

# The Operating Framework

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for the NHS in England 2012/13

**INFORMATION READER BOX**

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## Foreword by Sir David Nicholson KCB CBE



### Introduction

2012/13 is the second year of the quality and productivity challenge and the final year of transition to the new commissioning and management system for the NHS. It is therefore a vital period during which NHS leaders will have to respond to four inter-related challenges: the need to maintain our continued strong performance on finance and service quality; the need to address the difficult changes to service provision required to

meet the QIPP challenge in the medium term; the need to complete the transition to the new delivery system set out in *Liberating the NHS*; and the urgent need to ensure that elderly and vulnerable patients receive dignified and compassionate care in every part of the NHS.

### Getting the basics right every time

The scale of the changes we need to manage in the coming period mean that we need to focus more than ever on what the NHS is here to do. Recent reports by the Care Quality Commission and the Health Service Ombudsman have shown that some parts of the NHS are still failing to provide elderly and vulnerable patients with dignified and compassionate care, or to offer good basic standards in areas such as nutrition, continence and communication. The ongoing Mid Staffordshire Inquiry should act as a stark reminder of the consequences if we fail to focus on the fundamental quality of care and to listen to the concerns of patients and relatives. Many areas of the NHS are performing well on these issues, but too often variations in standards between and even within organisations remain.

The causes of shortcomings in dignity and basic care are complex and deep-rooted, often as much to do with culture and behaviour as with resourcing and prioritisation. But while local leadership is critical to addressing these issues, there is a clear role for the centre in supporting improvement and tackling poor performance. This NHS Operating Framework therefore includes requirements on clinical audit in key areas of basic care, a further programme of inspections by the Care Quality Commission, a renewed push on implementation of the national dementia strategy and increased support for carers. This issue resonates with the public and patients because it touches on the very purpose of the health service, in the words of the NHS Constitution, to support people "*at times of basic human need, when care and compassion are what matter most*". We lose sight of this mission at our peril.

## Maintaining a grip on performance

In spite of these important issues, overall performance to date in 2011/12 has been strong, building on our successful track record of delivery in recent years. Waiting times remain low and stable, although we must retain a focus on dealing with the longest waiters, quality improvements in areas such as infection control and reducing the use of mixed-sex accommodation have continued, and financial control remains firm at national level, despite some local exceptions. There are also encouraging early signs that we are making the sustainable changes needed to deliver the QIPP challenge as referral rates and emergency admission rates have stabilised. Given the complexity and uncertainty of the environment in which we are operating, this performance record is impressive: a testament to the commitment and professionalism of managers and clinicians across the NHS.

Maintaining strong day-to-day performance remains our over-riding priority for the remainder of 2011/12, including the difficult winter period we are now entering, and throughout 2012/13. That means keeping a strong financial grip, continually improving quality in priority areas, and maintaining operational resilience. Existing accountability arrangements, with PCT clusters and SHA clusters at their heart, will remain in place for the whole of 2012/13 and this NHS Operating Framework sets out clear performance expectations as well as the finance and business rules to support delivery. It seeks to maintain stability and balance risk between commissioners and providers, while recognising the need to shift to a greater focus on outcomes in future years and to accelerate our response to the QIPP challenge.

## Meeting the quality and productivity challenge

The scale and nature of that challenge, requiring us to make up to £20 billion of efficiency savings by 2014/15 to invest in meeting demand and improving quality, mean that all parts of the NHS will need to take bold, long term measures in 2012/13 to secure sustainable change. The role of innovation, too often the forgotten element of QIPP, will be critical. Rapidly spreading changes that improve quality and productivity to all parts of the NHS will be crucial: a clear example is the use of telehealth to improve services for patients with long term conditions. We must also create the right conditions for rapid diffusion of good practice and the forthcoming Innovation Review will set out specific measures to achieve this.

Achieving sustainable improvement will also mean taking on the challenge of service change, to provide services closer to patients wherever appropriate, to create centralised networks of clinical care where necessary, and to improve integration between services. The recent agreement on several significant service reconfigurations and the creation of a number of newly integrated organisations through the Transforming Community Services programme show that real change can be achieved where managers and clinicians work together with courage and skill. Where change is needed in the interests of patients and taxpayers,

for example to the organisation of care for long term conditions, to the configuration of stroke or trauma services, or to integration between different sectors of care, we must be prepared to take on the challenge during 2012/13. Failure to do so will mean we are forced to rely on short-term fire-fighting measures, and that is why this NHS Operating Framework makes clear that blanket restrictions on procedures or minimum waiting times that do not take account of healthcare needs of individual patients are not acceptable. We must continue to focus on quality and productivity together and to plan for the long term if we are to succeed.

## Building the new delivery system

2012/13 will also be the critical year in building the new system envisaged in *Liberating the NHS*. This will mean a great deal of technical and project work, and this NHS Operating Framework sets out clear expectations for delivering the changes. In taking this forward it is critical that we maintain a focus on our core purpose and build a system that will support us to deliver, particularly in difficult areas such as service change. That means developing clinical commissioning groups with a clear focus on improving long term conditions care, building on the role of GPs as navigators of the wider system. It means developing clinical networks and clinical senates which can support service redesign across wider areas where this is needed. And it means developing an NHS Commissioning Board with a relentless focus on improving outcomes and delivering value for money.

On the provider side, we must recognise the importance of the NHS Foundation Trust process not just as an end in itself, but as the means for ensuring we have the clinically and financially sustainable provider organisations we need to realise the QIPP challenge. And as we continue the roll-out of Any Qualified Provider during 2012/13, focusing on areas where patients themselves have told us there is a need for change such as wheelchair services and wound care, we need to recognise the role that choice and competition can play in driving improvement in service areas that have not always received a high priority.

As well as truly clinically led commissioning and a robust and diverse provider sector, service change requires the right environment at local level, an environment in which patients, the public and communities are highly engaged. That is why the focus on giving patients more information, choice and power is of such importance. And it is why Health and Wellbeing Boards have such a key role in integrating local commissioning and overseeing a clear local strategy across the NHS, public health and social care. Getting these aspects of the change right can help to create real pull for service change where to date there has too often been conflict.

## Conclusion

Each of these four areas represents an exacting challenge in its own right. Taken together, they constitute a truly formidable leadership agenda. This is not a time for the faint-hearted: we must sink our teeth into these issues if we are to have any chance of success. I recognise that this is particularly challenging given the personal and professional uncertainty that many across the NHS continue to face.

Subject to the passage of the Health and Social Care Bill, this will be the final NHS Operating Framework for the current delivery system of Primary Care Trusts and Strategic Health Authorities. This management system – whatever its imperfections – has been at the cornerstone of the successful delivery in recent years of continuously improving care for our patients and strong stewardship of financial resources for taxpayers. I want to take this opportunity to thank once again all those who have contributed to a track record of which we can justifiably be proud. 2012/13 will test our mettle once again, but it is safe to say that the next evolution of the NHS commissioning and oversight system already has a lot to live up to.



Sir David Nicholson KCB CBE  
NHS Chief Executive



# 1. Overview

## A year for improvement and transition

- 1.1 This NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which they will be held to account. The current NHS reforms set out a clear strategic vision around transforming service delivery so that it is focused on better outcomes for patients with real decisions increasingly being taken by patients and their GPs and services being held to account by them. We welcome the NHS Future Forum's interim advice on the importance of integrated care for patients. Delivery of high-quality services, based on clinical decision making and integrated care for patients and service users, will provide a strong platform for future years.
- 1.2 To improve services for patients, there will be four key themes for all NHS organisations during 2012/13:
- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;
  - completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
  - increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and
  - maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

In doing so, PCT clusters should support local authorities in establishing Health and Wellbeing Boards so that they become effective local system leaders across health, social care and public health.

- 1.3 It is imperative that all NHS organisations prepare themselves for the reforms that come into place for 2013/14 and as such this NHS Operating Framework sets out the steps to allow that to happen. From 2013/14, the Secretary of State will hold the NHS Commissioning Board to account on the basis of a "mandate", with the NHS Commissioning Board itself holding

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CCGs to account for their performance. The Secretary of State will use the NHS Outcomes Framework as the basis for the mandate to the NHS Commissioning Board so PCT clusters and emerging CCGs need to ensure that they are in a position to publish data when available and certainly from 2013/14. All indicators within the NHS Outcomes Framework will be published on an ongoing basis.

- 1.4 It will be equally important that, as more decision making is taken locally to reflect the needs of patients and the clinicians who support them, the NHS does more to integrate service delivery, not only across primary and secondary care between mental and physical health but also with social care organisations. Each sector needs to look at where it can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users rather than institutions. PCT clusters should actively promote the NHS Constitution in their localities so that the public can be fully informed when they exercise choice.

## Putting patients at the centre of decision making

- 1.5 The experience of patients, service users and their carers should drive everything the NHS has to do. This NHS Operating Framework puts patients at the centre of decision making with their experience of health and supporting care services central to the drive for further improvements. There will be no hiding place for those organisations that cannot provide basic levels of dignity and humanity in the delivery of service, and nor should meeting minimum standards be regarded as good enough. Throughout this NHS Operating Framework are expectations and enablers to support the NHS in improving patients' experiences of care. This includes a new national CQUIN goal that will incentivise use of the NHS Safety Thermometer to help keep patients safe from four areas of harm.

