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Foreword by David Nicholson CBE



We are at a critical juncture in the history of the NHS. After a decade of investment and reform that has helped drive real improvements for our patients, the NHS, along

with other public services, is about to enter perhaps the toughest financial climate it has ever known.

2010/11 is a pivotal year. The NHS still has a year of significant growth. The Chancellor's Pre-Budget Report announced that between 2011/12 and 2012/13, NHS frontline spending will rise in line with inflation. As set out in my 2008/2009 Annual Report, the NHS needs to identify £15-20 billion of efficiency savings by the end of 2013/14 that can be reinvested within the service so that it can continue to deliver year on year quality improvements.

So we need to use our growth in 2010/11 to put into effect the changes that we know will deliver the most benefits to patients in the future. *NHS 2010–2015: from good to great* sets out a five-year strategy to achieve this. It is important to recognise that 2010/11 is the first year of this new strategy, not just the final year of growth.

This will be tough but it is possible. We need a relentless focus on three things to make this possible. Firstly, improving quality whilst improving productivity, using innovation and prevention to drive and connect them. Secondly, having local clinicians and managers working together across boundaries to spot the opportunities and manage the change. It is simply not

possible to identify from the centre the kind of quality improvements that are necessary. And thirdly, to act now and for the long term.

The NHS Operating Framework for 2010/11 therefore provides a framework within which we can begin this journey. It maintains our consistency of purpose, with a renewed commitment to our national priorities. But it also sets out a number of new and powerful shifts in national policies and levers to support the NHS to rise to the challenge we have set ourselves. More than any other, this year's NHS Operating Framework is our response to the service, and provides a set of enablers and tools to support NHS staff to drive the transformation that will be required.

Important though policies and tools are, they are only powerful when connected to purpose, and only effective when accompanied by the right behaviours. So I want to stress that the policies set out in this year's NHS Operating Framework are intended to do four things – ensure a relentless focus on quality, encourage risk management across the system, bring into sharper focus the characteristics of the new system we are developing, both in terms of shape and behaviours, and encourage more creative thinking about integration.

Quality as the organising principle

NHS 2010–2015: from good to great made clear that we remain committed to the *Next Stage Review* vision of putting quality at the heart of all that we do. This NHS Operating Framework makes significant changes to the payment system to reward quality, with increases to hospitals only available by improving quality. Over time the link between payment, contracts and patient experience will be even stronger. For the first

time we have introduced “best practice” tariffs so that the prices we pay reflect the highest quality care, and the NHS will no longer pay for ‘Never Events’. These changes are bold, but the real challenge for providers is to ensure these tools and processes connect with and are meaningful to local clinicians.

Risk management

In order to achieve the transformation required, we need to focus on how we share risk across the system and re-balance the risk between providers and commissioners. This NHS Operating Framework starts to drive this shift, not least through the changes in payment and contractual systems. But it is vital that NHS organisations do not respond by just trying to transfer risk to another organisation. We will not succeed if we have islands of success in a sea of failure. We have to recognise that we have a zero sum game. If risk is transferred elsewhere in the system, it doesn’t take the risk away. The people who pay are patients. They don’t recognise organisational boundaries. What they recognise are services that are joined-up across the system.

The whole point of setting a marginal rate for non-elective care, for example, is to bring primary and secondary care health care professionals together to discuss how to manage demand better and improve care for patients. It must not disadvantage patients. The NHS is a system that has the potential to provide a seamless service for patients. We have a long way to go to achieve this, but our response to the swine flu pandemic shows that we can do it, and this NHS Operating Framework gives the NHS the tools to make it happen.

Managing risk is central to the commissioning and provision of health care services. From next year all NHS organisations will need to be registered with the new Care Quality Commission. This is an important step to provide public assurance that NHS services meet basic quality and safety standards, but it does not absolve NHS organisations of their own responsibilities in this area. Quality and safety are at the heart of what we do, and it is the responsibility of each and every board to assure itself that the services it provides are safe and of a high quality.

Characteristics of the new system

We need to start to understand the characteristics and the different ways of working required by the new system we are developing. If we are successful, the NHS in five years’ time will have more services closer to home and therefore less investment and activity in the acute sector. There will be much less variation, with the NHS pound increasingly spent on defined quality standards and patient pathways. Some of this will require new ways of organising services to deliver care in new ways, but we don’t have the luxury of prolonged debates. That is why the NHS Operating Framework for 2010/11 requires prompt and clear decisions to be made about the future shape of provider organisations so that we can get on with delivering the benefits to patients. Most of all, this must be a reforming system where changes continue to be shaped locally by the dynamics of co-operation, competition and patient choice.

Increasing importance of integration

The quality and productivity gains we need to make lie not within individual NHS organisations but at the interfaces between primary and secondary care, between health and social care, and between empowered patients and the NHS. At the heart of this is the importance of transforming patient pathways, leading to the integration of services and in some cases, the integration of organisations. Where organisational change takes place, it is not necessarily one organisation taking over another, but creating new services with patients and their needs at the centre.

The NHS Operating Framework for 2010/11 challenges all NHS organisations to reduce overheads and management costs. This is not meant to cause a rash of cuts or mergers, but to generate imaginative thinking about how organisations could better collaborate on some of their commissioning or provisioning functions, not just within the NHS, but with Local Authority and other partners.

The NHS Operating Framework for 2010/11 confirms the scale of the challenge ahead of us. Success requires bold and thoughtful leadership; re-thinking how we work; challenging current practice and thinking outside of our own organisational and professional interests so that quality genuinely is our organising principle.

This is not a time for rash, short-term decisions. The quality and productivity gains cannot be made by cutting how much we currently do or how many we employ. Success will not be achieved by analysis, counter-analysis, commentary or speculation.

The NHS Operating Framework for 2010/11 makes clear that this is a year for action. It is now time to tackle those things we have known about in the system for a long time, so we can significantly improve how we care for our patients and how the system is aligned to support that.



David Nicholson

NHS Chief Executive

chapter 1

overall context



- 1.1** This year (2010/11) is both the final one in the current planning round and the first in which the NHS needs to be properly prepared to meet the challenges set out in *NHS 2010–2015: from good to great*.¹ That document set out a five year vision for the NHS and should be read in conjunction with this NHS Operating Framework which operationalises the first year of that vision. This NHS Operating Framework offers stability in terms of service priorities but demands radical approaches and innovation if we are to realise the transformation necessary to improve the quality of services to patients at the same time as reducing costs. The principles set out in *Smarter Government*² will help identify ways to work. ‘Wait and see’ is not an option – action is needed at national, regional and local level.
- 1.2** This NHS Operating Framework confirms that, in terms of frontline services, the focus remains one of stability and improvement. We must continue to:
- deliver safe, high quality services with rapid improvement where there are unacceptable levels of variation;
 - deliver on those priorities that matter most, both nationally and locally; and
 - provide cost-effective services to keep people well, as well as delivering appropriate care at the earliest opportunity when it is needed.
- 1.3** To ensure that the NHS develops services that are able to meet the challenge of increased expectations around healthcare within the context of a tighter economic climate, this NHS Operating Framework sets out:
- the priorities for the NHS (Chapter 2);
 - the system levers and enablers (Chapter 3); and
 - the planning arrangements (Chapter 4).
- 1.4** *High Quality Care for All*³, published in June 2008, set out a challenging agenda to make quality the organising principle of the NHS. Quality must continue to drive all that the NHS does, and we should not be deflected from it when more challenging economic circumstances present themselves. Indeed, the current position with public finances means that how we deliver better quality services through system levers is not negotiable.
- 1.5** For 2010/11 we have secured an average 5.5 per cent increase in Primary Care Trust (PCT) allocations. This will be our last year of significant growth for some time. Standing still will not be an option: demand for services and patients’ expectations will increase. We have identified that we need to generate £15–£20 billion by 2013/14 from existing resources if we are to keep pace with system pressures. It is imperative that we use 2010/11 to make the radical changes to deliver the challenges set out in *NHS 2010–2015*, so that we are best

1 www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyandGuidance/DH_109876

2 www.hmg.gov.uk/media/52788/smarter-government-final.pdf

3 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_085825

placed to deliver when funding will be tighter.

1.6 This is a daunting challenge, but one which we can manage. The NHS is in a strong position – we have tackled the deficits that built up a few years ago, and in their place we have transparent and robust finance and performance regimes. In *High Quality Care for All* we don't just have an agenda for going forward, we have one that is clinically driven, following the most in-depth staff and patient consultation the NHS has ever seen. Each strategic health authority (SHA) has a clinically based vision to be delivered and we need to see that through; 2010/11 gives us the final year of financial headroom to make the necessary investments and changes needed so that our staff, patients and public can move forward with us.

1.7 By maintaining stability on national priorities we are providing a real opportunity for radical and innovative approaches to service delivery – there must be no sacred cows. We have put in place strong mechanisms to secure patient confidence and safety as we move forward:

- The NHS Constitution⁴ sets out that we are establishing a legal right to healthchecks and treatment within 18 weeks and 2 weeks for cancer waits or where this is not delivered, for the NHS to offer a range of alternative provision. PCTs will need to ensure that these rights are delivered from 1 April. PCTs will need to ensure that those patients

who have not been treated within minimum entitlements are identified and that redress mechanisms are in place so that patients are quickly offered the choice of alternative provision. Wherever suitable we would expect this to include private provision. PCTs should respond proactively to the new entitlements and ensure that effective working procedures are in place to offer everyone their legal entitlements without legal redress.

- A new system of regulation overseen by the Care Quality Commission (CQC) ensures that all NHS providers are registered against essential levels of safety and quality – the challenge is not only to become registered but also to maintain patient safety and stay registered on an ongoing basis.
- Monitor continues to ensure that NHS acute and mental health providers can function effectively as organisations – the push for all secondary and tertiary NHS provision in these sectors to be delivered out of NHS foundation trusts remains, and 2010/11 is the year for SHAs to identify how they will make that happen.
- The proposed National Care Service will strengthen the social care sector, and NHS organisations must continue to develop working arrangements with local authorities, partnership is no longer an optional lever – this is absolutely imperative if we are to achieve gains across public services. It is not a time to police boundaries – we need to break them down.

