PSA Delivery Agreement 19:
Ensure better care for all

October 2007

HM Government

© Crown copyright 2007

Published with the permission of HM Treasury on behalf of the Controller of Her Majesty's Stationery Office.

The text in this document (excluding the Royal Coat of Arms and departmental logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading context. The material must be acknowledged as Crown copyright and the title of the document specified.

Any enquiries relating to the copyright in this document should be sent to:

HMSO
Licensing Division
St Clements House
2-16 Colegate
Norwich
NR3 1BQ

Fax: 01603 723000

E-mail: hmsolicensing@cabinet-office.x.gsi.gov.uk

HM Treasury contacts

This document can be found on the Treasury website at:

hm-treasury.gov.uk

For general enquiries about HM Treasury and its work, contact:

Correspondence and Enquiry Unit
HM Treasury
1 Horse Guards Road
London
SW1A 2HQ

Tel: 020 7270 4558
Fax: 020 7270 4861
E-mail: public.enquiries@hm-treasury.gov.uk

Printed by The Stationery Office 10/07 380506

Printed on at least 75% recycled paper.
When you have finished with it please recycle it again.

PU375

CONTENTS

		Page
Chapter 1	Vision	3
Chapter 2	Measurement	5
Chapter 3	Delivery strategy	7
Annex A	Measurement annex	19

1 VISION

1.1 The Government is committed to ensuring that people have high quality, safe and accessible care that is sensitive to their individual health and adult social care needs and their particular lifestyles and aspirations. This PSA (and more broadly the Department of Health's (DH) Better Care for All strategic objective) sits alongside DH's other two strategic objectives (Better health and wellbeing for all and Better value for all). This reflects the ambitions set out in *Our health, our care, our say,*[1] to provide people with more convenient services, in more local settings, that help them to manage their own health and improve their experience of the whole care pathway.

1.2 The Government is now looking to take the next and most challenging step towards creating more locally led, innovative health and adult social care services, that put the needs and wishes of patients, staff and the public at the heart of care and addresses the challenges faced by society today and in the future. This is not just about transforming how care is delivered by individual organisations, but transforming the whole system of care delivery. Key features of the new system will include:

- delivery through a framework of reforms with the right incentives, levers and enablers;
- a focus on outcomes rooted in what matters to the public, patients, users and staff;
- freedom to the frontline – a shift from "central direction" to "local leadership";
- clear accountability to patients, users, the public and parliament;
- sustained improvement across the board;
- a stronger focus on prevention, safety, quality and better value; and
- health and adult social care working together around individual and community needs, based on a common performance regime.

1.3 Significant investment and implementation of a range of reform levers have helped to achieve major improvements in services:

- **patients are getting more choice** – for example, since January 2006 patients referred by their GP for elective care can choose between at least four local hospital providers, and from July 2007 patients have an increased choice of orthopaedics services;
- **patients are waiting less time for treatment** – for example, by June 2007 99 per cent of patients waiting for a first outpatient appointment had waited less than 11 weeks, and 98 per cent of patients waiting for surgery had waited less than 20 weeks from the decision to admit;
- **better care for those with long-term conditions** – for example, emergency bed days have reduced from 32.5 million to 30.7 million between 2003-04 and 2005-06 (emergency bed days reflect unplanned emergency admissions and provide a proxy for the extent to which people with long-term

[1] *Our health our care, our say White Paper: a new direction for community services,* DH, 2006.

conditions are being treated sooner and nearer to home before their condition causes more serious problems); and

- **healthcare associated infections are being tackled** – significant progress has been made towards meeting the current target to halve MRSA rates by March 2008.

1.4 But health and social care services are still some way short of providing people with the control, choice and convenience they experience in other parts of their lives, and important challenges remain:

- waiting times from GP referral to treatment are improving but more needs to be done;
- maternity service providers need to ensure that services are accessible to all women, including the vulnerable and excluded, so that a risk assessment can be completed, women can make informed choices about their care, and appropriate care and services are put in place to help improve life chances for children;
- healthcare associated infections (HCAIs) remain a concern for patients and the public. Health and social care services need to move to a culture where infection control is everybody's business and risks associated with patient safety issues such as HCAIs are minimised;
- people with long-term conditions want greater control of their lives and to be treated sooner before their conditions cause more serious problems; and
- evidence suggests that around 15 per cent of patients are not satisfied with the access to the GP services that they are entitled to.

1.5 This PSA aims to respond to these challenges by:

- improving the overall experience for users;
- ensuring that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment, where clinically appropriate;[2]
- improving outcomes for mothers and babies and strengthening maternity services;
- for patients with long-term conditions, improving their satisfaction with the support they are given to be independent and in control of their condition and reducing the number of emergency bed days;
- improving responsiveness, equity and the patient's experience of access to GP services; and
- continuing to tackle health care associated infections.

[2] For patients who choose to start their treatment within 18 weeks.

2 Measurement

2.1 Progress against this PSA will be monitored through eight key indicators set out below, with more detail set out in Annex A (Measurement Annex). A comprehensive range of indicators will also be used to show how the local system is performing in delivering continuous improvement across the Department of Health's wider strategic objectives.

Indicator 1: The self-reported experience of patients / users

- Better information about the experience of health and adult social care users will help commissioners and providers to provide services that are personal and sensitive to an individual's needs and designed to be responsive to their lifestyles and aspirations. It will also help to strengthen patients' and users' ability to shape their local health and adult social care services, and improve their overall experience of services.

Indicator 2: NHS-reported referral-to-treatment times for admitted patients

Indicator 3: NHS-reported referral-to-treatment times for non-admitted patients

- The Government is committed to ensuring that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks). This target will apply to both indicator 2 and 3 (covering admitted and non-admitted patients) in order to raise the minimum standard of access to elective care to the point where NHS patients are content that they can get the treatment they need without undue delay and improve patients' experience of the NHS overall.