## Development of the new system for delivery

- 1.6 It will be imperative that CCGs are supported so that the NHS Commissioning Board is in a strong position to authorise them as ready, willing and able to take on statutory responsibilities from April 2013.
- 1.7 Section 3 of this NHS Operating Framework sets out the technical requirements to support the development of CCGs. Within that, any decision going forward that does not incorporate a genuine viewpoint from local clinical leaders of emerging CCGs will be open to challenge.
- 1.8 Transparency, as well as integration and joint working across the health and social care sector, continues to be of vital importance as we move to a system with an emphasis on local accountability, supporting Health

and Wellbeing Boards and a new public health system. This document sets out the measures for national accountability in the Annex. However, performance against all existing quality indicators must be maintained or improved with local accountability required where performance may have slipped or require explanation.

## Quality, innovation, productivity and prevention

- 1.9 While funding over the Spending Review period will increase in real terms, the QIPP challenge has identified the need to achieve efficiency savings of up to £20 billion over the same period, to be reinvested in services to provide high-quality care. The NHS is on track in 2011/12 to meet QIPP objectives. Currently this is weighted towards central actions, including pay and administrative cost reductions and local efficiency programmes. For future years, delivering the additional efficiency savings and quality improvements will require the NHS to focus on delivering transformational change through clinical service redesign. For 2012/13, we need to build on the progress made in delivering efficient organisations and, through the reinvestment of those efficiencies, start to deliver transformational service change while maintaining the gains already made. Where cost improvement programmes are required, these must be agreed by Medical Directors and Directors of Nursing, involve patients in their design and include in-built assurance of patient safety and quality. A single national process is being developed so that all SHA clusters take a consistent approach to their quality assurance of cost improvement plans. This will be part of a broader common operating model for quality and safety that is being developed by the National Quality Team.
- 1.10 The NHS must prioritise the adoption and spread of effective innovation and best practice. The NHS Chief Executive's Innovation Review will be published in December 2011 and make further recommendations on how this can be taken forward.
- 1.11 CCGs will need to take on the QIPP challenge within their local community. The milestones for each PCT cluster described in Section 5 of this NHS Operating Framework, supported by the indicators in the Annex, will provide ongoing national assurance that progress against the QIPP challenge is being made. SHA and PCT clusters can and should supplement these with additional measures that reflect their own local circumstances and ambitions.

## Maintaining and improving performance

- 1.12 The agenda set out above in terms of efficiency and productivity savings, as well as reform of the commissioning regime, will be challenging but must be with the overall aim of improving quality of services. This NHS Operating Framework aims to limit the key performance measures that will be subject to national assessment in order to support more local decision making on priorities. The national measures are set out in the Annex and can be grouped in three categories:

**Quality:** those indicators of safety, effectiveness and patient experience that provide an indication that standards are being maintained or improved;

**Resources:** those indicators of finance, capacity and activity that demonstrate the robustness of organisations; and

**Reform:** indicators that demonstrate commissioner and provider reform, with more information and choice provided to patients.

- 1.13 This NHS Operating Framework provides a solid basis for a new health service that builds on current successes and patients, clinicians and local communities with the opportunity to take greater responsibility for local services that remain available to all on the basis of the key NHS principle of provision based on need and not the ability to pay.
- 1.14 The Government's Spending Review for 2011/12 to 2014/15 protected the total health budget with real terms increases in each of those years. This document is set out in four distinct but inter-related sections which amount to the basis on which success will be judged during 2012/13:

**Quality:** the national priorities to be delivered in 2012/13 to improve services for patients and to support the NHS Constitution and meet a more outcomes-based approach.

**Reform:** what needs to be done during 2012/13 to deliver a different architecture for delivery from April 2013, improving patient choice and local accountability.

**Finance and business rules:** where the quantum of resources is set out, together with incentives, enablers and business rules for the year.

**Planning and accountability:** a single planning process that brings together the above components, describing how local plans should be developed and assured, as well as how this information will be used nationally to hold NHS organisations to account.

## 2. Quality

### Improving services and patient experiences during 2012/13

- 2.1 Section 1 of this NHS Operating Framework sets out the context of a challenging year of transformation for the NHS. These changes will bring about a more devolved system to allow for decisions to be taken by local patients and their GPs, with local system leadership by Health and Wellbeing Boards to drive forward quality improvements.
- 2.2 The NHS is moving to a system where quality and outcomes drive everything we do. Our model of delivery needs to be overhauled and 2012/13 is the year to make that change happen. The NHS Outcomes Framework<sup>1</sup> will act as a catalyst for driving quality improvements and outcome measurement throughout the NHS. It defines and supports a focus on clinical outcomes, including the reduction of health inequalities, to drive a change in culture, behaviour and the way we deliver clinical services.
- 2.3 These changes give real power to clinicians to exercise their judgement on the best way of improving outcomes for their patients. Our clinicians are our best judges of clinical quality and, where survey results suggest that the staff believe the quality of services in their organisation needs to improve, then that must happen. The staff survey asks whether staff would recommend their hospital to patients. This is a key indicator of quality and the results of the staff survey should be monitored locally and nationally.
- 2.4 At a time of change, NHS organisations must act responsibly in fulfilling ongoing statutory and other core duties. All NHS organisations must comply with the Equality Act 2010 and its associated public sector Equality Duty. The NHS Equality and Diversity Council has developed an Equality Delivery System<sup>2</sup> so that NHS organisations may have a systemic approach to supporting quality performance. The promotion and conduct of research continues to be a core NHS function and continued commitment to research is vital if we are to address future challenges. Further action is needed to embed a culture that encourages and values research throughout the NHS.
- 2.5 Medical revalidation is central to improving the quality and safety of care. NHS organisations must be ready in 2012 (as indicated by their organisational readiness self-assessment returns) with clinical governance arrangements including appraisals for doctors in place, to support responsible officers in fulfilling their duties.

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1 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_122944](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944)

2 <http://www.eastmidlands.nhs.uk/eds>

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- 2.6 NHS bodies should ensure that they have arrangements in place to ensure that any person they appoint to a post has the knowledge of English necessary to perform their duties in line with the existing requirements under the Performers List Regulations 2004 and Health Circular 1999/137.

### Areas requiring particular attention during 2012/13

- 2.7 There are a number of key areas that require particular attention during 2012/13 to provide the bedrock for a health service driven by patients and clinicians.

#### Dementia and care of older people

- 2.8 Caring for patients with dignity and humanity goes to the heart of the purpose of the NHS. The Care Quality Commission's report *Dignity and Nutrition for Older People*<sup>3</sup> set out good examples of NHS providers treating patients with dignity and respect as well as other more worrying examples where the standards are not acceptable in a modern health service. An outcomes focused approach provides us with incentives we can use to improve services for older people. There is a systemic set of things we need to do which will require organisations to work together. These include:

- commissioners should ensure that providers are compliant with relevant NICE quality standards and ensure information is published in providers' quality accounts;
- commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome;
- ensuring participation in and publication of national clinical audits that relate to services for older people;
- initiatives to reduce inappropriate antipsychotic prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medicines;
- improving diagnosis rates, particularly in the areas with the lowest current performance;
- the continued drive to eliminate mixed-sex accommodation;
- the use of inappropriate emergency admission rates as a performance measure for national reporting; and

3 <http://www.cqc.org.uk/reviewsandstudies/inspectionprogramme-dignityandnutritionforolderpeople.cfm>

- non-payment for emergency readmissions within 30 days of discharge following an elective admission.
- 2.9 In addition to national leadership and incentives to support high-quality personal interactions between clinicians and patients, PCT clusters should ensure that all providers have a systematic approach to improving dignity in care for patients, to giving staff appropriate training and to incorporating learning from the experience of patients and carers into their work.
- 2.10 For the first time to support local accountability in 2011/12, PCTs were asked to work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy<sup>4</sup>. That requirement will also apply for 2012/13 with the additional expectation that any local or national CQUIN goals should be included.

### Carers

- 2.11 Carers play a vital role in our system and must receive help and support from local organisations. Following a joint assessment of local needs, which should be published with plans, PCT clusters need to agree policies, plans and budgets with local authorities and voluntary groups to support carers, where possible using direct payments or personal budgets. For 2012/13 this means plans should be in line with the Carers Strategy<sup>5</sup> and:
- be explicitly agreed and signed off by both local authorities and PCT clusters;
  - identify the financial contribution made to support carers by both local authorities and PCT clusters and that any transfer of funds from the NHS to local authorities is through a section 256 agreement;
  - identify how much of the total is being spent on carers' breaks;
  - identify an indicative number of breaks that should be available within that funding; and
  - be published on the PCT or PCT cluster's website by 30 September 2012 at the latest.