⁴ www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

- 1.8** In delivering the priorities, it is important to regard them as a means to an end and not the end in themselves. Better and faster access to diagnostics and treatment gets people into the system and ensures that more effective interventions can take place on the basis of clinical need. Reducing infections means a better patient experience. All these things contribute enormously to ensuring equality. Better services apply equally irrespective of personal circumstances. The NHS is for all. As well as the NHS Constitution setting out national expectations, the Equality Bill is scheduled to become law in early 2010, with its provisions coming into force during 2010/11. In preparation, NHS organisations need to take account of achieving *age equality in health and social care*⁵, the report of the review led by Sir Ian Carruthers and Jan Ormondroyd.
- 1.9** NHS organisations need to ensure they have proper arrangements in place for meeting their obligations for cross-border healthcare and patient mobility. New regulations and guidance will be published early in 2010 to give practical advice on the systems that need to be in place. The NHS also needs to be aware and start planning for the implementation of a proposed EU directive on cross-border healthcare.
- 1.10** This NHS Operating Framework is a call to action. While the vision set out in *High Quality Care for All* remains, as do the priority areas to be tackled in terms of existing commitments (see Annex B) and Vital Signs tiers 1 and 2 (Annex C), we need to see bold changes to the system to ensure we can respond with the necessary scale and pace to the challenges outlined in *NHS 2010–2015*. The NHS is a national system that requires local delivery to secure change and improvement. This NHS Operating Framework provides the system levers and enablers with which local organisations can make the changes necessary to embed quality into every aspect of service.
- 1.11** We need to change the perception of the NHS from one of a treatment service to one where more effective prevention and better support for lifestyle choices can result in healthier outcomes for all. Addressing lifestyle factors such as smoking, alcohol, diet and physical activity can both reduce the incidence of chronic disease and prevent premature deaths. In the past, prevention has been sidelined in times of challenge – we must not allow this to happen again. We must continue to prioritise prevention as the first area to be addressed.
- 1.12** Building on the success of the process to develop *High Quality Care for All*, David Nicholson identified four key principles that should apply when we tackle change. These principles have produced much greater local ownership of decision-making and need to be prominent as we tackle the challenges that lie ahead in 2010/11. They are:
- **clinical ownership and leadership** – we must all continue to mobilise and empower clinicians across the system. Clinicians must be on board when decisions are taken;

5 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_107278

- **co-production** – all parts of the system need to continue to work together on shaping and implementing change;
- **subsidiarity** – ensuring that decisions are taken at the right level of the system, which means as close to the patient as possible; and
- **system alignment** – achieving complex cultural changes, such as making quality our organising principle, which requires all the different parts of the system to pull in the same direction and to work with partners.

1.13 In taking change forward, each part of the system should focus on its role and do what it is best placed to do. National bodies need to refrain from micro-management, and local organisations need to resist ‘seeking approval’ from above. Each tier should centre its efforts on where it can make the most beneficial impact:

- **Local organisations** are the catalysts for change and as such must engage clinicians in leading and driving that change in ways that firmly embed it in the communities they serve.
- **Regional organisations** are the system managers and thus have a critical role in ensuring that local plans stack up and do not have undesirable consequences when considered in the round.

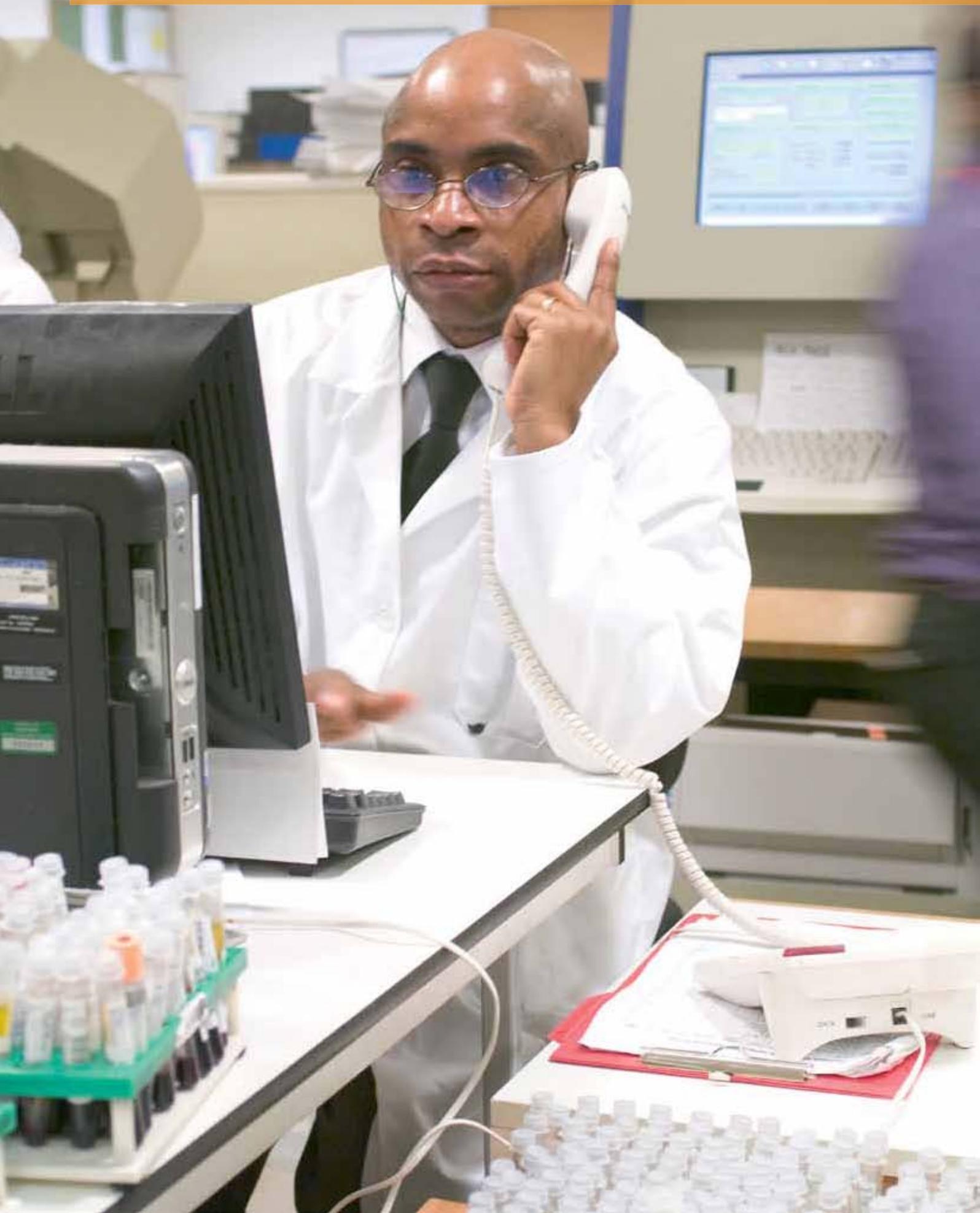
- **National organisations** and systems should have a role only where a national response is required, such as Interim Management and Support (IMAS) in providing recovery, the National Institute for Health and Clinical Excellence (NICE) in setting consistent, high quality and evidence-based guidelines, or the pay system when local decisions on pay need to be guided by a national framework.

1.14 We all have a corporate role to play to maintain the reputation of the NHS. In statements about the future direction of the workforce it will be important not to destabilise staff unnecessarily. Trusts should be clear that they would anticipate redundancies only as a last resort option in their overall approach to managing within tighter budgets.

1.15 This NHS Operating Framework sets out some serious and difficult challenges for the NHS in 2010/11 as it prepares for the future, but if the system does what it is best at – working together for the benefit of patients and the public – then those challenges can be met and the NHS can continue to deliver and improve the high quality services that we all expect.

chapter 2

priorities



- 2.1** Given the background set out in Chapter 1, we need to provide clarity by maintaining consistent service priorities if we are to deliver the system changes to secure quality improvements for 2010/11. That does not mean it is time to stand still, and in some areas the NHS has collectively agreed to go further, faster.
- 2.2** A systematic approach to identifying those organisations with the most room for improvement was set in train during 2009/10, with action occurring at both a local and a national level. Locally, PCTs have been tasked with using their commissioning and contracting powers to secure improvements. Nationally, the alignment of priorities across the NHS Performance and Regulatory Frameworks means that there is consistency of focus and transparency.
- 2.3** In 2010/11, the focus has to be on improving the performance of those organisations that are still not delivering. Nationally, the NHS has delivered significant and sustained improvements, but not all organisations have contributed equally to achievement of these performance improvements.
- 2.4** The NHS Constitution signalled a move away from a system of targets and central direction to one of rights and responsibilities, where empowered patients drive continuing improvements in services. The proposals in the current consultation on new rights in the Constitution take us still further by converting waiting time targets that have been achieved into legal rights for patients.
- 2.5** *NHS 2010–2015* reasserts our commitment to putting patients at the centre of care. A collective voice is a powerful lever for change. The NHS Constitution now gives patients a legal right to choose their provider when they are first referred to a consultant-led outpatient service, supported by directions published in April 2009. Choice has therefore been taken out of Vital Signs, as PCTs should be taking action on their legal duties. World Class Commissioning (WCC) and SHA Assurance programme will be used to ensure that PCTs are doing so.
- 2.6** This chapter sets out:
- the national priority areas against which NHS organisations will be required to continue to improve; and
 - areas outside the national priorities on which PCTs and their providers can decide whether they support the delivery of locally agreed priorities.
- National priorities**
- 2.7** The NHS Vital Signs are split into three tiers in support of the national priorities:
- 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. These are 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 improvements. The Department of Health is not involved in the performance management of tier 3.

2.8 The five national priorities remain:

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

2.9 For the purpose of performance assessment and performance management, the existing commitments and Vital Signs tiers 1 and 2 indicators set out in Annexes B and C are those that will be used to assess delivery of these national priorities.

Improving cleanliness and reducing HCAs

2.10 There have been continued and sustained reductions in MRSA bloodstream infections and *Clostridium difficile* infections. However, not all organisations have contributed equally to achievement of these targets, and we expect significant improvement from them during 2010/11.

2.11 To reduce variation in performance and better reflect the zero tolerance approach to preventable infections, the National Quality Board has developed a new objective on MRSA bloodstream infections for 2010/11. The Department of Health will publish a new minimum standard for *Clostridium difficile* in spring 2010 to allow preparation and implementation from April 2011.

2.12 NHS providers and commissioners should ensure that:

- their current plans deliver the MRSA objective;
- they are delivering their stretch targets as part of the national 30 per cent reduction in *Clostridium difficile*, and where these have been achieved agree stretching goals through contracts; and
- screen all relevant emergency admissions for MRSA as soon as possible – and definitely by 2011.

Access

18-weeks waiting times

2.13 Although the 18-week waiting time target is being met by all organisations, there are some specialties where this is not the case.

We know this can be achieved and expect it to happen. Patients are entitled to start their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions unless they choose to wait longer or it is clinically appropriate that they do so. There should be no other reasons for patients waiting longer than 18 weeks across all services and specialties.

- 2.14** Achievement of the 18-week standard meant that in *High Quality Care for All: Our journey so far*⁶ Lord Darzi was able to announce the removal of the 13-week outpatient and 26-week inpatient performance targets. We can also remove the maximum wait of three months for revascularisation as all three of these targets are now captured by delivery of the 18-week pathway. All NHS organisations should ensure that their drive to improve access is maintained across the full range of pathways, including urgent and emergency care.

