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# Operating framework 2008/9

**In December 2007, the Department of Health issued its third 'operating framework', which provides a set of priorities and guidance for the NHS for the next financial year (Department of Health 2007k). The operating framework is aimed at NHS trusts, strategic health authorities (SHAs) and primary care trusts (PCTs). It sets out national priorities for organisations to follow and, like last year, has been published alongside a number of other documents, including new guidance about managing competition and an updated standard contract for PCTs to use with NHS hospital trusts. This briefing summarises the main points from both the operating framework and supporting documents and offers some analysis of their content.**

## Priorities for 2008/9

The operating framework is described in the foreword as, 'enshrining the ability for local NHS organisations and the communities they serve to have greater autonomy in determining their own priorities'. Nevertheless, a large part of the operating framework is devoted to describing the Department of Health's 'ambitions' for local NHS organisations, many of them for delivery in the next financial year but also designed to inform planning for the next three years.

These ambitions are divided into three categories: national 'must dos'; areas of national 'concern' where organisations are allowed to decide how they respond; and local priorities that are entirely locally set.

There are five priorities in the 'must do' category.

- First, the NHS must reduce the number of health care associated infections, principally those caused by methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C difficile*). Organisations must aim to maintain progress towards a national MRSA target (to reduce infections to half the 2003/4 rate by April 2008) and a new national target is set for *C difficile* (namely, a 30 per cent reduction in infections by 2011 compared to a 2007/8 baseline). In addition, the NHS will have to screen all patients undergoing non-emergency surgery for MRSA from 2008/9 and prepare to screen emergency patients within the next three years. The recently announced 'deep clean' for all hospitals is not mentioned (Department of Health 2007g), but features in a new healthcare associated infections and cleanliness strategy (Department of Health 2008).

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- Under the second priority heading – 'Access' – the operating framework calls for progress in improving waiting times for both hospital treatment and primary care. Hospital waiting times are already subject to a national target with a deadline of December 2008, by which point nearly all patients should be seen for hospital treatment (either admitted or day case) within 18 weeks of being referred by their GP. At present, 57 per cent of patients who are admitted for inpatient treatment fall within the target time (Department of Health 2007j). The operating framework announces a new 18-week patient survey, to measure patient satisfaction with the service received, although it is not clear whether patients will be asked how long they report having had to wait. For primary care, the framework reiterates the government's commitment to expand the overall number of GP surgeries and extend the opening hours of GP surgeries in general (Department of Health 2007h). The operating framework marks the first stage of implementation by directing PCTs to ensure that at least 50 per cent of practices in their area offer 'extended' opening to their patients, although there is no fixed definition of what 'extended' means. PCTs will also be expected to complete procurements of new GP practices – the government has already named the 38 PCTs considered to be 'underdoctored' (Department of Health 2007f) – as well as new 'GP-led' clinics, although the earlier target of setting up 150 of these new clinics is not repeated here.

- The third national priority area is improving health and reducing inequalities. The operating framework does not contain any new targets on health promotion or reducing inequalities. PCTs are, however, expected to take action to meet the commitments in the new cancer plan released in late 2007 (Department of Health 2007a) – which contains new screening and waiting times targets mostly taking effect from 2010 – and setting up stroke care networks specified by the new national stroke strategy (Department of Health 2007d). They must also meet existing commitments to increase the percentage of pregnant women seen by a midwife by 12 weeks of pregnancy and agree action with local authorities to reduce childhood obesity.

- Actions required under the fourth priority, patient experience and staff satisfaction, include local NHS organisations delivering yearly improvements in patient experience (measured through surveys) and sustained improvement in the results of staff surveys. PCTs are required to 'demonstrably' use patient surveys to inform commissioning decisions, but it is not made clear how this will be monitored.

- Fifth, all organisations are expected to prepare for emergencies, specifically, to have 'robust' plans in place to deal with a flu pandemic by December 2008.

