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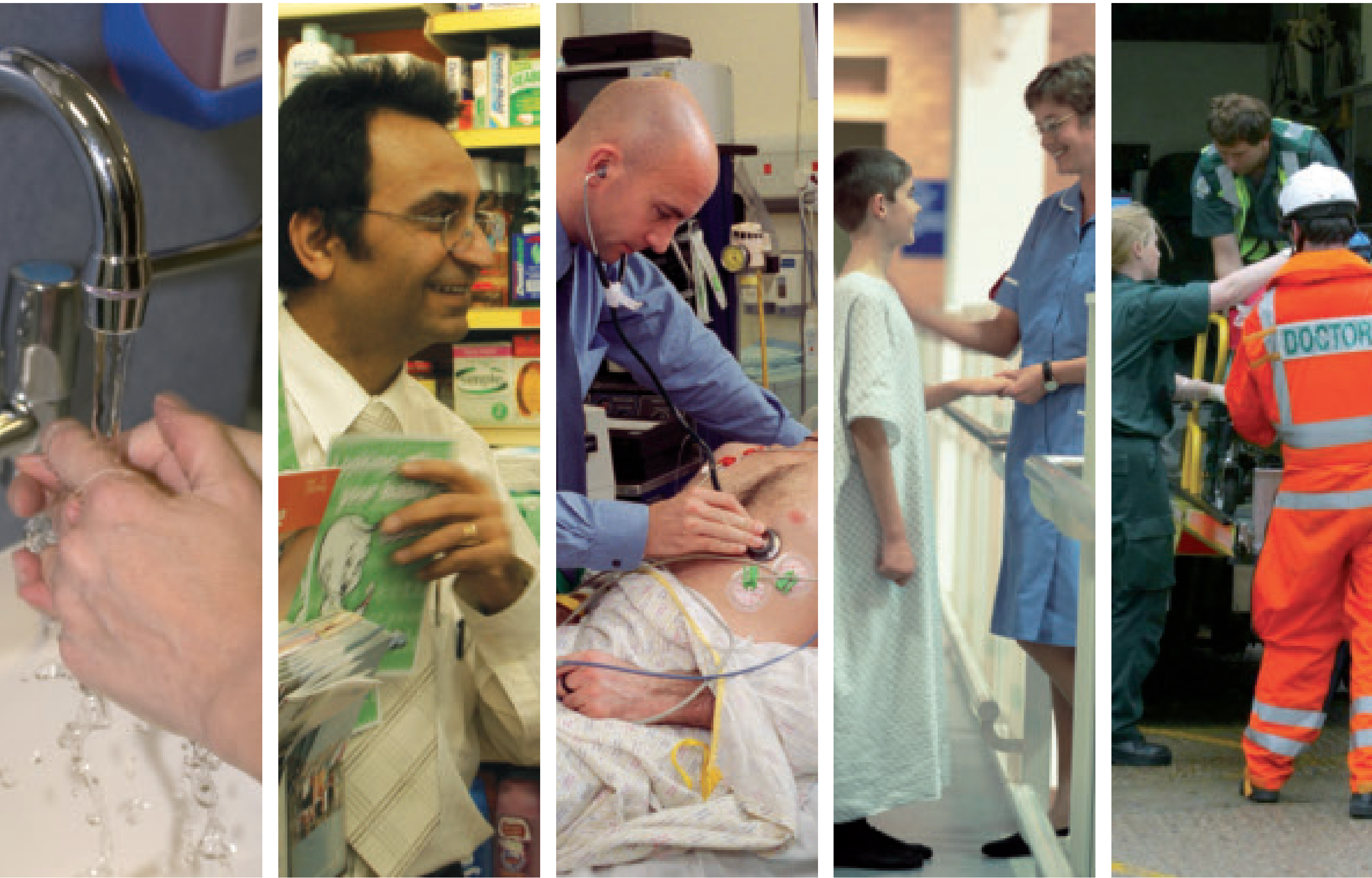

the operating framework.

For the NHS in England
2008/09

DH Department of Health

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Foreword

Foreword from David Nicholson, NHS Chief Executive

The Operating Framework for 2008/09 marks the beginning of a new chapter in the journey to transform the NHS, setting out a truly ambitious programme for the NHS over the next three years, and enshrining the ability for local NHS organisations and the communities they serve to have greater autonomy in determining their own priorities.

The new Comprehensive Spending Review (CSR) allows us to give primary care trusts (PCTs) an above inflation cash increase of 5.5 per cent – equivalent to a £3.8 billion increase in revenue allocations. This, coupled with the devolving of a further £1.7 billion of central budgets, means that more money than ever before will now be in the control of local PCTs.

Additionally, our emphasis on driving up the knowledge, skills, behaviours and characteristics that underpin world-class commissioning will now ensure that PCTs have both the power and the ability to effect real change.

The settlement also allows us to tackle some of the key issues that staff have raised over the last year, for example delivering a 6 per cent uplift in the growth of the Multi Professional Education and Training (MPET) budget to strengthen training and development opportunities in the NHS.

2008/09 will be the first of a three-year planning cycle, and therefore naturally this Operating Framework sets out in significantly greater detail our ambitions for the next three years. It also builds upon many of the themes outlined in the interim Next Stage Review report.

A core part of our ambition is responding to what our patients and communities have told us they want the NHS to achieve, including:

- improving cleanliness and reducing healthcare-associated infections;
- improving access through achieving 18-week referral to treatment and better access to GP and primary care services;
- keeping people well, improving overall health and reducing health inequalities;
- ensuring we improve the patient experience, staff satisfaction and engagement; and
- not being found wanting in our preparations to respond to emergencies such as an outbreak of pandemic flu.

Last year, the Operating Framework sought not only to fix the financial difficulties of the NHS, but to provide the kind of sustainable financial platform that would encourage more medium- and long-term local planning and create the headroom needed to allow NHS organisations to be more responsive to any in-year pressures such as new drugs coming on line.

Having achieved this in almost every part of the system – and with the Government having committed to annual real-terms growth in resources of 4 per cent over the next three years – the conditions are now absolutely right for developing a framework within which PCTs, in conjunction with their local communities, can set more of their own ambitions rather than having them mainly set by Whitehall.

We will publish a whole raft of indicators, or 'vital signs', from which local PCTs can choose where they want to focus their effort. 'Devolving power to the front line' is an increasingly popular mantra – but it is more than that. This Operating Framework is a key milestone in creating an environment in which there is greater freedom for clinicians and managers to exercise their judgement and skill at a local level – not because it's fashionable, but because I know that this is the best way real change will be delivered.

But I want to be clear that this is the beginning of this journey. The list of vital signs will by no means be exhaustive and will be fluid, to reflect the local and national direction of travel. Throughout this CSR period, I would expect that we will be able to shift even more autonomy over local target setting towards PCTs. The work on how we measure all these vital signs and how they are regulated is still ongoing, but the underlying principles of greater local autonomy and rewarding ambition will remain constant.

Our success in moving to this next stage of the journey doesn't just rely on me making the system more flexible and responsive, it also relies on the right response from local leaders across the NHS. Just as last year we made financial balance a priority and introduced a more rules-based professional financial regime, this year improving patient experience is an explicit priority rather than an assumption and needs to underpin the decisions that local organisations make about where their priorities will lie.

The priorities set out in the Operating Framework for 2008/09 will be delivered in the 60th anniversary year of the NHS. As well as continuing to provide better-quality services to today's patients, this year we must continue to drive forward reform, so that the NHS is fit for the patients, public and staff of the 21st century.

David Nicholson
NHS Chief Executive

1 Overall context

Introduction

1.1 Last year's Operating Framework marked the final year of the three-year planning cycle. The emphasis was on continuity as we set out how we expected NHS organisations to deliver on existing commitments. We also set a challenging target for the NHS to move towards a healthy surplus, whilst delivering ever better quality care to patients.

1.2 The NHS rose to that challenge, and we have now done what we said we would do:

- waiting times have fallen to record lows; clinical outcomes for cancer and heart disease have improved and many facilities have continued to be modernised;
- the NHS has returned to financial balance, delivering a surplus of £510 million in 2006/07, and is on course to achieve a surplus in 2007/08;
- primary care trusts (PCTs) have undergone major reorganisation to ensure that we have the right structures and leadership in place to enable effective commissioning;
- the process of embedding reforms such as patient choice, practice-based commissioning, Payment by Results and NHS foundation trusts has continued apace in order to ensure effective commissioning.

1.3 This progress has been achieved through the efforts of NHS staff, supported by significant investment of taxpayers' money and a programme of reforms to deliver better quality and more responsive patient care.

1.4 Looking forward, the Comprehensive Spending Review (CSR), announced in October, provides the NHS with an annual growth in resources of 4 per cent in real terms over the next three years. Whilst this is less than the historic rates of growth the NHS has enjoyed in recent years, it still represents a solid platform, enabling us to go into the next three years with confidence that we will make further improvements to the services we provide for our patients and deliver on our key promises.

1.5 This document sets out these promises; but it also marks a shift in emphasis towards having more of these set locally, in collaboration with local communities.

1.6 The challenge now is to take the investment and increased capacity on the one hand, together with the reforms on the other, and drive the necessary transformation to deliver real benefits for patients. To achieve this, we need to build the confidence and support of the staff who work in the NHS, the patients who use it, and the public who fund it.

We will make further improvements to the services we provide for our patients and deliver on our key promises.

1.7 In the interim report of the NHS Next Stage Review (*Our NHS, Our Future*), Lord Darzi set a vision for an NHS that focuses relentlessly on improving the quality of care, that delivers the kind of personalised care we all expect and that is:

- **fair**: equally available to all, taking full account of personal circumstances and diversity;
- **personalised**: tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice;
- **effective**: focused on delivering outcomes for patients that are among the best in the world;
- **safe**: as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive;
- **locally accountable**: so that staff are empowered to lead change and innovate locally, ensuring that this is based on the best clinical evidence, meets local needs, and is the product of engagement with patients and the public.

1.8 The second stage of the review will set out how we can deliver this vision, working with staff, patients and the public to ensure that it is developed and owned by all.