Indicator 4: The percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy

- Women who are able to access maternity services for a full health and social care assessment of needs, risks and choices by 12 completed weeks of their pregnancy will have the full benefit of personalised maternity care and improve outcomes and experience for mother and baby. Improving access to maternity care will improve outcomes for mothers and babies by providing opportunities for women to make informed choices and shared decisions about their maternity care, including where and how they give birth. This will lead to the more flexible, responsive and accessible maternity services envisaged in the National Service Framework for Children, Young People and Maternity Services. New and different types of care will be designed to meet the needs of all women and their families who need additional support such as outreach services for those who traditionally do not access maternity care early in their pregnancy. Increased choice can also improve safety, quality and family friendliness of maternity services and encourage good services to improve even further.

Indicator 5: Long-term conditions

- Embedding person-centred, effective and systematic approaches to the care and management of long-term conditions will result in the 15 million people who have one or more conditions feeling confident that they have the

choice, control and convenience they want from services. People will be treated sooner, nearer to home and before their condition causes more serious problems. The effect will be earlier detection of diseases, better control to minimise the effects of diseases and reduce complications. This will result in a reduction in the number of unnecessary admissions and subsequent bed days, resulting in empowered and independent patients taking greater responsibility for their own care, having greater control of their lives and extending their quality of life. From 2009/10 this indicator will measure the proportion of people with a long-term condition who are "supported by people providing health and social care services to be independent and in control of their condition". In 2008/09 this indicator will be measured using proxy data on emergency bed days.

Indicator 6: GP services

- Increasing patient satisfaction in primary care requires an emphasis on the entire patient experience, moving beyond narrow access measures focusing only on certain aspects of the interaction. This will help Primary Care Trusts (PCTs) to ensure that GP practices are more responsive to the needs and desires of patients as well as ensuring that patients have access to services when needed. For the first year this PSA indicator will measure patient reported experience of access to GP services (5 elements of the patient survey), from 2009-10 this will be broadened to include survey data on responsiveness, equity and patient experience of GP services.

Indicator 7: Healthcare Associated Infection rates – MRSA

Indicator 8: Healthcare Associated Infection rates - *Clostridium difficile*

- Controlling healthcare associated infections will increase patient confidence in the NHS as well as reducing associated morbidity and improving NHS efficiency. Indicator 7 will ensure that progress on reducing the number of MRSA blood stream infections achieved in the SR04 period is sustained over the comprehensive spending review period. Indicator 8 includes a national target for a significant reduction in *Clostridium difficile* infection by 30% by 2011. Together Indicators 7 and 8 thereby ensure better control of other healthcare associated infections.

3 Delivery strategy

3.1 Meeting the challenges for this PSA is not simply about increased investment and transforming how care is delivered by individual organisations, but transforming the whole system of care delivery.

3.2 The strategic framework for health and social care delivery[1] combines a balanced set of levers and incentives, transparency, plurality and patient choice, supported by better commissioning and a new outcomes and performance framework that encourages local leadership and accountability. For the specific aspects of this PSA, further details of how they will be delivered are set out below.

Improve the overall experience of users

3.3 Each individuals' judgement of their experience of health and social care services has a unique base and depends on many aspects of their care. Evidence shows these factors will include accessibility, timeliness, quality, safety, effectiveness, dignity and respect. Additionally, their experiences will be informed by whether services met their expectations in terms of giving them appropriate choices that are personal and sensitive to their individual health and social care needs and are relevant to their lifestyles and aspirations. The combined effect of improvements across the health and social care system will help to improve patient/user experience, and will be driven further by the system incentives set out in paragraphs 3.20-3.34.

Increasing users' ability to influence services and make informed choices

3.4 Two key strands of Department of Health (DH) policy and implementation will support the delivery of improved experiences for users of services: first, the widening and strengthening of the ways by which users can influence the services they receive, and, second, the availability of information with which users can make informed choices about their services.

3.5 Key initiatives include:

- a reformed single complaints system for health and social care which makes it easier for people to complain and which supports learning from complaints, to be developed by 2009;
- the National Patient Survey programme, run by the Healthcare Commission, which asks patients annually about the experience of their care. Every trust can use the results to help drive local service improvement based on patient experience;
- strengthened requirements on health and social care bodies to seek the views of users and the public on the planning, design and delivery of services, to come on stream in 2008;
- the *NHS Choices: Your Thoughts* website[2] enables patients to comment on their experiences as a hospital inpatient. This feedback provides valuable information to NHS trusts on the quality of their services and where improvements are needed to make services more responsive to patients' needs; and

[1] See paragraphs 3.20-3.34 below.

[2] http://www.nhs.uk.

- the creation of Local Involvement Networks (LINks), independent bodies that will collect the views and experiences of local people on their needs for and experiences of health and social care services, and will come on stream in 2008.

REDUCING WAITING TIMES

3.6 Delivery of this target and maintenance of the 18 week standard for the remainder of the CSR period will improve the experience of patients by addressing the full length of the wait for definitive treatment (or other clinically appropriate outcome) from the point of initial referral. Reducing waiting times will be driven by the system incentives set out in paragraphs 3.20-3.34, including:

- **patient choice**: patient choice, together with payment by results (where funding will follow the patient), provides a powerful incentive for providers to respond to patients' preferences. Specifically, from April 2008, patients will have free choice of any hospital provider across the country who advertises their services on the "national menu";
- **plurality of providers competing on quality**: to extend choice, increase quality and foster innovation; and
- **practice-based commissioning**: putting clinicians at the heart of decision making, giving them the tools to innovate and influence local service development for the benefit of the patients. PCTs will continue to work with practice-based commissioners and clinicians to transform local care pathways, and make demand management more effective.

3.7 Reducing waiting times is also being supported through other actions including:

- publication of referral to treatment data to raise public awareness and drive progress;
- improving the quality of real-time, prospective and retrospective data used to drive operational performance and service transformation;
- agreement of each Strategic Health Authority's (SHA) local delivery plan and contracts between commissioners and providers to drive progress towards 18 week milestones;
- a service transformation strategy to support the NHS build and sustain 18 week pathways and services around the patient through improved processes, and changed mindsets, cultures, activities, and organisational power bases;
- publication of good practice commissioning pathways for key specialty pathways (e.g. hip replacement) developed in conjunction with the Royal Colleges and other key stakeholders;
- provision of intensive support to high-risk local health communities who request it, for example to help with referral to treatment measurement and improve performance; and
- a staff engagement campaign.

