The operating framework for the NHS in England 2008/09

The document, *The NHS in England: the operating framework for 2008/09*, was published in December 2007. The operating framework sets out the Department of Health’s (DH) priorities and the specific policy, business and financial arrangements expected of the NHS for the year ahead. This Briefing details the key points of the operating framework and the timetable for implementation.

**Background**

The NHS Next Stage Review will set out the strategy and vision for the NHS over the next ten years. The Comprehensive Spending Review (CSR) set the public service agreements, 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. The rules set out in the operating framework and associated documents are binding.

**Priorities**

There are three sets of priorities which primary care trusts (PCTs) are required to deliver on during the coming year:

- national priorities – must dos (see box)
- national priorities which PCTs decide how to deliver
- locally decided priorities.

These are in addition to existing targets such as those on waiting times. Performance against all of the indicators (‘vital signs’) will be published annually.

**Locally decided priorities**

These will be based on joint strategic needs assessment findings and areas of weak performance. They will form part of local area agreements (LAAs) and will be chosen from a list of ‘vital signs’ which are currently being

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**Key points**

- Listening and responding to patients, public and staff and improving patient outcomes and experience are at the heart of the strategy for 2008/09.
- Other points include:
  - moving towards local targets whilst delivering on national priorities
  - developing world-class commissioning as the key agent for change
  - a financial regime that supports reform goals and incentivises improvements in services
  - a transparent approach to planning that supports locally-led decisions while providing accountability
  - an emphasis on partnership working between PCTs, local authorities and other partners to ensure local health needs are better understood and addressed.

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National priorities which PCTs decide how to deliver

These are:

1. Improve the delivery of crisis resolution teams.
2. Improve the delivery and quality of learning disability services – PCTs to prepare for the transfer of commissioning of learning disability services to local authorities.
3. Decrease levels of mixed-sex accommodation; also, there are to be no 16 or 17-year-olds treated on adult psychiatric wards by 2010.
4. Ensure equality of access to healthcare for disadvantaged groups.
5. Increase rates of diabetic retinopathy – all patients with diabetes to be offered screening.
6. Prepare implementation plans for psychological therapies.
8. Improve end-of-life care.

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<tr>
<th>National priorities – must dos</th>
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<tr>
<td><strong>Priority</strong></td>
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| Improve cleanliness and reduce healthcare associated infections (HCAI) | • Deliver on MRSA and C. diff PSA targets  
• Introduce MRSA screening for all elective admissions from 2008/09  
• Implement forthcoming HCAI and cleanliness strategy |
| Improve access 18 weeks: | • Deliver on 18 weeks elective referral to treatment time requirement (90% of patients) by December 2008  
• This will for the first time include a patient-reported measure; there will be shared responsibility for failure/success by all providers on the pathway  
• Pathway redesign and demand management work needed  
• At least 50% of GP practices in every PCT should offer extended opening  
• All PCTs to complete procurements for new GP-led health centres and new practices in deprived areas  
• Improve patient-reported experience of accessing GPs  
• Increase numbers of patients accessing NHS dentists year on year  
• PCTs to work more closely with local authorities to provide integrated and co-located services, including joint commissioning |
| Keep adults and children well, improve health and reduce health inequalities | • PCTs to tackle lifestyle issues, such as obesity and alcohol abuse, in local plans  
• Close gap in life expectancy between affluent and deprived areas; for major diseases close mortality gap  
• Cancer: implement cancer reform strategy  
• Stroke: implement stroke strategy  
• Children: reduce proportion of obese and overweight children to 2000 levels by 2020  
• Maternity: increase percentage of pregnant women with full health and social care needs assessed by the 12th week of pregnancy |
| Improve patient experience, staff satisfaction, and engagement | • Understand and act on patient survey results, and use to inform commissioning decisions  
• Understand and act on staff survey results  
• Proactively engage local communities in service planning on an ongoing basis (not just legal requirements where changes are planned) |
| Prepare for large-scale health emergencies | • All PCTs must have robust pandemic flu preparedness plans in place by December 2008 |
9. Increase range of services available to disabled children – increase range of short breaks, improve palliative care services, support transition to adult services.

Enabling strategies

Patients will be empowered by a free choice of elective care provider by April 2008. Providers will be able to promote their services responsibly. PCTs are expected to improve care and ensure more choices for people with long-term conditions.

World-class commissioning will be developed, designed to focus PCTs on the medium- and long-term objectives of reducing inequalities, improving the quality of healthcare and leading local change.

The new national contract will be used for all agreements between PCTs and provider organisations, and its use will be based on the best possible outcomes for patients and the taxpayer (making use of the private and voluntary sectors where appropriate). These agreements must all be agreed by 28 February 2008 and will include sanctions for poor provider performance – in the form of financial penalties.