1.9 It will set out the strategy and vision for the next 10 years. The Comprehensive Spending Review sets the Public Service Agreements (PSAs), which state the Government's priorities for improvement, and the financial envelope within which the NHS develops and delivers the strategy for the next three years. Within this context, the Operating Framework focuses on the year ahead. It sets out issues that require the particular attention of NHS staff, and the system changes that will help them locally to transform services in collaboration with its partners.

1.10 Specifically, the Operating Framework clarifies:

- **the health and service priorities for the year ahead**: freeing up the front line by moving towards local stretch targets, whilst delivering on national priorities. 2008/09 is the start of the next three-year planning round. In this context, we are clarifying the priorities for the next three years, whilst emphasising the issues that will need particular attention in 2008/09. The preparation of new Local Area Agreements (LAAs) offers PCTs an ideal opportunity to work with local partners in order to focus on shared priorities for improving health and wellbeing;
- **the reform levers and enabling strategies**: reform with a purpose – to improve quality and reduce health inequalities. Our focus is on developing world-class commissioning as the key agent for change on behalf of patients and the public, using the full range of levers and incentives to transform services and improve outcomes;
- **the financial regime**: setting out a framework that fully supports reform goals and incentivises transformational improvements in services within the available resources. Key to this will be the need to sustain the surpluses we are on track to deliver;
- **the business processes**: ensuring a business-like and transparent approach to planning that supports locally led decisions, whilst providing accountability. There is a strong emphasis on genuine partnership working between PCTs, local authorities and other partners (public, private and third sector – including social enterprise) to ensure that local health and wellbeing needs are better understood and addressed in partnership. Joint strategic needs assessments (JSNAs) will be vital in this context.[1] They will also provide robust information to support commissioners as they fulfil their legal duty to carry out equality impact assessments to assure themselves that services are both accessible to and appropriate for the whole community.

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1 JSNA guidance is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

1.11 At the heart of our strategy for the NHS, whether over the next one, three or ten years, is listening and responding to what matters to our patients, public and staff.

1.12 The implications of the national priorities for foundation trusts will be discussed with Monitor as part of the development of Monitor's 2008/9 Compliance Framework. Any requirements for NHS foundation trusts will be included either in the Compliance Framework or agreed in contracts with commissioners. The rules and systems in this document are not intended to cut across the compliance and reporting regime that Monitor has in respect of NHS foundation trusts.

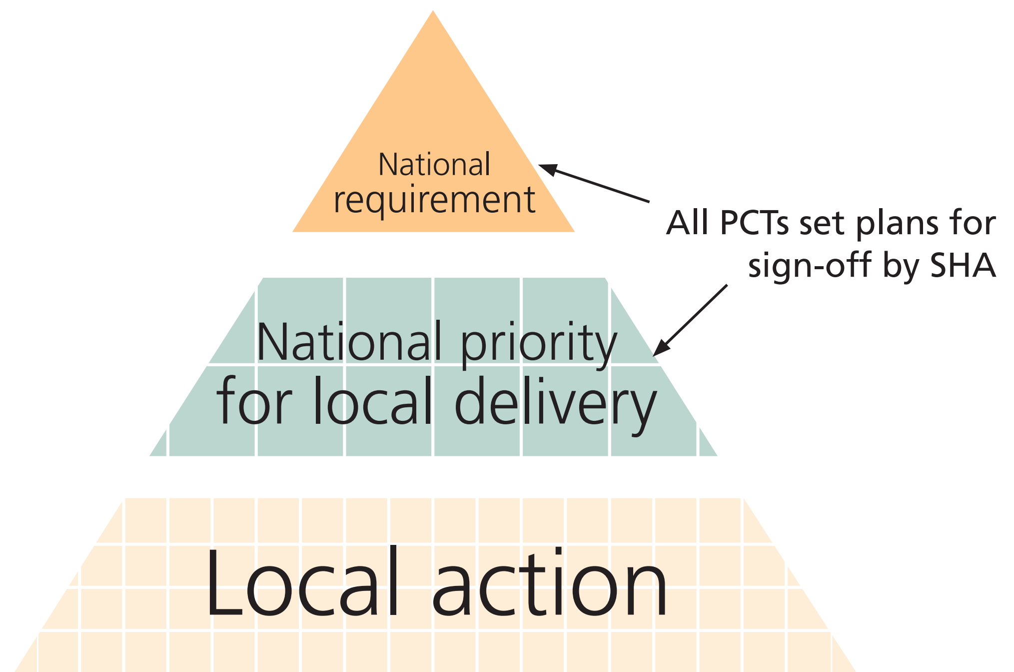
2 Priorities

Overall approach

2.1 As we head into a new three year planning period, there are a number of goals we have set ourselves as a system, both in terms of specific improvements to services but also in the way we do business. This section sets out an approach to delivering these, within a framework that gives local NHS organisations freedom to deliver better services to their local population.

2.2 As part of the framework, we are developing a list of indicators or 'vital signs', across a range of services. The vital signs are being developed to encourage and enable partnership working between PCTs and local authorities to deliver joint outcomes through LAAs and PCT operational plans. We will also shortly be publishing a health and wellbeing narrative to clarify how LAAs will operate alongside PCT operational plans.

2.3 Our intention is that performance against all of these indicators will be published annually. This will allow a local population to understand how well or poorly their local PCT is performing across a range of commissioner responsibilities, and will be part of a local conversation between PCTs and their populations.



2.4 We will be in a position to send out a list of the vital signs soon. It is important to be absolutely clear, however, that this will not be a list of top-down targets. It will in fact be completely the opposite: it is a decisive move towards greater local autonomy.

2.5 There will be three sub-sections to the vital signs. Firstly, the national 'must dos' – these are set out later in this section and will come as no great surprise, because they are the things that our patients, public and staff say are important – eg healthcare-associated infections (HCAIs). There will also be areas where nationally we know there is work to do, but where we recognise that organisations need a greater degree of flexibility about how they do it. These, too, are set out later in this section.

2.6 However, beyond these two will be a further range of other indicators where, for the first time, PCTs can, in conjunction with their communities, prioritise for themselves where to drive service improvement harder in the areas that will make the most difference to their population.

2.7 In choosing local targets, PCTs are **not** limited to those measures that will be included in the 'vital signs' – they will be expected to address those where the PCT is a major outlier, but they will also be expected to be identifying measures that make the most sense to their local populations and circumstances. So, we will benchmark vital signs (which will be an evolving set of measures over time), and that will be one important indicator of system health and commissioning strength, **but** we will **also** be looking for clear evidence that PCTs as local leaders have the ability to 'look out not up' in identifying other key areas for improvement.

Where there are significant areas of public and patient need or concern, we respond to these equally across the board.

2.8 The Healthcare Commission will build into its regime the national priorities set out in the Operating Framework and the local priorities that individual PCTs select from the vital signs.

2.9 The rest of this section sets out where – and how – organisations should focus their attention, using the vital signs, whilst also sustaining and building on the achievements already made, including delivery of existing standards (such as four-hour maximum waits for A&E and access to sexual health services). A list of those existing commitments that we will continue to monitor for public accountability purposes is set out in Annex A.

2.10 In summary, this document sets out:

- a small number of **national priorities** requiring particular and sustained attention from PCTs, working with every organisation that provides care to NHS patients;
- a number of areas where greater local action and effort is required, but where we recognise that PCTs have a great degree of local flexibility in how this action is taken forward;
- the opportunity for PCTs to select their own priorities and local stretch targets, which will enable them to focus on, and demonstrate improvement in, those areas most relevant to the needs and expressed views of their local populations.

National priorities for 2008/09

2.11 Last year's Operating Framework signalled our commitment to achieve greater clarity and consistency of purpose, so that we can increasingly devolve the way in which change is delivered at a local level. This commitment remains.

2.12 But that does not mean that there will never be any national commitments or priorities. In England, we are fortunate enough to have a *National* Health Service, and that means that we can and must be able to ensure that there are national standards, and that wherever there are significant areas of public and patient need or concern, we respond to them equally across the board.

2.13 In this year's Operating Framework, there are five key areas where we expect PCTs (working with providers and their local partners) to pay particular attention. We know from listening to our patients and public that these are the most important issues, regardless of where people live.

2.14 These are:

- improving cleanliness and reducing HCAIs;
- improving access through achievement of the 18-week referral to treatment pledge, and improving access (including at evenings and weekends) to GP services;

- keeping adults and children well, improving their health and reducing health inequalities;
- improving patient experience, staff satisfaction, and engagement; and
- preparing to respond in a state of emergency, such as an outbreak of pandemic flu.

2.15 Underpinning our whole approach to these areas is the explicit understanding that raising the satisfaction of the patients who use our services, and increasing the confidence of the public who fund it, must be at the heart of all we do. Decisions about how the NHS develops increased investment, reform and managerial effort must be informed by measurable evidence of what matters to our patients, public and staff.

Cleanliness and healthcare-associated infections

2.16 It is a significant cause of distress to patients, their families and NHS staff, that occasionally the action we take to help people sometimes results in unintended harm. It is also increasingly a key issue for public confidence in the NHS. No healthcare system can ever be entirely risk free, but we must do more to reduce the rate of HCAIs. Organisations need to take particular action in 2008/09 to ensure progress against the two national targets in this area:

- **MRSA**: maintaining the annual number of MRSA bloodstream infections at less than half the number in 2003/04;
- ***Clostridium difficile***: differential Strategic Health Authority (SHA) envelopes to deliver a 30 per cent reduction nationally by 2011, compared to the 2007/08 baseline figure.

2.17 Further information about how we ensure we meet this reduction in *Clostridium difficile* infections and expectations for local targets on MRSA performance will follow in the new year.

2.18 We expect the NHS to implement effective infection prevention and control policies and procedures, from board to ward. Managers must listen to and work with clinicians and maintain infection prevention and control as the highest priority. Organisations must ensure that they comply with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* and implement best practice from *Saving Lives*. Delivery of these HCAI targets will be supported by specific action required of all organisations. Given the priority attached to HCAI, work is already underway in 2007/08 across the NHS to support delivery of the targets. This must be maintained in future years.

