the "vital signs" is described in the table below.

	Targets	**Performance Management**
Tier 1 **National Requirements (ie 'must dos')**	Set nationally and cascaded to either SHA or PCT level	PCT plans agreed by SHAs and signed-off by DH. Central monitoring and performance management of all PCTs via SHAs
Tier 2 **National Priorities for Local Delivery**	Agreed locally and signed-off by SHAs	PCT plans signed-off by SHAs Risk-based approach to performance management focussed on weak areas or organisations only
Tier 3 **Local Action**	Priorities and any corresponding targets agreed locally	DH would not expect to be involved in performance management

Rationale for Distribution of Indicators between Tiers 1 and 2

11 All of the indicators included in Tiers 1 and 2 relate to the national priority areas set out in the Operating Framework. The difference between Tier 1 & 2 relates to the degree of central prescription and need for national focus through performance management.

- Tier 1 – relates to a national commitment where the requirements are very specific at a national level and must be cascaded to PCT level (e.g. maximum 18 Week wait from referral to treatment), or imposed in the form of SHA envelopes.
- Tier 2 – relates to a national commitment, but where delivery will be made up of differential contributions from PCTs, recognising the need for flexibility about how the commitment is delivered (e.g. mortality rates, which depend on starting point and relevant local, demographic factors but have a clear national target for improvement).

The Detail – Planning and Performance Management in 2008/09

12 PCT Operational Plans will need to reflect the requirements, as set out in the 2008/09 Operating Framework, including:

i. **National requirements** set by the DH and cascaded to PCT level, or in the form of SHA envelopes, and subject to performance management involving a significant degree of challenge. These areas will require plans submitted by PCTs or Trusts, agreed by SHAs, with SHA plans signed off by DH. These plans will be monitored and performance managed:[1]

MRSA number of infections (no plan required)

Clostridium Difficile

Delivery of 18-week referral to treatment

Improving access to primary care

Implementation of the cancer strategy	Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral
	Proportion of women aged 47-49 and 71-73 offered screening for breast cancer (plans deferred)
	Proportion of men and women aged 70-75 taking part in bowel screening programme (plans deferred)
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)

[1] Further detail on the indicators will be posted at http://nww.unify2.dh.nhs.uk/. Once within UNIFY2 this information can be found at >Systems Links, >Forums, >Vital Signs 2008-11, >Resources

	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)
	Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less than 62 days from referral to treatment
	Proportion of women receiving cervical cancer screening test results within two weeks (plans deferred)
Implementation of the stroke strategy	Patients who spend at least 90% of their time on a stroke unit
	% of higher risk TIA cases who are treated within 24 hours

A few national requirements require **supporting measures** to ensure delivery. These are:

18 weeks:

- waits for diagnostic tests and procedures
- direct access audiology waits
- activity levels

Primary care access:

- Extended opening hours for GP practices
- Increased capacity in primary care (no plan required)
- Patient reported access to out-of-hours care (indicator to be developed)

ii A set of **national priorities for local delivery** where nationally we know there is work to do, but where we recognise that organisations need a greater degree of flexibility about how they do it and where local targets will need to reflect different starting points and the challenges of different demographics. Where those national priorities are also represented by indicators in the National Indicator Set (NIS) for local authority partnerships, PCTs can with the agreement of local partners choose to utilise their LAA as a means to tackle the priority. PCTs will

agree annual plans with SHAs, and all plans will be held on Unify2 so that DH can see what will be delivered against each commitment. The degree of national involvement and frequency of performance management will be risk-based, focussed on weak areas or organisations only and depending on the degree of challenge and performance against plan:

- Primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the numbers of patients accessing NHS dental services
- All age all cause mortality *
- <75 CVD Mortality Rate *
- <75 Cancer Mortality Rate *
- Suicide and Injury of undetermined intent Mortality Rate
- Smoking prevalence among people aged 16 or over and, aged 16 or over in routine and manual groups (use local quit rates in 2008) *
- Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy.*
- Under 18 conception rate per 1,000 females aged 15-17 *
- Obesity among primary school age children *
- Proportion of children who complete immunisation by recommended ages
- Percentage of infants breastfed at 6-8 weeks (proxy measure in year 1)*
- Effectiveness of Children and Adult Mental Health Service (CAMHS) (percentage of PCTs and Local Authorities who are providing a comprehensive CAMHS) (proxy measure in year 1) *
- Prevalence of Chlamydia (proxy measure in year 1) *
- Number of drug users recorded as being in effective treatment *
- Patient experience *
- Staff satisfaction and engagement
- Public engagement (plans deferred)

* These indicators are also in the NIS.