There will be more open and transparent system management processes, subject to new rules and the principles of cooperation and competition. These will preserve the patient’s choice, allow for limited marketing of provider services, allow for mergers, acquisitions and joint ventures, and allow for vertical integration of services (for example, of primary and secondary care).

Strategic health authorities (SHAs) are expected 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. Providers are expected to focus on staff engagement and satisfaction, given its importance to patient care. Employers need to have robust plans for workforce planning. PCTs will be expected to have a coherent plan and ensure that providers’ workforce, finance and service plans are linked, and that medical and non-medical plans support existing and emerging models of care. All trusts are expected to use their service plan and clinical vision as the basis for a learning and development plan. Continuous improvement in services through workforce improvements is as important as ever. Providers can benchmark themselves against the ‘Better care, better value’ indicators developed by the NHS Institute for Innovation and Improvement.

PCT provider and commissioning functions will be separated by April 2008. PCT provider services will be treated by the commissioner equally to all other providers.

PCTs will put in place and lead local information management and technology (IM&T) plans with potential new data quality assessment by the Audit Commission. The DH will publish an informatics review. 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 the operating framework.

Principles for cooperation and competition

The principles, as set out in the operating framework, are outlined below.

- Commissioners should commission services from the providers who are best placed to deliver the needs of their patients.
- Providers and commissioners must cooperate to ensure that patients experience 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 is 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 shown to be in the best interests of patients’ and taxpayers’ interests and when there remains sufficient choice.
and competition to ensure high-quality standards of care and value for money.

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

**Commissioning services for military personnel and veterans**

When commissioning services, PCTs and providers need to take account of the special circumstances that apply to military personnel, their families and veterans. This includes making sure that when armed forces families move they are not disadvantaged. The DH will issue detailed guidance relating to transfers of care between secondary providers.

**The financial regime**

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.

The 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.

Other points include:

- SHAs will be required to have resolved all outstanding legacy debt in PCTs by 31 March 2008.
- 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.
- 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. The weighted capitation formula is unchanged for 2008/09, with all PCTs receiving the same percentage uplift.
- Although allocations are only being announced for 2008/09, there is sufficient information available to support the development of longer-term plans.
- To ensure the effective use of resources, targeted at locally and nationally agreed priorities, it is important that PCTs develop robust capital plans which are signed-off by SHAs.
- The capital regime for the NHS trust sector will operate under the same principles as in 2007/08.

**Business processes**

The operating framework sets out the business processes needed throughout the system. These include activity plans at PCT, SHA and DH levels; local processes agreed between the relevant bodies for planning, monitoring, reporting and delivery; plans that are well fitted to LAAs in a form that encourages local ownership and accountability; robust arrangements to discharge ‘coordinating PCT’ or equivalent roles; and a focus on forward-looking risk assessment.

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

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

**Local area agreements**

By June 2008, new LAAs should be agreed for each English locality. Each LAA should complement its PCT’s operational plan. LAAs and PCT operational plans should have the same level of standing in the local health and social care economy.

**Confederation viewpoint**

The document’s claim that the operating framework for 2008/09 is part of a continued shift towards more devolution is welcome but does not sit easily with the very large number of areas which NHS organisations, particularly PCTs, are
The operating framework for the NHS in England 2008/09

asked to pay attention to. Taking into account the supporting strategies, there are over 150 areas where action is required. Apart from a few exceptions, all of the areas for action are clearly important and difficult to argue with. It is their sheer volume that makes it hard to reconcile the content of the framework with the message about devolution.

This is reinforced by two other issues. Firstly, the timetable for a number of tasks is quite front-loaded. Secondly, while the framework makes little reference to the NHS Next Stage Review, it seems unlikely that this major exercise will not generate significant additional tasks.

A significant number of the areas to be delivered appear to rely on PCTs working closely with their providers, and some of this seems to go beyond what is in the national contract. Whilst close collaboration between PCTs and providers is necessary, there is an anxiety that having given away the power to directly instruct some providers there could be an attempt to reinvent provider performance management by using the PCTs to intervene in the details of provider management.

In various places the document refers to PCTs being required to develop various types of plan. Clearly, although this is not explicitly stated, these all need to be part of a single process. The development of planning expertise is going to be a major challenge. The timetable for operational planning is very tight, with PCTs effectively having only six weeks after the New Year to agree contracts and produce plans. We would hope that there might be a return to the longer period of time that was available for these difficult tasks in 2006.