Primary care access

- 2.15** PCTs will want to build on better access by ensuring ongoing improvements in patients' experience of access, as measured through the GP patient survey, and by continuing to ensure that the new GP health centres and GP practices deliver effective and innovative services.
- 2.16** The recent consultation on rights set out that patients should be able to choose a GP practice offering extended access to evening and

weekend appointments. Every PCT should ensure that they continue to make progress in ensuring that the availability of these services matches local needs. In particular, in so far as some local practices are not providing extended opening, PCTs should commission other services that secure commensurate benefits. When a new policy framework is agreed that ends the current system of GP boundaries, PCTs will need to work with local stakeholders to ensure a smooth transition to these new arrangements.

Dentistry

- 2.17** The NHS is committed to the aim of ensuring that by March 2011 everyone seeking NHS dental services has access to them. To provide a consistent measure of whether PCTs maintain this aim, we are introducing a new indicator of public experience of accessing dental services for use as an existing commitment from 1 April 2011. To aid with planning, PCTs will:
- have initial results of performance against the new measure available in summer 2010;
 - want to take into account the recommendations of Professor Jimmy Steele's independent review⁷ (subject, where necessary, to the piloting of some recommendations); and
 - use the inclusion of dental funding in unified allocations to focus their efforts to achieve their commitment to access.

6 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_101670

7 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_101137

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

- 2.18** *NHS 2010–2015* made clear the national-level priority being given to focusing on interventions that prevent the early onset of diseases and avoidable conditions, thereby improving the quality of people's lives and providing productivity savings and value for money for the NHS. This is the core business of all NHS organisations. The four areas of focus remain heart disease, cancer, children and maternity, but the aim is to reduce demand for acute services across the board and reduce health inequalities.
- 2.19** To achieve the challenging national health inequalities target and close the gap. Spearhead areas that are off track need to focus on commissioning and delivering a programme of the known evidence-based and cost effective interventions at sufficient scale to decrease rapidly the all-age all-cause mortality of their populations.
- 2.20** Achieving the vision in *NHS 2010–2015* will require culture changes driven at both a national and a local level. The Change4Life social marketing programme has been highly successful, and PCTs will want to continue to lead on local delivery. The existing families campaign will be joined in 2010 by Start4Life, for families with children under 2 years old and pregnant women, and by giving a focus to physical activity and adults aged 45 to 65.
- 2.21** Action on tobacco control at national, regional and local levels is already delivering significant savings to the

NHS and improving people's health. A new tobacco strategy will set out opportunities for PCTs to build on the current model through the use of different levers and describes the anticipated levels of savings that could be achieved.

Stroke

- 2.22** Despite good progress being made in improving stroke services, stroke patients are still being admitted to medical assessment units rather than stroke units, even though the evidence that outcomes are better when patients are treated and cared for by a multidisciplinary stroke-skilled team. Health economies should ensure that more patients can have a brain scan within one hour of admission and also help to accelerate the investigation and treatment of transient ischaemic attack.

Cancer

- 2.23** PCTs need to work with their cancer network to ensure that all screening services have:
- made plans to start the extension of breast cancer screening offered to women aged 47–49 and 71–73 from April 2010 so that the screening programmes are routinely inviting women until they are 73 by 2016; and
 - extended bowel cancer screening offered to men and women aged 70–75 from 2010.
- 2.24** In line with the recommendations of the National Radiotherapy Advisory Group, PCTs need to ensure that their providers have sufficient capacity in place to achieve the 31-day standard for radiotherapy by December 2010. The national Cancer Patient Experience

Survey will take place in 2010/11, and commissioners will wish to encourage their trusts to take part so they can use the findings to consider how services can continue to improve.

Children and young people

- 2.25** Tackling priority health issues of children and young people, is complex, requiring strong leadership and effective partnership working across the NHS, local authorities and partner agencies.
- 2.26** The child health strategy *Healthy Lives, Brighter Futures* was published in February 2009⁸. PCTs will want to review their service offer in line with this, including in their role as statutory partners in the local children's trust board, and with the national rollout of Sure Start Children's Centres. From April 2010, children's trust boards will be responsible for developing, monitoring and reviewing the local children and young people's plan (CYPP). The Healthy Child Programme 0–5 and the Healthy Child Programme 5–19 set out support for giving children and their families the best start in life. PCTs need to monitor workforce and caseload figures for Health Visitors.
- 2.27** In developing high quality child and adolescent mental health services (CAMHS), PCTs should have regard to the full Government response to the CAMHS Review⁹. In particular, they should consider the best practice guidance¹⁰ on reducing waiting times in CAMHS, published in August 2009, and the use of outcome measures to identify effective practice.
- 2.28** The framework for weight management services helps PCTs to procure pre-qualified services quickly and easily so as to address the needs of children in their population. Local delivery of the National Child Measurement Programme (NCMP) provides PCTs with the opportunity to target intervention services to meet local needs.
- 2.29** Levels of teenage pregnancy remain a key area of challenge, and this is a key issue of social exclusion and health inequalities that can significantly limit young people's chance to fulfil their potential. The delivery of well-publicised, accessible and high quality contraception and sexual health services for young people is key to reducing the number of unintended pregnancies. Additional funding has been made available to expand these services, including improving access, where appropriate, to the more effective long-acting reversible contraceptive methods, which have been shown to be highly cost-effective.
- 2.30** A partnership approach is critical to linking up services, for example in ensuring that frontline staff across different agencies are trained in and comfortable with addressing sexual health issues with young people. There are also benefits to joint working with local chlamydia screening programmes. Human papillomavirus vaccinations are a tool to preventing future demand for services and improving the health of future generations.

8 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_094400

9 www.dcsf.gov.uk/CAMHSreview/

10 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_103651

2.31 Safeguarding children should be an integral part of all NHS organisations' governance and commissioning arrangements, and this should include a board-level focus and support for all frontline staff. NHS organisations should contribute to effective partnership working locally, in particular in relation to local safeguarding children boards. In addition, they should continue to monitor and embed the minimum arrangements set out by David Nicholson¹¹ and build on this to improve services and outcomes for children, taking into account developments such as guidance on looked after children and safe recruitment.

Maternity and neonatal services

2.32 Ensuring that women access care by their 12th completed week of pregnancy enables the needs and choices of women and their partners to be met throughout the pregnancy and birth and the transition into parenthood. PCTs may want to introduce locally agreed metrics to demonstrate year-on-year improvements in quality, effectiveness and user satisfaction in these services. Achieving these ambitions will depend upon the appropriate workforce and skill mix being available to meet local demand.

2.33 The continuing high priority of maternity and early years services is

reflected by a commitment to bring forward the proposals for further transformation of these vital services set out in *Building Britain's Future*.¹² A cross-government report is expected in early 2010. Optimising the health of newborn babies and reducing the demand for neonatal care will realise health, well-being and cost benefits in the future. A number of tools are available to support the NHS in improving maternity and neonatal services, including:

- the focusing on normal birth and reducing caesarean section rates tool¹³ (produced by the NHS Institute for Innovation);
- implementation of the productive ward series for maternity services¹⁴ (NHS Institute for Innovation);
- the toolkit for high quality neonatal services¹⁵; and
- UNICEF's Baby Friendly Initiative (BFI)¹⁶.

Experience, satisfaction and engagement

2.34 Delivering high quality services with better value depends on PCTs taking innovative approaches to their relationships with patients and the public. We know there is more to do to give patients the high quality care they deserve. We need significant expansion of the measurement of patients' satisfaction with individual services, so staff can understand and improve the service they provide to patients. Patients' views will be

11 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_102864

12 www.hmg.gov.uk/media/22749/full_document.pdf

13 http://www.institute.nhs.uk/option,com_joomcart/Itemid,194/main_page,document_product_info/cPath,71/products_id,334.html

14 http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_ward_module_structure.html

15 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845

16 <http://www.unicef.org/programme/breastfeeding/baby.htm>

reflected in Quality Accounts and patient feedback on all services will be available on NHS Choices by December 2010. In addition, payment through the Commissioning for Quality and Innovation (CQUIN) scheme will require a patient experience element.

2.35 Specifically, PCTs should:

- work with providers to combine both nationally co-ordinated snapshot surveys and ongoing feedback, including real-time models – along with other sources of intelligence such as complaints and further development of patient experience measures – to build up a comprehensive and continuous picture of the views, experiences and priorities of patients and users to inform service improvement;
- ensure that their strategic investment plans build and secure engagement of people and communities;
- exploit the benefits arising from effective public engagement by using the views and feedback of people as a resource for innovation and service redesign;
- bring people and communities with them through the process of change so that they have a strong mandate to act and take difficult decisions on behalf of local people and communities;
- continue to build strong effective relationships with their Local involvement networks (LINKs) and overview and scrutiny committees (OSCs) and ensure proactive engagement through all stages of

the planning, development and delivery of service change. A number of LINKs have developed effective ways of engaging hard-to-reach groups, which can help PCTs ensure that real community views are reflected throughout the commissioning cycle; and

- identify and work with key local groups such as parents with disabled children.

2.36 Staff satisfaction and levels of engagement can be improved if organisations ensure that the importance of their staff's health and well-being are recognised. The Boorman Review, *NHS Health and Wellbeing 2009*,¹⁷ sets out ways in which staff satisfaction can be improved. Implementing the review findings could save the NHS up to £555 million nationally. Suggestions include focusing on prevention and health improvement, providing efficient support for staff who present with ill health, being proactive in tackling the causes of ill health (both work and lifestyle related) and, where there are clear benefits, providing early intervention services. Data on staff job satisfaction will be made available on NHS Choices. NHS organisations can take the following steps to realise the benefits set out by Boorman:

- put in place organisational health and well-being strategies, including being proactive in improving the quality of and speeding up access to occupational health services, and strengthening board accountability for the management of sickness and absence;

¹⁷ <http://nhshealthandwellbeing.org/>

- agree a target for reducing sickness absence over 2010/11 and identify the resulting potential savings (eg through reduced use of agency staff); and
- improve the quality of information they provide to the Electronic Staff Record (ESR) on sickness absence.

Emergency preparedness

2.37 All NHS organisations, other contracted healthcare providers, local authorities and other local organisations should give high priority to putting in place and testing plans and arrangements to deliver an effective response to threats and hazards. This should include chemical, biological, radioactive and nuclear (CBRN) threats, conventional terrorism, fuel and supplies disruption, flooding and public health incidents, and any impact from climate change.

2.38 The development of a new strain of influenza remains as likely now as it was last year. Building on the lessons learned from this year's response to swine flu, NHS organisations should review, test and update their pandemic plans, alongside developments in the national arrangements for pandemic flu preparedness.

2.39 The boards of NHS organisations are responsible for ensuring that their organisation has effective plans in place, as part of their corporate governance. Every NHS board should assure itself that the following strands of an effective response are in place and able to be deployed at short notice should the situation demand it:

- robust and tested command and control arrangements, which

also meet the organisation's local obligations under the Civil Contingencies Act;

- developed and tested clinically led surge plans, including for adult and paediatric critical care;
- business continuity and associated workforce protection strategies, including appropriate HR policies, patient and public engagement and vaccination delivery models;
- a strategy covering escalation of the service response to an emerging situation, including triggers, bed management, equipment and stock, staffing implications and communications; and
- a systematic, embedded and resilient approach to mutual aid, in collaboration with the local ambulance service.

