Celebrating the 60th anniversary of the NHS

NHS60

the operating framework

for the NHS in England 2009/10

high quality care for all

Department of Health

DH INFORMATION READER BOX

Policy HR/Workforce Management **Planning** Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
Document purpose	Action
Gateway reference	10967
Title	*The Operating Framework for 2009/10 for the NHS in England*
Author	DH/NHS Finance, Performance & Operations
Publication date	08 December 2008
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communications Leads, Directors of Performance
Circulation list	Voluntary Organisations/NDPBs
Description	This document sets out the specific business and financial arrangements for the NHS during 2009/10. The Operating Framework for 2009/10 describes the national priorities for the year and how the visions set out in *High Quality Care for All* can be delivered with the development of Payment by Results, tariff details and the standard contract. It sets out how we expect services to be transformed so that quality is our organising principle and patients are the arbiter of success.
Cross reference	N/A
Superseded documents	N/A
Action required	N/A
Timing	N/A
Contact details	David Flory NHS Finance, Performance & Operations Directorate Department of Health Richmond House 79 Whitehall London SW1A 2NS
For recipient's use	

Contents


Quality is the organising principle of the NHS

Foreword by David Nicholson CBE

Implementing High Quality Care For All

2009/10 will be a pivotal year for the NHS as implementation of *High Quality Care for All* gathers momentum. *High Quality Care for All* moves us into the third stage of a reform journey that began with the *NHS Plan* in 2000. The first stage was about increasing capacity and investment across the NHS. The second stage was about introducing levers to enable reform: choice; contestability; more freedom for providers; and better financial systems. And the third stage, underpinned by *High Quality Care for All*, is about using the additional capacity and the reform levers to transform services to deliver high quality care for patients and value for money for the taxpayer.

High quality and value for money

High Quality Care for All set out a compelling case for change, first by highlighting the range of drivers outside the NHS that we need to respond to, such as changing public expectations and health needs; and secondly by making clear that the NHS is simply not realising the full potential that developments in technology, medicine and informatics can offer. While there are many examples of good quality care in parts of the country, the ten regional visions that emerged from the local review process highlighted the variations in life expectancy and outcomes that need to be tackled.

So the overall vision which emerged from local reviews and which we set out in *High Quality Care for All* is to make quality the organising principle of the NHS. Quality spans three areas: safety, effectiveness and patient experience. It is these three things together that make a quality service – not one, not even two, but all three together. And, as *High Quality Care for All* made clear, it is equally important that we focus on preventing illness and helping people to stay healthy.

We have never been in a better place to deliver these ambitions. We have made tremendous progress in tackling the basics of quality that mattered most to our patients: drastically reducing waiting times; halving infection rates; and improving patient experience with new primary care centres and hospitals in most areas. These achievements have brought real benefits for our patients, but also give us the opportunity to now really go further and drive up quality in terms of safety, effectiveness and patient experience.

At the same time, we have succeeded in turning a financial deficit into a sustainable surplus which is a crucial achievement in light of the difficult conditions now facing the global economy. During the challenging period ahead, we will rightly be expected to focus more than ever on securing value for money for every pound invested in the NHS. In this context, high quality care is not a luxury but a necessity. Prioritising the most effective treatments, reducing errors and waste and keeping people healthy and independent for as long as possible are all things that contribute not only to the quality of care, but also to a more efficient and productive health service. High quality and value for money are not competing alternatives; they are one and the same thing. So our collective focus on high quality care could not have come at a better time, as we prepare for the challenge of contributing to substantial public sector efficiency savings in 2010/11.

Enabling change

This year's Operating Framework sets no new national targets. The priorities we set last year were based on what mattered most to our patients, public and staff, and so this year remain the same: pressing ahead with reductions in waiting times, continuing to tackle healthcare-

associated infections and maintaining financial stability. Delivering these priorities during 2009/10 will be a key focus for the service, but at the same time we need to build on the movement generated through the Next Stage Review process to make quality our organising principle. And we need to work in partnership with local authorities to address growing public health problems such as alcohol misuse and childhood obesity.

This Operating Framework sets out what we will do to support clinical teams and organisations to drive up quality. One element of this is ensuring that clinical and financial incentives are aligned, which is why we are adjusting the national tariff for 2009/10 to make the payment system more clinically relevant. But it is also vital that we do not lose the connection between the tools we are putting in place and our underlying purpose. It is no good if we have excellent quality metrics, for example, if we do not use them to make the necessary improvements to the quality of maternity care, or to access to dentistry. All of the ten strategic health authority (SHA) visions told us that maternity and dentistry were priority areas, so we expect to see real improvements for patients over the coming year.

During the past few months, I've talked to frontline staff across the NHS about how we can take forward the vision set out in *High Quality Care for All*. These conversations, and the success of the Next Stage Review process itself, have helped us to develop four principles to support the change process. These principles – co-production, subsidiarity, clinical ownership and leadership, and system alignment – describe the way we intend to do business in 2009/10. It's a big challenge to apply these principles consistently to our approach to change. But it's a challenge we all need to take on, because these principles will make the difference: applying them to the implementation of *High Quality Care for All* will greatly improve our chances of success.

The challenge for 2009/10

This Operating Framework therefore sets out a huge leadership challenge, as we are asking the clinical and managerial community to do four things simultaneously:

- Continue to deliver on the national priorities that matter most to our patients and public, so that our progress in these important areas is sustained and improved.
- Invest the additional resources wisely in order to prepare for the need to make substantial efficiency savings in 2010/11 and for a tighter financial climate thereafter.
- Start to put in place the strategic enablers and foundations that will help deliver the ten SHA regional visions and put quality at the heart of all that we do.
- Develop new ways of working and leading that reflect the evidence base and principles for driving large-scale transformational change.

This year will also see legislation to create the first NHS Constitution enter Parliament. During these difficult economic times, it is worth highlighting just one of the values in the draft NHS Constitution:

> ***'We use our resources for the benefit of the whole community, and make sure that no-one is excluded or gets left behind. We accept that some people need more help, that difficult decisions have to be taken, and that when we waste resources we waste other people's opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier'.***

It is vital that we use our resources wisely over the coming year in order to prepare for the leaner times which inevitably lie ahead. This does not mean hoarding our money or going on a spending spree; it means investing prudently in high quality care and planning for the next five years, rather than just the next two. So we intend to deploy the current surplus in a planned and managed way, reducing the overall surplus by £800 million during 2009/10 and 2010/11. Because better care means better value, it is more important than ever that we focus these resources on securing high quality for all.

David Nicholson
NHS Chief Executive


What matters most to our patients, public and staff

1 High Quality Care For All

Maintaining the momentum

1. This is the second NHS Operating Framework in the three-year planning cycle established by the 2007 Comprehensive Spending Review (CSR). The CSR provided the NHS with an annual growth in resources of 4 per cent in real terms over three years. This provided a solid platform for improving the quality of care and focusing on the priorities that matter most to our patients, staff and the public. We have done what we said we would do, and delivered on the following key national priorities:

   - On healthcare-associated infections (HCAIs), we are on course to maintain the annual number of MRSA (meticillin-resistant staphylococcus aureus) bloodstream infections at less than half the number in 2003/04; and, in cases of *Clostridium difficile*, to deliver a 30 per cent reduction (compared with the 2007/08 baseline figure) by 2011.
   - Access to services has improved and we are now poised to achieve the 18-week waiting target; and on GP services, practices are open for longer and a greater range of services is being delivered.
   - Health is improving and a range of health inequalities reduced; outcomes for people with cancer and cardiovascular disease are better, although we must still strive to reduce the gap in life expectancy between Spearhead primary care trusts (PCTs) and the whole of England.
   - Patient and staff experiences are getting better: both the patient and staff satisfaction surveys are showing better results in terms of how services are provided and with wider engagement in delivering them.
   - We have a much stronger system to respond to major incidents: robust plans on pandemic influenza and other major incidents will be in place in each PCT by December 2008.

2. At the same time as delivering on its key priorities for 2008/09, the NHS was engaged in a major process of developing a vision for the future: the NHS Next Stage Review. Across the country, and throughout each of the ten regions, thousands of clinicians, patients and stakeholders were involved in a process to produce a local vision for their area. *High Quality Care for All* was the final publication, responding to the ten SHA visions and setting out a range of enablers to help to make them a reality. *High Quality Care for All* made clear that quality should be the organising principle for the NHS, at the heart of all we do.

3. The Next Stage Review process accelerated the shift from top-down targets to more devolved ownership so that services are increasingly developed by frontline staff around the needs of empowered local populations. The existing national priorities remain but we are not adding to them. This means that we are providing more space for collaboration between local NHS organisations, local authorities and partner agencies and the people they serve to make *High Quality Care for All* and *Putting people first* a reality.

4. As well as getting the key service challenges under control, NHS finances are now much healthier with a surplus in the system as a whole and the vast majority of NHS organisations maintaining financial balance. The investment to deliver *High Quality Care for All* needs continued and improved financial management from the majority of NHS organisations that are now demonstrating financial stability, and we need to focus greater attention on those that require significant improvement.

5. In order to ensure that the NHS continues to address key public concerns and is able to press ahead with implementation of *High Quality Care for All*, this Operating Framework does four key things:

   - Chapter 2 sets out our **key priority areas** for the service for 2009/10. There will be no change to our priorities and no new national targets. However, the NHS must be ambitious in continuing to make improvements in key areas, going beyond expectations wherever possible. And we must begin to focus on the overriding long-term goal, set out in *High Quality Care for All*, of systematically improving quality across the NHS.
   - Chapter 3 describes the wide range of **enablers** to support the NHS in continuing to deliver *High Quality Care for All*. As part of this, we need to focus on how we deliver the transformational change required to truly make quality our organising principle. We must build on the movement and engagement that was developed during the Next Stage Review process and accept that traditional methods of management will simply not deliver the degree of ambition we have set ourselves. So, as well as a range of enabling tools, this chapter sets out a new model of change, and the evidence-based principles that underpin it.
   - Chapter 4 sets out the **financial regime** that will support the delivery of our priorities and strategy; this builds on the firm financial foundations laid in the previous two years, while recognising the outlook for public finances set out in the Government's Pre-Budget Report.
   - Finally, Chapter 5 sets out the **planning framework** and timetables for the coming year. It puts particular emphasis on joint planning and partnership working, especially with local authorities, which is crucial to achieving our goals.

6. 2009/10 must be the year in which we consolidate both our success on key national commitments and our strong financial position. And it must also be the year when we begin to put in place the enabling strategies and actions that will drive service transformation in the years to come. This agenda represents a major leadership challenge for all of us who work in the NHS.