### Military and veterans' health

- 2.12 SHAs should maintain and develop their Armed Forces Networks to ensure the principles of the Armed Forces Network Covenant<sup>6</sup> are met for the armed forces, their families and veterans. The Ministry of Defence/NHS Transition Protocol for those who have been seriously injured in the course

4 <http://www.dh.gov.uk/health/category/policy-areas/dementia>

5 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_122077](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077)

6 [http://www.mod.uk/NR/rdonlyres/0117C914-174C-4DAE-B755-0A010F2427D5/0/Armed\\_Forces\\_Covenant\\_Today\\_and\\_Tomorrow.pdf](http://www.mod.uk/NR/rdonlyres/0117C914-174C-4DAE-B755-0A010F2427D5/0/Armed_Forces_Covenant_Today_and_Tomorrow.pdf)

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of their duty should be implemented, meeting veterans' prosthetic needs and ensuring improvement in mental health services for veterans. NHS employers should be supportive towards those staff who volunteer for reserve duties.

### Health visitors and Family Nurse Partnerships

- 2.13 SHA and PCT clusters should work together to deliver the number of health visitors required as part of the Government commitment to increase the number by 4,200 by April 2015. Commissioners should ensure that new health visitors coming through the expanded training pipeline are effectively supported and deployed. The increased number of health visitors will ensure improved support for families through the delivery of the Healthy Child Programme and the Family Nurse Partnership programme. PCT clusters are expected to maintain existing delivery and continue expansion of the Family Nurse Partnership programme in line with the commitment to double capacity to 13,000 places by April 2015, to improve outcomes for the most vulnerable first time teenage mothers and their children.

### An outcomes approach

- 2.14 The NHS Outcomes Framework will set out the improvements against which the NHS Commissioning Board will be held to account from 2013/14 and NHS organisations should be preparing for this approach in 2012/13. Each of the five domains within the NHS Outcomes Framework will be supported by a suite of NICE quality standards which will provide authoritative definitions of what high-quality care looks like for a particular pathway of care.
- 2.15 To provide a strong base on which to introduce the NHS Outcomes Framework, we have identified outcomes measures or proxies for them for 2012/13 as set out below under the domains of the NHS Outcomes Framework. NHS organisations should also continue to work to meet the expectations in service specific outcomes strategies that have been published for mental health services, cancer, chronic obstructive pulmonary disease, asthma and long term conditions associated with premature mortality. In addition, all deadlines for the full roll-out of programmes highlighted in previous NHS Operating Frameworks, such as abdominal aortic aneurysm screening, should be completed within the established timescale.

### Domain 1: Preventing people from dying prematurely

- 2.16 In addition to the outcomes strategies, NHS organisations should continue to support the other clinical strategies aimed at reducing early mortality from cardiovascular disease, including heart disease, stroke, kidney disease and diabetes.

- 2.17 There is strong evidence that early treatment supports better clinical outcomes. There are a number of key areas where commissioners and providers can work together to ensure earlier diagnosis and treatment.

### The Summary Hospital Mortality Indicator

- 2.18 There are a number of different aggregate measures available for measuring hospital performance including Hospital Standard Mortality Rates and the Summary Hospital Mortality Indicator (SHMI). The SHMI has been developed through consensus and the methodology published on the Information Centre website. All hospital trusts, regardless of whether they are outliers, need to examine, understand and explain their SHMI and identify and act where performance is falling short. Should a trust be an outlier on any mortality measure it should scrutinise the underlying data to understand the reason and take appropriate action. Where any trust is identified as a high outlier on any published measure, SHA clusters must ensure that they have investigated the underlying reasons.

### Ambulance services

- 2.19 Responsive ambulance services are critical for emergency patients. We expect the operational standards of 75 per cent of Category A calls resulting in an emergency response arriving within eight minutes and 95 per cent of Category A calls resulting in an ambulance arriving at the scene within 19 minutes to continue to be met or exceeded.

### Cancer

- 2.20 Early treatment secures better outcomes where patients have cancer symptoms. We expect all four of the 31 day operational standards and all three of the 62 day operational standards to continue to be met or exceeded.

## Domain 2: Enhancing quality of life for people with long term conditions

### Long term conditions

- 2.21 Transforming care for long term conditions is a critical challenge central to delivering better quality and productivity. People with long term conditions are significant users of NHS services and for national performance purposes we shall track progress in improving their quality of life using the following key indicators:
- the proportion of people feeling supported to manage their condition;

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- unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); and
  - unplanned hospitalisation for asthma, diabetes and epilepsy (in under 19s).
- 2.22 Telehealth and telecare offer opportunities for delivering care differently but also more efficiently. Use of both of these technologies in a transformed service can lead to significant reductions in hospital admissions and lead to better outcomes for patients. Using the emerging evidence base from the Whole System Demonstrator programme<sup>7</sup>, PCT clusters working with local authorities and the emerging CCGs should spread the benefits of innovations such as telehealth and telecare as part of their ongoing transformation of NHS services. They should also take full consideration of the use of telehealth and telecare as part of any local reconfiguration plans.

### Mental health services

- 2.23 The mental health outcomes strategy, *No Health Without Mental Health*<sup>8</sup> sets out that mental health should have parity of esteem with physical health and six objectives for improvement. PCT clusters need to consider the strategy to support local commissioning. For 2012/13 particular focus is needed on improving:
- access to psychological therapies as part of the commitment to full roll-out by 2014/15 so that services remain on track to meet at least 15 per cent of disorder prevalence, with a recovery rate of at least 50 per cent in fully established services. During 2012/13 this will mean increased access for black and minority ethnic groups and older people, and increased availability of psychological therapies for people with severe mental illness and long term health problems;
  - the physical healthcare of those with mental illness to reduce their excess mortality;
  - offender health, working in partnership with the National Offender Management Service; and
  - targeted support for children and young people at particular risk of developing mental health problems, such as looked after children.

7 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_100946](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_100946)

8 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123766](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766)

- 2.24 Meeting the QIPP challenge includes a continued focus on investment in high-quality mental health services, and we shall judge progress using the indicators in the Mental Health Performance Framework<sup>9</sup>, monitoring nationally:
- the number of new cases of psychosis served by early intervention teams;
  - the percentage of inpatient admissions that have been gatekept by Crisis Resolution/Home Treatment Teams; and
  - the proportion of people under adult mental illness specialties on the Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care.

### Domain 3: Helping people to recover from episodes of ill health or following injury

#### Emergency admissions and readmissions

- 2.25 Emergency readmissions need to continue to reduce as patients receive better planned care and are supported to self-care more effectively. Commissioners need not reimburse hospitals for admissions within 30 days of discharge following an elective admission with locally agreed thresholds for other readmissions. The savings made need to be invested in clinically driven initiatives to support improved outcomes through reablement and post-discharge support. Commissioners should work with local providers, GPs, local authorities and Local Involvement Networks (LINKs) to ensure those initiatives are understood and used by their patients.
- 2.26 For performance reporting, we shall monitor emergency admissions for acute conditions that should not usually require hospital admission and seek confirmation on the deployment of savings.

### Domain 4: Ensuring that people have a positive experience of care

#### Patient experience

- 2.27 Each patient's experience is the final arbiter in everything the NHS does. The Health Service Ombudsman's report, *Listening and Learning*<sup>10</sup>, set out an inconsistent and at times unacceptable approach by some NHS organisations to complaints handling. Good complaints handling is vital in ensuring a culture in the NHS where patients are listened to and organisations learn from mistakes. NHS organisations must actively seek out, respond positively and improve services in line with patient feedback.

<sup>9</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_126848](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126848)

<sup>10</sup> [http://www.ombudsman.org.uk/\\_\\_data/assets/pdf\\_file/0019/12286/Listening-and-Learning-Screen.pdf](http://www.ombudsman.org.uk/__data/assets/pdf_file/0019/12286/Listening-and-Learning-Screen.pdf)

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This includes acting on complaints, patient comments, local and national surveys and results from “real time” data techniques. Patients and carers should feel that services are integrated and co-ordinated and this should form part of survey questions. The Government announced in its response to the NHS Future Forum on 20 June 2011 that it would introduce a “Duty of Candour”, a new contractual requirement on providers of NHS funded care to be open and transparent with patients and service users in admitting mistakes.

- 2.28 Commissioners should ensure their contracts allow for providers to complete central returns on mistakes, never events, incidents and complaints and use sanctions if they are not compliant. The national patient experience surveys should continue to be monitored and acted upon. In addition, as part of the National Standard Contract we shall expect each local organisation to carry out more frequent local patient surveys, including using “real time” data techniques, to publish the results – including data on complaints – and to respond appropriately where improvements need to be made.
- 2.29 Commissioners should also look to identify local measures of integrated care that will support improved delivery such as patient reported experience of co-ordinated care.