3.8 In addition, DH will continue to actively support Primary Care Trusts (PCT) in planning and demand management to ensure the commissioning of increased activity to reduce waiting times, including through independent sector treatment centres and community-based alternatives to hospital care.

MATERNITY CHOICE

Safe, high quality maternity care for all

3.9 The priority for modern maternity services is to provide choice of safe, high quality maternity care for all women, their partners and their babies. Specifically, commissioners and providers will be able to use a number of the elements of the health reform agenda to facilitate improvements. The challenge for local commissioners is to ensure that each element is sensitive to the specific nature and requirements of their population and service provision, for example by:

- establishing effective local commissioning frameworks;
- ensuring tariffs support the effective commissioning of high quality services;
- ensuring high quality and safe services are provided;
- ensuring an appropriately skilled maternity workforce with regular continuing professional development is in place; and
- developing monitoring frameworks for the future.

Role of Children's Centres

3.10 Children's Centres will provide antenatal and postnatal maternity care for women, for example providing access to health visitors.

LONG-TERM CONDITIONS

3.11 Improving the care for people with long-term conditions is already a priority for DH through the various commitments in the *Our health, our care, our say* White Paper including initiatives such as:

- care delivered through multi-agency, multi-disciplinary teams; and
- strengthened support to enable self care by:
  - increasing the capacity of the Expert Patient Programme from 12,000 places a year to over 100,000 by 2012;
  - encouraging primary care providers and others to focus their efforts more strongly on promoting individuals' abilities to manage their own conditions better;
  - ensuring that everyone with a long-term condition routinely receives information about their condition and about where they can receive other self care support through local networks; and
  - investing in professional education and skills development to change the culture and encourage support for individuals' empowerment and self care. The Department of Health will establish a self care competency framework for staff, but also embed key elements, including values and behaviours around assessment and support in appraisal and continuing professional development.

- offers, by the appropriate health or care professional, of personal health and care plans:
  - focussing initially on ensuring that everyone with both long-term health and social care needs has an integrated care plan if they want; and
  - ultimately, with an expectation that everyone with a long-term condition will be offered a care plan.

Person-centred care planning

3.12 Person-centred care planning will be led by the individual in partnership with their lead health or care professional and will reflect their strengths, goals and aspirations. Care planning will support:

- how care will be provided and by whom. Contingency planning for crisis situations prevents unnecessary admission to hospital and ensures the person's wishes are adhered to when they are at their most vulnerable;
- preventive care by providing information and self care/self management support;
- integrated working between health and social care and one lead professional leading on co-ordinating the plan, reducing fragmentation of services for the individual. This is especially important for people with complex health and social care needs; and
- choice through the person being at the centre, having a voice and being given information and choice through better management of risk.

RESPONSIVENESS, EQUITY AND PATIENT EXPERIENCE OF GP SERVICES

3.13 The GP patient survey[3] shows that patients generally report satisfaction across five access domains - telephone access (86 per cent satisfied); 48 hour access (86 per cent); booking ahead (75 per cent); seeing a preferred GP (88 per cent) and satisfaction with opening hours (86 per cent). 62 per cent of practices achieved in excess of these mean scores. The high national averages hide substantial variation, with a few practices performing exceptionally poorly. Effort has to be focussed on these. Evidence shows that where access to primary medical healthcare is good, patient concerns rapidly move to concerns over the interaction with clinicians and practice staff, and concerns with the quality of outcome.

3.14 Improving access to GP services is a priority for the Government with a number of work programmes underway in the Department of Health that will help drive improvements in patient experience:

- PCTs have been tasked with planning for improvement with first deliverables required by December 2007;
- two working groups under the leadership of David Colin-Thome and Professor Mayur Lakhani, are identifying ways to improve the NHS's ability to spread good practice and to improve the experience of black and minority ethnic patients; and

[3] *GP patient survey: your doctor, your experience, your say*, DH, April 2007

- quality improvements for patients are also considered as part of the contract negotiations with the General Practitioners Committee.

3.15 Improvements will be driven by system incentives described in para. 2.11 and the delivery strategy will be informed further by the NHS Review led by Lord Darzi.[4]

CLOSTRIDIUM DIFFICILE AND MRSA BLOOD STREAM INFECTIONS

3.16 DH will build on the current strategy which is successfully bringing down the number of MRSA bloodstream infections, and the actions which trusts are taking to meet existing local targets on *Clostridium difficile*. The strategy has four aspects:

- raising the focus on healthcare associated infections, for example through the statutory Code of Practice, with compliance against the Code assessed by the Healthcare Commission;
- providing targeted support through improvement teams. Funding for these teams has been doubled in 2007/08;
- performance management based on detailed information collected by the Health Protection Agency on *Clostridium difficile* and MRSA; and
- implementing best practice, for example through developing best practice guidance and spreading knowledge through the "clean, safe, care" website.

3.17 These aspects are being taken forward through six key themes

- driving improvements in clinical practice across the patient pathway;
- improving accountability and responsibility for infection prevention and control from Board to Ward and into the health economy;
- driving whole system solutions for reducing infections;
- improving the focus of NHS performance management and support;
- driving improvements in public confidence that hospitals are clean and safe; and
- agreeing and implementing a strategy to maximise gains and assure sustainability, including patient choice and regulation.