For the
benefit
of all
patients

2 High Quality Care for Patients and the Public

Setting the priorities for 2009/10

1. Over the last two years, we have progressively set out our intention to devolve greater power and autonomy to the local level. This commitment remains, and is strengthened with our renewed focus on subsidiarity.

2. This does not mean that there will never be any national commitments or priorities. The draft NHS Constitution makes clear that the NHS is a national system, funded by taxpayers for the benefit of all patients. This means that we can and must be able to ensure that there are national standards, and that wherever there are significant areas of public concern, we respond to them across the board.

3. Equally, while the NHS is a national system, its services are delivered locally. That is why last year's Operating Framework clearly distinguished the national 'must dos' from those areas where local organisations need to set their priorities based on local needs by establishing the Vital Signs framework.

4. The Vital Signs for the first time set out a differential approach to performance management, allowing local services to deliver in a way that meets local circumstances. The indicators are split into three tiers:

   - Tier 1 sets out a small number of **'must dos'**, which, because of the degree of importance our patients, staff and the public attach to them, apply to all PCTs. Tier 1 sets out national requirements about what needs to be achieved and by when, subject to performance management from the centre.
   - Tier 2 sets out a small number of **national priorities for local delivery** where we know that concerted effort and action is required across the board, but where we recognise that local organisations would benefit from a greater degree of flexibility on how they deliver. Strongly performing organisations are allowed to get on and deliver these indicators without interference from the centre.
   - Tier 3 provides a **range of indicators** available to PCTs and, following consultation with their local communities and partner organisations, they can choose areas where they want to target local action and effort for improvement. The Department of Health is not involved in performance management of tier 3.

5. Our five national priorities for 2009/10 were established through the last Operating Framework and remain:

   - improving cleanliness and reducing HCAIs;
   - improving access through achievement of the 18-week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services;
   - keeping adults and children well, improving their health and reducing health inequalities;
   - improving patient experience, staff satisfaction and engagement; and
   - preparing to respond in a state of emergency, such as an outbreak of pandemic influenza.

6. These goals hold throughout 2009/10 and will underpin our continuing drive to realise the expectations set out in *High Quality Care for All*, including the delivery of the SHA clinical visions. The level of progress required will apply differently in each PCT and across priority areas but progress should reflect important developments over the past year. A number of key strategies have been produced to support PCTs in achieving progress faster. These include the prevention package for older people that will support delivery across a number of the national priorities.

7. While progress in some priorities is commendable, a lot more needs to be done to improve access to dentistry, as well as the quality of care and oral health in the community.

8. Helping women and their families during pregnancy and birth is one of the health service's most important responsibilities. The NHS must strive to improve continually the service it provides to meet the individual clinical and emotional needs of mothers and their families. So we expect maternity services to make demonstrable overall improvements in services and to provide women with choices of type and place of care.

Cleanliness and Healthcare Associated infections (HCAIs)

9. NHS staff are to be congratulated on the efforts they have made to reduce significantly the number of infections: more than halving the number of MRSA bloodstream infections since 2003/04 and being on course to deliver the 30 per cent reduction in *Clostridium difficile* nationally. We have also embedded within the NHS the central importance of cleanliness. These achievements have significantly improved patient safety, the first dimension of high quality care.

10. Whilst the NHS has achieved the ambitious 50 per cent reduction of MRSA nationally, not every organisation has achieved this yet and for those organisations this objective should remain their immediate goal. Those that have already done so must continue to reduce infection rates. PCTs will agree stretching ambitions in contracts with provider organisations for reducing infection rates and improving cleanliness. SHAs will ensure PCT plans are robust in this respect and must be satisfied that those plans demonstrate, collectively, reduced variation in performance.

11. From April 2009, all elective admissions must be screened for MSRA in line with Department of Health guidance. This should be extended to cover emergency admissions as soon as possible and definitely no later than 2011.

12. As *High Quality Care for All* set out, once national targets are achieved they will become national minimum standards for all NHS organisations and a national standard for all patients, as with 18-weeks. This is therefore our intention with the MRSA target. However, unlike 18-weeks, which is an absolute performance level applicable at the organisational level, we need to define how the MRSA target enters the standards framework in a way applicable to all NHS organisations.

13. The new National Quality Board will commission a consultation in the New Year with the NHS, public, regulators and relevant experts about how to define the national minimum standard for MRSA, based on reasonable tolerance from best practice. We expect that this will mean that those organisations that are performing poorly, with higher MRSA-rates will have to make further significant improvements to achieve this national minimum standard.

14. The Care Quality Commission (CQC) will be asked to assess all NHS trusts and NHS foundation trusts against the MRSA standard, *Clostridium difficile* target and for compliance with the Hygiene Code as part of their independent periodic assessment.

Improving access

18 weeks

15. Providing timely access to care is central to improving quality, both by ensuring that care is received when it is most needed, and by contributing to a positive patient experience.

16. From December 2008, the minimum expectation of consultant-led elective services will be that no one should wait more than 18-weeks from the time they are referred to the start of their hospital treatment, unless it is clinically appropriate to do so or they choose to wait longer. PCTs and providers should plan how they will maintain, and ensure that the patient experience reflects delivery of this standard. Through the NHS performance regime, we shall continue to measure performance against minimum operational standards of 90 per cent (admitted patients) and 95 per cent (non-admitted patients). Every PCT and trust must strive to achieve this standard across all services and specialties, monitoring waits over 18-weeks so that patients do not wait for reasons other than choice or clinical exception.

17. Providers will be expected to accept all clinically appropriate referrals online and ensure that sufficient appointment slots are available to enable patients to book directly. This will require improvements in the operational management of outpatient capacity and demand. Without which, the system may fail to meet the right to choose at the point of referral for patients.

18. During 2009/10, we shall migrate from the interim solution for performance sharing to a full solution using the Secondary Uses Service (SUS) so that the contribution of every provider on inter-provider pathways can be reflected in the results used for performance management and assessment purposes.

19. New service models, including self-referral to allied health professional (AHP) services such as musculoskeletal physiotherapy, have improved patient outcomes and satisfaction and reduced demand elsewhere in the system. PCTs will want to consider such alternative models for other AHP and community services, where clinically appropriate, and promote their use to their local populations.

20. Reviewing the workforce mix, including the deployment of AHPs, will support further improvements in the accessibility and experience of services. PCTs will also want to consider how better access to AHP services, such as speech and language therapy or podiatry, will improve health outcomes and reduce health inequalities.

21. PCTs will be expected to maintain the reductions in waits for direct access audiology and hearing aid services they planned for delivery in 2008/09, and to support benchmarking of AHP services, referral to treatment data will become mandatory from April 2010. We shall consider alternative definitions and pilot alternative measures where providers do not have the IT capability.

Primary care access

22. Timely access also contributes to the quality of primary care. Last year, we asked PCTs to work with GP practices and other partners to improve the responsiveness of primary care services, and in particular to:

- ensure that at least 50 per cent of their GP practices offer extended opening outside core hours; and
- secure additional access to GP services through procurement for GP-led health centres (in each PCT) and over 100 new GP practices targeted at poorly served areas.

23. More than half of practices now have extended opening hours. Every PCT should ensure not only that they achieve and maintain this minimum standard, but also that they make ongoing progress in improving GP services. This includes ensuring that opening hours reflect patient needs and that patients have guaranteed access to a GP within 48 hours and can book appointments further ahead.

24. The majority of PCTs are well advanced in securing additional services through open and transparent procurement for GP-led health centres, which enable any member of the public to access GP services on a walk-in basis or by pre-booking appointments, 12 hours a day and 365 days a year, and – in the case of the 50 relevant PCTs – the procurement of over 100 new GP practices. During 2009/10, PCTs should ensure that there is timely implementation of these new services, including effective communications with the public, so that patients can benefit as soon as possible from improved access and choice.

25. Increasing the level, quality and range of services in primary care, particularly in under-provisioned areas, will require further increases in the number of doctors and other clinicians trained in primary care. This will require PCTs to work with GPs and other partners to upgrade and increase GP premises to add to the number of training practices and places.

26. PCTs should seek year-on-year improvements in patient satisfaction with GP services, as measured by the GP Patient Survey. The new GP Patient Survey will provide data not only on patient satisfaction with access, but also on their wider experience of the quality of GP services. PCTs should use this broader range of data to identify specific priorities for local improvement.

27. PCTs need to continue to develop NHS dental services so that they meet local needs for access, quality of care and oral health. This will include reviewing dental commissioning strategies, ensuring open and transparent procurement for all significant new investments in dental services, in order to provide access to anyone who seeks help in accessing services.

28. PCTs should also pay due regard to *Pharmacy in England: building on strengths – delivering the future*[1] when developing pharmaceutical services.

29. One other area where commissioners may want to consider reviewing service provision is urgent care, including the ease of access to information about the range of urgent/unplanned care services available in their community.

Keeping adults and children well, improving their health and reducing health inequalities

30. Each PCT has a responsibility to improve the health and well-being of people within its area and to tackle health inequalities. *High Quality Care for All* brought together a coherent national desire to do much more in terms of health promotion and preventative services. The Vital Signs contain a strong health improvement and prevention component, and PCTs must continue to drive

1 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_083815

real improvements across those services that need to make a step-change in people's health and well-being.

31. *High Quality Care for All* made clear that, for the NHS to be sustainable in the 21st century, it needs to focus on improving health as well as treating sickness, and that to achieve this goal the NHS should work closely with the many other local and national agencies that seek to promote health.

32. *High Quality Care for All* set the challenge of delivering greater equity with regard to health outcomes. To meet this challenge, the differences in the health status and outcomes within and between our different communities must be addressed. Improving life expectancy in Spearhead areas and tackling high infant mortality rates in disadvantaged groups remains a priority. To meet this challenge, Spearhead PCTs have recently submitted revised, ambitious all-age, all-cause mortality (AAACM) plans which need to be delivered. All areas should look to tackle health inequalities through putting them at the centre of service delivery. To sustain this, health inequalities should be at the centre of service delivery, disease prevention and partnership work, particularly with local authorities. Practical guidance has been set out in *Systematically addressing health inequalities*.[2]

33. In particular, *High Quality Care for All* called for PCTs to commission comprehensive well-being and prevention services, in partnership with local authorities and local partners, based on local identification of need, including, where appropriate, in early years. It called for the NHS to focus on six key goals: reducing smoking rates, tackling obesity, treating drug addiction, improving sexual health, improving mental health and reducing alcohol harm. Examples include:

    - vascular checks for people aged 40–74; and
    - the Prevention Package for Older People.

34. The Prevention Package for Older People will initially improve falls and fracture services, foot care, intermediate care, telecare and audiology services, with the aim of enabling older people to live longer, healthier and more independent lives. The package will evolve with new enhancements added over time.

