



Developing the NHS Performance Regime

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Foreword by the NHS Chief Executive

Let me be clear, first of all, that the NHS is performing extremely well. We are on course to achieve the historic 18-week maximum waiting time by the end of the year, and to meet challenging targets for reducing rates of healthcare-associated infection. Mortality rates for cancer and cardiovascular disease have been substantially reduced, while access to GP and other primary care services is quickly improving. In its 60th anniversary year, public confidence in the NHS and patient satisfaction with the quality of NHS care are both at their highest level for years.

The NHS is also in an enviably strong financial position, having fully recovered from the serious financial problems we were experiencing less than two years ago. This remarkable financial turnaround has taught us important lessons about tackling poor performance, and has shown the tremendous capacity of our system to achieve swift and sustainable recovery.

Yet this is no time to be complacent or rest on our laurels. Last year's Healthcare Commission report into the running of Maidstone and Tunbridge Wells hospitals provided a stark reminder, if one were needed, of the human cost of poor performance in the NHS. To me, it emphasised more than ever the need for a systematic and transparent approach to managing performance across the NHS.

This is precisely the goal of the new NHS Performance Regime: to consolidate and build on our current strong performance, while giving us the tools to intervene early to tackle the relatively few incidents of poor performance when they occur. The regime brings together a range of measures to safeguard minimum standards and to incentivise high performance in all parts of the NHS, from acute hospitals to community services, and from whole organisations down to individual leaders. The NHS Performance Regime is central to the system we are building, ensuring that we maintain consistent national standards even as we encourage more freedom and diversity among providers of care.

But what does this system look like? At the heart of it are Primary Care Trusts (PCTs) and practice-based commissioners, using the commissioning and contracting processes to drive high performance and tackle poor performance across all NHS services. Strategic Health Authorities (SHAs) also have a vital role to play, not only in overseeing their local PCTs, but also as regional system managers, building capacity and ensuring that the right blend of services is available across their region. We will also look to SHAs to tackle serious underperformance by PCTs and NHS Trusts, in those extreme cases where it occurs.

Alongside PCT commissioning and SHA system management, regulation is the third key element of the system. The newly integrated health and adult social care regulator, the Care Quality Commission (CQC), will help to ensure the safety and quality of care across all providers of NHS services, through its new registration process. Registration requirements will apply to both NHS and independent sector providers, ensuring that patients and the public can continue to have confidence in the quality of NHS services, even as the range of providers increases. The CQC will also play an important role in encouraging improvement in healthcare by carrying out periodic assessments of the performance of NHS Trusts and by publishing comparative information about commissioners and providers. And Monitor will continue to play an important role as the authorising body for the growing numbers of NHS Foundation Trusts.

The NHS Performance Regime aims to build and develop this system, to align roles and responsibilities, and to provide new tools where they are needed. The regime builds on a number of existing programmes, such as World Class Commissioning and the creation of the CQC. And it adds new components, such as a new performance regime for NHS Trusts; a new turnaround service, NHS Interim Management and Support (NHS IMAS), to support

organisational recovery; and plans for a failure regime to deal with extreme cases of provider failure.

Most importantly, the regime is part of our efforts to build a strong and sustainable NHS where power resides at the local level and change is driven locally. The Department has a clear role to play in setting the overall direction and ensuring a nationally coherent system, but the main responsibility for driving performance on the ground will continue to fall to PCTs and SHAs, supported by CQC and Monitor. The health service has proved in recent months and years that it can deliver against a range of complex and stretching goals; the new NHS Performance Regime will help to ensure that we maintain and improve on this high performance, realising the great potential of our health system.

Delivering positive change in the NHS is the focus of this document. However, I recognise that improvements in health outcomes cannot be delivered by health agencies in isolation. It remains important for PCT Chief Executives to continue to take personal responsibility, as established through the duty to co-operate under the local performance framework, for ensuring that their organisations contribute fully to the shared national and local priorities identified through Local Area Agreements (LAAs).