2.40 PCTs should develop plans for implementing a range of vaccination delivery strategies relevant to pandemic 'flu, considering community mass vaccination clinics, school-based vaccination campaigns and other innovative delivery strategies.

2.41 SHAs are responsible for ensuring that NHS-wide command and control arrangements are robust enough to deal with any contingency and for co-ordinating all resilience-related work in their regions. All local plans should be flexible enough to respond to a wide range of potential pandemic 'flu threats, up to and including viruses significantly more damaging to health than seasonal or swine 'flu.

Areas to support local prioritisation

2.42 As set out in *NHS 2010–15: from good to great*, the NHS needs to drive out variation in cancer, stroke, heart disease and maternity services. Where services are underperforming there needs to be clinically led improvements to secure better patient experiences. Those PCTs with the greatest variation will need to identify how they will drive up improvement as part of their operational plans.

2.43 The national priorities identified earlier in this chapter reflect those areas in which every PCT needs to make progress and underpin the two overarching ambitions of the NHS:

- Improve the health and well-being of the population and reduce health inequalities; and
- provide better care to those receiving treatment.

Developments in supporting areas may help NHS organisations, in collaboration with their partners, address local priorities and service preparations for the coming years.

Improving the health and well-being of the population

2.44 The NHS can make significant improvements to meeting and improving the immediate and future health needs of communities and equality target groups. Prevention work can help people to stay healthy, support those most at risk of ill health and provide a rapid diagnosis when symptoms of ill health present.

2.45 Implementing the *Let's Get Moving*¹⁸ physical activity pathway will enable PCTs to identify adults who do not currently meet recommended activity levels and support them in being more active. PCTs, working with local authorities, are encouraged to promote activities that improve the health of all sections of the populations they serve, such as schemes to promote physical activity, building on and complementing 5-A-DAY activity and interventions such as the school fruit and vegetable programme.

2.46 Intervention targeted potentially high need, high cost individuals and families can reduce demand for more intensive services later. The use of the family nurse partnership programme has produced positive results as an early intervention service. Introducing the alcohol high impact changes, such as alcohol screening to provide higher risk individuals with brief advice on alcohol consumption, additional counselling or an alcohol health worker to manage dependent drinkers within an acute setting can deliver benefits. *Together we can end violence against women and girls*¹⁹, sets out ways in which the NHS, working with partners, can help prevent violence and abuse against women and children and support the victims.

2.47 Under the NHS Health Check programme everyone eligible between the ages of 40 and 74 will be entitled to undergo assessment of their risk of heart disease, stroke, diabetes and

18 www.dh.gov.uk/en/publichealth/healthimprovement/physicalactivity/DH_099438

19 www.homeoffice.gov.uk/documents/vawg-strategy-2009

kidney disease. People will be helped to reduce their risk through lifestyle changes, such as smoking cessation or weight management, or clinical management, such as prescribed statins. As PCTs introduce NHS Health Checks they will want to ensure that appropriate services are in place to meet the anticipated demand.

2.48 Individuals who may benefit from additional support include children with additional, complex or acute health needs or disabilities and their families and carers of adults, for example through the provision of breaks for carers and recognising carers as expert partners in care. *Every Disabled Child Matters*²⁰ can provide helpful advice with regard to disabled children. Providing quality end-of-life care, such as enabling choice of place of death, is another area where PCTs will want to ensure they are using resources to the best effect locally.

2.49 Early detection of cancer presents individuals with the best possible opportunity to live with and beyond the disease. PCTs are encouraged to address variations in two-week referrals for suspected cancer by general practices. In 2010/11, PCTs will want to maintain and improve on reductions in waiting times for all diagnostics tests, moving towards the right set out in the recent consultation that the results of key diagnostic tests should be provided within one week, with an interim milestone of two weeks.

2.50 Keeping up momentum on diabetic retinopathy screening will continue to make a significant contribution to the prevention of avoidable blindness. The early identification of mental health issues as set out in the *New Horizons* strategy²¹ reduces demand on secondary health services as well as achieving better health outcomes, including higher employment rates and lower suicide rates. Offering evidence-based psychological therapies for people with mild to moderate depression or anxiety is another area that could deliver local priority improvements.

2.51 Improved outcomes and efficiencies in services for older people has been shown to result from:

- the early and accurate diagnosis of dementia;
- joint health and social care investment to reduce emergency bed days; and
- the Prevention Package for Older People,²² which has shown that a falls service can generate substantial savings for the NHS and social care.

Providing the best possible care

2.52 All NHS organisations must play their full part in supporting health research. To achieve the national ambition set out in the OLS blueprint publication, all providers of NHS care will want to continue to increase their level of participation and performance in hosting research funded by non-commercial and commercial research funders. As part of that, in their Quality

20 www.edcm.org.uk/Page.asp

21 www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons/index.htm

22 www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/Preventionpackage/index.htm

Accounts we propose that NHS providers should include the number of patients recruited to clinical research.

2.53 SHAs, as part of their duty to innovate, are expected to support the work of the NIHR Clinical Research Networks locally and to develop the collaborative capacity of the NHS to join in research studies and trials. In doing so they can identify where there are any shortcomings. In addition, SHAs should engage with the work of the new NHS Life Sciences Delivery Board on the uptake of innovation in medicines and medical technologies.

2.54 PCTs should ensure that all providers have published a declaration before the end of March 2010 that they have virtually eliminated mixed sex accommodation, and all providers of NHS care should have robust plans in place for continued delivery of this commitment. After March 2010, PCTs are to report to SHAs, on an exception basis, those organisations that have failed to provide same sex accommodation and have had funds withheld as a result. Providers of mental health and learning disability inpatient services should have plans in place to ensure that:

- men and women do not share sleeping areas; and
- women-only day areas are provided.

2.55 The ongoing deployment of UK armed forces means it is now more important than ever that PCTs work closely with military services to ensure that the needs of this community are appropriately met. In particular it will be important to:

- ensure that commissioning plans provide for a smooth transition into NHS care for the increasing numbers of returning personnel who have been injured in the course of duty;
- ensure that their dependants are not disadvantaged by their circumstances (eg if they move location); and
- provide priority treatment, including appropriate mental health treatment, for veterans with conditions related to their service, subject to the clinical needs of others.

Achieving these goals is a reputational issue for the NHS as a whole.

2.56 People with a long-term condition (LTC) and their families are intensive users of health and social care services, and the incidence is predicted to increase. There is real benefit still to be had by helping people with LTCs make the best use of an approach that is based on personalisation of care and reduced utilisation. The basic building blocks of case management, personalised care planning, supporting people to self-care and making the best use of new emerging assistive technology is based on the best evidence internationally.

2.57 The Chief Medical Officer wrote to all SHAs in 2008 to advise that all patients should receive a risk assessment for venous thromboembolism (VTE) on admission to hospital. To facilitate this a risk assessment template was published in September 2008, and impending NICE guidance (due for publication in January 2010), supported by a quality standard, will help to improve outcomes for patients as well as

allowing clinicians to make a better-informed judgement on courses of treatment. The Academy of Medical Royal Colleges will provide professional leadership to support implementation.

2.58 Other issues that PCTs and their providers will want to be mindful of include:

- the Department recognises that there may be unacceptable variation in the availability of cardiac rehabilitation. We shall look to develop a set of indicators to improve general access to cardiac rehabilitation because it can lead to improved outcomes and reduce demands for acute hospital beds;
- guidance to be published by the national specialised commissioning team on paediatric cardiac services and paediatric neurological services;
- learning from the independent inquiry by Sir Jonathan Michael into services for people with a learning disability;
- developing local arrangements to monitor access to services by allied health professionals; and
- adaptations and mitigation requirements required under the Climate Change Act.

chapter 3

system levers and enablers



3.1 This chapter sets out the system levers and enablers to deliver the priorities for 2010/11 set out in Chapter 2 and to support NHS organisations in preparing for the more challenging economic conditions that will prevail in future years.

3.2 Chapter 1 set out the need to view future decisions in the context of delivering cash-releasing strategies while sustaining and improving the quality of services. Work over recent months with NHS stakeholders on the quality and productivity challenge has identified the following characteristics of a system that can achieve this:

- more care closer to home;
- fewer acute beds;
- reduced unit costs;
- reduced variation;
- more standardisation of pathways;
- early and more upstream intervention; and
- greater co-production, with people taking greater ownership of their health.

3.3 All of the NHS has a role to play in realising these ambitions, and in 2010/11 a number of key levers and enablers will come into play to support NHS organisations as they move forward. In many cases radical changes and innovative approaches will be required as the NHS gears up for the challenges that lie ahead. These levers and enablers are inter-related and should be considered in the context of the wider system but can be grouped as follows.

- **Financial framework** – the strategy for the management of the NHS revenue surplus in

2010/11 and the next spending review period; revenue and capital allocations positions for 2010/11, including the SHA bundle and significant central budget areas previously transferred to the NHS outside of PCT allocations and SHA bundle processes; expectations for improvements in financial and efficiency management.

- **Incentives and business rules** – setting the shape and structure of national tariffs for 2010/11 and signalling the direction of further development; key business rules between commissioners and providers at a contractual and health system level; how CQUIN will operate in 2010/11.
- **Workforce** – pay, workforce flexibility, management and agency costs, education, training and staff well-being.
- **Commissioning and system reform** – commissioner development through WCC and practice-based commissioning and the next stage of supply-side reform.
- **Informatics** – the development and application of the next stage of the digital strategy, connecting all, supporting new models of care and impacting transaction costs.

Financial framework

Management of NHS revenue surplus

3.4 The NHS Operating Framework for 2009/10 recognised the significant improvement in the financial health of the NHS and the firm foundations that this provided going forward. As intended, the NHS has started to deploy, in a planned and managed

way, the surplus built up in PCTs and SHAs that was brought forward to 2009/10, and the NHS continues to demonstrate strong financial performance in the majority of its organisations.

3.5 However, notwithstanding the growth in funding for health in 2010/11, with the challenge for public finances ahead, settlements in the medium term will be tighter. Consequently the emphasis of the NHS financial strategy going forward should be to ensure that PCTs and SHAs have flexibility in their spending plans that provide the capability to manage risk and volatility.

3.6 Consistent with current policy, the aggregate surplus delivered in 2009/10 by SHAs and PCTs will be carried forward to 2010/11 and continue to be available to those organisations. The SHA and PCT sector will plan to end 2010/11 with an aggregate surplus of £1 billion, which is equivalent to approximately 1 per cent of NHS allocations. SHAs will determine and agree with the Department of Health the level of aggregate PCT/SHA sector surplus for their area and how that agreed surplus is distributed between their PCTs and themselves. SHAs will also determine and agree with the Department the quantum of surplus brought forward from 2009/10 that needs to be deployed in 2010/11.