2.19 Meeting the challenge of HCAI will require additional actions across the system for 2008/09, including:

- introducing MRSA screening for all elective admissions from 2008/09, and for all emergency admissions as soon as practicable within the next three years; and
- implementing the forthcoming HCAI and Cleanliness Strategy.

Improving access to services will not only help to improve patient experience but will deliver real improvements in health outcomes.

2.20 Improving cleanliness is an important part of the strategy to tackle HCAI, but it is also a high priority in its own right. Patients are right to expect a clean environment. The forthcoming HCAI and Cleanliness Strategy will set out further information, including the need for organisations to ensure that all staff receive appropriate training on infection prevention and control.

2.21 To support delivery of the necessary improvements, the tariff uplift for 2008/09 recognises the importance of tackling HCAI and improving cleanliness, and the NHS contract sets out what sanctions are applicable in the case of failure to achieve agreed improvements.

Improving access

2.22 Improving access to services will not only help to improve the patient's experience but will deliver real improvements in health outcomes. Access to services at the time and place that people want remains a key litmus test of the public's views of the NHS. Much progress has been made in improving access to secondary care over the past few years, but challenges remain:

- first we need to build on the progress we have made in waiting times for secondary care from the patient perspective by reducing the total time from referral to the start of treatment to a maximum of 18 weeks;
- second, we need to take the lessons from improving access and

responsiveness in secondary care and apply them to primary care, where the bulk of a patient's contact with the NHS takes place.

2.23 Specific progress in 2008/09 in two areas will be important in delivering real benefits to patients.

18-week access

2.24 Patient experience will be the ultimate measure of success in delivering further improvements in access. We will do this through a patient-reported measure, which will be underpinned by having an operational standard of delivery set for the NHS. We are testing an 18-week patient survey, which focuses on patients' satisfaction with the service they have received. We plan to roll this out nationally in early 2008/09.

2.25 By December 2008, no one should have to wait more than 18 weeks from the time they are referred to the start of their treatment, unless it is clinically appropriate or they choose to wait longer. Delivery of the 18-week waiting-time standard will reduce unnecessary delays and improve patients' experience of the whole journey.

2.26 In 2008/09, PCTs need to be working with providers on pathway redesign and demand management. Plans for 2008/09 need to put in place the necessary improvements to sustain performance after December 2008.

2.27 The operational standards of delivery for the NHS (after allowing for adjustments to reflect patient choice along the admitted part of the admitted pathways) will be:

- 90 per cent of pathways where patients are admitted for hospital treatment should be completed within 18 weeks; and
- 95 per cent of pathways that do not end in an admission should be completed within 18 weeks.

2.28 These operational standards allow for patient choice, compliance along the non-admitted parts of the pathway, and clinical complexity. The requirements of the contract will reflect the operational standard.

2.29 We will also introduce performance sharing between all providers on an 18-week pathway, so that each provider receives the credit for delivery, or the penalty for non-delivery, on inter-provider pathways. This will be similar to what is in place for cancer waits – so called 'breach sharing'.

2.30 We expect operational plans for 18 weeks to be underpinned by activity plans developed locally by PCTs and providers to provide the necessary capacity for delivery of 18 weeks. We expect these activity plans to be reflected in the contracts agreed between providers and PCTs, and the Department will collect high-level data on this as part of the operational plan submission from PCTs.

e expect PCTs and providers to use the flexibility of unbundling within contracts to facilitate delivery of 18 weeks, for example by moving part of the care pathway to alternative settings (where appropriate) or by increasing diagnostic capacity. This is consistent with the direction for 2009/10 and beyond towards unbundling of diagnostics within the national tariff structure.

Primary care

The Government has given a commitment that early action to improve the responsiveness of services will focus on improving routine access to GP services in the evening and at weekends. PCTs need to ensure that at least 50 per cent of GP practices in their area offer extended opening to their patients, with the additional opening hours based on patients' expressed views and preferences on access.

2.33 During 2008/09, all PCTs will complete procurements, based on open and transparent tenders, for new GP-led health centres and those PCTs identified as having the greatest need will procure new GP practices. PCTs will need to develop these new services in ways that provide the most convenient access to primary care services. Funding to support investment in health centres is reflected in growth in PCT allocations, with additional funding being made available for those PCTs procuring new GP practices.

2.34 PCTs need to work with GP practices to improve patient satisfaction with services, as measured through the results of the GP Patient Survey. This includes improved performance on current indicators of patient-reported experience of access to GP services (eg including access to a GP within 48 hours and the ability to book advance appointments) and wider indicators of responsiveness, equity and patient experience of GP services, as these are incorporated into the survey for future years.

2.35 PCTs also need to ensure robust commissioning strategies for primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services (as measured by quarterly data published by the Information Centre on the number of people receiving primary dental services within the most recent two-year period).

2.36 The NHS can only deliver better health and wellbeing outcomes by working closely with its partners, particularly in local government. Over the next few years, we expect to see increasing cooperation between the NHS and local authorities in providing more integrated and co-located services, supported by joint commissioning. In particular, we expect PCTs to work with local authorities to identify how new health centres can provide increased integration between health and social care, and support an integrated approach to health and wellbeing as defined in the *Putting People First* concordat.

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

2.37 It is one of the strengths of our National Health Service that patients have equal access to care when they need it. But we must do more to ensure that we have greater equality with regard to health outcomes. There are still unacceptable variations in the health status within and between our different communities.

2.38 People should expect to receive the best possible care, irrespective of where they live in the country, socio-economic status, race, age, gender, disability, religion or belief, or sexual orientation. Key to achieving this will be delivering on the national objectives to improve people's overall life expectancy and reduce health inequalities. As part of this, PCTs are expected to continue to tackle the biggest killers, focussing on areas where inequalities exist. This would include tackling cancer, cardiovascular disease (CVD), suicide and smoking, which all have a major impact.

2.39 PCTs, working with local authorities and other partners, will also need to consider how their local plans focus on ill-health prevention and on promoting good health; on helping people to live healthier lives, and to take more control of their own health; and on ensuring that health inequalities are reduced. This includes tackling lifestyle issues such as obesity and alcohol abuse, teenage pregnancy, sexual health problems and other areas where we know inequalities exist.

2.40 There are four areas where PCTs will need to take particular action in 2008/09 to ensure progress:

- **cancer**: going further on our existing commitments to make progress towards delivering the Cancer Reform Strategy;
- **stroke**: driving up standards of care to reduce mortality and morbidity through implementation of the Stroke Strategy;
- **children**: improving children's and young people's physical and mental health and wellbeing;
- **maternity**: improving access as part of the wider Maternity Matters Strategy to deliver safe, high-quality care for all women, their partners and their babies.

Cancer

2.41 The Cancer Reform Strategy sets out the next steps that need to be taken by commissioners and providers of cancer services. Attention needs to be given to prevention, earlier diagnosis to ensure better treatment, improving patients' experience of care, and providing care in appropriate settings. To support this, we need to go further on our existing commitments in a number of areas, such as screening, access and NICE guidance. The action we need to take is outlined in the Cancer Reform Strategy.[2]

2.42 PCTs will also need to ensure that providers of cancer services collect datasets as set out in national contracts.

Stroke

2.43 The National Stroke Strategy is a comprehensive 10-year framework aimed at driving up standards of care to reduce mortality and morbidity.[3] All PCTs are expected to set out, in plans for 2008/09, how they intend to improve stroke services.

2.44 Early specific priorities for 2008/09 include supporting the development of stroke care networks and redesigning services across networks to ensure appropriate urgent care for stroke and TIA (Transient Ischaemic Attack or 'mini stroke') and to meet needs for the long term.

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2 The Cancer Reform Strategy is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

3 The National Stroke Strategy is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062

Children

2.45 Children and young people are healthier now than ever, but inequalities persist. Improving the physical and mental health and wellbeing of children and young people needs to start at conception and run through to adulthood, with a focus on evidence-based prevention, early intervention, and access, designed around the needs of the individual.

2.46 PCTs should work with local authorities and other partners, in the context of Every Child Matters and the Children's Plan, to ensure that children's and young people's health and wellbeing needs are assessed and that action to address these is included in PCT plans, LAAs and NHS contracts, as appropriate.

2.47 In particular, PCTs should pay special attention to obesity as one of the most serious, and growing, health challenges for children. This requires action across services to change public perceptions and behaviours relating to physical activity and diet, and to empower children, young people and families to make healthy choices.

2.48 Nationally, the aim is to reverse the rising tide of obesity and overweight in the population, by ensuring that all individuals are able to maintain a healthy weight. The initial focus is on children: by 2020 to reduce the proportion of overweight and obese children to 2000 levels in the context of tackling obesity across the population. PCTs will need to work with local authorities and other partners to agree key actions to reduce obesity, with a particular focus on interventions aimed at children and families.

Maternity services

2.49 The Operating Framework for 2007/08 required PCTs to take preparatory action to improve access to, and choice of, maternity services.

2.50 In 2008/09, PCTs should aim to:

- increase the percentage of women who have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy; and
- ensure that sufficient numbers of maternity staff and neo-natal teams are in place to meet local needs.

Experience, satisfaction and engagement

2.51 Everything we do in the NHS must be geared towards improving the patient's experience of NHS services and clinical outcomes of care. In order to achieve this, the NHS must get much better at listening and responding to the patients who use our services, the staff who provide them, and the citizens who fund them. Personalised, responsive, safe and dignified treatment leads to improved patient satisfaction and better clinical care. Employers who engage with their staff, and support them to do a good job, tend to have higher rates of patient satisfaction with their services. And organisations that fully involve all their communities and respond to their needs are able to make better decisions and develop services that are fit for the future.

2.52 For the NHS to get better at listening and responding to the needs of patients, staff and the public will require sustained improvements in several areas.

2.53 **Patient experience**: people's comments and experiences, particularly concerns and complaints, provide invaluable evidence to help organisations continually improve patient experience. Nationally, the existing patient survey programme will continue to be used to assess progress on improving patient experience.