The vision for developing the NHS Performance Regime set out in this document represents the first of two stages in this work. This vision has been tested with key stakeholders – including the NHS Management Board, NHS Confederation, the Healthcare Commission and Monitor – and we would be grateful for any further feedback.

The second stage will involve working with colleagues in the service and across Government to develop the detail of our proposals, for implementation under the 2009/10 Operating Framework.

A handwritten signature in black ink, appearing to read 'D Nicholson', with a long horizontal flourish extending to the right.

David Nicholson
NHS Chief Executive



Chapter 1: Overview of the NHS Performance Regime

Introduction and context

1. Shorter waiting times in A&E and for elective operations, increased access to primary care and dramatic reductions in mortality rates for cancer and cardiovascular disease provide clear evidence that NHS performance has improved considerably since 1997.
2. Examples of poor performance have been relatively isolated – concentrated in a small number of organisations. And examples such as the ‘financial turnaround’ programme demonstrate the capability of the NHS to achieve recovery, having helped reduce the number of organisations in deficit from 104 at the end of 2005/06 to just 10 forecasting deficits at the end of 2007/08.
3. Although we have a strong track record on organisational turnaround, our approach to addressing underperformance and supporting recovery has not always been transparent and consistent. Commissioners locally have taken different approaches to contracting for service delivery and to determining when and how to intervene to address underperformance. Similarly, SHAs have taken different approaches to the performance management of organisations

in their regions, to supporting the recovery of organisations in financial difficulty and – through their role as system managers – to addressing risks to the sustainability of services. A new regulatory framework¹ is already being put in place to address this and this document highlights elements of it that will drive performance improvement and deal with poor performance and failure.

4. Local flexibility will continue to be essential to achieving success in commissioning and to providing and delivering services that are responsive both to patients and to the needs of local communities. And we must have local discretion over how we deal with specific problems so that decisions can be made in context.
5. But we also need to be clear with patients and the public about what they can expect from their NHS services and how the system will hold organisations, and the people that run them, to account. For example: what will be considered as underperformance and trigger intervention; what is a reasonable timescale within which an organisation will be expected to be able to demonstrate recovery; and what will happen if an organisation fails?
6. Our objective in developing the NHS Performance Regime is therefore to ensure greater transparency and consistency in:
 - identifying underperformance;
 - supporting recovery; and
 - managing failure.
7. Our approach needs to recognise that the relationship between central government and the NHS is changing. Commissioning decisions are increasingly driven by local priorities, while care is increasingly provided by NHS Foundation Trusts and by primary care, and other independent contractors that operate outside the traditional NHS management structure. This increasingly devolved and plural system cannot and should not be controlled from Whitehall.
8. In this context, we must develop a performance system which enshrines the essential levels of quality and safety that all providers will be expected to demonstrate in order to be eligible to provide NHS services. We need to have consistent measures of performance in service delivery, regardless of the

1 *The future regulation of health and adult social care in England: response to consultation*, Department of Health, October 2007.