New measures to tackle HCAIs

3.18 DH has already announced a range of new measures, including:

- introducing a “bare below the elbows” dress code to improve the quality of handwashing;
- releasing new guidance on isolating infected patients;
- extending the National Patient Safety Agency’s ‘cleanyourhands’ campaign to care settings outside hospitals;
- introducing legislation to give a new health and adult social care regulator tough powers, backed by fines, to inspect, investigate and intervene where hospitals are failing to meet hygiene and infection control standards;

[4] Our NHS: Our future, NHS Next Stage, Interim Report DH, October 2007

- a new legal requirement on chief executives, backed by fines, to report MRSA bloodstream infections and *Clostridium difficile* infections to the Health Protection Agency, as part of the forthcoming Bill;
- taking forward plans for a deep clean of all hospital wards as part of the drive for a culture of cleanliness;
- making £50 million available for SHA Directors of Nursing to spend on tackling HCAIs;
- doubling the size of the expert improvement team;
- introducing quarterly reporting to Trust boards by matrons and clinical directors on infection control and cleanliness;
- introducing annual infection control inspections of all acute trusts using teams of specialist inspectors;
- introducing MRSA screening for all elective admissions next year, and for all emergency admissions as practicable within the next 3 years;
- looking into ways of building financial penalties or rewards into the commissioning process linked to providers' performance in terms of HCAIs and cleanliness; and
- asking the Chief Nursing Officer to develop a clear plan and guidance for the NHS which increases the powers of local staff. This means empowering matrons to report any concerns they have on hygiene direct to the new regulator and to order additional cleaning.

3.19 Additionally, DH will develop the NHS Choices website so that it provides useful information, which patients can use when exercising a choice over where they have their treatment, thus incentivising providers to compete on quality.

STRATEGIC DELIVERY FRAMEWORK

3.20 Reform tools and levers, implemented and delivered locally, provide a range of incentives, centred around patients and users, to drive improvement in a more devolved system, and are the means by which the vision for Better Health and Wellbeing for all, Better Care for all, and Better Value for all will be delivered.

3.21 Together, the reforms create an environment where local commissioners and providers deliver better services around the needs and wishes of the public and patients:

- enabling more choice and a stronger voice for patients and service users who will be able to choose the highest quality of care appropriate for their needs, helping them to take better control of their health and care needs;
- empowering patients, the public and staff through the provision of information and sharing of good practice;
- stengthening commissioning, as practices, Primary Care Trusts (PCTs) and Local Authorities use their knowledge of local communities, extensive public and patient involvement, particularly with seldom heard groups, service reviews and robust joint needs assessment to secure services within available resources;

- supporting a richer landscape of diverse providers, including Social Enterprises and the wider third sector (including charities and the voluntary and community sector), to play an important role in providing choice, increasing quality and fostering innovation;
- money following service users, rewarding the best and most efficient providers, giving others the incentive to improve; and
- a framework of system management, regulation and decision making which guarantees safety and quality, fairness, equity and value for money.

Roles and Responsibilities

3.22 Within the reformed system, each part of the health and adult social care system has a unique responsibility to add value to the wider objectives of Better Health, Better Care and Better Value for patients and users. For example:

- **local boards** will need to be well organised to take greater ownership for continuous service improvement, and be accountable to their local communities for the outcomes they achieve;
- **practice-based commissioners** can use delegated indicative budgets and their role in the commissioning process to better design services for their patients;
- **PCTs and Local Authorities (LAs)** are responsible for undertaking joint strategic needs assessments in order to understand the needs and meet the expectations of their population. World-class commissioning will deliver the best possible health outcomes, including reduced health inequalities, and the best possible healthcare, within the resources available. Strategic planning will be based on high quality information and evidence, and will include all partners including patients, users and clinicians. Commissioners will specify outcomes and then work with providers to design services to best deliver these outcomes. Commissioners will then hold providers to account for delivery of the agreed outcomes. Strong local partnerships between PCTs and Local Authorities are critical to commissioning better services, using their commissioning muscle to deliver better outcomes;
- **local strategic partnerships** which will be underpinned by a legal framework, ensure all of the relevant statutory partners are participating in the production of sustainable community strategies and co-operate to agree local targets which will feed into local plans and local area agreements;
- **providers** whether public or private, are responsible for providing the very best care for patients and users;
- **Regional Public Health Group** (RPHGs) provide the leadership at regional level on Local Area Agreements (LAAs) and all other local delivery issues. RPHGs currently work with the Care Services Improvement Partnership (CSIP) who provide support and advice on adult social services, mental health and learning disabilities. In the future, DH's regional presence will be strengthened to deliver crosscutting issues. This will be the support mechanism for developing the place specific levers to enable local partners to respond more flexibly to local needs, enabling local communities to play a full part in the bottom-up process;

- **Government Offices** are responsible for coordinating central Government's relationship with each region, working closely with Strategic Health Authorities. This will include leading on the negotiation of improvement targets in local area agreements, reviewing progress and, where necessary, co-ordinating action to respond to underperformance;

- **Strategic Health Authorities (SHAs)** are responsible for actively ensuring that patients have access to sustainable primary, secondary and specialist care, and that across the regional health care economy, there is equity of access to choice and quality for all. SHAs will use the reform tools, liaising with RPHGs and Government Offices, to their best effect to improve local services in the best interests of their patients, users and citizens. PCTs will be supported and performance managed by SHAs on the extent to which they measure and meet the needs of their population, and whether they deliver what they say they will do. SHAs will be held to account by the Department of Health and Secretary of State for Health;

- **independent regulation** of health and adult social care services is important to make sure that organisations are meeting national requirements for quality and safety, and are using taxpayers' money in an efficient and effective way. Currently, the Commission for Social Care Inspection (CSCI) and the Healthcare Commission (HCC) monitor compliance with standards and assess performance, providing public accountability and incentivising improvement; and

- **The Local Government White Paper *Strong and Prosperous Communities*[5]** sets out proposals for an approach to independent external challenge and assurance from inspectorates. From April 2009, the Comprehensive Performance Assessment (CPA) will be replaced with a Comprehensive Area Assessment (CAA). The CAA will look at risk and the management of risks to outcomes in local areas rather than at the performance of local institutions and will focus more on citizens' experiences and perspectives. As part of the new local performance framework, the CAA will relate to anything done by Local Authorities working alone or in partnership.