2.54 Locally, NHS organisations will need to:

- measure patient experience as reported by the National Patients Survey, developing a thorough understanding of the drivers to improve experiences;
- develop robust strategies to ensure year-on-year improvements in reported patient experience;
- demonstrably use both national and local data of patient experience to inform commissioning decisions.

2.55 **Staff satisfaction and engagement**: motivated and involved staff are better placed to know what is working well and how to improve services for the benefit of patients and the public. Organisational interests should not be a barrier to staff working in true partnership in delivering improved patient care. We expect NHS organisations to take full advantage of their knowledge and experience. This includes:

- encouraging staff to participate in the NHS Staff Survey and act on the findings;
- helping staff understand their role in delivering a better NHS;

- monitoring and achieving sustained improvements in the Staff Survey;
- PCTs discussing staff engagement strategies developed by providers;
- SHAs using surveys as a benchmark for organisational 'health'.

2.56 **Public engagement**: increasingly, people are aware of their local NHS as citizens, not just as patients. They are interested in the range of high-quality, accessible local services, and in how tailored the services are to the current or future needs of both their fellow citizens and themselves. People are increasingly interested in the decisions that commissioners take on their behalf. Commissioners have a responsibility to ensure that their local communities have the opportunity to be fully engaged in the decisions that they take, and to take greater efforts to communicate what they are doing and why to their populations. Low levels of engagement can lead to poor decisions and low public confidence in the local NHS. PCTs will want to ensure that they and NHS providers:

- adopt a systematic and rigorous approach to seeking, collecting and acting on the views of individuals and partners in the local community, as required by Section 242[4] – not just during periods of change but on an ongoing basis;
- create greater opportunities for their communities to make their voices heard, raising awareness of those opportunities and empowering patients and the public to use them and LINks;
- take greater responsibility for communicating with their local populations and stakeholders to ensure better understanding of, and confidence in, local NHS services.

2.57 Improving patient experience, staff engagement and public engagement and confidence are key leadership responsibilities for all NHS organisations. SHAs will hold PCTs to account for making continuous progress in these key areas.

Emergency preparedness

2.58 It is essential that all organisations are well prepared to respond effectively to major emergency incidents, so that they can mitigate the risks to public and patients, and maintain a functioning health service.

4 Of the Local Government and Public Involvement in Health Act 2007

2.59 In particular, PCTs will want to work with NHS organisations and other contracted healthcare providers, to ensure that plans are in place locally, so that they are in a position to respond effectively to any emergency, including a pandemic flu outbreak or dangerous incident such as a chemical, biological, radiological, nuclear or terrorist attack. All NHS organisations must have robust plans in place to respond to a flu pandemic by December 2008.

Local priorities

2.60 In addition to those priorities that are of concern nationally, PCTs should set local improvement plans for areas of concern identified through consultation with patients, public and staff, Joint Strategic Needs Assessment, and in agreement with partners.

2.61 This marks a radical shift in NHS planning and is designed to give more authority to local NHS organisations and their communities.

2.62 There are two parts to this section setting out our approach:

- issues requiring local attention, particularly where recovery action is needed or preparation is required to enable future improvement; and
- issues to be determined and set locally with partners.

Recovery and preparatory action

2.63 There are issues that some PCTs will need to ensure are covered as part of their local priority setting process, but the nature of these issues means that successful delivery will not come from central prescription.

2.64 It will be important in particular that PCTs take recovery action on areas where performance is currently not meeting required standards. This includes:

- **equality**: in developing local plans, PCTs will need to ensure that they pay particular attention to the accessibility for disadvantaged, vulnerable groups, and for people who currently struggle to access services. Following the Office for National Statistics (ONS) Equality Data Review, work is also underway to consider how monitoring of equality should develop;

- **mixed-sex accommodation**: in May, the Chief Nursing Officer (CNO) published a report on progress, which included a commitment to publish good-practice guidance to help reduce the unacceptable variation in performance across the country. This guidance, which has been prepared by the NHS Institute for Innovation and Improvement, will be available from December. PCTs are now asked to:
  - review the current situation in all trusts;
  - work with all trusts, including mental health and learning disability services, to agree, publish and implement stretching local plans for improvement, with identified timescales and monitoring mechanisms. Where patient survey scores are available, monitoring should be based on seeking specific improvements in these scores in the next survey;
  - in addition, ensure that, by 2010, no 16–17-year-olds are treated on adult psychiatric wards, unless such an admission is in accordance with their needs, so that Section 31 of the Mental Health Act 2007 can be commenced;
- **learning disabilities**: a number of high-profile reports by the Healthcare Commission, Commission for Social Care Inspection (CSCI), Disability Rights Commission and Mencap have identified failures and shortcomings in learning disability services. Nationally, we are seeking to develop an indicator on learning disability health services in 2008/09. Local action should be taken to ensure that improvements are made quickly, including:
  - organisations will need to agree local action plans setting out what they are doing to address the shortcomings identified in the Healthcare Commission's audit;
  - PCTs need to work closely with local authorities, to identify local priorities and pursue service improvements in line with the vision (set out in *Valuing People Now*) of ensuring both quality of care and equality of access, with a particular focus on making progress on campus closures and developing and implementing plans with individuals on their care and health needs;
  - subject to the outcome of consultation, PCTs need to prepare for the transfer of learning disability funding to local authorities, as set out in *Valuing People Now*;

- **diabetic retinopathy**: many PCTs need to redouble their efforts to ensure delivery of the existing commitment, so that all people with diabetes are offered screening for early detection (and treatment if necessary) of diabetic retinopathy. Where PCTs are failing to deliver this standard, they should agree recovery plans with their SHAs to ensure improvement;
- **crisis resolution**: last year progress was made on establishing crisis resolution and home treatment teams. It is essential that the momentum to establish these teams continues during 2008/09, so that people receive appropriate treatment and help at the earliest opportunity.

2.65 PCTs will also want to begin preparing for action on those issues that will need addressing to secure future improvements in services and to ensure that they are in the best possible position to respond to future challenges. Specifically this includes:

- **mental health – improving access to psychological therapies (IAPT)**: in 2008/09, the IAPT programme will support the implementation of stepped-care psychological therapies services (as recommended by NICE) in 20 sites across all SHAs. To prepare for these services being available more widely in future, PCTs should begin planning how they will implement a stepped-care psychological therapies service, supported by best-practice guidelines. The first step will be to carry out a needs assessment of their local population, to understand what level of services will need to be provided;
- **older people – dementia**: providing people with dementia and their carers the best life possible is a growing challenge, and is one that is becoming increasingly costly for the NHS. Research shows that early intervention in cases of dementia is cost-effective and can improve quality of life for people with dementia and their families. The Department will shortly be publishing details of the clinical and economic case for investing in services for early identification and intervention in dementia, which PCTs will want to consider when developing local services;
- **end of life care**: we expect PCTs to build on their baseline reviews of end of life care services, which were undertaken to support the forthcoming End of Life Care Strategy that is due to be published in tandem with the NHS Next Stage Review in summer 2008. A key element of the strategy will be to improve people's access to high-quality services, close to their homes. Central to the delivery of this change will be the development of rapid-response services and coordination centres;

- **disabled children**: identifying actions and setting local targets on improving the experience of, and ranges of services for, children with disabilities and complex health needs and their families. This includes significantly increasing the range of short breaks, improving the quality and experience of palliative care services, improving access to therapies and supporting effective transition to adult services.

Priorities determined and set locally

2.66 The above sets a demanding agenda, but one that PCTs are largely working on already, and where there is a degree of flexibility around local implementation. Beyond this, PCTs working with their partners, should develop local priorities based on what their local communities tell them is important, using evidence from the vital signs, strategic needs assessment and best practice to support local decisions.

2.67 Delivery of national and local priorities requires effective business processes at a local level that support local accountability. Details of how we expect this to work are set out further in the Business Processes section of this document.

3 Enabling strategies

3.1 Enabling strategies can best be defined as those things which help organisations to achieve the kinds of improvements in services for patients outlined earlier in this document. This section sets out how we are creating a system that enables PCTs to carry out their roles effectively. Commissioners (PCTs working with practice-based commissioners) must take the lead in acting on behalf of their populations. We expect commissioners to be the catalyst for service transformation and health improvement locally, making the best use of the levers available to them, including competition, choice and the new contracts.

Empowering patients – choice, information and personalisation

3.2 Choice is an important way of building public confidence in the NHS, as well as of empowering individual patients. 'Free choice' will be fully introduced from April 2008 for all patients who require an elective referral. They can choose to be treated by any provider that meets NHS eligibility criteria, and can book their first appointment on-line. There will be a wide range of independent sector providers. For patients to exercise choice, they need to know that they are entitled to choose. We therefore expect PCTs to ensure that their public and all patients are aware that they have a free choice. PCTs should also use NHS Choices and their own publications to provide practical support and information for patients, carers and clinicians to support choice. PCTs are also expected to encourage all GPs to offer choice to their patients.

3.3 Patients also need to know what is available and how different providers compare. We will facilitate this by providing easily accessible and reliable comparative information about providers (including the independent sector) through NHS Choices. Providers will also be able to promote their services responsibly within the provisions of a promotion code. The Department's *Principles and Rules for Co-operation and Competition*[5] will ensure that no provider is inappropriately excluded from participating in free choice and from listing on Choose and Book menus.

5 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

3.4 We also expect PCTs to improve care for people with long-term conditions (LTCs) and to ensure more choices for these patients. We expect PCTs to roll out choice to all people in their area with an LTC, with local flexibility on the pace and priorities, and we are supporting this by publishing a model of care for long-term conditions, embedded in effective care planning, that provides good practice examples aimed at reducing inequalities.[6]

Choice is an important way of building public confidence in the NHS as well as empowering individual patients.