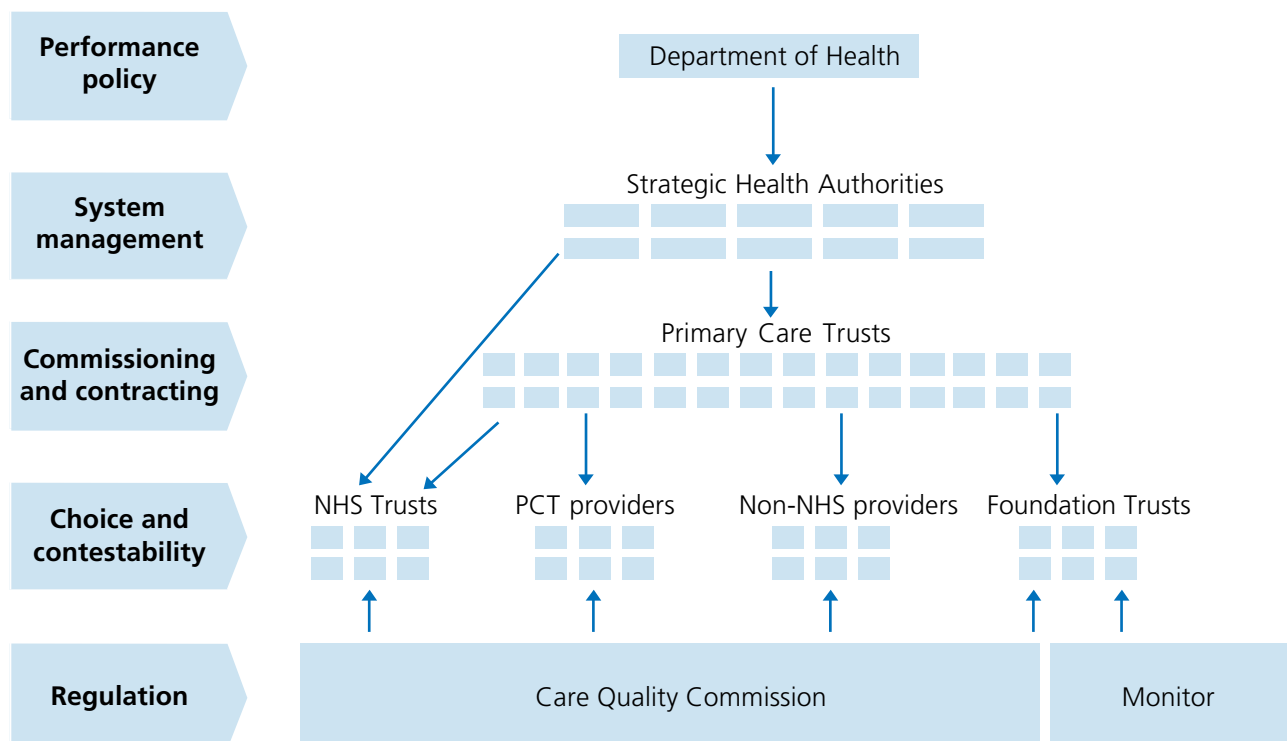
type of provider, which ensure services are personalised to the needs of patients, and take into account the requirement to promote equality of opportunity under disability, gender and race legislation and to protect human rights. And we must take a coherent approach to tackling underperformance that is consistent with lines of accountability and with roles and responsibilities within this system.

Roles and responsibilities within the system

9. This document provides a framework for managing the performance of all NHS health care provided, whether that care is delivered in a hospital, in a local GP surgery, or in a community care setting. The philosophy underlying our approach is that individual organisations, and in most cases their Boards, are responsible for improving performance and addressing underperformance. In this way, providers, commissioners and SHAs are held to account at organisational level. For example, where a PCT or NHS Trust fails to demonstrate recovery following remedial action, intervention on behalf of the NHS Chief Executive would be aimed at identifying and addressing weaknesses in Board capability and organisational governance.
10. NHS services today are delivered through a plurality of providers. Providers can be broadly placed in three categories, each with their own lines of accountability:
 - a) *NHS Trusts* which are accountable to SHAs, and ultimately to the Secretary of State; and, held to account through their contractual relationships with commissioners.
 - b) *NHS Foundation Trusts* which are accountable to their Board of Governors; regulated by Monitor for compliance with their Terms of Authorisation; and, held to account through their contractual relationships with commissioners.
 - c) *Independent contractors*, including GP practices and Independent Sector providers, who are held to account through their contractual relationships with commissioners.
11. Even though these different types of provider are performance managed in different ways, the new NHS Performance Regime will bring coherence to how the overall system operates. The key elements of the regime, applicable to all providers of NHS care, are as follows:

- the use of consistent **information** to define a 'spectrum of performance' and to support patient choice (see Chapter 2);
 - the **commissioning and contracting** processes used by PCTs to hold providers to account and to tackle early signs of underperformance (see Chapter 3);
 - the role of SHAs as regional **system managers**, coordinating the delivery of care across their patch and holding PCTs themselves to account (see Chapter 4); and
 - **independent regulation** by the CQC to safeguard essential levels of quality and safety (see Chapter 6).
12. In order to ensure that this system functions effectively, we will also introduce systems for holding PCTs and SHAs themselves to account, for their roles in commissioning, performance management and system management (see Chapter 4).
13. The role of these organisations and their functions within the new NHS Performance Regime are shown in Figure 1:

Figure 1: Roles and responsibilities within the NHS Performance Regime



14. Over time, the performance management role of SHAs will increasingly focus on the performance of PCTs, as commissioners. The reconfiguration of PCTs under *Commissioning a Patient-led NHS* is intended to help

strengthen commissioning through, for example, better alignment with local authorities and enabling greater economies of scale when investing in informatics infrastructure and analytical capacity. However, achievement of World Class Commissioning (WCC) in England is a long-term ambition and PCT commissioning is still relatively immature in some areas. At this stage, it is therefore important that we maintain some overlap between the role of commissioners in holding providers accountable for service delivery, the role of SHAs as performance managers of NHS Trusts, the role of Monitor's compliance framework for NHS Foundation Trusts. This illustrates the state of ongoing transition in the NHS from a centralised to a devolved system, and is essential for protecting the interests of patients and the public.

Scope of this document: Developing the NHS Performance Regime

15. This document encompasses the roles and responsibilities described above in relation to upholding standards and driving improvements in **service delivery**. It is not intended to cover the broader responsibilities of PCTs and SHAs, for example in relation to Joint Strategic Needs Assessment or commissioning of training and education. This document therefore focuses specifically on:
 - the role of providers in maintaining standards and driving quality improvements in service delivery;
 - the role of PCTs as commissioners in holding providers to account for service delivery through contracts;
 - the role of SHAs as performance managers of PCTs and NHS Trusts;
 - the role of PCTs and SHAs as 'system managers' in supporting recovery; and
 - the role of independent regulation in safeguarding minimum standards (ie the conditions of registration or authorisation).

Support for 'challenged' organisations

16. This document introduces the concept of 'challenged' organisations, building on the concept of Financially Challenged Trusts introduced under the 2007/08 Operating Framework. 'Challenged' organisations will have been

underperforming persistently over time and are likely to require support to achieve recovery. The roles of PCTs, as commissioners, and SHAs as system managers, in providing support for 'challenged' organisations are discussed in Chapters 3 and 4 respectively.

17. The explicit recognition that 'challenged' organisations may require support from PCTs or SHAs is an acknowledgement that the NHS is an integrated system rather than a true market, and it therefore may not always be within the gift of an organisation, acting alone, to effect recovery.
18. For example, there may be cases where PCTs can justify additional non-tariff income in order to ensure access to services for smaller, relatively isolated communities, or to encourage market entry, or to underpin investment in service developments. However, these decisions would need to be made locally, on a case-by-case basis; would need to balance considerations of access, quality, cost and value for money; and would need to be consistent with NHS principles governing cooperation and competition.
19. In other cases, SHAs as system managers may need to work with local commissioners and providers to address unsustainable service configurations such as over-capacity, or where individual services are unable to meet clinical standards due to insufficient volumes of patients or case-mix.

Publicly designating PCTs and NHS Trusts as 'challenged'