The operating framework then lists a further set of priorities 'requiring local attention', although how these are delivered will not be a matter for central prescription.
PCTs need to take 'recovery action' where performance is below standard in relation to equality; in particular, where disadvantaged or vulnerable groups are not accessing services, although the framework concedes that the data may be lacking in this area, describing equality monitoring as a 'work in progress'. Action, where appropriate, will be required for those organisations underperforming on: eliminating mixed sex accommodation; delivering improvements in services for people with learning disabilities; and delivering diabetic retinopathy services and crisis resolution (in mental health services). In addition, the operating framework advises PCTs to begin preparatory work in areas where improvement has been promised by government in the future: namely, end of life care, access to psychological therapies, services for people with dementia, and services for disabled children. In addition, progress also needs to be maintained against 20 other (older) targets, including waiting times targets for accident and emergency, inpatients and outpatients, GP access and so on.

Although it is recognised that all this represents a demanding agenda, PCTs are, nevertheless, expected to identify and agree a further set of local priorities, the content of which are not specified, but are likely to be informed by performance against the new 'vital signs' (a set of indicators that have yet to be finalised).

## Delivering the national and local priorities

The operating framework sets out the mechanisms for delivery of these various priorities: this section of the framework is aimed squarely at PCTs, who are described as the catalysts for service transformation with a number of levers available to them to deliver these goals.

### Choice

The first of these levers is patient choice. From April 2008, the NHS is already committed to offering 'free choice' of hospital provider to all patients needing elective surgery, and PCTs are instructed (again) to ensure that patients are aware of their right to choose. Results from the most recent round of the national patient choice survey show that around two-thirds of patients (61 per cent) did not recall having been offered a choice of provider (Department of Health 2007i). PCTs are also reminded of their responsibility to make available comparative information about providers and to ensure that the full range of eligible providers are available to patients. The operating framework also directs PCTs to 'roll out' choice for people with long-term conditions, although there is no timescale or milestones attached to this expectation. A document entitled 'generic choice model for long-term conditions' has been published alongside the framework, which sets out, in broad terms, the sorts of choices that patients might be offered (for instance, choices over the kind of treatment or social support available) (Department of Health 2007b).

### Commissioning

The operating framework sets out the steps for PCTs to commission better services through a focus on long-term health outcomes and better information and, if necessary, supported by 'external expertise', drawn from a list of government-approved private contractors (Department of Health 2007e). Included under this heading is practice-based commissioning, which, according to the framework, is 'here to stay'. The operating framework gives practice-based commissioning a new policy objective – addressing inequalities and equality issues – and it is described, for the first time, as 'our most powerful way of reaching local communities', but no further detail is given on this topic. At the other end of the spectrum, 10 national specialist commissioning groups should pool budgets and commission 'the majority' of specialist services, such as transplants or treatment for blood disorders, during 2008.

### National contract

A standard national contract for PCTs to use with all NHS trusts was pioneered in last year's operating framework and has been reissued (with some amendments and guidance) alongside this year's operating framework (Department of Health 2007m; Department of Health 2007n). This year more sanctions have been incorporated to give PCTs leverage over the volume and quality of services provided by hospitals. In addition to the existing fines (for breaching the 18-week referral to treatment waiting-time target or performing more operations than had been agreed in the contract), PCTs can now impose financial penalties on trusts that breach the *C difficile* target (the number of infections has been increasing year on year since

January 2004). The contract also mandates, for the first time, the collection of patient-reported outcome measures (PROMS) for a small selection of procedures. These go further than patient satisfaction surveys as they capture information about the health benefits of procedures (Department of Health 2007c). This contract is to be used for all NHS trusts, trusts about to become foundation trusts and for foundation trusts with whom the existing three-year contract has expired. The contract is not yet for independent sector providers, but the Department of Health expects that it will be possible in 2008.