35. It is important that services are provided when needed most. The standard contract for 2009/10 includes the requirement that providers of abortion services should also provide contraception advice and services after an abortion has taken place. Experience of this will be monitored as part of the Patient Survey.

36. Over the next two years, to ensure that those living with a long-term condition receive a high quality service and help to manage their condition, everyone with a long-term condition should be offered a personalised care plan.

37. The Carers' Strategy[3] sets out how we can ensure that we support carers. One key requirement is that PCTs should work with their local authority partners and publish joint plans on how their combined funding will support breaks for carers, including short breaks, in a personalised way.

2 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_086570
3 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_085345

38. There were four key areas identified in 2008/09 that required all PCTs to consider what action they needed to take. These areas were:

    - cancer;
    - stroke;
    - maternity; and
    - children.

Cancer

39. The *Cancer Reform Strategy*[4] says that patients should not wait more than 31 days for radiotherapy by December 2010. Delivery of this during 2010/11 for all patients needing radiotherapy requires a significant increase in capacity to achieve the level of an average of 40,000 fractions per million population, as recommended by the National Radiotherapy Advisory Group.[5] PCTs should ensure that local capacity plans are put in place to deliver this.

40. The 2005–08 Local Delivery Plan (LDP) round included six cancer IOGs (implementing outcomes guidance). Where necessary, PCTs and cancer networks should take urgent action to implement recovery plans to ensure full implementation. The Department, supported by the National Cancer Action Team, will continue to monitor progress.

Stroke

41. Each of the SHA visions committed to improving stroke care. Driving up standards of care to reduce mortality and morbidity through implementation of the National Stroke Strategy[6] continues to be an important activity for PCTs, supported by their local stroke care networks.

Maternity and neonatal services

42. It is critical that quality and safety in maternity services continue to improve in line with SHAs' commitments as part of *High Quality Care for All*. Putting women and their partners at the centre of local maternity service provision starts with encouraging women to see a midwife, or a maternity healthcare professional, for a health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy. By the end of 2009, there will be choice of:

    - how to access maternity care;
    - type of antenatal care;
    - place of birth – depending upon circumstances; and
    - place of postnatal care.

43. PCTs will want to demonstrate improvements in the experience of women and their families by developing more responsive services that meet local needs and react to user feedback. This will require ensuring that the workforce has sufficient numbers of maternity staff (including midwives, obstetricians and maternity support workers), neonatal teams and health visitors.

44. Nationally, the NHS is planning for an additional 1,000 midwives by 2009, rising to around 4,000 extra midwives by 2012, contingent on the rising birth rate. In January 2008, the Secretary of State announced that PCT baselines for 2008/09–2010/11 include £330 million of extra funding to support improvements in maternity services. The Healthcare Commission's review of maternity services should be taken into account when reviewing local services.

4 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_081006
5 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_074575
6 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_081062

Children

45. Combating child obesity remains a major challenge for us all, and the objective remains to reduce the proportion of overweight and obese children to 2000 levels by 2020. PCTs should lead this with their local authority and regional partners to support parents and families to make healthier choices. In particular, PCTs should deliver the *Change4Life*[7] social marketing programme and could include sharing results from the National Child Measurement Programme[8] with parents.

46. Breastfeeding is a vital part of a healthy start for babies and also reduces child obesity. All PCTs should be developing effective approaches to promote breastfeeding initiation and support mothers to continue to breastfeed for longer, including implementing the principles of the UNICEF Baby Friendly Initiative[9] in hospitals and community settings. In 2008/09, the Department of Health doubled its support to PCTs to promote this initiative to £4 million.

47. PCTs will want to review the transparency of their service offer in line with the Child Health Strategy, to be published shortly, and local priorities. These may include:

    - delivering a high quality Healthy Child Programme (formerly the Child Health Promotion Programme)[10];
    - implementation of the adolescent-friendly 'You're Welcome' standards;
    - improving the experience of services for children with a disability and their families, including palliative care;
    - reviewing and evaluating the effectiveness of Child and Adolescent Mental Health Services to ensure that vulnerable children have swift and easy access to services; and
    - services to reduce teenage pregnancy rates, including provision of a full range of contraceptive services.

48. All NHS organisations have statutory responsibilities in relation to safeguarding and promoting the welfare of children. All SHAs, PCTs and trusts will be expected to keep under review their arrangements to make sure that they have the policies, skills, competencies, partnership arrangements with other agencies, monitoring and assurance procedures to ensure that their statutory responsibilities are being met.

49. SHAs, PCTs and trusts are statutory partners in Local Safeguarding Children Boards (LSCBs). Other health agencies may also be involved in the LSCB. The individual members have a duty to contribute to the effective work of the LSCB.

50. SHA strategic workforce plans will need to be developed which deliver improved health outcomes in maternity, neonatal and children's services and help tackle inequalities. The plans should support the delivery of high quality services as close to home as possible and in a range of settings, for example children's centres. PCTs will want to consider how their local workforce plans support the local services offer.

7 Available at http://www.dh.gov.uk/en/News/Currentcampaigns/Change4Life/index.htm
8 Available at http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/DH_073787
9 Available at http://www.babyfriendly.org.uk/
10 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_083645

Experience, satisfaction and engagement

51. In working towards becoming 'world class commissioners' PCTs will want to fully engage and involve the public as citizens in a dialogue about health needs, service design and decision making and communicate with them to increase their understanding and confidence in using local services. This needs to be in the context of the proposed NHS Constitution right to choose the care that best meets their needs. Legal requirements to involve and consult patients and the public are set out in Real Involvement,[11] and will include an active and mutually supportive relationship with Local Involvement Networks (LINks) and local projects that provide feedback from local groups and communities.

52. Commissioners and providers will want to work in partnership to implement systems that respond to the views and experiences of patients and improve the patient experience of services. The opportunity to have near real-time feedback of patients' experience gives providers and commissioners an unprecedented opportunity to respond to changes and improve the patient experience. Examples include local projects to use real-time patient feedback in all organisations and the implementation of the new complaints system which will commence on 1 April 2009, *Making Experiences Count*.[12]

53. Strong staff empowerment and engagement are crucial to ensuring improved quality of care and effective implementation of the local clinical visions at the heart of *High Quality Care for All*. The challenge for all NHS organisations for 2009/10 is to sustain and build upon existing levels of staff engagement and empowerment. PCTs and SHAs will want to lead NHS providers in embracing partnership working at all levels.

54. The consultation on the NHS Constitution set out four pledges to NHS staff around quality work, well-being, learning and development, and involvement and partnership. They reaffirm our commitment that good workplaces and rewarding jobs should exist for all NHS staff. PCTs will want to endorse this commitment as a prerequisite to the provision of high quality services.

55. For NHS organisations, the quality of work will be measured through an indicator for staff satisfaction that the Care Quality Commission will use in its periodic assessment of these organisations.

56. Of particular importance to staff is the NHS pension. With the Pensions Choice Exercise due to begin in July 2009, NHS organisations need to ensure that the data they provide to the Business Services Agency (BSA) Pensions Unit is accurate and up to date to enable eligible staff to be offered the option to remain on the 1995 NHS Pension Scheme or to convert to the 2008 scheme.

Emergency preparedness

57. PCTs should work with NHS organisations, other contracted healthcare providers, local authorities and other local organisations to put plans in place to enable an effective response to major incidents, such as train derailments, natural disasters, terrorist attacks, or public health incidents. In addition, PCTs, together with local partners, were required to produce robust pandemic influenza plans by December 2008. During 2009/10 and beyond, these plans must be tested, reviewed and improved, as appropriate, to take account of lessons

11 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_089787
12 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_082714

learned and of developments in the national arrangements for pandemic influenza preparedness.

Priorities determined and set locally

58. In addition to the national priorities, PCTs, working with their partners, have developed local priorities based on what their local communities tell them is important and these are reflected in Local Area Agreements (LAAs). These discussions have been informed by evidence from data collections, strategic needs assessment and best practice.

59. The Vital Signs indicator set supports this approach, giving responsibility to PCTs for setting and owning local targets for health service priorities. The development of local quality indicators will further support prioritisation. Early evidence suggests that some PCTs are working towards more rapid improvement in services and outcomes than would have been expected from a traditional approach.

60. There have been a number of important developments in the last year within the context of *High Quality Care for All* that will help PCTs determine how they develop and implement their local plans. These cover the following areas:

- alcohol;
- dementia;
- end of life care;
- mental health;
- military personnel, their dependants and veterans;
- mixed-sex accommodation;
- people living in vulnerable circumstances; and
- people with learning disabilities.

Alcohol

61. Hospital admissions for alcohol-related conditions are at a worrying level. When reviewing their local priorities, PCTs should consider the longer-term benefits of their activity as well as the direct impact they can have, for example, on alcohol services. The Government's alcohol strategy, *Safe, Sensible, Social*: *The next steps in the National Alcohol Strategy*[13] set out local and national action to reduce alcohol-related ill-health and crime. The recent consultation on possible further action will also be of interest to those PCTs who have included alcohol within their operational plan. PCTs who have not included alcohol within their plan should consider if developments in alcohol services could contribute to other identified priorities.

Dementia

62. The National Dementia Strategy will be a comprehensive framework aimed at driving up standards of health and social care services to improve the quality of life and quality of care for people with dementia and their carers. PCTs will want to work with local authorities to consider how they could improve dementia services.

End of life care

63. To deliver the *End of Life Care Strategy – promoting high quality care for all adults at the end of life*[14] and the local SHA visions, PCTs will want to consider delivering extended and improved service provision with their partners.

13 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218
14 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_086277

Mental health

64. In addition to the introduction of the Improving Access to Psychological Therapies programme that will continue to roll out across PCTs, there are opportunities to review equitable access to and experience of services. The *Delivering race equality in mental health care* action plan[15] provides further advice to PCTs and providers.

65. PCTs and providers will want to adopt the principle of providing care in the least restrictive environment and as close to home as possible. The provision of improved physical care for people with severe mental illness, for example through regular health checks, will reduce inequalities as will also ensuring that early intervention services not only maintain the target of 7,500 cases, but also consider the length of care provided to individuals.

Military personnel, their dependants and veterans

66. When commissioning services, PCTs and providers need to take account of military personnel, their families and veterans in their area.[16] PCTs will want to assure themselves that their services do not disadvantage these groups in terms of their ability to access timely health care or dental services. The existing arrangements giving priority access to veterans for service-related conditions, subject to clinical need, is an issue that all PCTs and providers should now be delivering for all referrals.