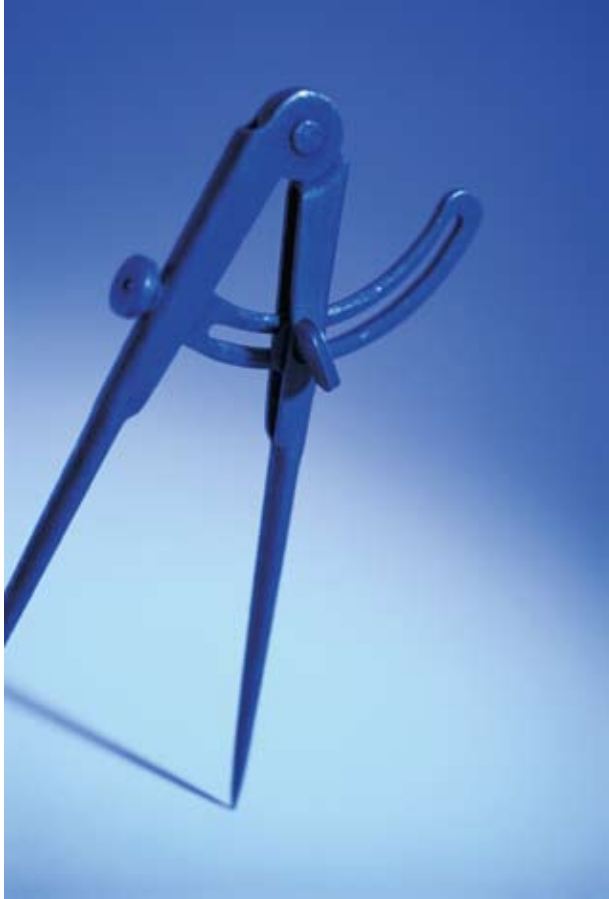
20. However, there may also be cases where a 'challenged' organisation is failing to address persistent underperformance because of weaknesses at board level or due to poor management.
21. For PCTs and NHS Trusts, this document takes the concept of 'challenged' organisations a step further and proposes that the NHS Chief Executive will publicly designate organisations as 'challenged' and subject them to intervention at board level. This approach aims to ensure greater transparency and establish clear timescales within which the public can expect issues to be resolved.
22. The basic criterion for designating a PCT or NHS Trust as 'challenged' is failure to address underperformance within a defined period (eg nine months). By implication, we would not expect to see organisations designated as 'challenged' on

1 April 2009 (ie the point from which we expect to be able to implement the regime described in this document).

23. However, SHAs should already be able to identify persistently underperforming organisations in their regions and should already be taking action to support recovery. For example, any PCT or NHS Trust that is rated as 'weak' on 'Quality of Care' and 'Use of Resources' by the Healthcare Commission should be taking action to improve; where such organisations are rated 'weak' over consecutive years, then we would expect the SHA to be intervening. Similarly, where any 'weak' organisation does not demonstrate evidence of recovery during 2009/10, it is likely to be publicly designated as 'challenged' by the end of the financial year and therefore subject to intervention at board level as described in Chapter 4.

Overarching principles

24. There are five overarching principles governing our approach to developing the NHS Performance Regime so that it is:
- **transparent** – clear and pre-determined performance measures and interventions;
 - **consistent** – a uniform approach across England and at different levels of the system;
 - **proactive** – thresholds for intervention should identify underperformance at an early stage so that it can be addressed; and action to address significant risk to patient safety should be swift and decisive;
 - **proportionate** – intervention should be related to risk, for example, problems at service level should be addressed through interventions at service level; and
 - **focused on recovery** – initial interventions will focus on recovery and should include action to address the root causes of issues, including 'system-level' risk such as over-capacity or where specific services lack credible alternatives.