3.5 People increasingly expect to receive health and care services that are personalised – tailored to fit in with their lives and focused on keeping them well and independent: not just dealing with crisis situations. That is why we have just published the cross-sector concordat *Putting People First: a shared vision and commitment to the transformation of adult social care*. This shows the Government's clear expectation that the NHS should work with local partners to promote a single community-based support system focused on the health and wellbeing of local people – not only because this provides better care, but because it is highly cost-effective. It also reflects a new, shared responsibility for the health and wellbeing of families, citizens and communities. This is particularly important for older people, who may use many different services from multiple organisations. As they take forward the redesign of care pathways, PCTs should aim to create a more personalised service that provides:

- choice and control;
- health and wellbeing outcomes that are as good as possible for the individual and their carers, for example by providing access to the Expert Patients or Expert Carers Programmes;
- joined-up services;
- access and convenience – including care closer to home;
- a good user experience, where service users feel that their dignity is respected;
- support for carers by (among other things) taking on board their views about the people they care for, and recognising their need for breaks from caring. The Prime Minister will publish a new Carers Strategy in the spring.

6 The generic choice model for long-term conditions is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081105

3.6 Commissioners should regularly tell their local populations – for example, through their Prospectus – what they have done to make personalisation a reality, and how they plan to go further.

World-class commissioning

3.7 World-class commissioning is about creating world-class clinical services and a world-class NHS. By improving their commissioning and by working closely with local authorities, PCTs will be better able to invest in order to achieve high-quality and personalised services that improve health and wellbeing for their local population. World-class commissioning is not an end in itself. In order to prove themselves successful, PCTs and their practice-based commissioners will need to demonstrate better outcomes, narrowing health inequalities, adding life to years and years to life.

3.8 We expect commissioners (PCTs working with practice-based commissioners) to take the lead on behalf of their population; to seek out their views as well as assess their needs; and to act as the catalyst for service transformation and health improvement locally.

3.9 The Department is collaborating with partners to develop four key elements of the work – outcomes, vision and competencies, an assurance system, and a support and development framework:

- **health outcomes**: world-class commissioning is focused on improving health outcomes and reducing health inequalities, to ensure that issues requiring a medium- to long-term focus are not crowded out by short-term imperatives. Thus, as part of the assurance system described below, there will be local emphasis on the 'vital signs' that PCTs are focusing on in relation to health improvement, reducing inequalities and building public confidence and patient satisfaction;
- **vision and competencies**: this articulates the step change that commissioners will need to make. We have also published the organisational competencies that a world-class commissioner will need;
- **assurance system**: this will drive performance and development and reward commissioners as they move towards world-class status. We will have one single assurance system managed by the SHAs. The three components of the system will be health outcomes, competencies and governance;
- **support and development**: this framework will offer resources for sharing, for building internal capability, and for buying in external expertise. We envisage having an outline framework in place by the end of the year to support road testing of the assurance system.

Practice-based commissioning

3.10 Practice-based commissioning (PBC) is central to world-class commissioning and is here to stay. It is up to PCTs to make sure that PBC succeeds – by ensuring that their practices have their 'fair share' of the budget, accurate and timely information on referrals and budgets, good governance arrangements and the wherewithal to drive change.[7] PCTs should also ensure that the governance around PBC fits within the overall PCT governance framework and is proportionate to the individual circumstances. PBC is our most powerful way of reaching local communities, and so it is a crucial part of how we expect PCTs to address equality issues and reduce inequalities. We expect PCTs to support PBCs in using their financial flexibility to make the simple changes that improve matters for patients – such as arranging for a replacement carer, so that an elderly person does not end up in hospital when their carer has a routine operation.

Specialised services commissioning

3.11 As a result of the Carter Review, the 10 Specialised Commissioning Groups (SCGs) were created to drive up the quality of specialised services, and prevent wasteful or even unsafe duplication of services. For that reason, we expect SCGs to create pooled budgets and to commission the majority of specialised services on their patch this year, extending this to all specialised services in 2009/10. This year, at least half of specialised services commissioned on each patch should be designated, in order to guarantee patient safety and ensure that scarce skills are used effectively. This must be done with a regard to published competition principles and rules.

3.12 In commissioning for world-class health services, SCGs should pay particular attention to areas where significant increases in demand are likely to lead to pressure on services. For example, demand for renal replacement therapy (dialysis and transplantation) is projected to rise by around 5 per cent per year until at least 2030. SCGs will wish to consider options for expanding the provision of satellite dialysis centres and offering more people the option of home dialysis, as well as expanding traditional acute dialysis units.

7 Updated PBC guidance is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081101

National contract

3.13 A key aspect of the moves to strengthen commissioning and develop a rules-based system was the introduction in 2007/08 of an interim version of a new standard NHS contract for acute hospital services. We have worked closely with a wide range of stakeholders since then to learn lessons from the introduction of the contract to make it fit for purpose and to extend its scope to the independent sector. From 2008/09, PCTs must use the new standard contract[8] as the basis for all agreements with NHS acute trusts. The contract is based upon the following principles for cooperation and competition:

- commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population;
- providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability;
- commissioning and procurement should be transparent and non-discriminatory;
- commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare;
- appropriate promotional activity is encouraged, so long as it remains consistent with the best interests of patients and the brand and reputation of the NHS;
- providers must not discriminate against patients and must promote equality;
- payment regimes must be transparent and fair;
- financial intervention in the system must be transparent and fair;
- mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible, when demonstrated to be in the best interests of patient and taxpayers interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money;

The contract is based upon the principles of cooperation and competition.

8 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100

- vertical integration is permissible, when it is demonstrated to be in the best interests of patients and taxpayers and when it protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money.

3.14 Agreements with newly authorised NHS foundation trusts (NHSFTs), and with those NHSFTs whose existing contracts have expired, must also be based on this contract. Details of the transition arrangements for independent sector providers, and the detailed requirements for implementation of the contract can be found in the NHS contract guidance published alongside this document (see Annex E):

- **agreeing contracts**: providers and commissioners will be expected to cooperate to achieve contract agreement by 28 February 2008. Where difficulties occur, a process to resolve disputes will be implemented. If an agreed contract is not in place by 1 April, the parties will not be able to benefit from its provisions and protections. This means that providers, for example, will not be able to be paid on the 15th of each month, but will be paid in arrears on receipt of an invoice for work done. Commissioners will have no performance management controls or control of activity levels.
- **contract sanctions**: the contract provides for nationally mandated sanctions. These are important levers, which we expect to be used where appropriate. These include:
  - **breaches of the 18-week target**: a financial adjustment of 0.5 per cent of contract income for every 1 per cent by which the 18-week target is breached, up to a cap of 5 per cent of elective income or 2 per cent of contract income, whichever is less;
  - **inappropriate excess activity**: non-payment for activity which has breached an agreed prior approval scheme, or has breached an activity management plan, etc;
  - **failure to provide required information**: temporary withholding of 10 per cent of the monthly contract value until the required information is provided;
  - **breaches of the *C difficile* target**: a financial adjustment of 0.2 per cent of contract income for each 1 percentage point by which the target is under-achieved, up to a cap of 2 per cent. High-performing providers will be exempt, so long as they maintain current performance.

Commissioning services for military personnel and veterans

3.15 When commissioning services, PCTs and providers need to take account of the special circumstances that apply to military personnel, their families where appropriate, and veterans. This includes making certain that processes are in place to ensure that, when armed forces families move around the country or move back to England, they are not disadvantaged as a result of their move; for example, they must be able to access NHS dental services. We will issue detailed guidance relating to transfers of care between secondary providers. In addition, PCTs and providers need to ensure application of the existing arrangements for priority treatment, subject to clinical need, of war pensioners, as well as their extension to all veterans for service-related conditions in relation to new referrals.[9]

System management

3.16 The NHS is not a collection of separate and autonomous units of varying degrees of independence, responding to the invisible hand of the market and incentives and reforms. It is, in fact, a healthcare system. The different parts, whether GPs or consultant nurses working in primary care or acute care, are all working for the benefit of patients, whose pathway of care often crosses the boundaries of professions and organisations. This system requires active management by both PCTs and SHAs as local system managers.

3.17 System management encompasses all NHS-funded services, services commissioned jointly with other partners, the linkage to the system management of social care, and commissioning-related interactions with other agencies, particularly local authorities and other local partners.

3.18 System management strives to make each local system the best it can be. There are three components to this:

- the tasks associated with building the system – rolling out practice-based commissioners, ensuring patient choice becomes a reality, getting providers ready for foundation trust status and so on;
- ensuring the system is coherent, for example by ensuring objectives on access are complemented by changes to contracts or processes;
- making the system operate effectively in the interests of patients – sometimes by injecting more competition or capacity through new providers; at other times it might require cooperation between providers to be enforced.

9 Further guidance is available at: www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_081171

3.19 System management is part of the core business of the Department, SHAs and PCTs. It requires both expertise and judgement, but, in the absence of clear rules to govern the system, its application can at times be variable and unpredictable.

3.20 In the future, system management will be conducted in a more open way, and with increased scrutiny. We therefore propose to strengthen and improve system management by:

- providing a clear statement of system management and the principles and rules for cooperation and competition (as described in the section on the national contract). See Annex D;
- providing guidance and advice on such issues as mergers and acquisitions, procurement, promotion, etc. A full list of products and the timetable for their publication is provided in Annex C;
- publishing a set of standard national NHS contracts (see Annex E);
- using the world-class commissioning programme to build PCT capability;
- asking SHAs to review and – where necessary – strengthen their capability to act as the principal system manager. The Department will develop and agree an appropriate assurance system;
- setting up an independent competition panel.

3.21 As in previous years, the rules set out in this and associated documents are binding. In exceptional circumstances, an SHA may request permission from the Department to introduce additional measures to dampen financial volatility in a particularly challenged community. This will be a last resort, will be for a time-limited period and will trigger very close attention from the Department's Recovery and Support Unit. Where an NHS foundation trust is affected, additional measures will only be implemented after they agreed with Monitor.

Provider development

Services provided by PCTs

3.22 The Operating Framework for 2007/08 highlighted a range of different provider models that commissioners can consider for community care. We are working with a small number of PCTs to explore the feasibility of foundation trust status for some providers of community services. This will be further considered in 2008/09.

3.23 During 2008/09, all PCTs should review their requirements for community services and use this process to consider all the options for models of provision. Whilst this is being undertaken, and from 1 April 2008, all PCTs should create an internal separation of their operational provider services, and agree Service Level Agreements for these, based on the same business and financial rules as applied to all other providers.