Mixed-sex accommodation

67. PCTs are expected to work with their local providers to deliver substantial and meaningful reductions in the number of patients in acute, general or community hospitals who report that they share sleeping or sanitary accommodation with members of the opposite sex. In deciding what constitutes a 'substantial and meaningful' improvement, PCTs are expected to take close account of local patient and public expectations.

68. PCTs are encouraged to promote the use of local intelligence to drive improvement. At national level we are seeking specific improvements in the Healthcare Commission's survey scores, or equivalent patient experience surveys, where these are available (for example the *Count me in* census for mental health). Patient experience is the final arbiter of success.

69. Plans for mental health and learning disability inpatient services should address the issues above, as well as:

    - ensuring men and women do not share bedrooms or bed bays; and
    - widening the availability of women-only day areas.

70. In addition, in order to comply with Section 31 of the Mental Health Act 2007, PCTs should ensure that, by April 2010, no 16–17 year-olds are treated on adult psychiatric wards, unless such an admission is in accordance with their needs. They should work across services to ensure an effective transition, giving young adults the best chance in independent adult life.

15 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4100773
16 Available at http://www.nff.org.uk/rn_medicaladvice/nhs_guidance/letter.pdf

71. PCTs will work with provider units to ensure that plans for all units will be jointly published by the end of March 2009. These plans should include identified timescales and performance monitoring mechanisms.

People living in vulnerable circumstances

72. Supporting people to return to work improves their physical and mental health, while reducing the risk of social exclusion. We shall be testing 'fit for work' services, including improved advice from GPs and a new 'fit note'.

73. On occasion, people find themselves vulnerable to the challenges of society, be that through illness (physical and/or mental), age or other social factors. The NHS has a role to play with its partners in providing services relative to need, supporting people to contribute to society and live fulfilled lives. It is critical that when they do so they reflect the diversity of the people they serve, so that all people receive personalised services. Seeking out those most at risk and providing joined-up services for those with complex needs are key factors.

People with learning disabilities

74. In line with the recommendations of the recent independent inquiry by Sir Jonathan Michael,[17] PCTs should ensure they secure general health services that make reasonable adjustments for people with learning disabilities. To support these improvements, we have introduced a directed enhanced service for annual health checks for people with learning disabilities who are known to local authorities, and the NHS Vital Signs indicator reflects the take-up of these health checks. PCTs need to ensure there are effective arrangements for communication and partnership working between primary care and other healthcare providers to improve the overall quality of health care for people with a learning disability.

17 Available at http://www.iahpld.org.uk/


Leadership
is vital
to
realising
our
ambitions

3 Enabling High Quality Care Across the NHS

A system designed to deliver quality

1. This chapter sets out how we shall work together to achieve the ambitions described in Chapter 2. Enabling all parts of the NHS to focus consistently and systematically on improving the quality of care is a major challenge. It requires a long-term transformation that touches all parts of the system, starting from the frontline. This chapter sets out how we will enable this transformation, by:

   - developing and embedding a *new approach to change*; and
   - putting in place a *series of enablers* for high quality care.

Defining quality

2. *High Quality Care for All* set out our ambition for a system-wide focus on quality, by setting out a definition of quality covering three specific domains:

   - **Safety** – the first dimension of quality must be that we do no harm to patients. This means ensuring that the environment is safe and clean and tackling issues such as healthcare-associated infections, where we have made great progress over the past year.
   - **Effectiveness** – this includes clinical outcomes, such as mortality and survival rates. Another important aspect of effectiveness is avoiding ill-health and helping people to stay healthy. But just as important is the effectiveness of care from a patient perspective, measured through patient-reported outcome measures (PROMs).
   - **Patient experience** – this includes the quality of care and the delivery of personalised care, focusing on the compassion, dignity and respect with which patients are treated and how easy it is for patients to access services, taking account of the need to promote equality for minority groups.

3. It is these three things together that make a quality service – not one, not even *two*, but all three. Our vision is to place improvement across all three dimensions of quality at the core of everything the NHS does – both as ends in themselves, but also because delivering the best quality of care will ultimately yield the best value from the whole system. Having clarity about what we mean by 'quality' gives us a common purpose and language so that we can talk to each other about how we are going to put quality at the heart of all we do.

4. Patient-centred care means organising services around patients, meeting their clinical needs, working in partnership and treating them with dignity and respect. It means providing timely and convenient services that prevent – as well as manage or cure – ill-health.

A new approach to change

5. The great strength of the ambition of driving up quality is that everyone involved with the NHS has a part to play. Releasing the tremendous energy of frontline staff is not an optional extra: it is crucial to achieving success. We simply cannot get the change we seek through traditional top-down methods. Improvements in quality are led and delivered by teams of health professionals and

supporting staff, working together as part of a system. Improvements in quality cannot be driven from Whitehall.

6. We need to build on the success of the Next Stage Review process, and learn from industries and countries where large-scale change has been successfully implemented. Our experience and evidence have helped us to develop four principles to support the change process. These principles describe the way we aim to do business in 2009/10:

   - **Co-production** means that all parts of the system need to continue to work together on shaping and implementing change. This sounds like management jargon, but what it means in essence is engaging people across the system to work together to make change happen. This approach is what made the Next Stage Review process so successful, and it has informed the World Class Commissioning programme and the development of this Operating Framework.
   - **Subsidiarity** means ensuring that decisions are taken at the right level of the system, which means as close to the patient as possible. It means an **enabling** role for the centre, with more power and responsibility residing with patients and clinicians. And it means looking 'out, not up' wherever possible.
   - **Clinical ownership and leadership** was crucial to the success of the Next Stage Review process, and this must be maintained during **implementation**. If we get it right, the quality agenda has great potential to mobilise and empower clinicians across the system. And, conversely, we will get nowhere without clinicians on board. So clinical leadership needs to be part of everything we do.
   - **System alignment** – achieving complex cultural changes, such as making quality our organising principle, requires all the different parts of the system to pull in the same direction and work with partners, in particular through LAAs.

7. Applying these principles consistently to our approach to change in 2009/10 will be a major challenge. But it is a challenge that we must take seriously, because this approach will make the difference; applying the principles to the implementation of *High Quality Care for All* will greatly improve our chances of success.

8. This bottom-up approach to system improvement can bring its own difficulties. Local initiative has all too often been stifled in the past by heavy-handed bureaucracy or mixed and contradictory messages. Breaking this cycle is a challenge for both clinical and managerial leaders across the NHS. We need a new enabling approach to leadership, which encourages innovation; and we need leaders who can look across whole systems, rather than patrolling the boundaries of their own organisations.

9. *High Quality Care for All* challenges us to go further to develop a health service that focuses systematically on improving quality, and which has quality as its organising principle. Quality has always been a central motivation for all who work in the NHS, but we know that staff have often felt that the system within which they work has frustrated rather than supported their ambitions to improve the quality of care.

10. Great progress has been made in many areas, such as cancer and heart disease. Nevertheless, it is also true that progress has been patchy, particularly on patient experience. The local clinical visions found unacceptable and unexplained variations in the clinical quality of care in every NHS

region. They identified important changes that need to be made in order to raise standards and ensure that all services are high quality.

The quality framework

11. *High Quality Care for All* also set out a framework for systematically improving quality, based on seven components. We need to make progress in each of these areas in 2009/10:

    - bring clarity to quality
    - measure quality
    - publish quality performance
    - recognise and reward quality
    - raise standards
    - safeguard quality; and
    - stay ahead.

12. **Bringing clarity to quality** starts with the definition of quality set out above. It also means that the National Institute for Health and Clinical Excellence (NICE) will have an enhanced role from 2009/10 and will, in time, become the home for all national quality standards. There must be no doubt that the evidence base and standards set out by NICE apply across the service.

13. *High Quality Care for All* provided a powerful exposition of the importance of **measuring quality**. Measurement is the backbone of the quality system because without measurement we cannot demonstrate improvement. Every multi-disciplinary team in the NHS has a role to play in measuring what it does and working to determine the most appropriate measures of quality for its areas. Our approach to stimulating and embedding measurement for improvement at all levels of the NHS was set out recently in *Measuring for quality improvement.*[18] This is a key element of the quality framework and should be an important priority for all NHS organisations and staff in 2009/10.

14. To help ensure the availability of quality information, from April 2010 onwards healthcare providers delivering services on behalf of the NHS, starting with acute trusts, will be required to **publish quality performance** in an annual 'quality account'. These will include any additional information that will help to inform the public about the quality of the services provided. Development of quality accounts is closely linked to the *Measuring for quality improvement* process.

15. *High Quality Care for All* introduced the concept of reflecting quality in providers' income. The Commissioning for Quality and Innovation (CQUIN) payment framework[19] aims to ensure that quality improvement and innovation form part of commissioning discussions. All PCTs will need to agree with NHS providers how to link payment to quality in their 2009/10 contracts. In the first year, organisations may choose to link the 0.5 per cent of contract value to measurement of quality. Acute contracts should include a CQUIN scheme linking payment to specific locally determined goals that cover the domains of quality and innovation. For community, mental health and ambulance service providers, payment may be linked to a quality improvement plan. In future years, the proportion will increase and will start to reflect quality improvements. The new Care Quality Commission will also recognise where quality has been achieved through high-profile publication of trusts' results.

18 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_090444
19 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_091443

16. Consistently **raising standards** across the NHS will require a clinical voice at each level of the system. In addition to existing work to extend clinical leadership and engagement including through the World Class Commissioning programme, this means that all SHAs will have regional medical directors in post in time for 2009/10. The National Quality Board will be established to provide strategic oversight and leadership on quality.

17. From April 2009, the Care Quality Commission will play a crucial role in **safeguarding quality** across the NHS and social care. The Care Quality Commission takes over responsibility from the Healthcare Commission, and will help to clarify expectations about quality by identifying compliance criteria for registration of providers. It will assess provider and commissioner performance using indicators of quality agreed nationally with the Department of Health, and will publish an assessment of comparative performance based on core standards, World Class Commissioning, existing commitments and Vital Signs tiers 1 and 2, and the move towards registration requirements in 2010/11. This will recognise levels of quality performance and contribute to raising standards, including improving the quality of care provided across the NHS.

18. *High Quality Care for All* made it clear that **innovation** must be central to the NHS if we are to improve constantly the quality of care. To achieve this, the NHS must play its full part in supporting health research. NHS trusts and NHS foundation trusts have a statutory duty to support education and training. All providers of NHS care will need to increase their participation in research. The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years. SHAs are expected to ensure that NHS trusts work with the National Institute for Health Research Comprehensive Clinical Research Network locally to contribute to this progressive increase. In addition, from 31 December 2008 there will be a new duty on SHAs to promote innovation across their regions.