### Planning process timetable

<table>
<thead>
<tr>
<th>2007 deliverables</th>
<th>Date</th>
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<tr>
<td>CSR settlement</td>
<td>October 2007</td>
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<tr>
<td>Operating framework</td>
<td>December 2007</td>
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<tr>
<td>PCT allocations announced</td>
<td>December 2007</td>
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<tr>
<td>Planning and technical guidance issued</td>
<td>January 2008</td>
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<table>
<thead>
<tr>
<th>2008 deliverables</th>
<th>Date</th>
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<tr>
<td>SHAs to submit initial financial plans (for all organisations within the SHA)</td>
<td>31 January 2008</td>
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<tr>
<td>Submission of PCT plans for priorities and activity to SHAs</td>
<td>31 January 2008</td>
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<tr>
<td>Agree central elements of contract</td>
<td>February 2008</td>
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<tr>
<td>Submission of PCT plans to SHAs</td>
<td>February 2008</td>
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<tr>
<td>SHAs to submit final financial plans (for all organisations within the SHA)</td>
<td>3 March 2008</td>
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<tr>
<td>SHA submission of plans for national priorities and activity to DH</td>
<td>3 March 2008</td>
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<tr>
<td>Contract sign-off</td>
<td>March 2008</td>
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<tr>
<td>SHA and PCT plan sign-off</td>
<td>31 March 2008</td>
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<tr>
<td>LAA sign-off</td>
<td>June 2008</td>
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<tr>
<td>First revision of plans</td>
<td>Winter 2008/09</td>
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<tr>
<td>Second revision of plans</td>
<td>Winter 2009/10</td>
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### System management – provisional timetable

<table>
<thead>
<tr>
<th>Product</th>
<th>Release month</th>
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<tbody>
<tr>
<td>Competition principles</td>
<td>With operating framework</td>
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<tr>
<td>Practice-based commissioning guidance</td>
<td>December 2007</td>
</tr>
<tr>
<td>Standard contracts</td>
<td>With operating framework during 2008</td>
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<tr>
<td>Procurement guide</td>
<td>February 2008</td>
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<td>Legal powers</td>
<td>March 2008</td>
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<tr>
<td>Market-making guide</td>
<td>March 2008</td>
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<tr>
<td>Promotion code</td>
<td>March 2008</td>
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<tr>
<td>System management assurance</td>
<td>March 2008</td>
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<tr>
<td>Technical manual</td>
<td>April 2008</td>
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<tr>
<td>Competition panel</td>
<td>May 2008</td>
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Another issue of concern is that whilst the increase promised in the CSR was 4 per cent growth in real terms, this does not seem to be what will reach PCTs. PCT allocations have increased by £3.9 billion (5.46 per cent). The total revenue allocation in the CSR increased by 6.67 per cent. Using the 2.3 per cent tariff uplift as a proxy for inflation this means that the real terms growth for PCTs is closer to 3.16 per cent. So, there is up to £872 million retained in central budgets, some of which is for a welcome investment in education, training and research. Some reserves may be prudent given the NHS Next Stage Review and a number of other potential policy changes but it is important that any money is released with enough time to spend it wisely so that an unplanned surplus is avoided.

PCTs are also receiving the ‘SHA bundle’ of funding for a number of services. The question is whether the funding will match the commitments. Previous experience of this sort of transfer will make many people nervous.

For the 2009/10 operating framework we will argue for a longer timescale, a shorter list of things to do and greater transparency.

For further information on the issues covered in this Briefing, contact nigel.edwards@nhsconfed.org

Further information

The NHS in England: the operating framework for 2008/09:
www.dh.gov.uk/operatingframework

Principles and rules for cooperation and competition:

Practice-based commissioning technical guidance:

The standard NHS contract (template and guidance):

The NHS Confederation

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. We help our members improve health and patient care, by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

Our ambition is excellence for patients, the public and staff by supporting the leadership of the new NHS. Our work is determined by our members. Our aim is to reflect the different perspectives as well as the common views of the many organisations delivering the new NHS. Our core membership covers all types of statutory NHS organisation and independent providers of NHS services. Our members are the organisations themselves. These are represented by individuals from board level – chief executives, chairs, non-executives and directors.
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National priority: improve access

- 50% of practices with extended hours
- 4,000 new GP health centres
- Access to services
- Improve patient satisfaction
- Work with LAs to identify how new health centres can provide increased integration

National priority: improve health and reduce HCAI

- 31-day wait extended to all cancers
- 18 weeks for elective patients by 2008/9
- 18 weeks for emergency patients by 2011
- Development activity & capacity plans
- Pathway redesign

National priority: keep adults and children well, improve health and reduce health inequalities

- 3% efficiency saving
- 3% of patients by 2010
- Improved patient experience of care
- Increase % who see a professional by 12 weeks

National priority: improve quality of care

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National priority: improve quality of care

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- Improved patient experience of care
- Increase % who see a professional by 12 weeks