[2] Further detail on the indicators will be posted at http://nww.unify2.dh.nhs.uk/. Once within UNIFY2 this information can be found at >Systems Links, >Forums, >Vital Signs 2008-11, >Resources

iii. A set of **local priorities** which PCTs can, in conjunction with their communities, prioritise for themselves where to drive service improvement harder in the areas that will make the most difference to their population. In choosing local targets PCTs are NOT limited to those measures included in Tier 3 of the "vital signs".

PCTs will set annual plans, to be jointly signed off by SHAs and in the case of any agreed LAA priority, by the GOs. DH's team in each GO will work with its SHA(s) to ensure this process is managed effectively in each region. PCT plans will be entered on Unify2 to allow efficient sharing with SHAs. Data will also be made available to GOs and LAs in support of LAA development.

The intention is that performance against all of these indicators will be published annually. This will allow a local population to understand how well or poorly their local PCT is performing across a range of commissioner responsibilities, and will be part of a local conversation between PCTs and their populations. PCTs will therefore want to track progress against all the lines of the "vital signs".

13 Trusts and PCTs will also be expected to continue to deliver all the relevant **existing commitments** (see **Annex B**). No trajectories are required for these, but central monitoring will continue. PCT Operational Plans will confirm the continued delivery of these existing national standards. The level of performance management by DH will depend on performance against these standards. We will ask the Regulator to include performance against existing standards in the annual healthcheck.

14 **Financial plans** will also be collected annually as part of the operational plan exercise. First cut plans will be submitted end of January and the guidance and forms were issued earlier in the year. Final cut plans are to be submitted in the first week of March and the guidance and forms relating to these will be made available by 11 February.

Baseline data and selection of local priorities

15 Baseline data will be provided for all lines included in the "vital signs" (paras 12i, ii and iii above, where available) and will be made available through Unify2, covering more than one year where possible. This baseline data will also support the process of LAA development where relevant. These datasets will rank PCT performance nationally, and also within cluster, allowing rational selection of local priorities, and providing evidence on which to base stretching plans.

16 For those lines where baseline data are not available at the start of the planning process, proxy data will be provided where possible, for example breastfeeding initiation data in place of breastfeeding continuation until a new data collection is in place. Where neither actual nor proxy data are available, indicators will be deferred until data are on stream.

17 PCTs will select local priorities from areas where they are a major outlier, for example where performance is in the lowest decile nationally, or is poor compared with other PCTs in their cluster. SHAs and GOs may want to ensure that plans are sufficiently stretching.

18 Plans will not be expected for tier 3 indicators which are not selected as local priorities. However, for these indicators, PCTs will be expected to at least maintain their current level of performance.

19 We expect the Healthcare Commission will build into its regime the national priorities (tiers 1 and 2) set out above.

Data management

20 Full technical definitions for all indicators will be provided, and the data collection process will operate through Unify2.

21 Unify2 will be used to share plans between PCTs and SHAs in an efficient manner. This will also allow DH access to SHA plans which require national sign off, and sight of delivery promises from locally agreed plans. Unify2 will also disseminate baseline data and monitoring data so that all of the key elements of the planning process are together in one system. Data queries will be set up in discussion with SHAs to allow easy, flexible access to the full range of data.

Working with local partners

22 We cannot achieve delivery of local and national priorities without local partners. Local partners have a critical contribution to make in allowing for improved health outcomes. Joint strategic needs assessment between PCTs and LAs will allow them to identify shared priorities that meet the needs of local people. Plan selection and setting must be a joint process with collective agreement as part of the Local Area Agreement process (LAA). To support this, baseline data and plans for those indicators in the new National Indicator Set will be shared with local authorities, other local partners and other Government Departments through CLG's Information Management Programme, which is expected to be available from April 2008.

23 The "vital signs" contain the 31 indicators which form part of the National Indicator Set (NIS), from which LAA targets will be drawn. PCTs will need to agree in consultation with local partners which of those national and locally determined priorities should contribute to the LAA though they should expect to assure their SHA that:

- any target agreed in a PCT Operational Plan for one of the 31 "vital signs" in the NIS should not have a lower value than a corresponding LAA target.
- relevant local priorities for health that are recognised in their joint strategic needs assessment directly inform the indicators they choose to recommend from the NIS;

- they are giving clear priority to those areas where they are most challenged – for example their current performance in the lowest decile nationally, is poor compared with other PCTs in the cluster or can be stretched to demonstrate exceptional strong outcomes;
- the operational plan submitted to the SHA clearly sets out the proposed contribution they intend to make to their new LAA(s).