### Other levers

The operating framework reiterates the government's existing commitment to extend the number of foundation trusts (eventually to all NHS acute and mental health trusts) and reconfirms the government's commitment to the private sector provision 'where it will provide value for money and meet patients' needs'. For the elective hospital sector, the operating framework states that the extent of private sector activity will be driven by the choices made by patients whereas in other areas the decision will lie with the commissioner. PCTs are also required to improve the quality of the workforce (with an increase of the professional training budget of 6 per cent compared to 2007/8) and ensure that providers' workforce plans are adequate to meet demand as well as the requirements of the European Working Time Directive. Improvements to IT are also required, including the submission of weekly data on activity by providers from April 2008 to make sure that the 18-week target is adequately monitored.

### System management

The operating framework emphasises that PCTs and SHAs need to actively manage the local NHS system, and states that 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'. Active management means that PCTs or SHAs will need to monitor whether the system works for the benefit of patients, which might involve, where appropriate, injecting more competition or requiring more co-operation between organisations. To assist with this the Department of Health has published, for the first time, a set of Principles and Rules for Co-operation and Competition (Department of Health 2007l). This sets out expected actions under 10 principles, which include ensuring a seamless services for patients, fostering patient choice, ensuring transparency and fairness, and establishing the ground rules for mergers, acquisitions, joint ventures and, where appropriate, 'vertical integration' between primary and secondary care. The expected 'actions' include PCTs and SHAs monitoring promotional material produced by providers and spotting potential collusion between providers.

### Finance

As in previous operating frameworks, guidance is offered on financial management. For the first time in three years, achieving financial health is no longer a national priority: this is a reflection of the growing financial stability as the NHS has moved from overall deficit to surplus during the period. The operating framework instructs SHAs to plan for a surplus in 2008/9 'at least equivalent' to the surplus achieved the previous financial year, which has been carried forward. The operating framework does not specify what the surplus is to be used for. SHAs will also be expected to establish contingency funds but their size is a matter for local agreement. The NHS is expected to deliver efficiency savings worth 3 per cent, and the tariffs underpinning Payment by Results have been increased by 2.3 per cent for 2008/9 (a figure that includes the 3 per cent efficiency saving). Allocations to PCTs are also specified in the framework: equivalent to a 5.5 per cent increase for 2008/9. Allocations for future

years are not specified, but the operating framework encourages PCTs not to hold back from entering into three-year contracts where appropriate. NHS organisations are encouraged to develop robust plans to spend the capital allocation increase of 10 per cent made in the Comprehensive Spending Review and to ensure that 'slippage' in capital spending from previous years is put right.

### Delivery

The operating framework sets out a timetable for local NHS organisations to agree on contracts and other plans. The most imminent is for PCTs and providers to have agreed contracts by the end of February 2008. PCTs should have agreed an operational plan (consisting of local targets) by March 2008 and a longer-term strategic plan by autumn 2008. Underpinning the strategic plan will be the new joint strategic needs assessment, which requires co-operation between PCTs and local authorities. In addition, PCTs are required to contribute to their Local Area Agreements by June 2008.

## Analysis and comment

The first operating framework, published in early 2006, referred to 2008 as a year in which the NHS in England would have completed its journey from a 'top-down target-led' style of governance to a 'local innovation and incentive-led' system. It is not clear from this latest operating framework whether this vision of the NHS has materialised. Although the ground is being prepared to allow the quantification and selection of local targets through the development of 'vital signs' indicators, the joint strategic needs assessment and the duty to co-operate in local area agreements, the list of centrally defined priorities in this year's operating framework is long. The critical question is not whether these priorities are reasonable – action on hospital-acquired infection and shorter waiting times are high priorities for patients and the public – but how far they should be prescribed at a national level. The concern must be whether efforts to meet these top-down priorities will crowd out efforts by a PCT to set a substantially different local agenda if they so choose. If a PCT, in conjunction with its local authority and local population, decided to make its main local priority fighting obesity or improving the quality of mental health services (still the biggest single area of spend for PCTs, but a clinical area that receives very little space in the operating framework) how much managerial effort and financial resource would be left over after the national 'must dos' have been done?