3.23 **The Department of Health and Department for Communities and Local Government** will work together to ensure that the whole health and adult social care system delivers improvements for service users. With a move to a more locally-led and incentive-driven system, the national role in delivering the PSA will be in supporting and challenging the performance of commissioners, and Strategic Health Authorities in the case of health. This will include:

- implementing and managing the new performance framework for PCTs and LAs, outlined below;

- providing better information to service users (for example through the NHS Choices website, and Community Profiles which are designed to show the health of people in Local Authorities);

- spreading best practice through issuing guidance to encourage improvement, and provide support, for example through improvement teams, to help local bodies tackle poor performance;

[5] *Strong and prosperous communities The Local Government White Paper*, CLG, Oct 2006.

- supporting excellence, for example through the NHS Institute, NHS Employers, "Skills for Care", Social Care Institute for Excellence and the Improvement and Development Agency;
- maximising the value gained from the work done by LINks achieving community engagement on the ground and building on the contribution made by health and social care Overview and Scrutiny Committees to the improvement of services delivery; and
- intervening to tackle poor performance where necessary, for example, when performance has been significantly off track to prolonged periods of time.

A new outcomes and accountability framework

Moving beyond top-down targets

3.24 Delivery of continuous improvement in a reformed system requires an approach to performance that goes beyond top-down targets, to support a more devolved, innovative system that encourages performance improvement across the range of services.

3.25 DH is therefore developing a new outcomes framework that aims to re-engage clinicians and staff by allowing government to set out the strategic priorities, whilst giving commissioners and staff locally the headroom needed to focus on local priorities that patients and users have said are important.

3.26 The outcomes framework starts with the Department of Health's Strategic Objectives (Better Health and Well-being for All, Better Care for All, Better Value for All), underpinned by a set of high-level aims covering the full range of health and adult social care services. Each outcome will be underpinned by indicators, rooted in public, patient, user and staff outcomes and experience and promoting equality across the board. DH carried out extensive engagement on the indicators to ensure the best possible indicators have been chosen.

3.27 The indicators are designed in a way that:

- encourages continuous improvement across the range of health and adult social care services;
- supports delivery of outcomes where there is joint working between NHS and local government and other local partners (by feeding into the Local Government 200 National Indicator Set to ensure alignment);
- exposes equality and inclusion issues so these can be addressed locally to meet the needs of increasingly diverse communities, and to meet legal duties on equality (NHS organisations are required to assess the equality impact of their services, policy and data collection and analysis with regard to race, disability and gender, and to also ensure non-discrimination in relation to age, sexual orientation and religion or belief); and
- supports delivery of the savings in health and adult social care identified by the Financial Sustainability Review. A Value for Money Delivery Agreement will be published later in 2007.

3.28 The indicators for this PSA, and DH's contribution to other cross government PSAs are designed to align with, and be supported by, the broader the outcomes framework, and will be embedded within this to create a single coherent framework that encompasses the full range of health and adult social care services.

Direct accountability to the public and patients

3.29 Greater accountability to the public will be a key feature of the new approach. Specifically, commissioners will:

- be able to set local "stretch" targets in relation to the indicators based on their local joint strategic assessment of need, taking account of national (and where appropriate, international) benchmarks of best practice, and national targets (for example 18-weeks). This would also inform the content of the LAAs to which local priorities will be set to meet place based needs in their local community; and

- publish a prospectus setting out their local priorities. For example, The PCT prospectus will signal the strategic direction for local services, highlighting commissioning priorities, needs and opportunities to service providers, offering a focus for discussion with patients and local community and an opportunity to open dialogues with potential providers.

3.30 Comparative data showing the performance of individual PCTs and Local Authorities on each of the indicators will be published annually (possibly in the form of a "report card" for each PCT). This published data will give local people an idea of how well their PCT is performing. It will also be a basis for scrutiny and performance management challenge of PCTs by Local Authority Oversight and Scrutiny Committees (OSCs) and SHAs. OSCs will get a range of powers to strengthen monitoring of local services including adult social services.

3.31 For health, the Operating Framework will set out further information about the NHS contribution to delivering the vision for Better Health and Well-being for All, Better Care for, and Better Value for All, to inform good local planning. As part of the approach, performance agreements between SHAs and PCTs will allow a degree of performance challenge down the commissioning side. SHAs, who are responsible for performance managing commissioners, will hold them to account for how well they are discharging their responsibilities in meeting local needs, in particular focusing on those areas where an individual PCT's performance is relatively poor compared to other PCTs.

Tackling poor performance

3.32 The relationship between DH and SHAs, and local government (through DH's presence in the Government Offices of the Regions) will increasingly focus on tackling significant underperforming / unacceptable variations.

3.33 In health specifically, the Department of Health will support and challenge SHAs to deliver continuous improvement. Where performance is off track, with a particular emphasis on prolonged and comparatively poor performance, action will be proportionate and appropriate to the specific issue, with a more transparent approach adopted.

3.34 Similarly, the new Local Government Performance Framework will create more space for local service providers to meet the needs and aspirations of local citizens and communities and provides clearer accountability arrangements, managed through Local Area Agreements.

CONSULTATION AND USER ENGAGEMENT

3.35 DH has carried out extensive consultations on its priorities and objectives throughout the past 20 months through a number of events, including the *Our Health, Our Care, Our Say* white paper process and the National Stakeholder Forum.

3.36 Specifically in supporting DH's direction for the priorities over the next CSR07 period, evidence of public and user engagement has been drawn from key sources:

- the White Paper *Our health, our care, our say* informed by a major public engagement exercise to support the next stage of reform and improvement in the NHS and social care. *Our health, our care, our say* also incorporated the findings of the adult social care Green Paper *Independence, well-being and choice: our vision for the future of adult social care in England;*[6]
- DH's consultation on *The future regulation for health and adult social care in England,*[7] which outlines how the new regulator could best work alongside other bodies in the health and adult social care system to fulfil its duties and powers, closed at the end of February this year. This would help the development of a regulatory framework that will support health reform;
- a consultation on a commissioning framework for health and well-being, which builds on the White Paper *Our health, our care, our say* and is a framework about action, with a particular focus on partnerships; and
- an extensive engagement process with stakeholders on the Department of Health's new performance approach, the objectives and the underpinning indicators. The programme of engagement has provided an opportunity for real clinical engagement, helping to identify the right balance of indicators that are meaningful at a local level.