Submission of Plans

24 We will collect SHA plans for 2008/09 to 2010/2011 in two stages. The first stage will be an initial and partial submission of the planning lines (at the end of January) relating to 18 weeks and patient experience of access to primary care. Draft technical definitions have previously been made available through Unify2 to support this process. The second stage will be a full submission of the planning lines at the beginning of March 2008.

Plan sign-off

25 DH will sign off SHA plans though a series of bilaterals between SHAs and DH, covering finance and the national priorities. DH will provide initial informal feedback on plans submitted at the end of January.

26 Indicators for local sign-off will be supported through Unify2 with reports on plan content and analysis against current performance.

27 DH will be able to view all plans, will expect alignment with LAAs, but will only intervene in local sign off arrangements if:

- aggregate plans at national level fall short of agreed PSA targets; or
- if the SHA or DH team in a Government Office for the Region believes a LAA is not well founded on its joint strategic needs assessment.

Supporting information

28 There will be no additional PCT plan information collected at the national level in this planning round, with the exception of the supporting measures identified in paragraph 12i) above.

29 In other areas PCTs may wish to make local arrangements to collect additional information (for example, blood pressure and cholesterol levels in support of the CVD indicator) to inform their local plan setting and design of their delivery strategy.

Refreshing and revising plans

30 For a number of indicators baseline data is not currently available and so plans cannot be developed for these areas in the short term. In the first iteration of plans (Winter 2007/08), some local priorities do not have a national baseline dataset currently available. **Annex A** lists those lines with baseline data.

31 A second iteration of plans will be required in Autumn/Winter 2008/09 when baseline data are available for all indicators. At this point PCTs will be required to review and revise their priorities for the remaining two years of the planning period.

32 A further opportunity to review and revise priorities and plans for the final year of the planning round will be offered in 2009/10.

Reporting progress

33 DH will monitor progress against all elements of the "vital signs" and all other commitments and standards at least once a year, and share this data, at individual organisation level, with the NHS via Unify2 to inform local performance management and reporting.

34 Report cards, based on the "vital signs" will be produced for PCTs to ensure that patients and the public can monitor PCT improvements alongside the local NHS's contribution to their Local Area Agreement (LAA). Similar information will be used in aggregate form for SHA and national level reports.

Timetable

35 The timetable below sets out the main stages and decision-making points for commissioners to be aware of during the planning discussions.

Deliverables	Date
2007	
CSR settlement	October 2007
Operating Framework	December 2007
PCT allocations announced	December 2007
Planning and technical guidance issued	January 2008

Deliverables	Date
2008	
Technical definitions, Unify templates and baseline data available	During January 2008
SHAs to submit initial financial plans (for all organisations within the SHA)	31 January 2008
Submission of initial plans for 18 weeks (plus all supporting lines) and Patient Experience of access to Primary Care	31 January 2008
Agree central elements of contract	February 2008
SHAs to submit final financial plans (for all organisations within the SHA)	3 March 2008
SHA submission of plans and activity to DH	3 March 2008
Contract sign-off	March 2008
SHA and PCT plan sign off	31 March 2008
LAAs signed off by	June 2008
First revision of plans	Winter 2008/09
Second revision of plans	Winter 2009/10

List of Annexes

Annex A – Indicators for Local Use from the "vital signs"

Annex B – List of Existing Commitments

Technical Descriptions, Excel Templates and Baseline Data (where available) for all of the indicators will be posted at http://nww.unify2.dh.nhs.uk/

Once within Unify2 this information can be found at:
>Systems Links
>Forums
>Vital Signs 2008-11
>Resources

Annex A

Indicators for Local Use from the "vital signs"