### Access to services

- 2.30 The NHS Constitution provides patients with a right to access services within maximum waiting times, including the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. If this is not possible, the NHS Constitution requires the NHS to take all reasonable steps to offer patients a range of suitable alternative providers. PCT clusters should publicise this right and the options available to local people where treatment within 18 weeks is at risk. It is the responsibility of the trust to ensure patients have the information they need to exercise those options if need be. Pilots will be carried out during 2012/13 in order to identify the best way(s) in which trusts can meet that responsibility in the best interests of patients. The pilots will focus especially on orthopaedics and the lessons will be available for full roll-out from April 2013.
- 2.31 The operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits as set out in the NHS Constitution remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks. The referral to treatment (RTT) operational standards should be achieved in each specialty by every organisation and this will be monitored monthly. We also expect less than 1 per cent of patients to wait longer than six weeks for a diagnostic test. Patients should

- have access to Choose and Book for planned treatments and commissioners should take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers, if the patient makes such a request.
- 2.32 The NHS Constitution also provides patients with a right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. Patients need to know that services are responsive when their GP recommends urgent specialist attention and we expect this and the standard for two week waits from GP referral for breast symptoms to be met.
- 2.33 Decisions on appropriate referrals should be made by clinicians in line with best clinical evidence. PCT clusters should ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits (that one or more providers are required to comply with) that do not take account of healthcare needs of individual patients.
- 2.34 Patients should be added to planned waiting, pending or review lists only if there are clinical or personal reasons why they cannot have a procedure or treatment until a specified time. Trusts must have systems in place to review such lists regularly to ensure that safety and standards of care are not compromised to the detriment of outcomes for these patients. All organisations must have reviewed planned waiting lists for all specialties and diagnostic services by no later than the end of December 2011.
- 2.35 Decisions on appropriate treatment should be made by clinicians in line with best clinical evidence. Commissioners must be clear whether they have strong evidence that a procedure is genuinely of low clinical value to patients or whether they believe there is evidence that a treatment may be of high value if given to the correct patient but achieves poor results by being used inappropriately on patients who will not benefit from it. PCT clusters should ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of blanket bans that do not take account of healthcare needs of individual patients.

### Accident and Emergency services

- 2.36 2011/12 saw the introduction of a set of clinically led indicators to allow a rounded view to be taken of the performance of Accident and Emergency services. Those indicators will continue to be in place during 2012/13 for local use, and this information should be published locally for patients and the public. The ability for local commissioners to impose fines through the national contract will continue. In judging performance nationally, we shall use the operational standard of 95 per cent of patients being seen within four hours.

## 2. Quality

### NHS 111

- 2.37 The development of the NHS 111 service will improve the quality, efficiency and coherence of our urgent care system. To support more effective access to urgent care, SHA clusters will need to be satisfied that roll-out is complete by April 2013 using a range of different systems and solutions, such as:
- proceeding to full local procurement, using Any Qualified Provider (AQP) principles;
  - establishing services initially through pilots, using single or multiple providers; or
  - an “opt-in” model involving a consortium of NHS Direct, ambulance services and other local providers.
- 2.38 The design of urgent care service provision accessible in each area through NHS 111 and the choice of provider and clinical assessment services must be led by CCGs. In any solution there must be demonstrable evidence of local clinical approval and the service must be compliant with the high-level national NHS 111 Service Specification.

### Maternity

- 2.39 Continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well co-ordinated and integrated care.

### Eliminating mixed-sex accommodation

- 2.40 The NHS has made significant progress in reducing mixed-sex accommodation over the last year and we expect this to be maintained or improved. We shall continue to track progress through the numbers of breaches of sleeping accommodation as set out in national guidance. Breaches will continue to attract contract sanctions through the NHS contract.

## Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

### Healthcare associated infections (HCAs)

- 2.41 Protecting the safety of our patients is of paramount importance. The zero tolerance approach to all avoidable HCAs will continue. All NHS commissioners and providers should identify and agree plans for reducing MRSA bloodstream and *Clostridium difficile* infections in line with the national objectives.

### Venous thromboembolism (VTE)

- 2.42 Patients need to be risk assessed for hospital-related venous thromboembolism and national monitoring will take place to oversee improvement.

### Safeguarding

- 2.43 PCT clusters will need to ensure a sustained focus on robust safeguarding arrangements, including work in partnership through Local Safeguarding Children Boards (LSCBs) and Local Safeguarding Adult Boards, and to ensure ongoing access to the expertise of designated professionals in line with local need. They will need to work with CCGs as they develop to ensure they are well prepared for their safeguarding responsibilities and that robust local arrangements, including future input to LSCBs and Local Safeguarding Adult Boards, are put in place.

### Public health

- 2.44 During 2012/13, PCT clusters will be working with local authorities on the transfer of responsibility for public health commissioning. It will be incumbent that PCT clusters maintain appropriate investment in public health services throughout transition, for instance continuing with screening and immunisation programmes as well as monitoring progress with obesity and alcohol-related harm. We will monitor the following areas nationally:
- number of four week smoking quitters; and
  - NHS healthchecks.

### Emergency preparedness

- 2.45 Emergency preparedness, resilience and response across the NHS continues to be a core function of the NHS, required in line with the Civil Contingencies Act 2004. Accountability arrangements should be clear at all times throughout the transition and organisations must continue to test and review their arrangements. All NHS organisations are required to maintain a good standard of preparedness to respond safely and effectively to a full spectrum of threats, hazards and disruptive events, such as pandemic flu, mass casualty, potential terrorist incidents, severe weather, chemical, biological, radiological and nuclear incidents, fuel and supplies disruption, public health incidents and the 2012 Olympic and Paralympic Games. PCT commissioners must also ensure that they maintain the current capability and capacity of existing Hazardous Area Response Teams (HARTs) in ambulance trusts.

## 2. Quality

### Good practice to support delivery of the QIPP challenge

2.46 As service improvement continues, the NHS should learn from initiatives that are successful elsewhere, adapting and improving their own plans. NHS organisations are encouraged to draw on a wide range of sources and evidence bases, such as the NHS Evidence website<sup>11</sup>, which provides a range of case study examples demonstrating how innovative local action can deliver real quality and productivity improvements. Some current examples that demonstrate the four key elements of QIPP are set out in the table below.

#### QIPP good practice examples

Quality	Innovation
<ul style="list-style-type: none"> <li>• Tools such as patient decision aids, health investment packs, the atlas of variation and approaches such as programme budgeting support a focus on offering the right treatment to the right patient. These tools should help shared decision making with patients about care options, as well as supporting commissioning for increased value to address unwarranted variation.</li> <li>• Tower Hamlets and South East Essex have worked with third sector partners on more effective procurement and flexible use of staffing in services to provide wheelchairs for children. This has been shown to deliver significantly reduced waiting times and better quality equipment at no extra cost or even while delivering financial savings. Commissioners should consider whether this is a service that could benefit locally from patient choice, as part of ensuring that they deliver timely and cost effective access to good quality wheelchairs for children.</li> </ul>	<ul style="list-style-type: none"> <li>• Innovative service models such as the RAID (Rapid Assessment Interface and Discharge) 24/7 psychiatric liaison service have been shown to generate significant cost savings and health improvements.</li> <li>• The Innovative Technology Adoption Procurement Programme (iTAPP) identifies innovative technologies that can be adopted by local organisations. A small number of evidence based technologies, including the Oesophageal Doppler Monitoring, are suggested for wide adoption by local health economies.</li> </ul>

<sup>11</sup> <http://www.evidence.nhs.uk/>

## 2. Quality

### Productivity

- The NHS Institute's Productive Series has supported NHS teams to redesign the way they work. It has allowed staff to spend more time directly caring for patients and demonstrated improvements in patient experience, quality of care and productivity.
- Consolidation of pathology services can improve productivity and deliver increased standardisation and quality services.

### Prevention

- Risk stratification, care planning, patient involvement and supported self-care can transform the care of people with long term conditions and prevent the need for some reactive, expensive acute based care. This is particularly true where there is strong integration between the NHS and Social Care and existing resources, such as specialist community based nurses, are effectively used to meet the needs of patients with multiple long term conditions. Providing services supported by telehealth and telecare delivered at scale can maximise benefits for individual patients.
- Tools such as the Safety Thermometer can be used to prevent avoidable harm and deliver safer care by measuring progress against ambitious improvement goals, looking at a bundle of measures such as reducing falls, pressure ulcers, catheter acquired urinary tract infections, and venous thromboembolisms.



## 3. Reform

### The challenge

- 3.1 The NHS at the end of 2012/13 will look and feel very different to that at the beginning of the year. By the end of the year, the NHS will have transformed the commissioning landscape into one focused on local clinical decision making, with the development and authorisation of CCGs, assisted by commissioning support vehicles and overseen by the NHS Commissioning Board. Local authorities will take on the lead role in public health, alongside the new Public Health England.
- 3.2 Central to the new system will be the establishment of Health and Wellbeing Boards, who will provide local systems leadership across health, social care and public health. Communities, patients and their GPs will be empowered to improve their local health services, with choice and better information. PCT clusters must support this cultural shift as we move to an outcomes approach.
- 3.3 Alongside this, developments will continue to the provider landscape, through the extension of Any Qualified Provider, progress with the NHS Foundation Trust pipeline and the establishment of the new NHS Trust Development Authority. There will also be developments to the health education system, with new education and training partnerships and Health Education England.
- 3.4 The need for good systematic engagement with staff, patients and the public is essential so that service delivery and change is taken forward with the active involvement of local people. Our staff and patients provide essential insights into the quality of services. Organisations should listen closely and act on any information from staff about where services need to improve. Organisations should also listen closely to patient feedback and complaints, using this information to improve services.
- 3.5 Throughout 2012/13, PCTs and SHAs remain statutory organisations. To make the best use of our management capability, as well as creating space for new organisations, they will be held to account on a clustered basis. PCT clusters will deliver the requirements of this NHS Operating Framework, under the supervision of SHA clusters who themselves will be accountable through to the NHS Chief Executive. In doing so, there should be no trade off between delivering ongoing performance and supporting and facilitating the development of new and emerging organisations and clinical leadership for commissioning.