3.37 Furthermore, the reforms DH is implementing will embed user engagement into the system and ensure that users of services, particularly those in hard to reach groups, are central to designing services to meet the needs on the local population.

3.38 To set us on the path to the next stage of the transformation of the NHS, the Government has asked Lord Ara Darzi to carry out a wide-ranging review of the NHS to ensure that a properly resourced NHS is clinically-led, patient-centred and locally accountable. The priorities set out in this PSA have been informed by the first stage of the review, which culminated in the interim report published by the Department of Health on 4 October 2007.

ACCOUNTABILITY AND GOVERNANCE

3.39 The Secretary of State for Health is the lead minister for this PSA. The relevant Cabinet Committee/s will drive performance by regularly monitoring progress, holding departments to account and resolving inter-departmental disputes when they arise.

3.40 The Senior Responsible Officer within government for the PSA will be agreed by end 2007 and will chair a Senior Official PSA Delivery Board, which will monitor progress, review delivery regularly, and report to the relevant Cabinet Committee/s.

[6] *Independence, well-being and choice: Our vision for the future of social care for adults in England,* DH, 2005

[7] *The future regulation of health and adult social care in England,* DH, 2006

A MEASUREMENT ANNEX

Indicator 1	The self reported experience of patients / users
Data provider	The Healthcare Commission.
Data set used	The national patient/user survey programme[1] is service or setting based, and gathers feedback from patients/users on different aspects of their experience of the care delivered by health and social care providers. Services/settings covered include: Inpatients; Outpatients; Emergency care; Maternity care; Mental health services; Primary care services; Ambulance services
Baseline	The baseline will be established from the results to surveys conducted as part of the 2007-08 programmes (see definition of key terms for further information). Results will be available in autumn 2008 on the DH website via the following link. http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/index.htm.
Frequency of reporting	Surveys are conducted on a rolling programme. The programme is designed so that each provider conducts at least one patient/user survey per year, although the precise setting/service may vary.
Data Quality Officer	DH social Researcher, Public and Patient Involvement Team.
95 per cent confidence interval at last outturn	The national patient survey programme is one of (if not the) largest survey programmes in existence. In total, well over one million patients have taken part in the programme to date, and the number of taking part in any one survey has ranged from 55,000 through to 123,000. It is not straightforward to calculate 95 per cent confidence intervals for each area. Using an analytical technique called bootstrapping it is possible to calculate a confidence interval for a representative survey and domain. This indicates that a range of +/- 0.2 is a good estimate of the 95 per cent confidence interval. In most areas, patient experience scores are high and we would not expect large numerical changes in the scores. A small improvement in the national figure would usually represent steady improvement across the country, together with larger changes in providers with below average scores. Performance information is available on the Department of Health website at http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/index.htm.

[1] It is acknowledged that there is a mixed economy of care and that patients/users can choose to have their social and health care needs met by a wide range of providers. The national patient/user survey programme will continue to evolve in line with changes to the way services are delivered.

DEFINITION OF KEY TERMS

- *Independently validated surveys:*
  Patient/user surveys that are conducted under the administration of the Healthcare Commission, as part of the national patient/user survey programme. Further information is available on the website of the Healthcare Commission and the survey coordination centre, see http://www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys.cfm and http://www.nhssurveys.org/

- *Patient/user experience:*
  Defined by 5 key dimensions rated by patients/users are important:

  - Access and waiting;
  - Safe, high quality coordinated care;
  - Building closer relationships;
  - Clean, friendly comfortable place to be; and
  - Better information, more choice.

  A subset of questions from each survey are used to construct a measure of each domain. Confirmation of these question sets are published in the Better Metrics report, available on the Healthcare Commission website, see http://www.healthcarecommission.org.uk/serviceproviderinformation/bettermetrics.cfm

- *Sustained improvements:*
  The PSA methodology is based on the scoring system developed by the Healthcare Commission for deriving to performance indicators for use in the annual health check. For each survey, a subset of questions are used to calculate a score for the 5 domains of a good patient/user experience; in turn, these are used to construct an overall experience index score for each survey. More details about the PSA methodology are available on the Department of Health website and the Better Metrics publication, see http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/index.htm; and http://www.healthcarecommission.org.uk/serviceproviderinformation/bettermetrics.cfm

  The Department of Health and the Healthcare Commission have conducted an extensive review of the methodological issues involved in using the national patient/user survey programme as the metrics for this target. A technical paper summarising this work is available on the Department of Health website, see http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/index.htm

  Taking a baseline of 2007-08 or the most recent preceding survey if no survey was carried out in 2007-08, success is defined as an increase in the index score for each survey, as measured across the entire PSA period. The increase is defined as being above the minimum movement required for performance assessment. PSA results for surveys conducted to date

(covering SR 2002 and SR 2004) are available on the DH website (via the above weblink).

- *Involvement in decisions about health-care, including choice of provider:* All of the surveys include questions measuring the extent to which patients/users want to be involved, and whether these needs were met. The policy on choice of provider commenced in January 2005, and is included in all appropriate surveys.

Indicators 2 and 3	Percentage of patients seen within 18 weeks for: i. admitted patients ii. non-admitted patients
National target	To ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks).
Data provider	Primary Care Trusts (commissioner based data).
Data set used	Referral to treatment (RTT) monthly data collection.
Baseline	Baseline for admitted patients is 54 per cent (June 2007). Data for non-admitted patients has been collected since April 2007 and a baseline will be published for the first time later in Autumn 2007.
Frequency of reporting	Monthly.
95 per cent confidence interval at last outturn	Confidence interval not applicable as the indicator is not a sample – it covers all appropriate patients who completed their referral to treatment (RTT) pathway within the month.
Data Quality Officer	Head of Performance Measurement, Knowledge & Intelligence, DH.
Minimum movement required for performance assessment	Not applicable as indicator covers all appropriate patients who completed their referral to treatment (RTT) pathway within the month.