Foundation trusts

3.24 As part of our reform of NHS service providers, we expect all NHS acute and mental health trusts to apply to become NHS foundation trusts at the earliest opportunity, building on the success of applicants so far. More NHS patients and service users should be able to benefit, as we expect more and more care to be delivered through the NHS foundation trust model.

3.25 All SHAs are required to work with those trusts that have not yet achieved NHS foundation trust status, so that they can improve and develop their management structures and strategic outlook in ways that will allow them to bring to their patients and service users the benefits that come with NHS foundation trust status.

3.26 Since 1 April 2004 (up to 1 December 2007), 83 NHS foundation trusts have been approved, are operating with greater accountability to their service users, staff and local people, and are delivering services in a way that is most appropriate to their own communities. The Department is working with SHAs with a view to re-prioritising trusts going through the application process. Monitor has also been allocated additional resources to deal both with the existing backlog and with the higher number of applicants coming through. SHAs will also be working with their ambulance trusts to ensure that they are in a strong position to apply to become NHS foundation trusts in 2009.

Private and third sector

3.27 The independent and voluntary sector has shown that it can make an important contribution to increasing capacity, patient choice and service innovation. We will therefore continue to encourage independent sector provision where it will provide value for money and meet patients' needs. For acute elective provision, the extent of independent sector provision will be patient led. For other services, it will be commissioner led. We expect commissioners to recognise and make appropriate use of independent sector providers to optimise patient care across all sectors. The focus for procurement from the independent sector, however, will move to the local level, led by commissioners, and will reflect their assessment of capacity gaps and patient needs. We believe this will be a more effective route for increasing the quality of the role which the independent sector can provide in the NHS.

3.28 This will be enabled by:

- **strengthening the commissioning capability of PCTs** through the Framework for Procuring External Support for Commissioners (FESC) (which will enable PCTs to use independent sector expertise in developing their commissioning function), by sharing with the regions current central commercial expertise and the world-class commissioning programme;
- **an independent sector procurement forum**, through which independent and third sector providers will advise the Department on policies and practices related to local procurement of clinical services, in order to ensure a 'fair playing field';
- **patient choice**: free choice of elective care will be fully implemented by April 2008 (see paragraph 3.2);
- **a promotion code** to advise and enable providers to inform patients about the services and choices available to them;
- **principles and rules for cooperation and competition**: we have published, in Annex D to the Operating Framework, clear principles and simple rules governing cooperation and competition for commissioners and providers to apply consistently to all those that provide services on behalf of the NHS, including social enterprise and third sector organisations, as well as the independent sector;
- **a competition panel** to provide independent advice on competition issues to SHAs, which they would be expected to follow. The panel will only consider issues where all steps to resolve the matter have been exhausted. The panel will be set up by April 2008.

Leadership and workforce

3.29 Leaders throughout the health service can make a difference every day in building the confidence and support of the staff who work in the NHS, the patients who use it and the public who fund it. That is why this year we challenge PCTs and other leaders throughout the service to learn how to strengthen conversations with these groups and to be increasingly responsive to what matters locally. In particular, we expect SHAs to take responsibility for managing leadership and workforce across the system. This includes taking lead responsibility for talent management and encouraging joint training with other organisations (across all sectors) on shared issues, such as patient/user empowerment and commissioning.

3.30 Staff who deliver NHS services tell us that they want to be more involved in designing ways of improving services. All too often, reform and change can feel very technical and distant from the reality of caring for patients. We therefore expect providers to focus on staff engagement and satisfaction, given its importance to patient care. This is the responsibility of all employers who deliver NHS services, but the PCTs have a role in assuring themselves that providers are taking action where standards are not high enough. This was identified earlier in the document as a national priority.

3.31 Talent spotting more future leaders is also what good leadership is all about. This is why we expect all providers to do what the best are already achieving – to spot and develop more leaders with a greater diversity of backgrounds and experiences. PCTs and SHAs will be asked to produce a separate talent and capability plan, in order to provide assurance that plans are in place across the healthcare system to identify and develop more leaders from what is one of the world's largest talent pools. We will issue guidance early in 2008.

3.32 Using a clear clinical vision to improve workforce planning is also a priority. Employers need to have robust plans, and we expect PCTs, as commissioners of services, to ensure that providers' workforce, finance and service plans are linked, and that medical and non-medical plans support existing and emerging models of care. We expect PCTs to have a coherent plan and to have assessed and mitigated any risks to service delivery caused by lack of capacity and capability in the workforce, including compliance with the European Working Time Directive.

3.33 Training and development effectiveness matters to staff when it is relevant, useful and supports the delivery of high-quality care. That is why we are increasing the Multi Professional Education and Training (MPET) budget by 6 per cent in 2008/09, on the nationally allocated budget for 2007/08. We expect all trusts to use their service plan and clinical vision as the basis for a learning and development plan for closing the gap between current capability and capabilities needed for the future. There also need to be clear measures of progress, and this should be supported by systematic feedback from staff about training effectiveness. We also expect trusts to support staff who choose to be reservists: reservists are a very important source of health expertise for the armed forces, and the experience they gain in the armed forces also benefits the NHS. PCTs, together with their SHAs, will wish to ensure that local Learning and Development Agreements properly reflect the requirements of providers' workforce delivery plans and are aligned with the agreed clinical vision for service provision.

3.34 Continuous improvement in service through workforce improvements is as important as ever. Following a period of substantial expansion in healthcare, we now expect providers to make best use of the extra capacity, and to have clear plans to realise the benefits of recent reforms. Providers can benchmark themselves against the Better Care, Better Value indicators development by the NHS Institute for Innovation and Improvement.[10]

Information

3.35 The Department of Health is undertaking an Informatics Review to ensure that the information and IT architecture needed to deliver world-class patient care continues to be established. It has identified the following national priorities that we expect to be delivered in 2008/09:

- From April 2008, we expect providers to deliver initially coded datasets weekly to support achievement of the 18-week target, and comprehensively coded datasets monthly. These are expected to be through the Secondary Uses Service (SUS), as soon as each provider can make the necessary technical changes. This is in preparation for April 2009, when the NHS should use SUS as the standard repository for activity for performance monitoring, reconciliation and payments.
- From April 2008, the data warehouse fed from the Electronic Staff Record will increasingly be used for strategic workforce planning and monitoring purposes. Trusts should focus on workforce data quality.
- Formal data-quality audits will be developed and introduced, possibly by the Audit Commission, in the same way as for financial accounts. We are discussing the way forward for foundation trusts with Monitor.
- All NHS organisations will need to focus on the capture, coding and submission process to ensure that data used via data warehouses is as reliable as the data currently used and manually returned to the Department. This focus on quality will be offset by reduced information requests to trusts as data warehouses are used.
- Trusts should continue to ensure that patient identifiable data is safeguarded, and there should be rigorous processes, administration and technology controls to ensure that it is used appropriately.

10 Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081104

3.36 We will continue to focus on, and invest in, the information management and technology (IM&T) that is required to underpin the delivery of world-class patient care. During 2007/08, the transfer of resources from central to local ownership of the National Programme for IT was completed, re-emphasising local accountability for implementation and benefits realisation. In 2008/09, we expect the NHS to build on this progress, with:

- PCTs further developing their leadership role, with PCT chief executives leading local health community programmes to develop IM&T;
- individual NHS organisations working collaboratively within community-wide governance arrangements to produce an inclusive IM&T plan that supports service transformation and local and national objectives, and that demonstrates how the following priorities will be delivered:
  - the implementation of strategic solutions from local service providers;
  - effective information governance and mandated use of the NHS Number in all relevant administrative and clinical systems;
  - deployment of the Summary Care Record and Healthspace, GP to GP record transfer, GP Systems of Choice, direct booking through Choose and Book and the Electronic Prescription Service;
- SHAs continuing to assure themselves that the local NHS has the capability and resources to deliver these plans.

3.37 A full list of the national IM&T expectations is included in the Guidance on Preparation of Local IM&T Plans for 2008/09, issued with this Operating Framework.[11] Support will be provided to the NHS in all the above activities.

11 The guidance is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081102

4 Financial regime

4.1 The Operating Framework for 2008/09 will build on the principles underlying the management of NHS finances stated in 2007/08: transparency, consistency, independence and fairness.

4.2 The aggregate resource accounting and budgeting (RAB) surplus delivered in 2007/08 by SHAs and PCTs will be carried forward to 2008/09 (after adjustment for any over/underspend movements from the 2006/07 audited accounts). Each SHA area should then plan for a surplus in 2008/09 at least equivalent to that total. This will enable the full deployment of baseline and additional resources made available to the service in 2008/09. Within these plans, the requirement will be for SHAs to have resolved all outstanding legacy debt in PCTs by 31 March 2008. In exceptional circumstances, by agreement between the Department and the SHAs, this can be extended to 31 March 2009.

4.3 The aggregate surplus for the NHS in 2008/09 also needs to recognise the surplus generated in the NHS trust sector. This will come from trusts continuing to recover from legacy deficit positions and/or the further generation of surpluses to service working capital loan repayments. The Department will work with SHAs during the 2008/09 planning process to determine what this means for each SHA area.

4.4 SHAs will have the flexibility to determine, within their economies, the level of contingency necessary to ensure delivery of their financial plans, and where this contingency is best held. There will be no central determination of the level of contingency necessary.

4.5 SHAs will also be able to determine and agree locally with PCTs the arrangements for the transfer and lodging of resources with the SHA, within the limit of the overall SHA planned surplus. Such an arrangement must adhere to the four principles above, and SHAs will be accountable for the management of these flexibilities.

4.6 In line with the rest of the public sector, the NHS is required to deliver 3 per cent cash-releasing efficiency savings in 2008/09, and SHAs, trusts and PCTs will need to demonstrate within their plans how this will be achieved.

4.7 HM Treasury has announced its intention of adopting the International Financial Reporting Standards (IFRS) for the public sector in 2008/09. The Department has also announced changes to some aspects of capital accounting from 2008/09. Further guidance will be issued separately to the NHS in due course.