## 3. Reform

### The new commissioning landscape

#### NHS Commissioning Board

- 3.6 The NHS Commissioning Board has been established as a special health authority to allow it to prepare for taking on its full statutory duties from April 2013. Its broad responsibilities will be to provide leadership and hold CCGs to account for delivering their statutory responsibilities, and to commission services such as primary care, specialised services, prison/offender health and military health. There will be further guidance during 2012/13 on the operational requirements for the transfer of these responsibilities from PCTs to the NHS Commissioning Board.

#### Clinical commissioning groups

- 3.7 PCT clusters must:
- support all CCGs in making progress to full authorisation by the NHS Commissioning Board;
  - support exploration and the development of commissioning support offers from a range of suppliers, which might include the independent sector, voluntary organisations and local authorities, that will be responsive to the needs of CCGs;
  - establish an effective transition to the NHS Commissioning Board for a common model for commissioning services for which the NHS Commissioning Board will be directly accountable;
  - prepare for formal transfer of staff to the new commissioning architecture;
  - demonstrate that they are allocating both non-pay running costs and staff to support emerging CCGs, commensurate with the level of budgets for which emerging CCGs have delegated responsibility; and
  - work with GP practices to undertake a full review of practice registered patient lists, ensuring patient anomalies are identified and corrected by March 2013.
- 3.8 SHA clusters will be held to account for the delivery of plans to support the development of the new commissioning architecture, whether for the establishment of CCGs, commissioning support or the transfer of commissioning responsibilities to the NHS Commissioning Board.
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### Health and Wellbeing Boards

- 3.9 Health and Wellbeing Boards will operate in shadow form from April 2012 and will be statutorily operational from April 2013. Health and Wellbeing Boards will act as the local system leader through work on Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS), and NHS organisations need to be active leaders within this process. The JHWS sets shared priorities and a plan for what the NHS and local authorities can do individually and collectively to deliver seamless care, improved outcomes and reduced health inequalities. The JSNA and JHWS inform CCGs' commissioning plans and support integration of delivery.
- 3.10 SHA and PCT clusters should support shadow Health and Wellbeing Boards and encourage CCGs to play an active part in their formation, including participation in the programme of accelerated learning sets. Health and Wellbeing Boards will contribute to the authorisation process and will play a part in supporting the NHS Commissioning Board in holding CCGs to account.

### CCG development and authorisation

- 3.11 We shall support the development of CCGs during 2012/13, helping them to become the best they possibly can. Specific guidance on the process for authorisation will be issued in due course. As far as possible CCGs should be coterminous with a single local Health and Wellbeing Board.
- 3.12 Ahead of that, SHA clusters should be working to support practices and emerging CCGs to resolve configuration issues. By 31 January 2012, SHA clusters need to be confident that any outstanding configuration issues can be resolved by the end of March 2012. Where this is not the case, the timetable for authorisation means that discussions on alternatives will need to take place. SHA clusters will be responsible for oversight of the readiness of CCGs for authorisation.
- 3.13 Almost half of available budgets have already been delegated to emerging CCGs and we expect the rate of delegation to continue to increase. In preparation for becoming a statutory clinical commissioning group, CCGs will need to:
- build a track record:
    - manage those budgets well and play an active role in the planning round for 2012/13, taking ownership of those parts of a PCT cluster's plan which it will inherit;

## 3. Reform

- develop relationships with local partners, including social care, and engage with the local community, in particular playing an active role in the emerging Health and Wellbeing Boards;
- deliver the relevant share of the QIPP agenda for the PCT cluster;
- prepare for establishment:
  - address any issues arising from the configuration risk assessment by the end of March 2012;
  - prepare an application in line with the forthcoming guidance;
  - identify how they wish to secure commissioning support and plans to utilise the running costs allowance;
- become a successful organisation:
  - undertake the development plan agreed with the PCT cluster in 2011/12 as a result of the self-assessment diagnostic, and agree governance plans locally, including relationships with the Health and Wellbeing Board.

### Commissioning support

- 3.14 Effective commissioning support will be critical to the quality and affordability of the future commissioning system. Commissioning support must be commercially viable, customer focused and develop distinctly and separately from the PCT cluster. It may occupy a different geographic and service footprint to that of clusters or their constituent PCTs. Opportunities to aggregate demand from CCGs in aspects of commissioning support should be facilitated by PCT and SHA clusters.

### Clinical networks and senates

- 3.15 Work is ongoing to design the role and function of clinical senates. There will be a process of widespread engagement with stakeholders and it is expected that clinical networks and senates will be established in 2012/13. One of their key roles in 2012/13 will be to contribute to engagement on clinical service redesign across wider health communities.

### The new public health landscape

- 3.16 Public Health England (PHE) will be in a shadow year of operation in 2012/13, and a statutory Executive Agency from April 2013. Significant functions from the current NHS commissioning infrastructure will need to transfer to PHE.

- 3.17 The NHS will be accountable for delivering a successful public health transition and it will need to do so in co-production of the new system with local authority colleagues. PCT clusters and SHA clusters will need to include robust local plans for the public health transition, as set out in Section 5.
- 3.18 In 2012/13, PCT clusters will need to work with local authorities to:
- develop the vision and strategy for the new public health role;
  - prepare local systems for new commissioning arrangements;
  - ensure new clinical governance systems are in place;
  - prepare for formal transfer of staff; and
  - test the new arrangements for emergency planning, resilience and response.

## The new provider landscape

### NHS Foundation Trust pipeline

- 3.19 Progress on the NHS Foundation Trust (FT) pipeline is not an end in itself but a critical means for creating clinically and financially sustainable organisations across the provider sector. NHS trusts are expected to achieve NHS FT status on their own, as part of an existing NHS FT or in another organisational form by April 2014, with a few concluding beyond this date by exceptional agreement. Plans for all NHS trusts have been agreed under Tripartite Formal Agreements (TFAs), which codify the locally owned issues, actions and processes and set out the journey each organisation must take going forward.
- 3.20 Local actions will ultimately drive the transition to an all NHS FT sector. However, for a small number of NHS trusts, there will be areas of development where additional support may be required. These potentially include support on underlying financial issues, including PFI and liquidity issues, and Board assurance development. Options for national support will only be considered where solutions are beyond the capacity of local organisations and the pre-defined criteria for these solutions are met.

### Any Qualified Provider

- 3.21 In 2012/13, PCT clusters should start to offer patients choice of AQP in at least three services which are local priorities. PCT clusters should work with CCGs and patients to set outcome-based specifications that encourage

## 3. Reform

providers to deliver high-quality services. Commissioners may find it useful to refer to the published implementation packs and other material on NHS Supply2Health<sup>12</sup>. We expect that commissioners will use the national qualification process and questionnaire to qualify providers.

### Empowering patients

#### Choice and personal health budgets

- 3.22 Choice is critical to giving patients more power in our system. PCT clusters should drive forward improvements in patient choice so that there is a presumption of choice for most services from 2013/14. During 2012/13 this means continuing the implementation of:
- choice of named consultant team;
  - choice of diagnostic test provider;
  - choices post-diagnosis including choice of treatment;
  - choice of treatment and provider in mental health services;
  - choice in care for long term conditions as part of personalised care planning; and
  - choice about maternity care.
- 3.23 Patients' rights under the NHS Constitution continue, including the right to treatment within 18 weeks from referral, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. From April 2012, all patients referred for a first consultant-led outpatient appointment will be able to choose a named consultant-led team. Providers' obligations are set out in standard contract guidance to accept patients who are referred to a clinically appropriate named consultant-led team and list their services on Choose and Book in a way that allows users to book appointments with named consultant-led teams.
- 3.24 PCT clusters should work collaboratively with GP practices to establish new outer areas to enable patients who move house locally to stay with their existing practice. The NHS will also pilot in three areas new arrangements to open up patient choice beyond traditional practice boundaries. PCT clusters will need to support the pilots, including ensuring that patients who register with a practice beyond their local area have appropriate access to local urgent care services.

12 <http://www.supply2health.nhs.uk/default.aspx>

- 3.25 PCT clusters should prepare for wider roll-out of personal health budgets, following the completion and evaluation of the pilot programme, due to end in October 2012. Subject to evaluation, this should include preparation for all patients with NHS continuing care to be offered a personal health budget for relevant aspects of care by April 2014 at the latest. The NHS will need to consider how to deliver personal health budgets locally and include this as part of transition planning.