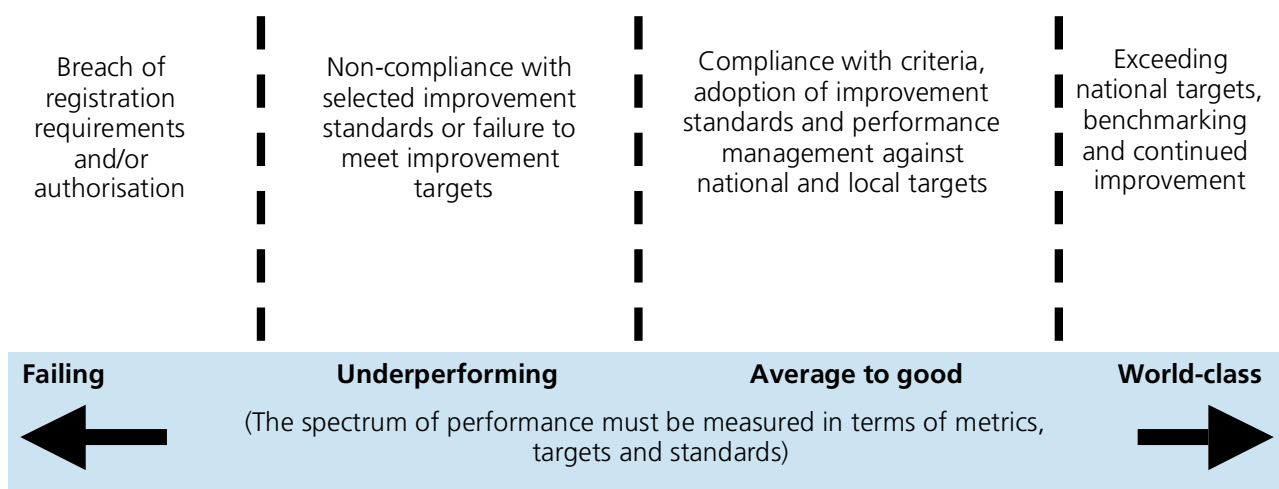
Chapter 2: Measuring performance, driving improvements in quality and safeguarding minimum standards

The performance spectrum

25. Driving improvement in the NHS depends upon measuring how services perform and using this information to inform the judgement of clinicians, commissioners, performance managers and regulators. Where the measures of performance are standardised this will support comparative analysis and benchmarking, as well as informing patient choice.

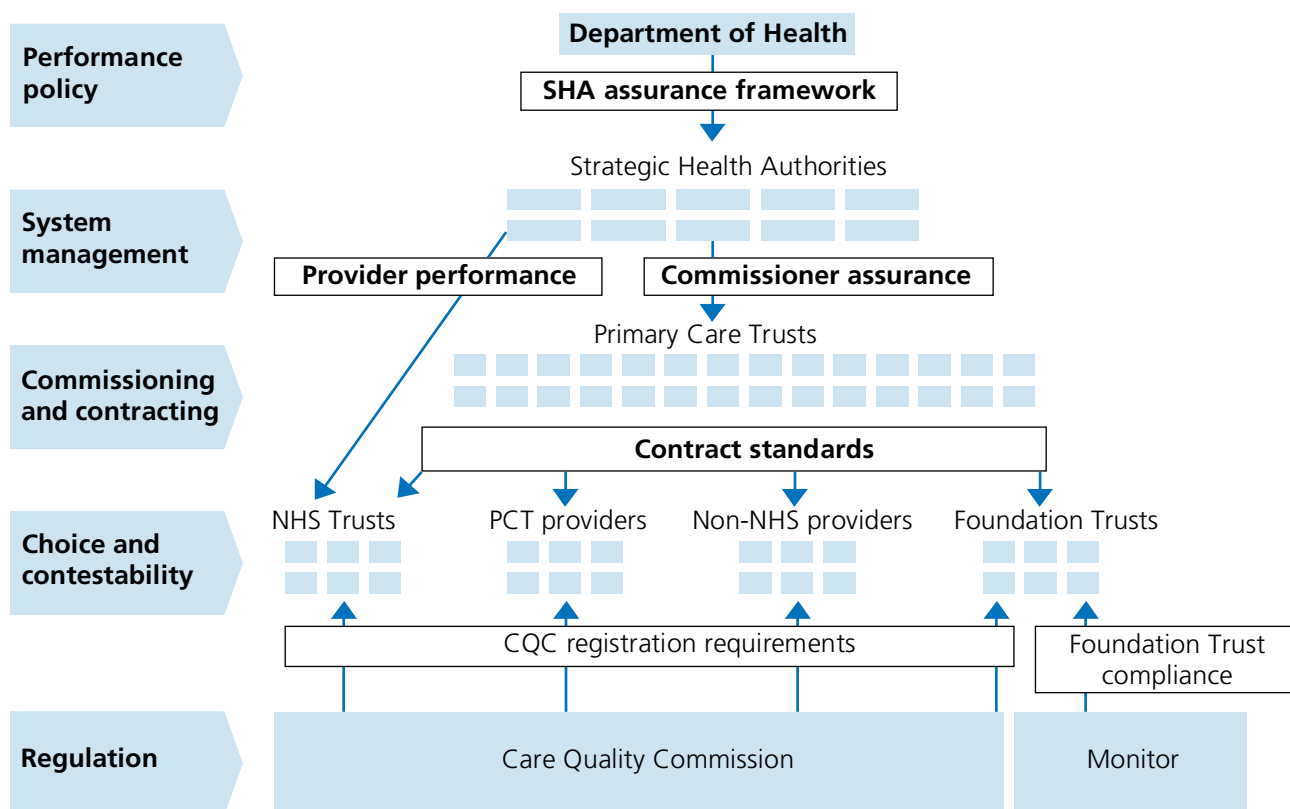
26. A performance regime based on clear comparative information will provide:
- an **evidence-based** approach for commissioners, regulators and system managers, by giving a quantifiable measure of performance;
 - **consistency** in allowing regulators and system managers to categorise organisations and services according to their performance;
 - **transparency** by giving organisations and services a clear view of their own performance of the circumstances under which regulators and system managers will intervene to address underperformance and of their performance benchmarked against that of their peers; and
 - public **accountability** by helping patients and the public to understand how well their local NHS is performing and what level of performance they should expect.
27. The NHS Performance Regime will use metrics and other information sources to identify a **spectrum of performance**, stretching from underperforming or failing performers at one extreme to excellent or world class performers at the other. This spectrum, which can be applied to individual services as well as whole organisations, is underpinned by the use of metrics as shown in Figure 2:

Figure 2: The performance spectrum



28. Information and metrics will be used by organisations across all the different areas of the NHS Performance Regime, as shown in Figure 3.

Figure 3: Use of metrics in the NHS Performance Regime



29. Information and metrics are at the heart of the NHS Performance Regime, but they should not be used in isolation. An approach to performance management which relied purely on metrics to measure and categorise performance would be far too mechanistic. So the judgement and discretion of commissioners, performance managers and regulators will remain a central feature of the NHS Performance Regime, particularly when determining when and how to intervene to tackle poor performance. In short, the role of metrics is to **inform**, not to **automate**, the judgements of regulators, commissioners, performance managers and patients themselves.
30. In addition, the quality of metrics and information systems in use will vary between individual services and will be higher for some service areas than others. For example, performance metrics and data collection systems are more developed in primary care and acute hospital services than in mental health

and community services. We are developing a number of new metrics and metrics frameworks, further details of which are provided in the Annex.

Informing quality improvement

31. Improving the quality and effectiveness of care and increasing user satisfaction levels must be the driving force behind everything we do to transform NHS services. Indeed, these are principal objectives of the NHS Next Stage Review and the 10-year 'visions' for the development of healthcare, which clinicians have been leading in each of the SHA regions.
32. However, the NHS Performance Regime should encourage service improvement as an end in itself and not simply as the means to reward. The most powerful incentive we have in the system is the motivation of clinicians to improve services for their patients. We can maximise the impact of this incentive by publishing comparative information on the performance of services as described above.
33. A successful pursuit of this objective depends on evidence: being able to measure clinical outcomes and user satisfaction levels and to determine 'what works'. It also depends on the use of effective mechanisms – levers and incentives – within the system to influence behaviours and, where necessary, to enable intervention.
34. For example, the Quality and Outcomes Framework for primary medical care has provided an evidence base for monitoring compliance with clinical protocols and a basis for performance-related pay for GP practices. Similarly, the consultation document *Options for the Future of Payment by Results* has proposed the use of contract-level rewards for performance against a locally determined set of quality indicators for secondary care.
35. The idea of financial rewards for quality is being developed further as part of the NHS Next Stage Review and the Prime Minister's speech to the House of Commons in May made clear our ambition that payment for NHS services should ultimately include a component driven by user experience. So in future, not only will patients be empowered through their choice of provider, but their experience of services will also be a key determinant of how much providers are paid.