3.7 SHAs must ensure that PCTs do not recurrently commit the totality of their recurred funding in their 2010/11 plans, such that at least 2 per cent of recurrent funding at the aggregate regional level is only ever committed non-recurrently.

These resources are available to be deployed non-recurrently in-year to support service transformation, but it is very important that they retain the characteristic of being recurrently uncommitted to create financial flexibility in PCTs. SHAs will be able to vary the requirement across their PCTs as necessary to meet the regional quantum in 2010/11.

3.8 In support of medium-term financial planning, the NHS should expect that the surplus produced by the PCT/SHA sector at the end of 2010/11 will be carried forward for full deployment during the next Spending Review period, indicatively 2011/12 to 2013/14, at a rate determined by SHAs. Additionally, SHAs should plan for the 'at least 2 per cent recurrently uncommitted resource' requirement to continue through the Spending Review period such that by 2013/14 all PCTs meet the 2 per cent requirement as a minimum. SHAs will set the 'pace of change' for PCTs to ensure this requirement is met. Where a PCT is unable to meet the requirement for this recurrent under-committment with agreement from its SHA, the SHA will ensure it is met from elsewhere in the patch to maintain the aggregate regional level at 2 per cent.

3.9 SHAs will also continue to be able to determine and agree locally with PCTs the arrangement for the transfer and lodging of revenue resources with the SHA, within the limit of the aggregate SHA/PCT planned surplus. SHAs continue to be accountable for the management of these transactions and balances, adhering to the

underlying principles of transparency, consistency, independence and fairness.

3.10 Though not part of the aggregate surplus requirement, the performance agreement between the Department of Health and each SHA will recognise the financial plans of NHS trusts in their area. The Department expects that trusts will plan to deliver the surpluses necessary to recover from legacy deficit positions, service working capital loans and/or the need to strengthen financial positions as a precursor to NHS foundation trust authorisation.

3.11 The Department continues to expect that no NHS organisation will plan for an operating deficit in 2010/11 unless this is part of a planned recovery path agreed with the relevant SHA and the Department.

Revenue and capital allocations

3.12 The 2009/10 NHS Operating Framework sets out the headline revenue funding growth for PCTs in 2010/11, and the detailed allocations have been published. These remain unchanged, with average PCT allocation growth in 2010/11 at 5.5 per cent and a minimum floor growth of 5.1 per cent, which results in no PCT receiving less than 10.6 per cent revenue growth since 2008/09.

3.13 Following the publication of the Government's Pre-Budget Report in December 2009, PCTs can allow for flat real revenue allocations growth for the years 2011/12 and 2012/13 in their medium-term planning.

3.14 The NHS Operating Framework for 2009/10 also stated that PCT local

capital scheme funding would be £565 million in 2010/11. This is not changed and will be allocated to PCTs on the basis of their capital plans agreed with their SHA. As before, these plans need to accurately reflect slippage in programmes from previous years to ensure that ongoing commitments are recognised. They should appropriately phase expenditure to ensure capital affordability. NHS trusts' capital plans will continue to be agreed with the SHA. Any unspent capital allocation in 2009/10, as with previous years, will not be carried forward.

3.15 Although there are no changes planned in 2010/11 to the capital regimes currently operating in either the PCT or the NHS trust sectors, the Department of Health expects a reduction in capital expenditure over the next Spending Review period in line with official published projections of public capital investment. This will have a bearing on the levels of capital available for NHS organisations, and consequently all organisations should be preparing for a period of capital constraint.

3.16 In recognition of this, the Department will continue to review the levels of central programme capital and will work with SHAs to develop an appropriate capital prioritisation process to ensure that limited capital resources are made available to those projects that are demonstrably the most necessary. The Department will also consider the implications of likely capital constraint on the operation of funding support mechanisms, such as the NHS Foundation Trust Financing Facility.

3.17 The appropriateness of the private finance initiative (PFI) and local investment finance trust (LIFT) as suitable vehicles to develop capital infrastructure in the PCT and trust sectors will continue to depend on demonstration of value for money and revenue affordability under the framework set by HM Treasury's *Consolidated Budgeting Guidance from 2009/10 (IFRS updated)*²³ published in June 2009.

SHA bundle and central allocations

3.18 The proposed value of the bundle of central initiative budgets devolved to SHAs for local management is £6.167 million, compared with the bundle value for 2009/10 of £6.116 million. A limited number of budget funding amendments have been made to the bundle package, which have seen relatively small budget additions and deductions in arriving at the proposed value. Discussions are continuing between the SHAs and the Department to determine the final detail of the bundle.

3.19 It is likely that 2010/11 will be the last year for the SHA bundle in its present form. SHAs have commissioned a further review of the bundle and the specific service and programme areas it supports, and the Department will work with them to inform its conclusions.

3.20 There are two related developments in the management of the budgets for general ophthalmic, pharmacy and primary dental services. Firstly, the Department has decided to devolve the central budgets for general

ophthalmic services and pharmacy to PCTs and to include primary dental service resources (which are already devolved) within unified allocations. This will support the overall policy of devolving NHS funding to PCTs as far as possible. These budgets will be allocated separately in 2010/11, with the funding for these three services being included within PCT baselines from 2011/12.

3.21 Secondly, as part of the package of measures to manage the response to the 2009 Budget announcement requiring the Department of Health to contribute £2.3 billion to the Government's announced £5 billion efficiency savings required for 2010/11, responsibility for funding £500 million of activity will be passed to the NHS, allowing central budgets to be reduced. This is affordable to the NHS from an additional 0.5 per cent efficiency requirement incorporated into service tariffs. Funding for the three service areas set out above will be allocated to PCTs at 2009/10 cash levels, with the growth required for 2010/11 coming from the headroom in PCT budgets as a result of lower like-for-like tariff prices.

3.22 Further guidance on the full breakdown of central budgets included within the £500 million transfer is being discussed with SHAs and will be made available in due course to support 2010/11 planning. Guidance on the detail of PCT-specific allocations for these three service areas will be issued following the publication of this NHS Operating Framework.

²³ www.hm-treasury.gov.uk/psr_bc_consolidated_budgeting.htm

Improvements in financial management

- 3.23** The Audit Commission publication *Auditors' Local Evaluation and Use of Resources 2008/09*²⁴ (October 2009) demonstrated the continued improvements in the financial management arrangements within most PCTs and NHS trusts. However, it is clear that there continues to be a small number of organisations that are failing to meet the basic minimum standards of financial management. The Department of Health expects SHAs to ensure that these organisations have robust and demonstrable plans to improve their performance significantly within an acceptable timeframe.
- 3.24** Similarly, there is a large number of PCTs and NHS trusts that have only ever met minimum acceptable standards since this assessment regime was introduced. This cannot continue, as it presents a risk to the sustainable financial health of these organisations as the NHS goes forward. The Department also expects SHAs to ensure that appropriate plans for improvement are developed and implemented so that these organisations achieve higher assessments.
- 3.25** NHS organisations are expected to produce financial plans for 2010/11 that are fully compliant with the International Financial Reporting Standards (IFRS), and NHS financial planning guidance will reflect this.

The divergence in 2009/10 in respect of International Accounting Standard (IAS) 27 (Consolidated and Separate Financial Statements) with regard to linked NHS charitable funds will no longer apply in 2010/11. However, linked charitable funds are not to be included in NHS plans for NHS trusts, PCTs or SHAs. Application of IAS 27 is a financial reporting issue and not part of the financial performance regime.

- 3.26** NHS organisations should assume in their plans that the IFRS revenue impact (when compared with accounting under UK generally accepted accounting principles (GAAP) of bringing International Financial Reporting Interpretations Committee (IFRIC) 12 (Service Concession Arrangements) schemes onto the balance sheet will remain as technical for NHS trusts and will continue to be covered by a non-cash-backed resource limit for PCTs.
- 3.27** The accounting strand of the Alignment of Central Government Accounting²⁵ is due to be fully implemented by 2011/12. NHS organisations should be aware of this project in order that any change in requirements for 2010/11 are appropriately discharged, to ensure that the full implementation is achieved for 2011/12.

Efficiency management

- 3.28** The findings of the Operational Efficiency Programme (OEP),²⁶

24 http://www.audit-commission.gov.uk/health/nationalstudies/financialmanagement/pages/91001aleuor200809_copy.aspx

25 There are currently four different expenditure frameworks in government (national accounts, budgets, parliamentary estimates and resource accounts), all seeking to measure public expenditure. The Alignment (or 'Clear Line of Sight') Project, announced by the Prime Minister in the *Governance of Britain* Green Paper in July 2007, is designed to bring greater coherence to the public spending frameworks and consistency in the measurement of public expenditure.

26 www.hm-treasury.gov.uk/vfm_operational_efficiency.htm

published in 2009, set out the scope for efficiency improvement across the public services in back-office functions, IT, property and collaborative procurement. *Smarter Government*, published in December 2009, reinforced this by setting out new comparator benchmarks for some back-office functions²⁷ and announced an aim to reduce consultancy spend by 50 per cent, marketing and communications spend by 25 per cent and IT project spend by 10 per cent. *NHS 2010–2015* underlined the importance for NHS organisations to bear down on their back-office management, procurement and estates costs in the coming years. Specifically, in 2010/11 NHS organisations should:

- rigorously consider how to reduce their back-office costs – with reference to benchmarks and targets set out in *Smarter Government* – including the option of NHS shared business services or other shared services options. They should also comply with the OEP requirement that all public sector organisations employing more than 250 people collect and publish data using the UK Audit Agency’s approved value-for-money indicators for back-office operations.²⁸ The Department will issue guidance to the NHS on how they should be developed;
- explore how they can drive better value from their procurement, including through greater use of collaborative arrangements – including NHS Supply Chain and

regional commercial support units – in light of the OEP recommendation that 50 per cent of procurement spend in the wider public services go through collaborative channels by the end of 2010/11; and

- develop robust plans to reduce their estate running costs and carbon emissions, drawing on available tools, including the new NHS Premises Assurance Model, which is currently being tested and will be launched in April 2010.

Incentives and business rules

3.29 The design and structure of the tariff for 2010/11 and its subsequent development will incentivise providers to maximise the efficiency and quality of care by achieving real cost-efficiency improvements. It will encourage joint and shared responsibility between providers and commissioners in managing clinical pathways, shifting care from hospitals to community settings while focusing on quality.

3.30 In setting the tariff for 2010/11, we have recognised the impact of the significant changes made to in 2009/10 with the move to Healthcare resource groups 4 (HRG4). Changes for 2010/11 are intended to consolidate the HRG4 design and to re-align aspects of its current operation and are based on feedback from the NHS and our stakeholder groups. Testing the 2010/11 tariff has been wider than that previously undertaken, with more trusts and

²⁷ This includes increasing the ratio of HR to non-HR staff to 1:77 and reducing the cost of finance functions to 1 per cent of organisational spend.