19. Embedding this quality framework across the NHS will be a long-term process. But 2009/10 is a crucial year, in developing the infrastructure to support quality improvement and work to enable a culture of measurement for improvement. This must be a priority for all parts of the NHS in 2009/10.

Enablers for improving quality

20. Alongside a new approach to change, we need to develop enabling strategies and support tools to help both staff and patients to contribute to quality improvement. This includes:

    - empowering patients to improve quality;
    - ensuring that commissioning focuses on quality;
    - leadership for quality and a high quality workforce;
    - developing high quality providers; and
    - using informatics to support quality improvement.

Empowering patients to improve quality

21. Recent reforms have increasingly put patients at the centre of care, with a key role in driving up quality using equality impact approaches to take account of diversity across the population. The introduction of free choice for elective care from April 2008 and the right to choice in the draft NHS Constitution clearly signal our ongoing commitment to empowering patients. And *High Quality Care for All* takes us further,

with its clear focus on measuring and understanding quality from a patient perspective.

22. In order to contribute to improvement, patients need clear information on the quality of each service offered by every NHS-funded organisation across all settings of care. NHS Choices will support the work of clinicians to inform the public, patients and carers about health choices and choice of service providers. PCTs should contribute to the continuing development of NHS Choices by integrating it into local support and advice for their patients and encouraging GP practices to improve the information about services.

23. PCTs need to improve awareness so that people know that they have a choice of provider and GP. They should also continue to develop their Expert Patient programmes to ensure that they are able to respond quickly to the needs of service users.

24. The draft NHS Constitution sets out a proposed new legal right of choice about care. Directions will specify what services should be covered. Once announced, all SHAs and PCTs must make adequate preparation for any new legal right, which could be in place as soon as April 2009. In addition, the Department would issue guidance setting out how PCTs will be able to fulfil this duty.

25. PROMs – short questionnaires used to measure patients' assessments of their own health and well-being – will play an important role in measuring the effectiveness of care, and contribute to the CQUIN payment framework.

26. PROMs put patients at the centre of determining the quality of services and will be introduced under the standard NHS contract for acute services. From April 2009 they will cover patients undergoing elective hip and knee replacements, varicose veins and groin hernia surgery.

27. PCTs should identify local priorities in discussion with their communities and then keep local people up to date with how the PCT and partners are performing against their tier 3 Vital Signs.

Commissioning for quality

28. Commissioners are the key to delivering the local visions set out in *High Quality Care for All*. World class commissioners will demonstrate their competence through having a coherent strategic plan that underpins not only their operational plan, but also the LAA, as well as in their financial plan and workforce development strategy.

29. The *Commissioning Assurance Handbook*,[20] published earlier this year by the Department of Health, was co-produced with the NHS and local government. This document sets out how the annual assurance system for World Class Commissioning will be implemented by SHAs and PCTs. It is one nationally consistent system, locally managed by SHAs, holding PCTs to account and supporting their development towards becoming world class commissioners.

30. Nationally, there is a range of tools to assist PCTs and specialised commissioning groups in delivering their priorities as world class commissioners. These include, but are not limited to:

    - the **Health Inequalities Intervention Tool**,[21] which assists PCTs and their partners to narrow the life expectancy gap and reduce within their areas health inequalities;

20 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_085148

21 Available at http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

- the developing **National Support Teams** (NST) for health inequalities, tobacco, alcohol, infant mortality, teenage pregnancy, sexual health, vaccinations and dementia; and
- **quality standards** (as described in the Next Stage Review for neonatal care, due to be published in June 2009).

31. Practice-based commissioning (PBC) provides the clinical leadership at the heart of World Class Commissioning. Strong support from PCTs is key to successful PBC. PBC groups will be entitled to improved information, management and financial support, for which PCTs will be held to account through the World Class Commissioning assurance system.

32. Commissioners need to develop a full understanding of the benefits and costs associated with the services that they are sourcing for their communities. Three new standard contracts have been developed for implementation in 2009/10:
    - mental health and learning disabilities;
    - community services; and
    - ambulance services.

33. The Pricing Framework for Community Services (to be published in December 2008) will inform contracting for 2009/10. PCTs should have community service portfolios that are described in terms other than professional groups, initially:
    - health and well-being;
    - children and families;
    - acute care provided in the community;
    - long-term conditions;
    - rehabilitation; and
    - end-of-life care.

    Further information about standard classifications will be published early in 2009.

34. The standard contract for NHS acute services has been refined to take in key *High Quality Care for All* components of having regard to the NHS Constitution and the CQUIN payment framework. From April 2009 PCTs should implement the revised version of the standard contract for their agreements with all those providers currently on it, and transfer onto it the independent sector providers and NHS foundation trusts whose existing contracts are due to expire on or before April 2009. PCTs that implemented the standard contract in 2007 should use the contract variation process to introduce the required amendments.

35. The framework set by the *Principles and rules for co-operation and competition*[22] and the *PCT Procurement Guide*[23] provide strong levers for commissioners to improve quality through their own expertise. PCTs need to ensure that the procurement of clinical services is undertaken fairly, transparently and non-discriminatorily and using the Supply2Health procurement portals. Where complaints about alleged breaches of the *Principles and rules of co-operation and competition* cannot be resolved through local disputes process, they may be referred to SHAs and – if not resolved by them – to the independent Co-operation and Competition Panel.

36. This range of tools and enablers will put commissioners at the forefront of efforts to improve systematically quality and focus on preventative care and health inequalities during 2009/10.

22 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_081098
23 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_084778

Leadership for quality and a high quality workforce

37. Ensuring that we have the right leadership, with the right skills, will be vital to realising our ambitions. Successful leaders will need not only to deliver on national and local priorities, but also to have the skills to focus on quality, with the confidence to look out to their communities rather than up to Whitehall for direction. The evidence shows that leaders who are successful in driving transformational change are those who focus their attention on success rather than failure, and who can operate across organisational boundaries. The National Leadership Council will have a key role to play in 2009/10 in helping local organisations to have the right set of talents and skills to drive forward the quality agenda.

38. All NHS leaders need to share an understanding of the high-level framework required to deliver the real and sustained benefits outlined in *High Quality Care for All*:

    - **Vision** – what quality improvements they are trying to achieve and how they will benefit patients and local communities.
    - **Method** – how they will make change happen and the method they will use for implementation and measuring success.
    - **Expectations** – what the difference will mean for people, the behavioural change that will be necessary and the values that underpin it.

39. SHAs, deaneries and higher education institutions should work closely with the Department of Health and each other to embed leadership skills at the earliest stages of career development into undergraduate and postgraduate curricula for healthcare professionals. SHAs and PCTs will also produce talent and leadership plans, in accordance with guidance released early in 2009. This will better equip all new entrants to meet the leadership demands of working in the NHS.

40. Developing a high quality workforce is also central to achieving our ambitions. NHS organisations need to take on board the findings from Dame Carol Black's *Working for a healthier tomorrow*,[24] which include the responsibility of the NHS towards its own staff.

41. All organisations that receive central education funding should adopt the government skills pledge to nominate a board champion to oversee education and development and publish its annual expenditure on continuous professional development for 2009/10 onwards.

42. SHAs are expected to put in place learning and development agreements with the NHS and other service providers to ensure that multi-professional education and training paid to them is used to provide high quality education and training in clinical settings, and that workforce information is made available to support workforce planning.

43. PCTs will want to assure themselves that NHS providers, other than NHS foundation trusts, have a comprehensive training and development plan that sets out the current requirements and puts in place a programme for the longer term.

44. We must also ensure that our workforce is empowered to deliver innovative and pioneering healthcare. Of the workforce required to provide NHS care over the next ten years, 60 per cent have already entered employment. Developing existing staff is essential to the *High Quality Care for All* ambition of providing high quality patient-centred services, enabling staff to keep

24 Available at http://www.workingforhealth.gov.uk/Carol-Blacks-Review/

abreast of advancing techniques and supporting continuous professional development.

Developing high quality providers

45. As part of this, *High Quality Care for All* committed to developing a quality framework for community services. This will be piloted from June 2009, prior to national roll out from April 2010. We shall publish compendiums of best practice to support transformation of community services across six key clinical areas: children and families; public health; long-term care; end-of-life care; acute services; and specific treatments in the community and rehabilitation.

46. Our success in developing a more diverse provider sector with the freedom to respond to local needs has been a key driver for improvements in recent years. The number of NHS foundation trusts continues to grow and we are committed to accelerating progress in 2009/10 so that all NHS trusts achieve NHS foundation trust status at the earliest opportunity. At the same time, we are keen to extend freedom and local accountability to providers in all parts of the NHS, giving them the time and space to focus on improving quality.

47. PCTs should ensure that their operational provider services are fit for purpose and able to perform effectively alongside all other providers. By April 2009, provider services should be in a contractual relationship with their PCT, providing sufficient separation from commissioning roles to avoid potential conflicts of interest. Following the Operating Framework we will publish advice and tools to support this, setting out the organisational forms available for the future provision of community services, including the steps PCTs will need to take as commissioners and providers.

48. PCTs will need to consider how they engage with and support staff who request to develop a social enterprise. A 'how to guide' for staff was published in November 2008 and will be followed by an assurance framework to assist PCTs in assessing requests. Nationally, we will procure a call-off contract of accredited providers who can provide practical business support for PCTs and staff wishing to set up social enterprises.

49. The 2009/10 tariff for acute services is based on a new classification, HRG4, that has been designed to take greater account of casemix complexity. This new classification system has been developed with the input of a significant number and range of clinicians so that it more accurately reflects modern clinical practices and pathways.

Informatics to support quality

50. In the past, informatics have too often failed to support adequately improvements in the quality of care. The Health Informatics Review, which ran alongside the NHS *Next Stage Review*, highlighted that achieving the benefits from investment in technology depends on local leadership and capability. It emphasised the importance of senior managers and clinicians leading and owning the informatics agenda. In addition, it focused on the need to improve the informatics capability of the general and management workforce and to strengthen the capacity of the specialist workforce. This focus will be essential in meeting the challenges set out in *High Quality Care for All*.

51. The introduction of the Summary Care Record (SCR) will improve patient care, in particular for those with a long-term condition or requiring urgent care. SHAs will agree the timeline for implementing the SCR with PCTs as commissioners.

52. Quality and safety of patient care will be improved through better data quality. Data quality metrics for the NHS number, patient demographics, secondary uses and other key priority areas will be routinely published and monitored. Making consistent and effective use of NHS numbers and the Personal Demographics Service will reduce the number of mis-associated records and will support the appropriate sharing of patient information with partners in the delivery of patient care.