	Local Priorities (Tier 3)	Monitoring	Baseline Available
	Achievement of CNST risk management standards	Annual	Yes
	Proportion of people with depression and/or anxiety disorders who are offered psychological therapies	Quarterly	In development
*	Proportion of adults (18 and over) supported directly through social care to live independently at home	Annual	Yes but incomplete
*	Proportion of people achieving independence 3 months after entering care/ re-hab - rate per 10,000	Annual	In development
*	Proportion of adults with learning disabilities in settled accommodation	Annual	In development
*	Proportion of adults in contact with secondary mental health services in settled accommodation	Annual	In development
*	Proportion of adults with learning disabilities in employment	Annual	In development
*	Proportion of adults in contact with secondary mental health services in employment	Annual	In development
	Patient reported unmet care needs	Annual	In development
*	Number of delayed transfers of care per 100,000 population (aged 18 and over)	Annual	Yes
	Proportion of people with long-term conditions supported to be independent and in control of their condition	Annual	No. Proxy in first year
*	Timeliness of social care assessment	Annual	Yes
*	Timeliness of social care packages	Annual	Yes
	Ambulance conveyance rate to A&E (to be developed)	TBC Annual	In development
*	Proportion of all deaths that occur at home	Annual	Yes

	Local Priorities (Tier 3)	Monitoring	Baseline Available
	Patient reported measure of choice of hospital	TBC	November data available shortly
*	Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)	Annual	Yes
*	Proportion of carers receiving a 'carer's break' or a specific carers' service as a percentage of clients receiving community based services	Annual	Yes
	Prescribing indicator (TBC)	Annual	TBC
*	Number of emergency bed days per head of weighted population	Quarterly	Yes
	Rates of hospital admissions for ambulatory care sensitive conditions per 100,000	Annual	Yes
	Learning Disabilities (Indicator to be developed)	TBC	In development
	Vascular risk score	Annual	Yes
	Percentage of patients admitted with a heart attack who were prescribed an anti-platelet, a statin, a beta-blocker	Annual	Yes
*	Healthy life expectancy at age 65	Annual	TBC
*	Rate of hospital admissions per 100,000 for alcohol related harm		Yes
	Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality Outcomes Framework (QOF)	Annual	Yes
	Proportion of people where health affects the amount/type of work they can do	Annual	TBC

	Local Priorities (Tier 3)	Monitoring	Baseline Available
	Hospital admissions caused by unintended and deliberate injuries	Annual	Yes
	Mortality rate from causes considered amenable to healthcare		
*	Self-reported measure of people's overall health (EQ5D)	Annual	TBC
*	Patient and user reported measure of respect and dignity in their treatment	Annual	In development
*	Parents' experience of services for disabled children	Annual	In development
	NHS estates energy/carbon efficiency	Annual	Yes

Planning level = PCT except achievement of CNST risk management standards and number of delayed transfers of care per 100,000 population.

Annex B

Existing commitments

Whilst there is a need to focus on new priorities, it is essential that the levels of service set through previous commitments, which should have been achieved by April 2008, are maintained. We will ask the Regulator to feed the following specific commitments into their performance assessment of NHS bodies, alongside its performance assessment of other issues:

- 4-hour maximum wait in A&E from arrival to admission, transfer or discharge;
- guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours;
- a maximum wait of 13 weeks for an outpatient appointment;
- a maximum wait of 26 weeks for in-patients appointments;
- three month maximum wait for revascularisation;
- a maximum two-week wait standard for Rapid Access Chest Pain Clinics;
- thrombolysis "call to needle" of at least 68 percent within 60 minutes, where thrombolysis is the preferred local treatment for heart attack[3];
- guaranteed access to a GUM clinic within 48 hours of contacting a service;
- all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment is funded at the time and hospital of the patient's choice;
- delayed transfers of care to be maintained at a minimal level;
- all ambulance trusts to respond to 75 percent of Category A calls within 8 minutes;

[3] We will consider whether there needs to be an equivalent measure where the local preferred treatment is primary angioplasty for 'call to balloon' time.

- all ambulance trusts to respond to 95 percent of Category B calls within 19 minutes;
- a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals;
- a maximum waiting time of one month from diagnosis to treatment for all cancers;
- a maximum waiting time of two months from urgent referral to treatment for all cancers;
- 100 percent of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy;
- deliver 7,500 new cases of psychosis served by early intervention teams per year;
- all patients who need them, to have access to crisis services with delivery of 100,000 new crisis resolution home treatment episodes each year;
- all patients who need them, to have access to a comprehensive child and adolescent mental health service, including 24-hour cover/appropriate services for 16- and 17-year-olds and appropriate services for children and young people with learning disabilities;
- chlamydia screening programme rolled out nationally.

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285975 1p Jan 08
Produced by COI for the Department of Health

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