²⁸ <http://www.public-audit-forum.gov.uk/publicat.htm>

PCTs involved in modelling the indicative implications for themselves and their health systems.

3.31 Tariffs in 2010/11 for accident and emergency services will continue to be based on the existing tariff structure and will not be moved onto the HRG4 classification. We shall, however, be working with a number of SHAs to pilot the HRG4 tariff ahead of its possible introduction in future years. This and other significant structural changes will be set out in the operational detail and draft guidance published alongside this NHS Operating Framework.

3.32 Specialist orthopaedic and children's services will continue to attract a top-up in 2010/11, pending a fundamental review of the current methodology that will be concluded to inform tariff calculations for 2011/12. However, we have used the output of the review of the specialised service definition set by the NSCG in determining the amount of work that attracts top-ups for specialised services.

3.33 As part of our drive to incentivise providers to offer the highest quality care, we will introduce the first set of best practice tariffs in 2010/11 for two elective and two emergency areas of service:

- cataracts;
- cholecystectomy;
- fragility hip fracture; and
- stroke.

Though we will want to see how successful these best practice tariffs are in reducing the variation in quality between providers, this is a

development that we shall want to expand significantly in future years.

3.34 As the first step in introducing Payment by Results to mental health services, a new currency for adult mental health services will be made available for local use in 2010/11. This is in preparation for 2011/12 when all health economies should be using the currencies in some form and establishing local prices. We are also developing a currency for community services, establishing local prices, we will aim to have currencies for specific community services by 2011/12.

3.35 Also under our drive for high quality care, CQUIN continues for 2010/11 and subsequent years, but it will have a more significant impact on provider income than in 2009/10. In 2010/11, the income quantum that can be earned under agreed CQUIN schemes will treble to 1.5 per cent of contract income. All CQUIN schemes will be required to include a patient experience element, including a national goal linked to outcomes from the national inpatient survey. SHAs will be responsible for assuring that schemes adhere to the CQUIN framework guidance for 2010/11. From 2011/12 we shall give PCTs the power to withhold a significant proportion of contract payment, rising to 10 per cent over time, if providers fail to meet agreed patient satisfaction goals on a service by service basis.

3.36 PCTs should continue to use the national set of 'never events' as part of their contract agreements with providers. Never events should be reported to the National Patient Safety Agency (NPSA) and publicly reported

The Quality Framework

Quality is our organising principle – the full national enabling framework will be in place from 2010/11

Bringing clarity to quality

First four NICE quality standards by April 2010 on stroke care, VTE prevention, dementia and neonatal care

Measuring quality

Over 200 quality indicators now available on the Information Centre website

Publishing on quality

First Quality Accounts to be published in June 2010

Rewarding quality

National CQUIN goals on VTE, patient-reported outcome measures and patients' experience

Raising standards

National Quality Board review of system alignment

Safeguarding quality

Full CQC registration against essential levels of safety and quality in place from April 2010

Staying ahead

Connecting innovation to our core purpose – the quality and productivity challenge

as part of annual reporting on quality and safety. From April 2010 no payment will be made where treatment results in one of the following seven never events:

- wrong site surgery;
- retained instrument post-operation;
- wrong route of administration of chemotherapy;
- misplaced naso- or orogastric tube not detected prior to use;
- inpatient suicide by use of non-collapsible rails;
- in-hospital maternal death from post-partum haemorrhage after elective caesarean section; and
- intravenous administration of mis-selected concentrated potassium chloride.

The NPSA plans to consult on whether further 'never events' ought to be added to this list for future years.

3.37 *NHS 2010–2015* explicitly set the aim for the payment system to incentivise providers to maximise cost efficiency. Accordingly in 2010/11 there will be a zero per cent uplift in national tariff prices, and the uplift for the following three years will be a maximum of zero per cent. The uplift in 2010/11 includes an efficiency requirement of 3.5 per cent offsetting the inflationary impacts of pay and prices. It is expected that the efficiency requirement will increase over the following three years.

- 3.38** The zero per cent uplift applied to the national tariff in 2010/11 will also apply to all prices in non-tariff service contractual arrangements. Providers should expect this also to be the case over the next Spending Review period.
- 3.39** In support of the shift of care out of hospital settings and to encourage closer working between providers and commissioners, the quantum of income that can be earned from emergency activity levels above those contracted will be constrained.
- 3.40** In 2010/11 any emergency activity²⁹ that occurs above the value of the contracted baseline at the aggregate level will only attract 30 per cent of the relevant emergency tariff. The point at which the actual value of emergency activity exceeds the contracted baseline value will trigger the introduction of the 30 per cent tariff rate. This baseline will be 2008/09 emergency activity at the aggregate level costed at the 2010/11 tariff. The only exception to the value of the baseline will be where a PCT is able to demonstrate that emergency activity has sustainably reduced in 2009/10. PCTs will be expected to manage their contracts to absolute levels of emergency work using the contractual levers available and by ensuring that any obligations placed on them under those contractual arrangements are fully met.
- 3.41** In recognition that PCTs have a joint responsibility with providers in managing health system risk. SHAs will be expected to remove the savings accruing from the triggering of this business rule from PCTs to create a regional pool for system risk management and transformation.
- 3.42** The changes to the market forces factor (MFF) element of tariff payments introduced in 2009/10 will continue in 2010/11. For those trusts that have further transition towards their actual MFF in 2010/11, the impact will again be capped at 2 per cent. Independent sector organisations providing services under free choice will continue to be paid at the appropriate tariff plus MFF.
- 3.43** SHAs will retain the relevant flexibilities set out in the 2009/10 NHS Operating Framework (paragraph 28, section 4). In addition, SHAs may exercise discretion to temporarily suspend contractual arrangements between PCTs and providers in their region where these arrangements are demonstrably not operating in the interests of their patients. In these extreme circumstances, the SHA will have to apply to the Department, setting out the particular circumstances in question before this discretion may be exercised. Monitor will be fully consulted and engaged with where any such development involves a NHS foundation trust.
- 3.44** After 2010/11, we shall move to a position where national tariffs represent the maximum price payable by a commissioner, as opposed to the mandated price for particular activity. We recognise that this direction of travel will have implications for such areas as best practice tariffs and has the potential for increasing

²⁹ Emergency activity does not include some non-elective work such as maternity admissions and any activity covered by a best practice tariff.

contracting and transaction costs in the system. Accordingly, the Department will work through these with the NHS before implementation.

- 3.45** In addition to the extension in the development of best practice tariffs for implementation after 2010/11, the Department will also explore the development and implementation of pathway and 'year of care' tariffs, most likely commencing with those services for patients with LTCs.

Workforce

- 3.46** PCTs will be expected to manage their contracts to absolute levels of emergency work using the contractual levers available and by ensuring that any obligations placed on them under these contracted arrangements are fully met.

- 3.47** As services are re-designed around patients' needs, commissioners and providers must maximise security of employment across their health economies and to facilitate continuity of employment across organisational boundaries. This will require pay restraint over the coming years to ensure that organisations are better able to plan and ensure that jobs and services are developed around patients. There will be work to be done with staff representatives nationally, regionally and locally to achieve the right balance between pay increases, workforce flexibility, increased productivity and security of employment.

Pay

- 3.48** The NHS will need to exercise considerable pay restraint if it is to meet the quality and productivity challenges of the next few years. The

NHS Pay Review Body has confirmed that it will not seek a remit to review the pay increase for the final year of the three-year pay deal for Agenda for Change staff in 2010/11. Employers must now honour the deal in full and ensure they maximise the cost-effective use of existing contracts and resources to promote improved quality and productivity.

- 3.49** Our recommendations for those staff who are not covered by a multi-year deal are necessarily more constrained. The Department has recommended that consultants and very senior managers receive no increase for 2010/11.

- 3.50** In evidence to the Doctors and Dentists Pay Review Body, the Department has indicated that for 2010/11 any increase in NHS income for general practices should be restricted to projected increases in practice expenses and that practices should be expected to make at least 1 per cent cash-releasing efficiency savings.

Workforce flexibility

- 3.51** To enable the NHS workforce to respond to changing demands and to avoid redundancies organisations must:
- support workforce flexibility and mobility by enabling the easier transfer of employees between different employers within local health and social care economies;
 - ensure collaborative arrangements to support newly qualified staff coming into employment; and
 - use the NHS Staff Passport toolkit, launched in November 2009, to

support NHS staff facing transfer. The Staff Passport provides staff, their representatives and HR specialists with an easy-to-use and practical guide to the employment standards and rights staff can expect when being transferred either to another NHS provider or outside the NHS to a provider who is contracted to offer NHS services.

Management and agency costs

3.52 Management and administrative support costs must be reviewed and reduced to maximise the proportion of NHS resources that is invested in frontline services. To achieve this, each SHA must meet an aggregate target reduction of 30 per cent in management and agency costs by 2013/14. It will be for SHAs to determine how this is managed across PCTs. For absolute clarity, the expectation is that:

- while there is no specific target for 2010/11, most progress needs to be made in 2010/11 and 2011/12;
- co-terminosity can be used as a driver; and
- provider arms are to be included in the aggregate.

3.53 In addition, all organisations must ensure they code their costs accurately and consistently on ESR to enable fair and effective comparisons. All organisations must report in their audited accounts details of their management costs, management consultancy costs and expenditure on temporary and agency staff to enable comprehensive benchmarking and cost control.

3.54 SHAs need to investigate and strengthen workforce benchmarking

tools and help local managers identify the optimum skill mix for quality and productivity.

3.55 NHS improvement organisations, including IMAS, need to ensure that support is directly linked to the quality and productivity challenge and that external management consultancy is used only when there are no other options.

Education, training and professional regulation

3.56 Redesigning jobs to better meet patients' needs and improve productivity will help to protect employment within NHS organisations. The response to the apprenticeships initiative has been excellent, and we are on course to deliver an additional 5000 apprenticeships starts in 2009/10. To promote a responsible approach to education and training, SHAs, PCTs and employers must:

- review their training plans and align them to support the delivery of local clinical visions and new ways of working;
- review and where possible reduce the number of postgraduate medical specialty training posts, consistent with long-term requirements;
- review and where possible reduce the number of pre-registration commissions for nursing, allied health professionals and healthcare scientists (HCSs), consistent with long-term requirements;
- ensure sufficient investment to support the redeployment of staff into new ways of working, especially those moving to new roles and settings; and

- implement Education Commissioning for Quality and the review of the Multi-professional Education and Training (MPET) review to give education commissioners the metrics and financial levers to incentivise and reward high quality education.

3.57 Preparing for the introduction of medical revalidation in 2011 will help organisations to deliver better quality of care and patient safety by ensuring that doctors remain up to date throughout their career. PCTs should be seeking assurance that the clinical workforce in the organisation from which they commission services is appropriately regulated to ensure patient safety.