DEFINITION OF KEY TERMS

- *Referral to treatment (RTT):*
  The time between initial referral through to the start of first definitive treatment (or when a clinical decision is made that treatment is not required). RTT is the part of a patient pathway covered by the 18 week referral to treatment target.

- *Admitted patients:*
  Patients whose treatment requires admission to hospital

- *Non-admitted patients:*
  Patients who do not require admission to hospital

- *Percentage of patients seen within 18 weeks:*
  Proportion of patients who completed their RTT pathway within 18 weeks

- *Percentage of patients seen within 18 weeks - admitted patients:*

  Indicator numerator – the number of admitted patients who completed their RTT pathway during the month who waited 18 weeks or less.

  Indicator denominator – the total number of admitted patients who completed their RTT pathway during the month.

- *Percentage of patients seen within 18 weeks – non-admitted patients:*

  Indicator numerator - the number of non-admitted patients who completed their RTT pathway during the month who waited 18 weeks or less.

  Indicator denominator – the total number of non-admitted patients who completed their RTT pathway during the month.

National target

- To ensure that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome (for clinically appropriate patients who choose to start their treatment within 18 weeks).

A.1 The following milestones have been agreed with the NHS to be achieved by the end of March 2008:

1. For admitted patients, 85 per cent within 18 weeks; and
2. For non-admitted patients, 90 per cent within 18 weeks

PCTs will be required to deliver on both parts of the March 2008 milestone.

A.2 Note - It is recognised that there are three groups of patients for whom it would be inappropriate to expect treatment to begin within 18 weeks:

1. patients with complex conditions who are clinically unsuitable to be treated within 18 weeks;
2. patients who choose to wait longer than 18 weeks; and
3. patients who do not attend appointments, causing delay.

A.3 DH continue to investigate both the tolerance and adjustment system options for dealing with these groups of patients and the outcome of this work will be announced in Autumn 2007.

Indicator 4	Access for Women to Maternity Services – Percentage of women who have seen a midwife (or obstetrician) for health and social care assessment of needs and risks by 12 weeks of their pregnancy
Data provider	2008-09 – 2009-10 – Local Delivery Plan Returns – DH Knowledge and Intelligence. 2009-10 – The NHS Information Centre.
Data set used	The information will be collected by the Information Centre in DH and will be provided through Hospital Episode Statistics collection. This is a new collection, which will not be in place for April 08, LDPR will be used to collect key summary data in the first year.
Baseline	Data should be available in winter 2008.
Frequency of reporting	Quarterly.
95 per cent confidence interval at last outturn	To be determined once baselines established in winter 2008.
Data Quality Officer	Senior Manager – DH Knowledge and Intelligence /Head of Hospital Statistics – Information Centre.
Minimum movement required for performance assessment	At present a baseline or full understanding of likely return rate and hence sampling error/confidence intervals are not available. This information will be determined once baselines are established in winter 2008.

DEFINITION OF KEY TERMS

- *Pregnancy:*
  Defined as all maternities that extend past the first trimester, this would include still births and miscarriages and terminations after 12 weeks where known. It excludes pregnancies where care is provided outside an NHS setting or that have been terminated before 12 weeks.
- *Midwife:*
  To qualify as a midwife in this definition the person must hold current registration with the nursing and midwifery council and being in active employment as a midwife with the NHS.
- *Maternity healthcare professional:*
  This is a description which covers doctors with current registration with the General Medical Council and working for the NHS providing maternity services.
- *12 completed weeks:*
  Relates to the measured gestation of the pregnancy calculated following ultrasound assessment. This may be retrospective if the dates have not been confirmed until after 12 weeks.
- *Health and Social Care needs, risks and choices assessment:*
  A Health and Social Care Needs Assessment must be undertaken using the NICE antenatal care guidance (a draft revised guideline is expected to be

published in the Autumn with the final version in March 2008 and will include a health and social care needs assessment).

- *Maternity healthcare professional:*
  This is a description which covers doctors with current registration with the General Medical Council and working for the NHS providing maternity services.

Indicator 5	People with long-term conditions supported to be independent and in control of their condition
Data Provider	Healthcare Commission.
Data set used	Primary Care Trust patient survey. From 2009-10 this indicator will be a patient experience measure of the proportion of people with a long-term condition who are "supported by people providing health and social care services to be independent and in control of their condition”.
Baseline	We expect this information to be collected for the first time in the 2007-08 survey. This will deliver results in summer 2008.
Proxy	In 2008/09 this indicator will be measured using proxy data on emergency bed days. See below for further details.
Frequency of reporting	Annual.
95 per cent confidence interval at last outturn	No previous data. Though based upon sample size in this survey, national estimates will have a confidence interval of less than +/-1%.
Data Quality Officer	Lead analyst on long-term conditions, Department of Health.
Minimum movement required for performance assessment	A one percentage point movement will show actual change.

DEFINITION OF KEY TERMS

- *The proportion of people with a long-term condition who are "supported by people providing health and social care services to be independent and in control of their condition"*

  The denominator will be the number of people who define themselves as having a long-term conditions using standard survey question such as “Do you have any long-standing illness, health problem or disability which limits your daily activities or the work you can do? The numerator will be the subset of the denominator that said they were "supported by people providing health and social care services to be independent and in control of their condition" or similar question to be cognitively tested.

- *Emergency bed day:*

  An overnight stay in a publicly funded hospital where the patient was admitted in an unplanned way. The link http://www.dh.gov.uk/ asset Root/04/08/69/19/04086919.pdf gives the more technical definition from the 2005-2008 Public Service Agreement on emergency bed days.