### Information Strategy for the NHS

- 3.26 Choice will be of little value to patients without meaningful information. NHS organisations need to prepare for the forthcoming Information Strategy for Health and Social Care and work to:
- give patients better access to their records;
  - provide information on outcomes to support choice;
  - support integrated care through enabling the appropriate sharing of information between organisations; and
  - allow for better use of aggregated information.
- 3.27 On 7 July 2011, the Prime Minister set out a number of key NHS datasets that have been identified for public release<sup>13</sup> and these will be added to during 2012/13. NHS organisations must ensure the availability and quality of these data sets.
- 3.28 Patients who have been written to about the Summary Care Record should have a record created by March 2013 at the latest. Data is being published on the proportion of patients with greater control of their care records and we are considering the feasibility of making this an entitlement from 2013/14.
- 3.29 No single technical change has greater power to improve the integration of services than the consistent use of the NHS number. NHS organisations are expected to use the NHS number consistently in 2012/13 and commissioners should link the use of the NHS number to contractual payments in line with the guidance. There will be punitive contract sanctions for any organisation not compliant by 31 March 2013.
- 3.30 The protection of sensitive patient information remains a top priority for the NHS. Incidences of data loss continue to occur and in some cases these are both significant and clearly in breach of national guidelines. Data loss is not acceptable where adherence to agreed national policies would have

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13 <http://www.number10.gov.uk/news/letter-to-cabinet-ministers-on-transparency-and-open-data/>

## 3. Reform

prevented the breach. We expect all organisations to be vigilant at all times and to ensure that appropriate governance policies and guidelines are implemented and followed in practice. This is particularly important during this time of change and transition.

### Workforce throughout the transition

#### Leadership and supporting staff

- 3.31 The reforms set out above require changes to the NHS workforce. NHS values, clinical leadership and working together are fundamental when decisions are taken that have an impact on our staff and the safety and quality of patient outcomes. It is essential that all NHS and their partner organisations work together to create and sustain the talent pipeline for critical posts. At national level, the new NHS Leadership Academy will provide a talent management and development focus for all those involved in the leadership of healthcare services.
- 3.32 Our staff continue to be our most vital resource. All organisations should use the results from the NHS staff survey to improve continuously staff experience and services to patients.
- 3.33 Organisations can take a number of steps to support work to improve staff health and wellbeing. These include ensuring their occupational health services are accredited to the Faculty of Occupational Medicine Standards, implementing recommendations set out in the NICE public health guidance, making pledges through the Public Health Responsibility Deal in relation to food, alcohol, physical activity and health at work and working to promote improved programmes of flu vaccination for staff.
- 3.34 *Healthy Staff, Better Care for Patients*<sup>14</sup> and the *NHS Health & Well-being Improvement Framework*<sup>15</sup> provide a model for improvement, detailing how organisations can ensure their staff have access to appropriate health interventions when required and, overall, support better staff health at work. This will contribute to achieving the Boorman ambition of reducing sickness absence levels towards 3 per cent and will contribute towards meeting the QIPP challenge.

#### Education and training

- 3.35 In the future, Health Education England will provide sector-wide leadership and oversight of workforce planning, education and training in the NHS. During 2012/13, SHA clusters remain accountable for education funding, commissioning decisions, medical recruitment and working with healthcare providers, and will be responsible for setting up provider-led partnerships to take on these responsibilities from April 2013. SHA clusters

14 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_128692](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128692)  
15 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_128691](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691)

should work with healthcare providers and the education sector on education commissioning for 2012/13 and 2013/14 as well as 2012 medical recruitment, supported by the recommendations of the Centre for Workforce Intelligence (CfWI).

- 3.36 SHA clusters will be responsible for ensuring a level of business continuity during the reforms. They will need to plan for the novation of education and training contracts and other agreements, both formal and informal to their successor bodies.
- 3.37 During 2012, SHA clusters should plan for the implementation of the revised education and training tariffs resulting from the Multi Professional Education and Training (MPET) review in relation to undergraduate medical and non-medical clinical placement rates. In doing so, SHA clusters should plan transition based on a safe pace of change to minimise disruption from funding changes.

#### Pension and pay

- 3.38 On pension reform, the NHS will be required to implement increased employee contributions from April 2012 and the NHS Pension Agency (NHS PA) will provide the necessary administrative arrangements to support employers delivering this legal requirement. Additionally, there will be a Pension Charter clarifying the roles and responsibilities of employers and the NHS PA to ensure that there is effective administration of pensions for all NHS employees as required.
- 3.39 This is the second year of the Government's two-year pay freeze for public sector workers. To protect the low paid, the Government will again recommend that staff earning £21,000 or less receive a flat rate increase of £250 from April 2012.



## 4. Finance and business rules

- 4.1 The finance and business rules are in place to help ensure that there is consistency and transparency across NHS organisations in the way the financial framework is applied. In particular, for 2012/13, they are designed to enable continued financial stability with no part of the new system inheriting problems not of their own making and going further and faster on QIPP delivery, including driving up value for the taxpayer.

### Surplus strategy and financial control 2012/13 onwards

- 4.2 Strong financial management and control during 2012/13 will be crucial to ensure successful delivery through transition and into the reformed NHS landscape.
- 4.3 As with previous years, the aggregate 2011/12 SHA and PCT surplus will be carried forward into 2012/13. We shall continue to draw down the surplus generated from previous years in a planned and managed way. The expected level of the national SHA and PCT surplus drawdown will be £150 million, based on the 2011/12 quarter one forecast. It is expected that the surplus deployment will be primarily available to SHA clusters to support the successful delivery of transition.
- 4.4 It is a requirement that no PCT or SHA will plan for a deficit in 2012/13. PCTs carrying legacy debt into 2012/13 must clear it.
- 4.5 CCGs will not be responsible for resolving PCT legacy debt that arose prior to 2011/12. It is expected that aspirant CCGs will continue to work closely with PCTs and PCT clusters in 2012/13, to ensure that no PCT ends 2012/13 in a deficit position.
- 4.6 NHS trusts are expected to plan for a surplus consistent with their NHS Foundation Trust pipeline plan and their TFA. Breakeven or operating deficit plans will only be countenanced where an NHS trust is in formal recovery, it has been agreed with its SHA cluster, and it is consistent with the TFA.
- 4.7 The final year-end aggregate surplus generated by SHAs and PCTs in 2012/13 will be carried forward to the NHS Commissioning Board in 2013/14, with an expectation that PCT originated surpluses will be made available to the relevant local health systems in future years.

## 4. Finance and business rules

- 4.8 As in 2010/11 and 2011/12, the requirement for all PCTs to set aside 2 per cent of their recurrent funding for non-recurrent expenditure purposes only will continue. It is expected that SHA clusters will hold these funds for this expenditure until appropriate business cases for the expenditure have been approved. The non-recurrent cost of organisational and system change during 2012/13 will need to be met from the 2 per cent.
- 4.9 The requirement to identify a quantum of recurring funds that are only committed on non-recurrent expenditure each year is an important component of the NHS financial strategy. It provides flexibility and mitigates financial risk. It is expected that this approach to financial risk management will continue into the new health system to underpin continued financial control and support QIPP delivery.

### PCT allocations

- 4.10 The total amount allocated through PCTs' recurrent allocations in 2012/13 will grow by at least two and a half per cent. The PCT 2012/13 revenue allocations will be announced in December 2011 and will be reviewed in light of the Office for Budget Responsibility's forecast for inflation.
- 4.11 Transfers of funding between PCTs and local authorities were included in the NHS Operating Framework 2011/12. This includes £622 million in 2012/13 for social care services to benefit health. In making decisions about use of this funding in 2012/13, local authorities and their NHS partners should be aware that financial support from the health system for social care will continue in 2013/14 and 2014/15. Allocations for primary dental care, pharmaceutical services and primary ophthalmic services will also be announced in December 2011.
- 4.12 The 2012/13 shadow allocations for CCGs, the shadow allocation for the NHS Commissioning Board and shadow grants for local authorities' new public health responsibilities will be published after PCT allocations.

### Running costs

- 4.13 The target running cost savings for 2012/13 will be set at the SHA cluster level, but with an assumption that there will be no further savings at the SHA organisation level during 2012/13. This recognises the impact of the decision to extend the life of the SHAs for another year, as part of the strategy to deliver effective transition to the new system.
- 4.14 From 2013/14, the running cost allowance for CCGs is expected to be £25 per head of population per annum: this is before any entitlement to a quality premium.

- 4.15 By 2014/15 the overall running costs of the new NHS superstructure will be, on average, one third lower than the running costs of the NHS in 2010/11. The running cost allowance for the core functions of the NHS Commissioning Board will be at least £492 million.

### Capital

- 4.16 NHS trusts must continue to ensure that they provide a clean and safe environment that is fit for purpose, based on national best practice. A key factor in delivering such an environment is that backlog maintenance and upgrading work must be managed effectively, with an emphasis on eliminating any backlog maintenance that affects safety or the provision of high-quality healthcare. To support the elimination of mixed-sex accommodation, improve patients' privacy and dignity, and provide increased isolation facilities for infection control, capital investment to provide additional single en-suite rooms needs to be considered as part of the capital planning process.
- 4.17 Capital expenditure plans for NHS trusts and PCTs will be agreed by SHA clusters. In 2012/13, any capital funding for community services will follow the regime applicable to the organisation into which they transfer. As with previous years, any unspent capital allocation in 2011/12 will not be carried forward.