3.58 The Department will issue details of the MPET review that will introduce improved metrics and the equivalent of a tariff for education to incentivise and reward quality. We should not transfer funds between SHAs in 2010/11, but will allow time for feedback and further piloting with a view to phased implementation from April 2011. In the meantime, SHAs retain their discretion to vary the distribution of existing resources within their areas.

Commissioning and system reform

3.59 We need bold, capable commissioners if we are to meet our goals of improved health outcomes, reduced health inequalities, improved provider quality and increased productivity. PCTs should demonstrate this through their strategic commissioning plans, which will be assessed through WCC assurance. There will be a clear and

rigorous focus on the extent to which these plans enable the delivery of increased quality and productivity, and on PCT's capability to deliver the plans.

3.60 PCT operational plans setting out delivery on existing commitments and Vital Signs tiers 1 and 2 will be signed off as set out in Chapter 4. We shall strengthen the guidance (principally the PCT Procurement Guide for 2010/11) and contractual levers available to PCTs. We shall work through regional commercial support units to help build PCTs' capability in health market analysis and market development, and strengthen their commercial skills to secure improvements in quality, productivity and prevention, encourage innovation and reduce overhead and back-office costs to release resources to the front line.

3.61 PCTs will need to commission transformed and integrated pathways to optimise health gains and reduce health inequalities. This will require stronger joint commissioning between PCTs and local government, and also wider public sector partners, including housing, education and the police. Working collaboratively, PCTs will stimulate innovation efficiency and better service design, increasing the impact of the services commissioned.

3.62 A revised suite of standard national NHS contracts will be published for 2010/11. These will cover hospital services, community services, mental health services and ambulance services. A separate national NHS contract for care homes will be published by July 2010. New

contract models that move away from funding episodic hospital care and reward the provision of integrated care will be developed for 2011/12. The hospital contract will require providers and commissioners to agree elective schedules that support the 18-weeks waiting time commitment, guarantees patients' rights under the NHS Constitution including choice, and ensure delivery of existing commitments and Vital Signs performance measures. Commissioners may specify thresholds and conversion rates for specific interventions, and may withhold payment if these are breached without good reason.

World Class Commissioning

3.63 Through WCC assurance, by April 2011 all PCTs are expected to have attained a 'green' rating for governance, and at least seven out of 11 competencies in each PCT should be rated 3 or above. PCTs should also be on trajectory to deliver agreed improvements in health outcomes. This requires action from all PCTs. They need to ensure that they have a strategic commissioning plan that is fit for purpose in delivering the required levels of increased quality and productivity, and the capability to implement these plans. WCC assessments will focus on the delivery of the strategic plan. PCTs should evidence competency by demonstrating practical actions they are taking to deliver the strategy.

3.64 Where a PCT's year 1 WCC assurance performance has been poor, and where PCTs have never attained

a Healthcare Commission or CQC rating above 'fair/fair', then SHAs will be expected to work closely with these PCTs to support their accelerated improvement. This will be developed through the Commissioner Performance Framework, which will set thresholds for SHA intervention. This will also apply to PCTs that do not attain the expected levels in WCC assurance set out above.

Clinical commissioning

3.65 To drive up both quality and productivity, and to improve care and outcomes for patients, it is vital that clinicians are actively engaged in determining the best clinical care pathway redesign processes that deliver improved outcomes. This applies equally to clinicians in primary, community and secondary care. PCTs must have clinical engagement embedded in their commissioning process. WCC assurance has been strengthened to reinforce this. PCTs must meet the information obligations set out in *Clinical Commissioning: our vision for practice-based commissioning (PBC)*³⁰ and use practice-based commissioning as an enabler for improved quality and productivity. Provider organisations are also expected to collaborate and support PCTs. SHAs need to maintain strong oversight to ensure immediate delivery.

High performing organisations

3.66 We will identify the leading edge PCTs and providers to pull the system forward and trailblaze new approaches to improving quality and productivity. This cadre

³⁰ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_095692

The NHS Performance Framework

The NHS Performance Framework sets out our approach to identifying and intervening in underperforming NHS organisations

Purpose

- Informs NHS organisations (not foundation trusts) of the criteria against which their performance will be assessed
- Sets out when SHAs and PCT commissioners should intervene to address poor performance

Assessment against existing NHS and regulatory requirements

- Service performance: existing commitments plus Vital Signs Tiers 1 and 2
- Finance: existing rules from Operating Framework
- Quality and safety: CQC registration for providers; WCC assurance scores for commissioners

Application

- Acute and ambulance NHS trusts: in operation – to include CQC registration from April 2010
- Mental health trusts: from April 2010 – to include a limited set of additional indicators on organisational governance
- PCT commissioners: from April 2010 – outcomes based on existing commitments plus Vital Signs Tiers 1 and 2 and capability assessed through WCC

of organisations will be drawn from commissioning and provider organisations. They will be identified and a programme of support will be in place by April 2010, and these organisations will be expected to have a strong role in support.

remaining sustainable clinically and financially. This will require new service delivery models, greater co-operation between providers and different commercial partnerships within the NHS and with the independent and third sector, delivered at pace.

A world class healthcare delivery system

3.67 A vibrant, resilient supply-side will be needed to deliver the step changes required in quality and productivity. Providers will need to be able to develop affordable, innovative integrated care pathways, while reducing transaction costs and

3.68 We remain clear that change should only happen when it will deliver quality improvements for patients. We are clear that the process of change should be led by local clinicians and local commissioners and include consultation with local people and a continuing role for local government.

We shall enable this by:

- simplifying and accelerating the assessment and approval of corporate transactions such as mergers, acquisitions and joint ventures, revising the *Transactions Manual* (including linkages to the Performance Regime), reviewing how the Co-operation and Competition Panel works and strengthening the role of SHAs to ensure that proposed transactions take into account the likely impact on the whole health system and deliver clear benefits to patients and taxpayers;
- the NHS foundation trust model combines clear accountability, strong financial management and robust governance with the freedom to innovate. We expect all remaining acute and mental health NHS trust boards to come forward by the end of this financial year with a clear trajectory to reach NHS foundation trust status by the end of 2013/14 at the latest.
- re-affirming our commitment to the 'any willing provider' approach for free choice of elective care, reducing the barriers to the entry of new providers through enabling greater movement of staff between providers, reviewing access to the NHS Pension Scheme, the Clinical Negligence Scheme for Trusts, providing affordable access by the third sector (including social enterprises) to the national care record and other essential information systems, and implementing the 'Staff Passport'. The staff passport builds on the pledges in the NHS Constitution and sets out the common standards that staff transferring between NHS funded services can expect;
- stimulating innovative service models, new partnerships and, where needed, new providers. Making it easier to do business with commissioners by building the capability of PCTs in health market analysis and market development, by strengthening their commercial skills, through the WCC programme, the regional commercial support units and national Strategic Commissioning Development Unit. In addition, the revised PCT Procurement Guide – provides advice on longer-term agreements, the management of demand risk and incentives necessary to underpin effective strategic partnerships to deliver service transformation;
- investing in developing transformational capacity, leadership and business skills, particularly in organisations providing community services where the need is greatest. We will launch a provider development programme for community services leaders early in 2010/11, and later, one for middle managers and clinical team leaders in NHS community services; and
- enabling greater participation in the provision of health care, treatment and support services by social enterprises, pump-priming their development through the Social Enterprise Investment Fund and supporting successive waves of NHS 'right to request' social enterprises led by entrepreneurial NHS community staff.

Preferred Provider

3.69 We have said that the NHS is our preferred provider. As we go forwards and transform the system, we need to find more engaging, less polarising ways of making change happen. We will empower and enable NHS staff to lead change and service transformation. We are asking the NHS and its staff to go through an unprecedented amount of change. It will be led by the NHS, but it can also include partners from other sectors, including the life science industry. This will not allow underperformance to continue, nor to freeze out our partners in other parts of the NHS, the third sector and the independent sector. This 'NHS First' approach will be set out in more detail through guidance (Commercial Skills for the NHS and a revised PCT Procurement Guidance).

Transforming Community Services

3.70 We shall work to transform community services and drive greater service integration. We will build on proven models such as NHS foundation trusts and the power of social enterprise and the third sector to reach out to marginal individuals and communities. We will make the most of the skills and expertise of the independent and third sectors where they can contribute best. Direct provision by PCTs will remain an option where it meets our tests and is partnered by strong commissioning. Social enterprise 'right to request' schemes provide a further option. Strong proposals for community NHS foundation trust status will be considered, where these meet

our tests. In some areas, horizontal or vertical integration may deliver the best outcomes. We will not prescribe solutions, but instead will set demanding national standards for provider reform which leave PCTs to innovate locally, to create a system that best meets local needs but that has sufficient challenge to ensure patients and taxpayers come before administrative convenience.

3.71 To provide certainty for staff and a stable foundation for service transformation, by March 2010 PCTs must have agreed with SHAs proposals for the future organisational structure of all current PCT-provided community services. PCTs will need to demonstrate that any provider changes are needs and pathway driven and will provide more integrated sustainable primary, community and secondary care services, which bind in the support of primary and social care. Proposals must deliver improved quality and patient experience, as well as increased productivity; must be affordable (reducing management costs and transaction costs); and must help to manage the demand for services more effectively (eg reducing acute admissions and lengths of stay). Potential providers will be expected to show how they will provide the leadership capability, governance structures and culture to engage and empower staff to lead service transformation. We shall build these 'tests' into the assurance and approval processes for proposals – testing fitness for purpose. We shall issue guidance shortly confirming the range

of options available and the approval, assurance and engagement processes, which will build on *Enabling New Patterns of Provision*.³¹

Informatics

3.72 Ambitious and innovative approaches to digital technology should underpin the delivery of strategic business and service objectives. To support local health economies in developing their local ambitions for digital technological advances, a national strategy will be developed in collaboration with the NHS. A new direction for the National Programme for IT has been agreed that will give the NHS more involvement in decision-making with respect to scope and timing of implementations. The ongoing development of informatics capability within the general and management workforce, as well as strengthening the capacity of the specialist workforce, will be central to delivering the improvements set out in this chapter.

3.73 Digital technologies will connect all parts of the service together, by enabling access to health services through a wider range of communication channels. Increased connectivity supports the national priority of empowering patients and staff by connecting patients with information and clinicians, and connecting clinicians with each other and information. For example using text messages to remind people of GP appointments.

3.74 Innovative use of new and emerging technology and systems, alongside implementation of national capabilities, including the summary care record (SCR) service and electronic prescription services (EPS), can support the development of new models of care. Recent pilots have demonstrated innovative use of such technologies; these will now be extended in partnership with local health communities to include the accelerated evaluation and roll-out of assisted care pilots, extraction of learning from the National Pandemic Flu Service and exploration of mobile working for community nurses.