Proxy indicator for Year 1 monitoring (2008-9)

A.4 Because this indicator relies on a new data source and baseline information will not be available until later in the CSR period, for the first year of the period a proxy indicator on emergency bed days will be used to monitor performance. Key information about this proxy is below:

- **Data provider:** Information Centre for Health and Social Care;
- **Data set used:** Hospital Episode Statistics;
- **Frequency of reporting:** Hospital Episode Statistics are published annually around 9 months after the end of the financial year to which they relate. However, provisional figures are available quarterly around 3 months after the period to which they relate and the Information Centre is working to publish provisional monthly figures six weeks after the end of the month to which they relate;
- **95 per cent confidence interval:** not applicable, as nationally drawn from administrative records;
- **Data quality officer:** Analytical lead on long-term conditions, Department of Health; and
- **Minimum movement required for performance assessment:** Given that figures are drawn from administrative records and cover the whole country, there is minimal natural fluctuation in the numbers. Therefore, a movement of 1 per cent is significant.

Indicator 6	Patient experience of access to primary care
Data provider	Department of Health.
Data set used	GP patient survey.
Baseline	In 2006-07, 84 per cent of people were satisfied with access to primary care. This is made up from: 86 per cent Satisfied with telephone access to GP practice; 86 per cent say they are able to see GP within 48 hours if wanted; 75 per cent say they are able to book GP consultation 3+ days ahead if wanted88% say they are able to see a specific GP if wanted; and 84 per cent are satisfied with GP practice opening times.
Frequency of reporting	Annual (surveys run Jan-March each year), though potential for quarterly surveys from 2008-09 is being explored. There is around a 2-3 month lag between fieldwork and results being available.
95 per cent confidence interval at last outturn	Using the annual GP patient survey, the 95 per cent confidence interval is less than 1 per cent.
Data Quality Officer	Lead analyst on primary care, Department of Health.
Minimum movement required for performance assessment	Using the GP patient survey, a movement of around 1per cent would be significant.

A.5 In Year 1 (2008-9) this indicator will be measured using the average of five elements of access to primary care, namely:

- Satisfaction with telephone access to GP practice
- Ability to see GP within 48 hours if wanted
- Ability to book GP consultation 3+ days ahead if wanted
- Ability to see a specific GP if wanted
- Satisfaction with GP practice opening times
- From 2009-10 onwards the indicator will be broadened to include new survey data on the proportion of people who were satisfied with their overall experience of their GP practice.

DEFINITION OF KEY TERMS

- *Telephone access:*
  The denominator would be the number of people who expressed an opinion on whether they are satisfied with ability to get through to someone on the phone at their doctor's surgery. The numerator would be the subset of the denominator that said they were satisfied.

- *48 hour access:*
  The denominator would be the number of people who (in the last six months) tried to get a GP appointment within 48 hours and expressed an opinion on whether they were able to do this. The numerator would be the subset of the denominator that said they were able to get a GP appointment within 48 hours.

- *Booking ahead:*
  The denominator would be the number of people who (in the last six months) tried to book a GP appointment more than two days in advance and expressed an opinion on whether they were able to do this. The numerator would be the subset of the denominator that said they were able to book a GP appointment more than two days in advance.

- *Specific GP:*
  The denominator would be the number of people who (in the last six months) wanted to book an appointment with a particular GP and expressed an opinion on whether they were able to do this. The numerator would be the subset of the denominator that said they were able to book an appointment with a particular GP.

- *Opening times:*
  The denominator would be the number of people who expressed an opinion on whether (in the last six months) they were satisfied with the hours their GP surgery was open. The numerator would be the subset of the denominator that said they were satisfied with the hours their GP surgery was open.

- *The proportion of people who were satisfied with their overall experience of their GP practice:*
  The denominator would be the number of people who expressed a preference on whether they were satisfied with their overall experience of their GP practice. The numerator would be the subgroup of the denominator who said they were satisfied with their overall experience of their GP practice.

Indicators 7 & 8	Health Care Associated Infection Rates (i) MRSA (ii) *Clostridium Difficile*
National targets / standards	For MRSA the average annual number of MRSA bacteraemias for the period 2008-9 to 2010-11 should be less than half the 2003-4 figure. For *Clostridium difficile* the target is to deliver a 30 per cent reduction in the number of cases reported in 2010-11 compared to an agreed baseline in 2007-8.
Data provider	Health Protection Agency.
Data set used	MRSA blood stream infection surveillance data and *Clostridium difficile* infection surveillance data.
Baseline	MRSA: half of the number of bacteraemias recorded in 2003-04, or 3,848 cases per year *Clostridium difficile*: The number of *Clostridium difficile* infections in patients aged 2 and over recorded in 2007-08. The collection of *Clostridium difficile* infection rates for 2-64 year olds is a new data collection and will form part of the 2007-08 baseline. There may be uncertainty about the baseline until summer 2008.
Frequency of reporting	MRSA infections are reported quarterly. *Clostridium difficile* infections are also reported quarterly. They were previously reported only on those aged 65 and over. Surveillance was extended in April this year to all those aged 2 and over. Numbers include cases reported outside acute hospitals (around 20 per cent of the total).
95 per cent confidence interval at last outturn	Not applicable – the indicator includes all recorded cases.
Data Quality Officer	Lead analyst Health Protection Team, Department of Health.
Minimum movement required for performance assessment	Not applicable, the indicator includes all recorded cases, therefore any movement is significant.

DEFINITION OF KEY TERMS

- *MRSA Bacteraemia:*
  Meticillin resistant Staphyloccocus aureus is a bacterium involved in various types of infections (eg in surgical wounds). This indicator is based only on MRSA bacteraemias (blood stream infections), which are the most serious type of MRSA infection.

National target

A.6 MRSA: The indicator is the annual number of MRSA bacteraemias in each of the years 2008-09. 2009-10 and 2010-11. The target is that the total number of cases for each year should be below 3,848 (half the 2003-04 baseline).

A.7 *Clostridium difficile*: The indicator is the number of cases of *Clostridium difficile* associated diarrhoea reported in 2010-11. This should be 30 per cent less than the figure (not yet available) for 2007-08.