### Tariff

- 4.18 Developments of the payment system in 2012/13 are intended to increase the links with the quality of care, to drive integration of services and to incentivise delivery of the QIPP challenge. Increasing the scope of a more transparent rules-based funding system will be a priority in 2012/13. To this end, Payment by Results (PbR) will expand and develop to incentivise best clinical practice and better patient outcomes.
- 4.19 In 2012/13, we will expand best practice tariffs to:
- incentivise more procedures being performed in a less acute setting;
  - incentivise same-day emergency treatments where clinically appropriate;
  - increase the payment differential between standard and best practice care for fragility hip fracture care and stroke; and
  - promote the use of interventional radiology procedures.

## 4. Finance and business rules

4.20 In 2012/13, we shall expand the scope of tariff to:

- require that the recently developed currency is used when contracting for adult mental health services;
- introduce mandatory currencies for use when contracting for chemotherapy delivery, external beam radiotherapy and ambulance services;
- introduce non-mandatory currencies for HIV outpatient services and some community podiatry services;
- introduce a “quality increment” which may apply to patients being treated at regional major trauma centres, designed to reward high-quality care and facilitate the move to trauma care being delivered in designated centres;
- introduce national “pathway” tariffs for services such as maternity care, cystic fibrosis and paediatric diabetes; and
- introduce tariffs for post discharge care for some procedures, which will be mandatory where acute and community services are integrated in one trust.

4.21 In 2012/13, we shall continue to:

- retain the 30 per cent marginal rate, which will continue to apply for increases in the value of emergency admissions; and
- apply the policy of non-payment for emergency readmissions, subject to some exemptions.

4.22 The Department is jointly sponsoring with the Foundation Trust Network a number of sample audits of emergency readmissions, designed to help to inform more detailed guidance on the operation of the policy in 2012/13.

4.23 The PbR guidance and accompanying Code of Conduct will describe one system and one set of rules for England that are mandatory. Where commissioners and providers find the rules prevent them doing the best for patients, then local variation is permitted. However, variations which in effect enable the continuation of poor-quality, inefficient models of care or restrict patient choice are not valid.

4.24 In response to concerns about the “cherry picking” of patients, commissioners will now be required to adjust the tariff price if the type of patients that a provider treats results in it incurring lower costs than the average of the tariff category.

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- 4.25 Commissioners are required to pay the appropriate rate of Market Forces Factor to the organisation providing treatment. This must not impede free choice of provider for the patient.
- 4.26 The national efficiency requirement for 2012/13 is 4 per cent. This will be offset by pay and price inflation. The tariff price adjuster will be a reduction of at least 1.5 per cent, and this will also be applied to non-tariff services. This will be confirmed in the 2012/13 PbR Guidance following allocations.
- 4.27 Some best practice tariffs for 2012/13 have an in-built efficiency assumption, allowed for in the overall tariff price adjuster. Some best practice tariffs will lead to reduced payments where best practice is not achieved and this is not allowed for in the tariff price adjuster.
- 4.28 For 2013/14, we shall continue to work with the NHS and social care providers and commissioners on existing long term condition tariffs and so support the development of higher-quality primary and community-based services to deliver better care and outcomes for patients with long term conditions.

### CQUIN framework

- 4.29 Commissioners are reminded that CQUIN is a quality increment that applies to a level of service over and above the standard contract. In 2012/13, CQUIN will be developed so that, for all standard contracts, the amount that providers can earn will be increased to 2.5 per cent on top of actual outturn value. The two national goals on VTE risk assessment and on responsiveness to personal needs of patients will continue to be in place. With the additional quantum that is now available for local determination, three new requirements will be brought in:
- a third national goal on improving diagnosis of dementia in hospitals;
  - a fourth national goal to incentivise use of the NHS Safety Thermometer; and
  - where CQUIN funding has been used previously to achieve a higher standard of quality, that funding may be made recurrent through CQUIN only where the commissioner is satisfied it is the necessary means to maintain the improvement.
- 4.30 The national goals must continue to be linked to around one fifth of the 2.5 per cent value of schemes unless commissioners decide there is negligible room for improvement. Commissioners must share agreed schemes on the NHS Institute website.

## 4. Finance and business rules

- 4.31 The NHS Safety Thermometer is an improvement tool that allows NHS organisations to measure harm in four key areas (pressure ulcers, urine infection in patients with catheters, falls and VTE) and the proportion of patients who are “harm free”. The CQUIN scheme will reward submission of data generated from use of the NHS Safety Thermometer. While all data collected through the Safety Thermometer will be published, there will be a particular emphasis on pressure ulcer prevalence data, which will be presented alongside pressure ulcer data from Hospital Episode Statistics and national incident reporting for all providers, to support the wider Government Transparency Agenda.
- 4.32 Commissioners and providers should have due regard to the NHS Chief Executive’s Innovation Review, due to be published in December 2011, when developing local CQUIN schemes for 2012/13. This will be used as a pre-qualification criterion for CQUIN in 2013/14 and during 2012/13 commissioners and providers should be preparing for it.

### Clinical audits

- 4.33 The current contract states that providers will participate in the national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) relevant to the services they provide.
- 4.34 Preparatory work is under way to transfer the cost of established national clinical audits within NCAPOP to providers of relevant and tariffed services from 2012/13. The intention is to do this on a subscription basis, with the aim of providing stability in funding for audit and to provide financial headroom in the central programme budget to support the development and commissioning of new audits. The clinical audit subscription will be recognised in an adjustment to the tariff for the services associated with the subscription.

### SHA bundle

- 4.35 The proposed value of the bundle of central initiative budgets devolved to SHAs for local management is £6,394 million, including MPET, administration costs and the National Programme for IT Local Ownership Programme (NLOP). This is the same amount as in 2011/12 and takes account of changes to the bundle after the NHS Operating Framework 2011/12 was issued. The detail will be issued with the financial planning guidance. Clinical networks will also continue to be funded through the SHA bundle in 2012/13.

## Joint working with local authorities

- 4.36 PCT clusters will need to work together with local authorities to agree jointly on priorities, plans and outcomes for investment of the monies allocated for reablement in 2012/13. This could include:
- current services such as telecare<sup>16</sup>, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services;
  - new services such as:
    - funding the social care aspects of the National Dementia Strategy; and
    - actively impacting on Delayed Transfers of Care, using local opportunities to develop the provision of post-discharge care and support services which are the responsibility of social services.
- 4.37 PCT clusters will need to continue to transfer the social care funding within allocations to local authorities to invest in social care services to benefit health and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the NHS Act 2006.

## Procurement

- 4.38 Trusts' non-pay expenditure typically accounts for 30 per cent of their expenditure, therefore in the current economic climate it is vitally important that this expenditure is managed efficiently and effectively. We know trusts can do more to generate savings through better procurement and all organisations need to look at how they can do this better, individually and collectively. This is an important part of meeting the QIPP challenge.
- 4.39 The Department is preparing a procurement strategy to be launched by April 2012, to help trusts improve their procurement performance. We will expect trusts that spend more on goods and services than their peers and do not use national frameworks where they exist, to justify why they are doing so under a comply or explain regime.

## Contract management arrangements

- 4.40 The 2012/13 NHS Standard Contracts will see the implementation of the first phase of the fundamental review of the contracts signalled in the NHS Operating Framework 2011/12.

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<sup>16</sup> Further evidence on the effectiveness of telecare as part of a holistic response to managing long term conditions will be available shortly as part of the Whole System Demonstrator sites.

## 4. Finance and business rules

- 4.41 The 2012/13 NHS Standard Contract will be a single agreement for use by commissioners when commissioning services from providers seeking to deliver NHS funded secondary and community services. Commissioners must enforce the standard terms, in particular the financial penalties for under performance.
- 4.42 PCT clusters should ensure that providers use the Secondary Uses Service (SUS) for performance monitoring, reconciliation and payments and may use contract sanctions if they are not satisfied over the completeness and quality of a provider's data.
- 4.43 Introduction of a single agreement recognises that the delivery of care is now in a range of different settings. The restructured contract is more "user friendly" and easier to follow. The revised supporting guidance will further assist organisations and new commissioners.
- 4.44 Contracts and variations to contracts must be signed prior to the start of the financial year and before service commencement.
- 4.45 Contracts, in general, will be limited to 12 months for 2012/13. Anything beyond that time period would be by exception and would have to meet defined criteria.
- 4.46 During 2012/13, further review will take place to ensure that, subject to the passage of the Bill and Regulations, the contract drafting reflects the revised requirements for CCGs and the NHS Commissioning Board.
- 4.47 The 2012/13 contract will be published with accompanying guidance to support the commissioners and providers. The standard variation documents to reflect the policy requirements covering prior year standard contracts will be published shortly afterwards.
- 4.48 The involvement of local clinicians in the contracting round for 2012/13 will be essential, as PCT clusters will be mindful that contracts with providers of NHS funded services must transition smoothly to CCGs, the NHS Commissioning Board or local authorities.
- 4.49 It is planned to integrate the interim care homes and the High Secure Services contract terms into the 2013/14 standard contract, and engagement with stakeholders will take place as part of this process.