3.75 The NHS needs to identify, adapt and adopt technical innovation, including maximising the leverage of investments already made to positively impact on transaction costs. PCTs and local health communities are expected to take up the quality and efficiency benefits available by moving to NHS Mail, utilising Choose and Book for all referrals, using products made available via NHS enterprise-wide agreements (EWAs) and realising the full potential of picture archiving and communications systems (PACS). Local health communities are expected to publish data on costs and other key benchmarks to allow for peer comparison.

³¹ www.dh.gov.uk/en/Healthcare/Primarycare/TCS/EnablingNewPatternsofProvision/index.htm

chapter 4

planning



- 4.1** Planning arrangements need to take into account the wider landscape of new systems and a changing economic context for 2010/11 and after. The changing economic climate and the challenges set out in *NHS 2010–2015* necessitate preparations for the long term.
- 4.2** We need to have a single view on what ‘excellent’ looks like, and in doing so we can identify those organisations furthest away from it and in need of intervention. The priorities set out in this NHS Operating Framework need to be planned for in the context of system developments:
- registration against essential levels of safety and quality by the CQC;
 - the CQC’s periodic review of NHS organisations, which assesses delivery against the national priorities set out in this NHS Operating Framework;
 - Monitor’s Compliance Framework, which ensures that NHS foundation trusts are meeting their terms of authorisation, including delivery against the national priorities set out in this NHS Operating Framework;
 - WCC assurance, which assesses PCTs’ capability to secure improved services;
 - the NHS Performance Framework, which takes a sectoral view of NHS trusts that have not achieved NHS foundation trust status and PCT commissioners;
 - the NHS Quality Framework and refreshing the Next Stage Review (NSR) visions that will support the quality and productivity challenge in meeting the national priorities set out in this NHS Operating Framework and provides the tools for local organisations to go further, faster; and
- SHA assurance, which looks at how SHAs are performing as regional system managers.
- 4.3** Thus, a ‘performing’ PCT will need to be delivering against existing commitments and Vital Signs tiers 1 and 2, achieve a good rating under WCC assurance and meet its financial duties. At the same time, an NHS trust that is categorised as ‘performing’ under the NHS Performance Framework will be registered with no conditions by the CQC, will be delivering on existing commitments and Vital Signs tiers 1 and 2, will be meeting its financial duties and should have an NHS foundation trust application at an advanced stage.

System requirements

- 4.4** Planning by PCTs with oversight by SHAs needs to reflect this background as they work to agree priorities in their operational plans. For absolute clarity, the Department of Health will review, by the end of March 2010, the plans for 2010/11 with each SHA. In doing so, the Department shall apply key assurance tests to the plans to ensure that they:
- are based on robust demand and activity assumptions that support delivery of the 18-week standard and other key expectations as set out in existing commitments and Vital Signs tiers 1 and 2;
 - provide assurances on the delivery of national priorities and reconcile these across finance, workforce and activity;

- are consistent with contracts agreed locally; and
- are aligned with the priorities within their local area agreement (LAA) for health and well-being.

4.5 NHS organisations should already be meeting the patient and staff rights in the NHS Constitution. Its pledges, principles, values and responsibilities need to be fully embedded and ingrained into everything the NHS does. To do this, SHAs, PCTs and trusts will need to ensure they are acting on the recommendations in the State of Readiness Group's report³², published in December.

4.6 2010/11 will see the full roll-out of registration to NHS providers by the CQC. All NHS providers will be required to ensure that they comply with essential levels of quality and safety, as failure to comply will lead to enforcement action. PCTs may want to work with their providers of primary medical services to develop systems for incident reporting, safeguarding arrangements and risk management to help prepare for their registration by the CQC.

Performance monitoring and assessment

4.7 This NHS Operating Framework provides the context and principles for prioritisation and measurement that underpins the alignment of the CQC's periodic review, Monitor's compliance framework, the NHS Performance Framework and WCC. These frameworks look at those things an NHS organisation does in support

of national priorities, and therefore organisations need to be entirely driven by existing commitments and the NHS Vital Signs tiers 1 and 2.

4.8 The NHS Performance Framework sets clear thresholds for intervention to address under-performance and a rules-based process for escalation. As set out in *The NHS Performance Framework: Implementation guidance*,³³ the framework will be extended to PCT commissioners and mental health trusts from April 2010. A framework for PCT providers is in development.

4.9 In terms of the CQC's periodic review, the Department will ask it to provide an assessment of each NHS organisation's performance against the national priorities set out in this NHS Operating Framework and as measured by existing commitments and Vital Signs tiers 1 and 2. NHS providers will also be subject to ongoing registration, and the Department will work with the CQC to agree how performance against registration compliance can be incorporated into the overall assessment. For mental health trusts, the NHS performance framework will include a small set of additional indicators about the organisation's 'health' and the Department will ask the CQC to use these indicators in its assessment of mental health providers.

4.10 The quality of services commissioned by PCTs will be assessed by the CQC's periodic review solely in terms of existing commitments and Vital Signs

³² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109417

³³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098525

tiers 1 and 2. PCTs will also receive a rating through WCC assurance that will cover outcomes, competencies and governance, and the CQC does not cover these areas.

- 4.11** For both NHS providers and PCT commissioners the CQC's periodic review provides a unique means to identify high performers. Just as the ambition set out in *NHS 2010–2015* is to move the service nationally from good to great, so do we expect each organisation to share that ambition and aim to be identified as a high performer in terms of delivering high quality services.
- 4.12** Alongside the organisational mechanisms or programmes, there are system-wide influences to improve the prioritisation process and overall performance. The SHA assurance system aims to develop and future-proof the capability of SHAs in their role as regional system managers, as well as providing greater accountability.
- 4.13** The Department of Health's External Gateway function serves to assure all national communications to NHS and social care audiences from the Department are fit for purpose in terms of content and policy governance. This includes compliance with the NHS Operating Framework as well as other key aspects such as ensuring financial affordability and meeting our obligations in terms of better regulation and promoting equality and inclusion. All communications requiring the attention of NHS management include a Gateway reference number.

Partnership working

- 4.14** PCTs have a wealth of information and opportunities to gather evidence to support partnership working and the delivery of local priorities. In particular, during 2010/11 PCTs will need to:
 - work with partners in responding to the Comprehensive Area Assessment, which provides an independent assessment of outcomes achieved by the local partnership;
 - participate in the annual review of progress on LAAs; and
 - consider reviewing the joint strategic needs assessment (JSNA) to reflect the recent guidance and lessons learnt, including that all sections of society are considered.

The publication of performance against all Vital Signs should support PCTs in pursuing these goals.

- 4.15** Many PCTs are already involved in 'Total Place' pilots – the cross-sector approach to achieving better outcomes for less resource. They are exploring how local collaboration can improve productivity and prevent ill health, for example by keeping older people independent, tackling alcohol misuse or giving children a healthy start. All NHS organisations should consider the critical role of partnership in meeting the quality and productivity challenge, and SHAs will make links with Total Place pilots in regions.
- 4.16** PCTs will continue to work as a member of the Crime Disorder Reduction Partnership to identify and share information effectively in order to support local action on reducing

violent crime – especially, serious youth violence, including knife crime, and violence against women and children. This may include engaging (where these are in place) multi-agency risk assessment conferences (MARACs). PCTs will want to consider how new commissioning guidance and recommendations of the Violence Against Women and Children Health Taskforce findings could help deliver the outcomes agreed with their partners and deliver its obligations on gender equality. PCTs have a crucial role in working with local partners to ensure that a properly resourced sexual assault referral centre can be in place in every area by 2011. The National Support Team on Response to Sexual Violence and additional central funding will be available to help with this process.

- 4.17** The Government published its response to addressing the health needs of offenders in April 2009.³⁴ This will support PCTs in understanding and addressing the needs of this group as part of their mainstream population.

Planning arrangements

- 4.18** The operational plan for 2010/11 is the central plan to bring together activity, finance, workforce and informatics plans. Ensuring that these plans support the delivery of performance against the priorities in the Vital Signs, will realise the *Next Stage Review* visions, address the productivity challenge and provide an overall coherent picture of the expectation of each PCT during the

year. The operational plan needs to be consistent with the contracts agreed with local providers and the principles set out in the *Commissioning Assurance Handbook*. It also needs to take into account the need for consistency with the Joint Strategic Needs Assessment and the Children and Young People's Plan. The Department will consider the outputs of the review of the National Indicator Set, but does not anticipate this having any impact on the priorities set out in tiers 1 and 2 of the Vital Signs.

- 4.19** Local health communities plans for 2010/11 should demonstrate how informatics, including digital capabilities, are being actively developed. The implementation of these plans requires underpinning standards, architectures and robust information governance systems to be in position and complied with. More detailed guidance on the informatics and technology elements of operating plans and required standards is available in the *Informatics Planning Guidance 2010/11*.

Timetable

- 4.20** We shall collect SHA plans for 2010/2011 in two stages. The first stage, due on 29 January 2010, will cover the planning lines relating to the Vital Signs tiers 1 and 2, initial finance plans and initial workforce plans. PCTs will need to ensure that these plans are consistent with each other, are in line with agreements within their local strategic partnerships and reflect their SHA's *Next Stage Review* vision.

³⁴ www.justice.gov.uk/publications/bradley-mental-health-cjs-gov-response.htm

- 4.21** 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 26 March 2010. Again, these must reconcile with each other and with LAAs.
- 4.22** SHAs will refresh their *Next Stage Review* visions to ensure they address the quality and productivity challenge for the period beyond 2010/11.

annex a: planning 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	December 2009
Revised suite of national contracts published (covering acute, mental health and ambulance trusts and learning disability and community services)	By 16 January 2010
Applications for registration submitted to CQC	29 January 2010
Initial SHA plans for finance, informatics, vital signs, workforce and NSR refreshed visions shared with Department of Health	29 January 2010
LAA progress review discussions between local strategic partnerships and government offices	January 2010
Department of Health feedback on the component part of SHA plans	February 2010
Contracts to be agreed	1 March 2010
Final LAA submitted to Department for Communities and Local Government	Early March 2010
Contracts to be signed	15 March 2010
Final SHA plans for 2010/11 submitted	26 March 2010
NHS providers publish declaration on elimination of mixed sex accommodation	31 March 2010
PCTs to agree with SHAs future structures of PCT-provided community services	March 2010
Department of Health / SHA bilaterals to sign off plans	April 2010
Providers delivering services on behalf of the NHS to publish Quality Accounts	June 2010
National NHS contract for care homes published	July 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 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 <i>Clostridium difficile</i>	<i>Clostridium difficile</i> 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 <i>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</i>	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 <i>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)</i>	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	
	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	
	NHS health check	
	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	
Finance	Parents' experience of services for disabled children	
	Financial balance (PCT)	
	NHS estates energy/carbon efficiency	

Key

Tier 1
National requirement

All PCTs set plans for sign-off by SHA

Tier 2
National priority for local delivery

Tier 3
Local action

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

Supporting measures are required for performance management purposes



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