PCT allocations

Revenue

4.8 PCTs will receive an increase of 5.5 per cent or £3.8 billion in revenue allocations in 2008/09. Allocations are only being announced for one year. In the context of the headline revenue settlement in the CSR of 6.7 per cent growth, the increase in PCT allocations does not take account of central allocations previously in the SHA bundle that will go direct to PCTs nor the higher growth to fund commitments within the NHS in education, training and dentistry.

PCTs will receive an increase of 5.5 per cent or £3.8 billion in revenue allocations in 2008/09.

4.9 The weighted capitation formula is unchanged for 2008/09, with all PCTs receiving the same percentage uplift. The introduction of a new weighted capitation formula, including the market forces factor, will be considered when the Advisory Committee on Resource Allocation (ACRA) has completed its review of the existing formula and made its recommendations.

4.10 PCT revenue allocations for 2009/10 and 2010/11 are intended to be made in summer 2008, once ACRA's final recommendations have been received and the new Office for National Statistics (ONS) population projections have been published.

4.11 The Spending Review settlement set out the overall high-level priorities and funding growth for the Department for the period 2008/09 to 2010/11. Although allocations are only being announced for 2008/09, there is sufficient information available to support the development of longer-term plans.

4.12 Specifically, PCTs should not feel prevented from entering into three-year agreements with local partners (including small and medium enterprises and the third sector) that establish practical measures to maximise their capacity to deliver health and wellbeing outcomes.

4.13 No changes have been made to PCT baselines for 2008/09.

Capital

4.14 Part of the CSR settlement was a capital funding increase of 10 per cent in 2008/09, which will support continued growth in capital investment programmes. In 2008/09, £400 million is being made available to fund PCT local capital schemes, with an additional £250 million to

fund national initiatives, such as the community hospitals programme. Indicative comparative funding available for future years is: £480 million (local) and £260 million (national) in 2009/10; and £565 million (local) and £150 million (national) in 2010/11.

4.15 To ensure the effective use of resources, targeted at locally and nationally agreed priorities, it is important that PCTs develop robust capital plans that are signed off by SHAs. The Department is in discussion with SHAs to determine an appropriate methodology for the deployment of these increased capital funds.

4.16 Slippage in programmes in the SHA and PCT sector from previous years should be included in these capital plans and phased in the years the expenditure will be incurred, to ensure existing commitments are recognised.

4.17 The capital regime for the NHS trust sector will operate under the same principles as in 2007/08. NHS trusts will develop plans which will be signed off by SHAs with the financing arrangements agreed by the Department. NHS trusts should use internally generated cash as the first source of capital financing with the primary source of additional financing being provided through interest-bearing loans.

Resource accounting and budgeting

4.18 NHS trusts no longer have income adjustments caused by the RAB regime. The effect of this is that any underspend or overspend by an NHS trust will affect the balance sheet of that trust, but will not result in a carry forward of surpluses or a carry forward of deficit into the following year in the form of a RAB adjustment. Full RAB rules continue to apply to PCTs and SHAs.

4.19 However, until NHS trusts become NHS foundation trusts, it will be the responsibility of SHAs to ensure that any underspending or overspending on the part of NHS trusts is accommodated within the planned surplus for that SHA.

Financially challenged trusts

4.20 In 2007/08, 17 NHS trusts were designated as 'financially challenged', as they required additional working capital cash but could not adhere

to the conditions of the trust loans system introduced at the end of 2006/07. They were the subject of independent reviews commissioned by their SHAs to support the development of proposals to provide long-term solutions for their financial and service stability.

4.21 In 2008/09, a trust will be deemed 'financially challenged' if it meets either of the following criteria:

- It requires a cash loan but it and its SHA are unable to provide sufficient assurance of its ability to generate the required level of surplus to repay a loan over a reasonable period.
- It already has a working capital loan, but defaults on its terms, most probably by moving into deficit and so not being able to make planned repayments from generated surpluses.

4.22 SHAs are responsible for monitoring, identifying and intervening where necessary to prevent their NHS trusts from triggering either of the above criteria.

4.23 In the event that either criterion is triggered, the Department will intervene directly to determine corrective action on a case-by-case basis. This will include managerial and/or organisational change, which may involve market testing, as part of a robust performance improvement process.

Payment by Results

4.24 Alongside this document, the final Payment by Results (PbR) package for 2008/09 is being published. This contains full details of how PbR will operate in 2008/09, including the updates discussed below, and is available at www.dh.gov.uk/pbr

4.25 The PbR package confirms the tariffs released as part of the recent road-testing exercise, which have been uplifted to 2008/09 prices. The uplift is 2.3 per cent, which includes the efficiency requirement of 3 per cent in line with the Spending Review settlement. The tariff uplift recognises the importance of tackling HCAI and improving cleanliness by ensuring that some flexibility has been built into the tariff to allow organisations to accelerate their strategies for reducing infection.

4.26 This figure should be used as the benchmark for contract arrangements for services that are currently out of scope of the national tariff. It will be for commissioners to determine with providers the extent to which there are legitimate additions or deductions from tariff uplift when considering contracting for the delivery of non-tariff services.

4.27 The PbR specialist top-up percentages have been revised, and in 2008/09 these top-ups will only be payable to a list of eligible organisations.

4.28 In 2008/09, independent organisations providing services under free choice will be paid tariff plus market forces factor (MFF).

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

SHA flexibilities

4.30 There are specific instances in which an SHA may exercise its discretion to provide support in addition to tariff income, or to recover support that was previously given. These are:

- managing the financial impact at the end of PbR transition;
- recovery of agreed support given in 2007/08 to capped gainers;
- managing risk associated with PbR development sites;
- SHAs can agree, exceptionally, to allow top-ups to be paid to a provider who is not on the list but where the commissioner can make a compelling case for inclusion;
- where services are being unbundled:
  - mandating the use of indicative tariffs for unbundled elements of the pathway, eg diagnostics;
  - varying the mandatory outpatient tariff where indicative tariffs are mandated locally.

Efficiency

4.31 The NHS is required to deliver 3 per cent cash-releasing efficiency savings in 2008/09 and in each of the two successive years of the Spending Review period. There is a substantial body of evidence of the potential to deliver both quality and efficiency through better procurement, commissioning, organisation and management, with any additional savings being reinvested in new or better local services.

4.32 Efficiency strategies should be developed in all organisations that are underpinned by 'Best Value' principles recognising service delivery and quality improvement, as well as cost reduction.

4.33 An NHS-led working group has been reviewing and developing strategies for sustainable future efficiency delivery.[12] It is expected that these opportunities will form a basis for the organisational strategies that will be developed. A more comprehensive report and delivery strategy is planned to be published in early 2008.

SHA bundle

4.34 There will continue to be a bundle of central budgets devolved to SHAs for their local management. The value is £5,859 million.

4.35 A number of budgets that were included in the 2007/08 bundle will now be an additional allocation paid directly to PCTs. The value of these budgets is £1,387 million; the most significant are primary medical services, GP pay, Quality and Outcomes Framework, and national specialist commissioning.

4.36 Details of the SHA bundle will be issued separately to SHAs.

Central budgets

4.37 The most significant remaining central budget is the funding to support PCTs in commissioning primary dental services, which is £2,081 million for 2008/09, net of patient charge income. This is an increase of 11 per cent on the 2007/08 budget. Details of the allocations will be issued separately.

4.38 Further allocations from Departmental Central Budgets will be agreed and details issued in due course.

Information for financial planning

4.39 In addition to this document, the following key financial information that will impact on NHS trust and PCT income and expenditure in 2008/09 is now available:

- details of PCT allocations for 2008/09;
- the final road-tested PbR tariff;
- the central budgets that will be devolved to the SHAs in the SHA bundle and changes to that in 2007/08;

4.40 This information will allow the development of robust plans in advance of the start of the new financial year.

12 Immediate key opportunities on efficiency can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081104

5 Business processes

5.1 Delivery of the goals set out in this document requires effective business processes throughout the system to support local accountability in driving transformations for the benefit of patients. In particular, it requires:

- explicit and agreed activity plans at PCT, SHA and Department level;
- local processes agreed between the relevant bodies for planning, monitoring and reporting, and for delivery;
- plans that are well fitted to LAAs in a form that encourages strengthened local ownership and accountability, and that meets statutory public sector duties towards equality;
- robust arrangements to discharge 'coordinating PCT' or equivalent roles;
- focus on forward-looking risk assessment.

5.2 To achieve these objectives, the business process for 2008/09 will have the following key elements:

- '**vital signs**': indicators of how the NHS is performing locally and nationally;
- an initial focus for 2008/09 on an annual **operational plan** for each PCT that:
  – describes local targets and how they have been agreed;
  – defines success;
  – details milestones;
  – details their proposed LAA content on health outcomes;
- **strategic plans** for the medium term, developed by PCTs by autumn 2008 and signed off by SHAs;
- **a talent plan and leadership development plan** at SHA level for 2008/09. From 2009/10 onwards, PCTs will also have these in place.

5.3 The following sections give details of the arrangements that will apply in 2008/09.

Contract implementation

5.4 PCTs and providers are expected to agree the central elements of contracts for 2008/09 by the end of February 2008. As well as signing up to an agreed statement of NHS principles and inclusion of the required schedules, it is also expected that:

- commissioners agree a realistic and affordable activity plan with providers, with clear assumptions and plans for resource utilisation, which ensures that patients receive the most appropriate care in the most appropriate setting;
- any disputes on the agreement of contracts will be resolved locally. SHAs will help commissioners and providers to resolve any disputes to which a local solution cannot be found, working with Monitor whenever NHS foundation trusts are involved.

PCTs and providers are expected to agree the central elements of contracts for 2008/09 by the end of February 2008.

5.5 A simple framework to track local progress in reaching agreement will be established by the Department and SHAs to provide assurance around financial, activity and service plans for 2008/09.

Roles and responsibilities

5.6 NHS trusts will:

- sign off contracts with commissioners;
- show how required efficiency gains are being generated;
- sign off fully worked-up cost-improvement programmes, risk rated and profiled on a month-by-month basis;
- have board approval of budgets and operational plans (including workforce numbers) that incorporate cost improvements and cost pressures. These are to be monitored at the board on a monthly basis;
- profile and monitor their workforce numbers and the payroll on a month-by-month basis.