53. Robust information governance is essential in maintaining public and patient confidence in the way that the NHS handles all health information, and requirements have been strengthened in relation to secure storage and transfer of patient identifiable data. All NHS organisations will need to demonstrate compliance with information governance standards through the achievement of a minimum of Level 2 performance against key requirements in the *Information Governance Toolkit* (October 2008)[25] In addition, NHS accounting officers are required to report on the management of information risks in statements on internal controls from 2008/09 and to include details of data loss and confidentiality breach incidents in annual reports. Information governance performance, controls and reporting are subject to audit.

54. PCT chief executives will continue to lead local health informatics programmes, using structured programme management techniques to that ensure that informatics underpins the implementation of service transformation. Local informatics planning will ensure that a systematic approach is deployed to identify costs and benefits and to ensure that benefits are achieved and evidenced. Guidance and more detailed expectations are provided in *Informatics Planning Guidance 2009/10*, published alongside this Operating Framework. Supported by evidence of robust local technical infrastructure, plans will identify the 'roadmap' that achieves the five key elements for secondary care determined in the Health Informatics Review as soon as possible and demonstrate how community services will be supported in a more integrated way with primary care and other local services.

25 Available at http://www.igt.connectingforhealth.nhs.uk/


Building on
firm
financial
foundations

4 Investing in Quality

Financial framework for 2009/10

1. The financial strategy for the NHS for 2009/10 and beyond is built on the firm financial foundations laid in the two previous years of surplus delivery and a significant reduction in the number of NHS organisations with operational deficits. It also recognises the outlook for public finances from next year onwards set out in the Government's Pre-Budget Report published in November 2008.

2. The aggregate surplus delivered in 2008/09 by SHAs and PCTs will be carried forward to 2009/10. This surplus can then start to be deployed in a planned and managed way and based on SHA and PCT planning to date, this will probably total some £800 million over the next two year period. This means that the NHS will continue to plan for appropriate and reasonable levels of surplus over the next two years whilst accessing a significant quantum of the accumulated surplus set aside to move faster in the local implementation of the developments necessary to meet the priorities set out in this Operating Framework.

3. Each SHA area will determine and agree with the Department of Health the level of accumulated surplus deployment required for 2009/10 based on their local planning requirements. Each SHA area shall then plan for a surplus in 2009/10 at least equivalent to its surplus brought forward less the level of planned surplus deployment. This approach once again enables the full deployment of baseline and additional resources made available to the service in 2009/10.

4. Within these plans, the Department expects all PCT debts caused by previous years' deficits to be fully resolved, except where there has been specific agreement between the SHAs and the Department. There is also an expectation that no NHS organisation will plan for an operating deficit in 2009/10 unless this is part of a planned recovery position agreed between the SHAs and the Department.

5. The aggregate surplus for each SHA area and in overall terms for the NHS also needs to recognise the surplus generated in the NHS trust sector. This arises from trusts continuing to recover from legacy deficit positions, the need to service working capital loans and/or the need to strengthen financial positions as a precursor to foundation trust authorisation. The Department will work with SHAs during the 2009/10 planning process to determine what impact this has for the aggregate surplus position for each SHA area.

6. The planned surplus for the SHA and its PCTs after the impact of the agreed level of surplus deployment and the necessary level of trust surplus will represent the final planned surplus for the SHA area. The total 2009/10 surplus for the NHS is expected to be in the region of £1.35 billion.

7. As the headquarters of the local NHS, SHAs will continue to have the flexibility to determine within their economies the level of contingency necessary to ensure delivery of their financial plans, and where this contingency is best held. There will be no central determination of the level of contingency necessary. Accordingly, SHAs will again also be able to determine and agree locally with PCTs the arrangements for the transfer and lodging of revenue resources with the SHA, within the limit of the overall SHA planned surplus. SHAs will be accountable for the management of these

flexibilities and will be expected to ensure that any such arrangements adhere to the underlying principles of transparency, consistency, independence and fairness.

PCT allocations

Revenue

8. PCTs' allocations for 2009/10 and 2010/11 are published alongside this Operating Framework, together with details of the revised weighted capitation formula and market forces factor (MFF) indices that have been used to inform these allocations. The report and recommendations by the Advisory Committee on Resource Allocation in respect of its review of the previous formula, as requested by the Secretary of State, will also be published. The new formula builds and improves on the previous formula by introducing:

    - a separate, transparent formula targeting funds at the places with the worst health outcomes;
    - a new needs formula which enables need according to age and other factors to be assessed together for the first time; and
    - a new market forces factor (MFF), which reduces the variation in the MFF for neighbouring PCTs and secondary care providers.

9. In headline terms, average allocations growth for PCTs in 2009/10 is 5.5 per cent, with a minimum growth floor of 5.2 per cent. This supports the movement by PCTs towards the capitation targets calculated following the application of the revised formula. For 2010/11, average allocations growth is also 5.5 per cent, with a minimum floor growth of 5.1 per cent. This represents a total increase in PCT direct funding of £8.6 billion over the two years, over which time no PCT will receive less than 10.6 per cent growth over the two years.

Capital

10. In 2008/09 there is £500 million available to fund PCT local capital schemes. That amount will be made available again in 2009/10, together with £100 million brought forward from 2010/11 to upgrade up to 600 GP surgeries to support training in practices. The Department will discuss with SHAs the best way to distribute this funding to ensure that it is appropriately targeted and effectively deployed in the year. In 2010/11 PCT local capital scheme funding will increase to £565 million. Additional capital funding for PCTs to support central initiatives is currently being reviewed, and will be discussed with SHAs through the 2009/10 planning process.

11. There are no changes in 2009/10 to the capital regimes currently operating in either the PCT or NHS trust sectors. PCTs will continue to develop robust capital plans that are agreed with their SHAs, which will inform their capital allocations. These plans need to reflect accurately slippage in programmes from previous years to ensure that existing commitments are recognised and to phase appropriately expenditure to ensure capital affordability.

12. The capital regime for the NHS trust sector will continue. Internally generated cash is the primary source of capital funding with additional finance provided through interest bearing loans. NHS trust capital plans will continue to be agreed with the SHA.

Accounting regime

13. The NHS and the Department are currently preparing for the full adoption of the International Financial Reporting Standards (IFRS) in accordance with HM Treasury requirements from April 2009.

14. NHS organisations that bring private finance initiative (PFI) or NHS LIFT assets on to their balance sheets in accordance with IFRS

should assume that there is no adverse impact on their capital resource limit positions. Information on the accounting implications under IFRS has been published.[26] NHS organisations should not assume any specific national action to address instances of additional revenue pressures arising from bringing assets on balance sheet or other changes under IFRS.

15. NHS organisations are expected to produce financial plans for 2009/10 that are fully IFRS compliant, and NHS financial planning guidance will reflect this.

16. Since 2008/09 NHS bodies have been able to choose the frequency and method of their property valuations, within the constraints of the Government's Financial Reporting Manual (FREM). NHS organisations will need to have carried out a full revaluation of their property assets under the new valuation rules to be reflected no later than the 2009/10 accounts.

17. The ability for NHS trusts to apply for working capital loans from the Department remains in 2009/10, under the existing rules that loans must be affordable over a sensible time-period and that principal repayments are made from operating surpluses and improvements in working capital. Similarly, defaulting on the terms of an existing cash loan, most probably by a trust moving into deficit and so not being able to make planned repayments from generated surpluses, will still result in being designated "financially challenged" with the implications that are set out in the 2008/09 Operating Framework. This is consistent with conditions set out in the NHS performance regime, as explained in paragraph 20 in Chapter 5.

Payment by Results

18. The proposed tariff for 2009/10 has been developed with substantial differences from tariffs in previous years. A new set of healthcare resource groupings (HRGs) have been developed with significant clinical involvement and we are planning for it to take effect from April 2009 – this is HRG4. It significantly increases the number of HRGs available to capture in a more sophisticated way the clinical activity taking place so better reflects the range of clinical services. There is also a significant change to the market forces factor element of the tariff.

19. The changes underpinning the new tariff have already been extensively discussed and tested with a wide range of stakeholder groups, many of which were set up following the recommendations of the tariff review in July 2006. We have also widely tested the impact of the tariffs on previous years' activity information both nationally and with specific organisations. We will shortly publish the tariff operational detail and draft guidance inform by the results and feedback from the testing. SHAs will need to work closely with all local NHS organisations to develop a full understanding of how the new HRG4 works so that we can identify only unintended consequence and consider mitigating actions required before final decisions on how to progress SHAs where particular organisations are having difficulties implementing HRG4.

20. We have already determined that in order to help trusts adjust to the new tariff, the full range of potential changes will not be introduced in 2009/10. Tariffs for accident and emergency services will remain based on the structure of HRG3.5 and, although HRG4 has the capability to generate HRGs for procedures delivered in outpatient clinics,

26 Available at http://www.info.doh.gov.uk/doh/finman.nsf

there will not be a mandatory tariff for these procedures in 2009/10.

21. In previous years the MFF element of tariff payments has been handled as a central adjustment with the Department holding funds on behalf of PCTs and reimbursing providers through a central mechanism. From 1 April 2009, PCTs will retain the responsibility and the funding to enable them to pay the relevant MFF directly to providers. The MFF is non-negotiable and the new MFF indices for all providers are included on the PbR website. As further help to trusts, the impact of MFF changes from 2008/09 has been capped at 2 per cent.

22. As HRG4 has been designed to take account of casemix complexity more accurately, the number and quantum of specialist top-ups to the tariff have reduced. Only two top-ups remain – for orthopaedics and specialised services for children. All providers are eligible for the orthopaedic services top-up, but as in 2008/09, only eligible providers will be able to claim the top-up for specialised services for children.

23. Independent sector organisations providing services under free choice must also be paid appropriate tariff plus MFF.

24. The tariff includes an uplift of 1.7 per cent to reflect 2009/10 prices. This includes an efficiency requirement of 3 per cent, in line with the Spending Review settlement. The tariff uplift recognises the importance of providers ensuring their services are Working Time Directive compliant. A breakdown of the main components of the uplift is contained within the operational tariff information that will be published. An increase equivalent to an additional 0.3 per cent in the uplift has been factored into the relevant tariff prices for particular services in recognition of specific increases in CNST premia for some clinical specialties.

25. The uplift of 1.7 per cent should be used as the benchmark for contracted services that are currently outside the scope of the national tariff. It will be for commissioners to determine with providers the extent to which there are legitimate additions or deductions from the uplift when contracting for the delivery of non-tariff services. As a further planning assumption, providers should assume that the uplift for the year 2010/11 will not exceed 1.20 per cent on a comparable basis.