- 4.50 During 2012/13, work will continue on the preparation of the transfer of the clinical contracts from current commissioners to the new commissioning authorities as planned as part of the NHS reforms. Guidance on the initial phases of this work has been published, and further guidance on the later stages of the transfer process will be issued during 2012.

### The principles and rules for cooperation and competition (PRCC)

- 4.51 PCT clusters are required to review their practices in light of the Cooperation and Competition Panel's report on the operation of any qualified provider in elective care, and the Department's response, to ensure they are compliant with the PRCC.
- 4.52 Any decisions that would restrict patient choice must be taken at Board level and published annually, including the rationale, impact and period of operation. SHA clusters will have oversight of the PRCC locally in 2012/13 and should ensure compliance by local commissioners and NHS trusts.



## 5. Planning and accountability

### Overall context

5.1 In 2012/13, the Department of Health will work through SHA clusters to hold PCT clusters to account for delivery of the requirements set out in this NHS Operating Framework. The accountability arrangements in 2012/13 are:



Throughout the year, NHS organisations must maintain or improve the quality of services provided, while delivering transformational change and maintaining financial stability. Under performance will trigger proportional action that may include intervention from the centre.

5.2 From 2013/14, the NHS Commissioning Board will be held to account by the Department of Health and NHS commissioners should anticipate the introduction of a more outcomes-based approach through the NHS, Public Health and Social Care Outcomes Frameworks. Local publication and benchmarking should take place for all available quality measures, in addition to those set out in this NHS Operating Framework for national reporting.

5.3 The accountability arrangements described in this NHS Operating Framework sit within an overall context of the NHS system during 2012/13, key to which continue to be:

- the current statutory framework, where PCTs and SHAs continue to be the statutory units of accountability;
- the NHS Constitution, which secures patient and staff rights;
- contracts, which form the means of doing business between commissioners and providers;
- the Care Quality Commission, who carry out inspections and other activity to regulate NHS providers against essential standards of safety and quality; and
- Monitor, who ensure NHS Foundation Trusts are meeting their terms of authorisation, including their contribution to delivery against the national priorities set out in this NHS Operating Framework.

## 5. Planning and accountability

### Planning arrangements

- 5.4 Each PCT cluster is required to have an integrated plan, consisting of a narrative supported by data trajectories for each PCT. PCT clusters should build on the plans that were in place for 2011/12 to 2014/15, reviewing and refreshing as necessary, for the period 2012/13 to 2014/15.
- 5.5 The integrated plan should have a clear focus on quality and the national priorities set out in this NHS Operating Framework, bringing together QIPP, finance, activity, workforce, informatics and transition to the new structures. This plan should include robust milestones for transformational change for QIPP and reform, and should align with the data trajectories for quality indicators, activity, finance and workforce at PCT level. There should be a clear read across between planned transformational change and the impact the planned change will have on data trajectories.
- 5.6 The technical planning guidance will be published in December 2011 and will set out the national expectations of key milestones for reform, to deliver the requirements set out in this NHS Operating Framework. Financial planning guidance will be issued in January 2012 and will include the detailed rules underpinning the financial strategy, control and plans for 2012/13.

### Providing a base for the reformed system

- 5.7 As a minimum, PCT clusters must ensure that their emerging CCGs explicitly support the plan for 2012/13 and beyond so that they have a strong base on which to build their own planning from 2013/14. Plans should be clinically sound and agreed by Medical Directors and Directors of Nursing.
- 5.8 Plans should reflect the outcomes of the local Joint Strategic Needs Assessment and PCT clusters need to ensure that the public health transition elements of their plan are supported by local authorities, again to ensure that those organisations have a good understanding of the basis on which they will take on responsibilities from 2013/14.
- 5.9 The contracts agreed with local providers need to be consistent with the integrated plan to allow for alignment with Tripartite Formal Agreements for NHS trusts.

### Performance monitoring and assessment

- 5.10 The Annex to this NHS Operating Framework sets out the indicators that will be used nationally to assess how SHA clusters and PCT clusters are delivering during the year. The indicators are grouped under three domains:
- **quality**, covering safety, effectiveness and experience;
  - **resources**, covering finance, workforce, capacity and activity; and
  - **reform**, covering commissioning, provision and patient empowerment.
- 5.11 Alongside these indicators, PCT clusters will be held to account against the key milestones for the transformational change elements of QIPP and reform, agreed with SHA clusters as part of the planning round. These milestones should reflect the relevant national milestones, set out in the technical planning guidance. Success against these milestones as well as national indicators set out in the Annex mean that NHS organisations will be providing high-quality services within the current financial envelope, whilst achieving the transformational change that creates the platform for delivery in the future.

### System requirements and timetable

- 5.12 By the end of March 2012, all PCT clusters should have an integrated plan as specified above, which has been assured by SHA clusters, through a process overseen by the Department of Health. There will be two stages of submissions by SHA clusters, with the first set of submissions in draft format on 27 January 2012 and the second in final format on 5 April 2012. From each SHA cluster, the Department of Health will require:
- data trajectories for all PCTs for the relevant indicators set out in the Annex to this NHS Operating Framework;
  - milestones for each PCT cluster (drawn from their integrated plan), covering transformational change elements of QIPP and reform;
  - milestones for each SHA cluster about the transition of the functions within the SHA to new bodies; and
  - a short narrative outlining the SHA cluster's assurance process and the SHA cluster's assessment of key risks and mitigating action within the region (both geographical and programme based).

## 5. Planning and accountability

- 5.13 The Department of Health's External Gateway function serves to assure that 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, creating space for local decision making, meeting our obligations in terms of better regulation, and supporting equality and inclusion. All communications requiring the attention of NHS management during 2012/13 will include a Gateway reference number.

# Annex – National performance measures

Quality	
<b>1</b>	<b>Preventing people from dying prematurely</b>
	<ul style="list-style-type: none"> <li>Ambulance quality (Category A response times)</li> <li>Cancer 31 day, 62 day waits</li> </ul>
<b>2</b>	<b>Enhancing quality of life for people with long term conditions</b>
	<ul style="list-style-type: none"> <li>Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)</li> <li>Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)</li> </ul>
<b>3</b>	<b>Helping people to recover from episodes of ill health or following injury</b>
	<ul style="list-style-type: none"> <li>Emergency admissions for acute conditions that should not usually require hospital admission</li> </ul>
<b>4</b>	<b>Ensuring that people have a positive experience of care</b>
	<ul style="list-style-type: none"> <li>Patient experience of hospital care</li> <li>Referral to Treatment and diagnostic waits (incl. incomplete pathways)</li> <li>A&amp;E total time</li> <li>Cancer 2 week waits</li> <li>Mixed-sex accommodation breaches</li> </ul>
<b>5</b>	<b>Treating and caring for people in a safe environment and protecting them from avoidable harm</b>
	<ul style="list-style-type: none"> <li>Incidence of MRSA</li> <li>Incidence of <i>C. difficile</i></li> <li>Risk assessment of hospital-related venous thromboembolism (VTE)</li> </ul>
<b>Public Health</b>	
	<ul style="list-style-type: none"> <li>Smoking quitters</li> <li>Health checks</li> </ul>

Resources
<ul style="list-style-type: none"> <li>Financial forecast outturn &amp; performance against plan</li> <li>Financial performance score for NHS trusts</li> <li>Delivery of running cost targets</li> <li>Progress on financial aspects of QIPP</li> <li>Acute bed capacity</li> <li>Activity (eg Elective and non-elective consultant episodes; Outpatients; Referrals)</li> <li>Numbers waiting on an incomplete Referral to Treatment pathway</li> <li>Health visitor numbers</li> <li>Workforce productivity</li> <li>Total pay costs</li> <li>Workforce numbers (clinical staff and non-clinical)</li> </ul>
Reform
<ul style="list-style-type: none"> <li><b>Commissioning Development</b> <ul style="list-style-type: none"> <li>% delegated budgets</li> <li>Measure of £ per head devolved running costs</li> <li>% authorisation of clinical commissioning groups</li> <li>% of General Practice lists reviewed and "cleaned"</li> </ul> </li> <li><b>Public Health</b> <ul style="list-style-type: none"> <li>Completed transfers of public health functions to local authorities</li> </ul> </li> <li><b>FT pipeline</b> <ul style="list-style-type: none"> <li>Progress against TFA milestones</li> </ul> </li> <li><b>Choice</b> <ul style="list-style-type: none"> <li>Bookings to services where named consultant led team was available (even if not selected)</li> <li>Proportion of GP referrals to first outpatient appointments booked using Choose and Book</li> <li>Trend in value/volume of patients being treated at non-NHS hospitals</li> </ul> </li> <li><b>Information to Patients</b> <ul style="list-style-type: none"> <li>% of patients with electronic access to their medical records</li> </ul> </li> </ul>



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