5.7 PCTs will:

- work closely with their local partners to tackle major challenges in their local community, and particularly in conducting the joint strategic needs assessment and LAAs;
- develop a strategic plan by autumn 2008 that describes the context for the next three to five years and is informed by the 'vital signs' and the local joint strategic needs assessment;
- develop an operational plan by the end of March 2008 that:
  - describes local targets, how they have been agreed and how they will be achieved;
  - defines success;
  - details milestones;
  - details their proposed LAA content on health outcomes;
- sign off costed plans that show income and expenditure balance, and clearly state assumptions about activity levels with 'best', 'worst' and 'likely' scenarios;
- agree contracts with providers that are reflected in the operational plan, and manage contracts in ways that are consistent and compatible with the national contract;
- profile and monitor income and expenditure on a month-by-month basis;
- show how growth monies, and those generated through improved efficiency, will be deployed;
- agree contingency actions to respond to the 'worst case' scenario;
- profile and monitor workforce numbers and the payroll on a month-by-month basis;
- have reporting and monitoring of the operational plan and contracts sign-off at each board meeting;
- use the 'vital signs' to demonstrate how services are performing locally;
- be held to account for, and rewarded for, their development towards world-class commissioning through one national assurance system that will focus on commissioning outcomes, competencies and governance.

5.8 SHAs will:

- sign off PCT strategic plans and ensure that the priorities reflect local health needs, informed by the 'vital signs' for each PCT;
- work in partnership with the Department of Health's team in each region's Government Office to encourage PCTs to develop new LAAs that reflect those vital signs for health and social care, against which local performance is in the lower quartile nationally, is poor compared to other PCTs in the cluster, or can be stretched to demonstrate exceptional strong outcomes;
- assess and sign off PCT operational plans with a more risk-based approach, looking at 'best', 'worst' and 'likely' scenarios for the year, particularly around hospital activity and care and resource utilisation. Clear, quantifiable contingency measures need to be identified before the commencement of the year to deal with 'worst-case' scenarios;
- reconcile plans across health communities, so that the different expectations of money and activity held by commissioners and providers are known to all parties and unrealistic expectations are moderated;
- be able to describe the regional position on expenditure, staffing, service improvement and health improvement in the same way as the Department does nationally;
- profile expenditure, workforce and cost-reduction programmes on a month-by-month basis and report it through their boards;
- performance-manage PCTs and NHS trusts on behalf of the Department;
- develop a talent and leadership plan;
- locally manage the national assurance system for world-class commissioning, ensuring that their PCTs are held to account for, and supported in, their development towards becoming world-class commissioners.

5.9 The Department will review, with each SHA, the plans for national priorities, activity plans and financial plans by the end of March 2008. In doing so, it will apply key assurance tests to plans to ensure that they:

- are based on robust demand and activity assumptions that support delivery of the 18-week target;
- give assurances as to delivery of national priorities and existing standards, and reconcile across the three elements of finance, workforce and activity;
- are well aligned with their LAA's priorities for health and wellbeing.

5.10 The rules and systems in this document are not intended to cut across the compliance regime that Monitor has in respect of NHS foundation trusts.

5.11 SHAs are expected to play a supporting role, providing visible leadership to local leaders in developing approaches to responding to patients and reforming services, whilst enabling local creativity and innovation. SHAs will only intervene where it is necessary in the interests of patients or the taxpayer. When SHAs do intervene, they will act quickly and decisively. It is important that SHAs work closely with Monitor where the application of this document could have an impact on NHS foundation trusts.

The NHS's contribution to Local Area Agreements

5.12 By June 2008, new LAAs should be agreed for each English locality. PCTs and NHS trusts now have the opportunity to work with their partners in their Local Strategic Partnership (LSP) to agree LAA priorities for local people that improve health outcomes.

5.13 Each LAA should prove itself a strong complementary ally to its PCT's operational plan. LAAs will include up to 35 targets from the National Indicator Set (NIS) published in November. The NIS of 198 indicators includes those vital signs that a PCT will expect to achieve by working with local government and its partners.

5.14 LAAs and PCT operational plans should have the same level of standing in the local health and social care economy. The Local Government and Public Involvement in Health Act (2007) places duties on both PCTs and local authorities to work together to achieve local people's priorities. This duty of partnership at a local level is also incumbent upon SHAs and Government Offices in their regional roles.

5.15 PCTs will be free to propose their own contribution to their LSP's proposed LAA, though they should expect to be able to assure their SHA that:

- relevant local priorities for health that are recognised in their joint strategic needs assessment directly inform the indicators they choose to recommend from the NIS;
- they are giving clear priority to those areas where they are most challenged – for example, where current performance is in the lower quartile nationally, or is poor compared with other PCTs in the cluster;
- the operational plan submitted to the SHA in February 2008 clearly sets out the proposed contribution they intend to make to their new LAA(s).

Timetable

5.16 The outline timetable for the planning process is attached at Annex B, and the detail of this process will be specified in separate guidance to be issued later in December. This will include unambiguous definitions for plans, to enable greater consistency in approach and clarity about what plans are demonstrating.

Existing commitments

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

- four-hour maximum wait in A&E from arrival to admission, transfer or discharge;
- guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours;
- a maximum wait of 13 weeks for an outpatient appointment;
- a maximum wait of 26 weeks for an inpatient appointment;
- a three-month maximum wait for revascularisation;
- a maximum two-week wait standard for Rapid Access Chest Pain Clinics;
- thrombolysis 'call to needle' of at least 68 per cent within 60 minutes, where thrombolysis is the preferred local treatment for heart attack;[13]
- guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting a service;
- all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice;
- delayed transfers of care to be maintained at a minimal level;
- all ambulance trusts to respond to 75 per cent of Category A calls within 8 minutes;
- all ambulance trusts to respond to 95 per cent of Category A calls within 19 minutes;
- all ambulance trusts to respond to 95 per cent of Category B calls within 19 minutes;
- a two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals;
- a maximum waiting time of one month from diagnosis to treatment for all cancers;

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

- 100 per cent of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy;
- deliver 7,500 new cases of psychosis served by early intervention teams per year;
- all patients who need them to have access to crisis services, with delivery of 100,000 new crisis resolution home treatment episodes each year;
- all patients who need it to have access to a comprehensive child and adolescent mental health service, including 24-hour cover/appropriate services for 16- and 17-year-olds and appropriate services for children and young people with learning disabilities;
- chlamydia screening programme to be rolled out nationally.

Annex B

Planning process timetable

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

2007

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

2008

Deliverables	Date
SHAs to submit initial financial plans (for all organisations within the SHA)	31 January 2008
Submission of PCT plans for priorities and activity to SHAs	31 January 2008
Agree central elements of contract	February 2008
Submission of PCT plans to SHAs	February 2008
SHAs to submit final financial plans (for all organisations within the SHA)	3 March 2008
SHA submission of plans for national priorities and activity to DH	3 March 2008
Contract sign-off	March 2008
SHA and PCT plan sign-off	31 March 2008
LAA sign-off	June 2008
First revision of plans	Winter 2008/09
Second revision of plans	Winter 2009/10

System management timetable of products

The following table sets out the current provisional timescales for products related to system management, prior to the new financial year.

Product	Description	Release month
Competition principles	Simple principles and clear rules for commissioners and providers of NHS services.	With Operating Framework
PBC guidance	Further guidance setting out the governance procedures for practice-based commissioners.	December 2007
Standard contracts	DH is publishing the standard contract for acute services in December 2007, and this will apply, over time, to all secondary and tertiary care services purchased by PCTs, irrespective of the type of provider organisation.	With Operating Framework
	The same contracting framework will in due course be used to cover mental health, ambulance and community services. Over time, all locally commissioned contracts will include the same competition- and system management-related clauses as found in the standard contract.	During 2008
Procurement guide	Guidance to PCTs on their procurement obligations under EU law. The guide will clarify EU legal requirements on public sector procurement. It will provide criteria and process to help PCTs decide whether formal tenders for contracts are required, rather than how to procure. It will also require PCTs to advertise their formal tenders in a PCT contracts portal.	February 2008
Legal powers	Summary of basic legal powers (in the context of system management) of principal stakeholders in the healthcare system.	March 2008
Market making guide	A web-based tool to assist SHAs and PCTs in the process of deciding whether and how to increase diversity of supply to support patient choice or provider responsiveness.	March 2008

Product	Description	Release month
Promotion code	Code for appropriate promotion of NHS services by all providers, in order to protect the reputation of the NHS and the integrity of the NHS brand, and to ensure appropriate and accurate information for patients.	March 2008
System management assurance	How SHAs and PCTs will be held to account for their system management responsibilities (details to be confirmed).	March 2008
Competition panel	Details of an independent advisory panel, constituted on the basis of the competition principles, to advise SHAs and central government publicly on competition-related disputes (details to be confirmed).	May 2008
Technical manual	Manual for NHS corporate transactions, covering mergers, acquisitions, demergers, joint ventures and franchises. The manual will explain how organisations go about planning and executing corporate transactions. It will cover all corporate transactions where the PCT is a direct contracting party, as well as joint ventures between NHS and non-NHS bodies (however, it will not cover provider/provider subcontracts).	April 2008

Please note that all timetables are subject to change. It is DH's intention that all of the above products should be ready for the beginning of the new financial year. However, where appropriate development and consultation require longer timescales than anticipated, DH's priority will be to ensure the quality of the product, and this will take precedence over strict adherence to timescale.

Full links to relevant websites are listed below.

Principles and rules for cooperation and competition (system management):
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

Practice-based commissioning technical guidance:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081101

Contract (model and guidance): **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/**

Principles and rules for cooperation and competition

Further details of the new system management framework, including competition principles, are published at:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

Annex E

Contract

The documentation for the new standard NHS contract for acute services is published at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100

It includes:

1. the standard NHS contract;
2. guidance on the standard NHS contract;
3. a standard activity plan template;
4. guidance on using the activity plan template;
5. a model consortium agreement for PCTs;
6. consortium agreement legal guidance.

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