26. The uplift for 2009/10 does not include a quality element as was the case in 2008/09. Providers will have the opportunity to secure additional income from commissioners through their local arrangements under Commissioning for Quality and Innovation schemes (CQUIN). PCTs are expected to make 0.5 per cent of their contract values (for both tariff and non-tariff services including MFF impact) available and to agree with their providers how this potential additional income for them is linked to quality in 2009/10 contracts. For acute providers this additional income will need to be related specifically to locally agreed CQUIN goals.

27. Providers will submit activity data monthly, and the information supplied as of 30 days after the ends of the month will be the basis for payment reconciliation. Consideration of any further payment adjustment in respect of changes made after the 30 days will be a matter for contracting parties to resolve locally, and in the absence of agreement may be referred to dispute resolution.

SHA flexibilities

28. There are specific instances in which an SHA, involving its PCTs where appropriate, may exercise its discretion to provide support in addition to tariff income, or to recover support that was previously given:

- Managing the transition towards the full implementation of the revised MFF indices.
- Managing the financial impact of the move to tariffs based on HRG4.
- Managing risk associated with PbR development sites.
- Managing exceptional revenue pressure as a result of changes in national accounting requirements.

Efficiency

29. The Operating Framework for 2008/09 was clear that the NHS is expected to identify and deliver 3 per cent cash-releasing efficiency savings for each of the three years of the current spending review period, ending 2010/11.

30. However, in the current economic climate, it is appropriate that the NHS with the other public services goes further and deeper in making efficiencies to contribute to returning the economy to balance in the timescales identified in the Pre-Budget Report. Our ambition is to achieve very substantial efficiency savings in 2010/11.

31. Accordingly, both PCTs and NHS trusts will be expected to explore the opportunities identified under the cross-Government Operational Efficiency Programme, where further efficiency savings can be secured from 2010/11. The themes of this programme, though cross-cutting, are all highly applicable to the NHS:

    - The use of shared services in back office operations, including the human resources, finance, estate and security functions. NHS Shared Business Services serves over 100 NHS bodies using recognised best practice processes and systems to deliver improved management information, improved financial and payroll management and cost efficiencies.
    - The increased use of collaborative procurement including improved compliance with centrally negotiated commercial deals.
    - The more commercial and efficient use of assets owned by organisations and an additional specific theme focused on efficient public sector property management that has great significance for the NHS.
    - Further development of local empowerment and incentives to help foster and disseminate front-line innovations that help improve efficiency. Better coordination with our partners will make care more efficient. The Partnerships for Older People programme is an example.

32. The Department will work closely with the NHS in the 2009/10 planning process to identify how these programmes can deliver efficiency gain to support front-line investment.

33. The Department, in conjunction with HM Treasury, is also pursuing specific additional efficiencies identified within the Public Value Programme as part of its contribution to supporting recovery and delivering long-term savings. These programmes involve key developments that are expected to deliver efficiency gains in the future:

    - The further development of tariff into non-acute services and the controlled move towards tariffs based on evidence-based 'best practice, best value' information from 2010/11.
    - The implementation of World Class Commissioning across all PCTs. This programme has the potential to unlock a range of productivity opportunities such as by reducing pre-operative bed days and reducing outpatients DNAs.

- The development of a more transparent system of workforce planning and training that secures value for money and ensures the adequate and flexible supply of clinical staff in the future.
- Improvements in the utilisation of the NHS estate and introduction of new models of providing primary care estate in order to secure maximum value from the capital budget, as detailed in the Pre Budget Report.

34. Both the Operational Efficiency Programme and the Public Value Programme will announce final conclusions in the 2009 Budget.

SHA bundle

35. There will continue to be a bundle of central initiative budgets devolved to SHAs for their local management. The proposed value is £6,116 million. This represents a 4.4 per cent increase compared with the bundle value in 2008/09. Options for 2010/11 and beyond, including putting more budget funding into PCT allocations, will be reviewed and discussed with SHAs during 2009/10.

36. A small number of new developments have been added to the bundle package, including aspects of the National Cancer Programme and the establishment of an Innovation Fund. Discussions between the SHAs and the Department will determine how the bundle value can best be deployed, which will determine the final detail of the bundle for SHAs.

Central budgets

37. The most significant remaining central budget is the funding to support PCTs in commissioning primary dental services, which is £2,257 million for 2009/10 net of patient income. This represents an increase of 8.5 per cent on the 2008/09 budget quantum. Details of the allocations will be issued separately.

38. Further allocations from the Departmental central budgets will be agreed and details issued in due course.

Meeting duties of equality

5 Making Quality Happen

Planning and partnership working

The planning framework

1. The planning guidance for the current three-year CSR cycle was set out in *Operational Plans 2008/09–2010/11*.[27] That guidance holds, and applies to the 2009/10 year.

2. The Department of Health will review, by the end of March 2009, the plans for 2009/10 with each SHA. In doing so, we shall apply key assurance tests to plans to ensure that they:

   - are based on robust demand and activity assumptions that support delivery of the 18-week target and other key targets;
   - give assurances on the delivery of national priorities and reconcile these across the three elements of finance, workforce and activity;
   - are consistent with contracts agreed locally; and
   - are aligned with their LAA's priorities for health and well-being.

National priorities

3. Performance management of SHAs by the Department of Health and assessment on national priorities by the Care Quality Commission will continue to be based on standards-based criteria, existing commitments and Vital Signs tiers 1 and 2. This means that the Care Quality Commission will be asked to use standards-based criteria, existing commitments and Vital Signs tiers 1 and 2 in its periodic assessment of NHS organisations. Monitor will base its compliance framework for NHS foundation trusts on the priorities set out in this document.

4. SHAs will hold PCTs and NHS trusts to account for improvements where performance is falling short. PCTs need to ensure that their contracts with NHS trusts, NHS foundation trusts and other service providers allow them to achieve national priorities. PCTs are also a partner in LAAs that will form part of the Comprehensive Area Assessment and be reviewed annually by Government Offices.

Local priorities

5. The Department of Health will not performance manage Vital Signs tier 3, and neither will the Care Quality Commission be expected to use performance against them as part of its periodic assessment. SHAs will need to be satisfied that PCTs have identified and are acting on those tier 3 indicators where performance needs to improve. As part of the national indicator set, the outcomes from tier 3 Vital Signs will be part of each Comprehensive Area Assessment but they will not be included within organisational assessments.

6. Performance against the whole range of the Vital Signs will be published in 2009/10 to reflect the 2008/09 position. This will enable local comparison and facilitate PCTs in determining future priorities in partnership with local stakeholders.

27 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_082542

7. In 2009/10, where there is substantial or good evidence of health inequalities arising from discrimination or disadvantage, we will review the Vital Signs at a national level by socioeconomic group, ethnicity and other dimensions in order to consider any trends relating to equality or inequalities. PCTs and SHAs will want to consider how they assure themselves that new and existing services are accessible to those most at risk and that they have met their duty of equality.

8. The NHS can make significant contributions to reducing its carbon impact. Every NHS organisation should ensure that it measures and progressively reduces its own carbon footprint. This will save resources now, improve health today and set an important example to deliver high quality and sustainable services for the future.

Operational plans

9. We expect each PCT to prepare an operational plan for 2009/10. These plans need to ensure that activity, finance and workforce plans are consistent and can be reconciled. They should include the following elements:

    - that national priorities will be met;
    - that local priorities have been identified and will be met;
    - plans are consistent with the contracts agreed with local providers;
    - they are consistent with the Joint Strategic Needs Assessment undertaken by the PCTs and local authorities;
    - they are consistent with the Children and Young People's Plan; and
    - they are consistent with the principles set out in the *Commissioning Assurance Handbook*.

Financial plans

10. Each January, all PCTs and NHS trusts must submit to the Department of Health an annual financial plan – a complete set of financial statements – for the year ahead, via the Financial Information Monitoring System.

Workforce plans

11. *High Quality Care for All* highlighted that high quality care could only be provided through a high quality workforce. PCT commissioners should assure themselves that NHS provider organisations have fully integrated the operational, financial and workforce implications within their business and service plans. A comprehensive assessment of the workforce risks and benefits of any proposals should have the same importance as financial considerations.

12. PCT commissioners need to understand fully the strategic workforce implications of their commissioning strategies and service developments for their health economy as a whole. In doing so, they must be prepared to offer constructive challenge to NHS providers about the workforce assumptions in their service plans. They must carry out a robust risk assessment to identify any potential workforce capacity and capability issues, including the need for NHS organisations to comply with the European Working Time Directive.

13. We expect each SHA to establish its own regional advisory machinery to provide multi-professional and clinical pathway advice on workforce planning, and a subsequent education commissioning plan at SHA level. The functions were set out in *A high quality workforce: NHS Next Stage review*[28] and there will be further information shortly.

28 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_085840

14. All NHS organisations must continue to improve the quality of their workforce data to enable effective strategic workforce planning from 2010, when the Electronic Staff Record will be the main source of NHS workforce data. At national and SHA levels, this information will also be used to provide metrics to support workforce planning, education commissioning and, where appropriate, for benchmarking processes.

Never events

15. From April 2009, PCTs may wish to use the national set of 'never events' as part of their contract agreements with providers. During 2009/10, implementation will mainly focus on promoting clear reporting and management systems for never events. This will inform the work we undertake with the NHS to propose link to payment regimes from 2010/11 onwards. PCTs will monitor the occurrence of never events, within the services they commission, and report these to the National Patient Safety Agency (NPSA) and publicly report them as part of their annual reporting on quality and safety.

16. SHAs will support PCTs and providers by providing advice on root-cause analyses of never events, should they occur. The NPSA will provide web resources and publish an annual report on never events, disseminating the lessons learned.

Partnership working

17. Personalised healthcare cannot be delivered without close working with local government and its partners. The planning process last year facilitated the alignment of PCT operational plans and LAAs to ensure wide stakeholder buy-in to priorities. PCTs should work with their local authorities and other partners through the Local Strategic Partnership to deliver LAAs. *Delivering health and well-being in partnership: The crucial role of the new local performance framework*[29] gives details of the LAA indicators which are relevant for PCTs.

18. As an active partner in the local Crime and Disorder Reduction Partnership (CDRP), PCTs will have looked at how to prevent crime and support the victims of crime within their local area. This could include playing an active role in local offender management and crime reduction forums.

19. PCTs will work with CDRPs to identify and share information effectively in order to support local action on reducing violent crime – especially knife crime. This will include, wherever possible by March 2009, having local arrangements in place for collecting and sharing with police depersonalised A&E data on victims of violent assault in all nine Tackling Knives Action Programme areas.