This year's operating framework continues a trend by setting out clearly the rationale behind the recent NHS reforms – choice, Payment by Results, greater competition and strategic commissioning by PCT and GP practices. Last year, a chapter devoted to the same topics was headed 'reform'. This year it has been changed to 'enabling strategies', perhaps to emphasise the point that the reforms are not ends in themselves but mechanisms to improve patient care. How effective these mechanisms are yet is still an open question. It is still not entirely clear from the operating framework and accompanying documents just how much the Department of Health believes there will be significant patient movement through choice (and therefore patient-led competition between providers) over the next year. On the one hand, the framework states explicitly that the extent of private sector provision of non-urgent acute services (a key plank of the reform mechanisms) should be 'patient led', in other words respond to local patient demand. However, on the other hand, the detail contained in the standard contract implies a high degree of planning (albeit local), with an emphasis on activity plans, demand management techniques and freedoms for PCTs to fine providers who exceed the activity plans. This, coupled with the survey findings about the low level of public

awareness of patient choice, would tend to suggest that the reality of patient movement is at best limited and the assumption is that it can be predicted and contained within contracts.

Nevertheless, the expectation is still there that over the longer term, free choice of hospital provider, greater diversity of providers in general and incentives that allow resources to follow patients will have a much greater impact. It has prompted the Department of Health to devote more attention to how PCTs and SHAs should manage competition (to ensure fairness for providers and patients) and manage the overall impact of competition on the local health economy. The actions set out both in the operating framework and the Principles and Rules for Co-operation and Competition (Department of Health 2007l) represent additional functions, which overlap with commissioning but will require new competencies and skills to be performed well. The Principles and Rules state clearly that competition, driven by patient choice, should underpin acute elective services: PCTs should enable this to happen by not excluding any 'willing provider', by making sure that patients have adequate information, by monitoring potential collusion and monitoring promotional material to make sure it is compliant with the existing guidelines. In addition, PCTs with the help of SHAs can also decide how much competition to inject into other areas and decide on the merits of 'mergers, acquisitions, de-mergers, joint ventures' and even 'vertical integration' (between primary and secondary care providers). PCTs and SHAs will have to judge whether these are in 'patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money'. It is still not clear how PCTs will overcome the potential conflict of interest raised by their status as providers of services in many areas.

The Principles and Rules for Co-operation and Competition also flag up an important area for PCTs to focus on in the future: whether the service delivered by different organisations (some of them perhaps competing with each other) is seamless from the patient's perspective. Much of the NHS Next Stage Review is now focused on the effectiveness and convenience of patient pathways: seamlessness may now become as important a feature of quality as low waiting times have been in the past. There is some degree of overlap between the two ideas: the delivery of the 18-week referral-to-treatment target implies better planned and more seamless pathways for patients, but does not guarantee them. For PCTs, however, ensuring seamless pathways will imply a new intensity of monitoring patients' experiences across organisational boundaries, which will be challenging but certainly welcome from a patient perspective.

## Summary

There can be no doubt that the operating framework represents a 'truly ambitious' programme for the NHS over the next year (and three-year planning cycle) in the words of its chief executive, David Nicholson. Whether it allows for PCTs in the future to set more of their own ambitions 'rather than having them mainly set by Whitehall' is uncertain. Within a month of publication of the operating framework, the NHS heard that it was to provide a new generation of screening programmes to prevent a range of conditions, from abdominal aortic aneurysm to diabetes, none of them mentioned in the operating framework (Brown 2008). It is highly likely that the final report of the Next Stage Review will also result in some new initiatives.

Nevertheless, regardless of the provenance of these 'ambitions', many of them are to be welcomed, including the emphasis on improving the patient experience and better measurement of patient-reported outcomes. It is also encouraging that PCTs (and SHAs) are being prompted to consider how they can both enable and regulate the effects of competition locally. This is a challenging task, and more work will be needed to ensure that PCTs have sufficient skills to do this and that the process is transparent and subject to effective scrutiny both locally and nationally.

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