Performance regime

20. *Developing the NHS Performance Regime*[30] outlined the Department of Health's vision for: affording greater consistency and transparency in how the NHS identifies under-performance; how the system intervenes to support recovery; and how organisations would be managed, where services are not clinically or financially sustainable.

21. Working with colleagues in the NHS, we are setting clear thresholds for intervention to address under performance and a rules-based process for escalation, including defined timescales for demonstrating recovery so that all organisations can be clear about what is expected of them and by when.

29 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_081146
30 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_085215

22. We are proposing that where local recovery efforts have been unsuccessful, and an organisation continues to under-perform significantly, the NHS chief executive will have the option of triggering a new statutory rules-based regime for unsustainable NHS providers.

23. The Department of Health is also working with colleagues in the service to develop an SHA assurance system for implementation in 2009/10. The system will apply to all SHAs, setting clear expectations on their roles and responsibilities and defining the criteria for success.

Informatics

24. PCT chief executives will continue to lead local health informatics programmes to ensure that informatics underpins the implementation of service transformation. Local informatics planning will ensure that NHS organisations are ready to meet the informatics requirements of service improvement plans using a systematic approach to identify costs and benefits, and to ready ensure that benefits are achieved and evidenced. Guidance and more detailed expectations are provided in *Informatics Planning Guidance 2009/10*, published alongside this Operating Framework. Supported by evidence of robust local technical infrastructure, plans will identify the 'roadmap' that achieves the five key elements for secondary care determined in the Health Informatics Review as soon as possible, and demonstrate how community services will be supported in a more integrated way with primary care and other local services.

Community services

25. PCTs will want to review their community information sources and systems against guidance on information models (to be published in December 2008) and develop clear plans that identify methods to improve their local systems, including migration to NHS National Programme for IT community solutions.

Timetable

26. We will collect SHA plans for 2009/10 to 2010/2011 in two stages. The first stage, due on 30 January 2009, will cover the planning lines relating to tiers 1 and 2 Vital Signs, initial finance plans and initial workforce plans. PCTs will need to ensure that these plans are consistent with each other and are in line with agreements within their Local Strategic Partnerships.

27. The second stage will be a full submission of all planning lines relating to the Vital Signs tiers 1 and 2, finance plans and workforce plans, and is due on 20 March 2009. Again, these must reconcile with each other and with LAAs.

28. The Department of Health will provide initial feedback on plans submitted at the end of January, and will sign off SHA plans though a series of bilaterals between SHAs and the Department, covering the national priorities, activity, workforce and finance plans.

Annex A: Planning Process Timetable

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

Deliverable	Date
Planning and technical guidance issued	January 2008
PCT strategic plans developed	October 2008
SHA talent and leadership plans developed	Autumn 2008
PCT allocations 2009/10	December 2008
Tariff 2009/10	December 2008
Standard contract 2009/10	December 2008
Pandemic influenza and other major incident plans to be completed	December 2008
Initial SHA plans submitted for 2009/10–2010/11 for finance, workforce, Vital Signs and informatics	30 January 2009
Contracts to be agreed	28 February 2009
Local Area Agreements submitted to Government offices	2 March 2009
Final SHA plans submitted for 2009/10–2010/11 for finance, workforce, Vital Signs and informatics	20 March 2009
PCTs and provider units to publish joint plans on eliminating mixed-sex accommodation	31 March 2009
NHS providers register with the Care Quality Commission	1 April 2009
Quality framework for community services to be piloted	June 2009
PCTs to have developed plans for the future provision of community services	October 2009
Providers delivering services on behalf of the NHS to publish 'quality accounts'	June 2010

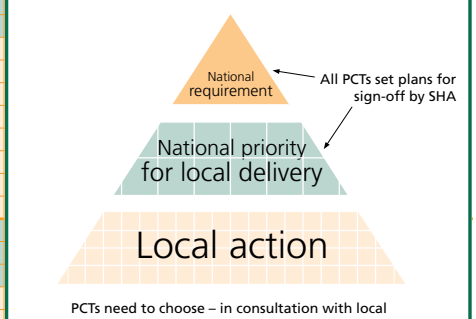
Annex B: Existing Commitments

- A four-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 an inpatient appointment.
- A 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 per cent within 60 minutes, where thrombolysis is the preferred local treatment for heart attack.
- Guaranteed access to a genito-urinary medicine 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 to be 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 per cent of Category A calls within eight minutes.
- All ambulance trusts to respond to 95 per cent of Category A calls within 19 minutes.
- All ambulance trusts to respond to 95 per cent 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 wait of one month from diagnosis to treatment for all cancers.
- A maximum wait of two months from urgent referral to treatment of all cancers.
- 100 per cent 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 it to have access to a comprehensive child and adolescent mental health service, including 24-hour cover and appropriate services for 16- and 17-year-olds and appropriate services for children and young people with learning disabilities.
- Chlamydia screening programme to be rolled out nationally.

Annex C: Vital Signs

National Priority	Vital Signs	Commitment
Cleanliness and healthcare-associated infections	MRSA number of infections	MRSA levels sustained, locally determined stretch targets taking us beyond the national target.
	Rates of *Clostridium difficile*	*Clostridium difficile* reduction of 30 per cent by 2011, differential SHA envelopes to deliver a 30 per cent reduction nationally by 2011.
	Achievement of Clinical Negligence Scheme for Trusts risk management standards	
Access to personalised and effective care	Percentage of patients seen within 18 weeks for admitted and non-admitted pathways *Supporting measures: Number of diagnostic waits > 6 weeks* *Percentage of patients seen within 18 weeks for direct access audiology treatment* *Activity levels* *Patient-reported experience of 18-week pathways*	To ensure that, by December 2008, no one waits more than 18 weeks from referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks)
	Patient experience of access to primary care *Supporting measures: Extended opening hours for GP practices* *Increased capacity in primary care* *Patient-reported access to out-of-hours care (indicator to be developed)*	*At least 50 per cent of GP practices in each PCT offer extended opening to their patients. 100 new GP practices, including up to 900 GPs, nurses and healthcare assistants introduced into the 25 per cent of PCTs with the poorest provision*
	Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	All patients by December 2009
	Proportion of women aged 47–49 and 71–73 offered screening for breast cancer	NHS Breast Cancer Screening Programme will be extended to all women aged 47–73 by 2012
	Proportion of men and women aged 70–75 taking part in bowel screening programme	NHS Bowel Cancer Screening Programme will be extended from 2010 to invite men and women aged 70–75 to take part
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)	Patients wait no more than 31 days from decision to treat to start of treatment, extended to cover all cancer treatments by December 2008
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	Patients wait no more than 31 days from decision to treat to start of treatment, extended to cover all cancer treatments by December 2010
	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	All patients with suspected cancer, detected through national screening programmes or by hospital specialists, wait no more than 62 days from referral to treatment by 2009.
	Primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services	
	Proportion of people with depression and/or anxiety disorders who are offered psychological therapies	
	Proportion of adults (aged 18 and over) supported directly through social care to live independently at home	
	Proportion of people achieving independence three months after entering care/rehabilitation rate per 10,000	
	Proportion of adults with learning disabilities in settled accommodation	
	Proportion of adults in contact with secondary mental health services in settled accommodation	
	Proportion of adults with learning disabilities in employment	
	Proportion of adults in contact with secondary mental health services in employment	
	Patient-reported unmet care needs	
	Number of delayed transfers of care per 100,000 population (aged 18 and over)	
	Proportion of people with long-term conditions supported to be independent and in control of their condition	
	Timeliness of social care assessment	
	Timeliness of social care packages	
	Ambulance conveyance rate to A&E	
	Proportion of all deaths that occur at home	
	Patient-reported measure of choice of hospital	
	Adults and older people receiving direct payments and/or individual budgets per 100,000 population (aged 18 and over)	
	Proportion of carers receiving a 'carer's break' or a specific service for carers as a percentage of clients receiving community-based services	
	Prescribing Indicator (to be developed)	
	Number of emergency bed days per head of weighted population	
	Rates of hospital admissions for ambulatory care sensitive conditions per 100,000 population	
	Learning disabilities	
Improving health and reducing health inequalities	Implementation of the Stroke Strategy	
	Proportion of women receiving cervical cancer screening test results within two weeks	All women should receive the results of their cervical screening tests within two weeks by 2010
	All-age, all-cause mortality rate per 100,000 population	
	<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 (quit rates locally 2009)	
	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	
	Effectiveness of Children and Adult Mental Health Service (CAMHS) (percentage of PCTs and local authorities that are providing a comprehensive CAMHS)	
	Number of drug users recorded as being in effective treatment	
	Prevalence of chlamydia	
	Vascular risk score	
	Percentage of patients admitted with a heart attack who, upon discharge, are prescribed an anti-platelet, a statin or a beta-blocker	
	Healthy life expectancy at age 65	
	Rate of hospital admissions per 100,000 population for alcohol-related harm	
	Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality Outcomes Framework	
	Proportion of people where health affects the amount/type of work they can do	
	Hospital admissions caused by unintended and deliberate injuries	
	Mortality rate from causes considered amenable to healthcare	
Reputation, satisfaction and confidence in the NHS	Self-reported experience of patients and users	
	Public confidence in local NHS	
	NHS staff survey scores-based measures of job satisfaction	
	Self-reported measure of peoples overall health	
	Patient- and user-reported measure of respect and dignity in their treatment	
	Parents' experience of services for disabled children	
Finance	Financial balance (PCT)	
	NHS estates energy/carbon efficiency	

Key



Annex D: Contract

The documentation for the new standard NHS Contracts is published at www.dh.gov.uk/en/publicationsandstatistics/publications/policyandguidance/DH_091451

It includes:

- Standard NHS contract for acute services
- Guidance on the Standard NHS acute services contract
- NHS multilateral contract for Mental Health Services
- Bilateral contract for Mental health
- Guidance on the Mental Health Services contract
- NHS multilateral contract for Community Services
- NHS bilateral contract for Community Services
- Guidance on the Community Services contract
- NHS multilateral contract for Ambulance Services
- NHS bilateral contract for Ambulance Services
- Guidance on the Ambulance Services contract
- Consortium agreement
- Consortium agreement legal guidance
- Guidance on the routine collection of Patient Reported Outcome Measures (PROMS)

290516 2.6k December 08 (CWP)
Produced by COI for the Department of Health

If you require further copies of this title visit
www.orderline.dh.gov.uk and quote:
290516/*Operating Framework* or write to:
DH Publications Orderline
PO Box 777
London SE1 6XH
Email: dh@prolog.uk.com

Tel: 0300 123 1002
Fax: 01623 724 524
Minicom: 0300 123 1003 (8am to 6pm, Monday to Friday)

www.dh.gov.uk/publications