36. In addition, the new statutory regime envisaged in the current Health and Social Care Bill establishes an additional role for improvement standards. The working definition of improvement standards is that they should be 'authoritative statements of levels of performance or results that can range from minimum through acceptable to excellent'. Unlike the national registration requirements described elsewhere in this document, improvement standards will not be enforceable by the CQC, but may be considered by them in their assessment of performance of NHS organisations and of services.
37. The role of improvement standards will be to support the use of commissioning to drive service improvements, and to benchmark best practice and promote further improvements in service quality. Their emphasis will be behavioural, for use as an incentive for continuous improvement.
38. However, at the heart of public service reform is the argument that these mechanisms may be insufficient to drive improvements in quality on their own. What is needed in addition is to empower the people who use public services through the provision of information, the offer of choice and the dynamic of contestability.

Informing patient choice

39. The NHS exists for the benefit of patients who use its services and because of the public which pays for it. Information about the performance of NHS services is essential for public accountability. Moreover, information has an important role in helping patients and their families to get the best out of local NHS services. This includes information about:
 - standards of access and quality;
 - performance;
 - patient and staff satisfaction levels; and
 - how and to whom to complain.
40. However, information has the greatest potential for empowering patients when combined with choice, such as when patients are offered a choice of provider at the point of GP referral. In this way, choice and contestability have the potential to drive improvement and responsiveness in NHS services. Providers that are successful in responding to patient preferences have the potential to thrive under this system. But if providers fail to be responsive then patients may choose to

go elsewhere and unpopular services could be forced to close where there are viable and accessible alternatives.

Informing independent regulation

41. Information and standards are also central to the regulation of NHS services. Subject to the passage of legislation, all providers of health and adult social care in England will be required to register with the new CQC and the requirements of registration will enshrine national levels of quality and safety. The Department is currently consulting on the scope of registration and the proposal that the CQC's role should cover primary care services.²
42. We are proposing a single set of registration requirements, to be applied across all health and adult social care providers that come within the scope of registration. These requirements will concentrate on the essential levels of safety and quality of care that people have the right to expect, and which will be enforceable by the CQC. The registration requirements are built around the main risks inherent in the provision of any health or adult social care service and developed from the most appropriate of the current regulations and standards, and the CQC will develop criteria for monitoring compliance with them. For example, we have proposed that the scope of the requirements should include standards relating to the safety and effectiveness of care in areas such as cleanliness, hygiene, infection control and nutrition.

² *A consultation on the framework for the registration of health and adult social care providers*, Department of Health, March 2008 (this consultation runs until 17 June 2008).

Table 1: Proposed registration requirements for all health and adult social care providers (currently out for consultation)

People's health and wellbeing are better because the care and treatment they receive are safe and effective

- Making sure people get the care and treatment that meet their needs safely and effectively
- Safeguarding people when they are vulnerable
- Managing cleanliness, hygiene and infection control
- Managing medicines safely
- Making sure people get the nourishment they need
- Making sure people get care and treatment in safe, suitable places which support their independence, privacy and personal dignity
- Using equipment that is safe and suitable for people's care and treatment and supports people's independence, privacy and personal dignity

People's health and wellbeing are better because the care and treatment they receive are personalised and fair

- Involving people in making informed decisions about their care and treatment
- Getting people's ongoing agreement to care and treatment
- Responding to people's comments and complaints
- Supporting people to be independent
- Respecting people and their families and carers

People get better care and treatment because systems are operated to manage and deliver safe, effective, fair and personalised services

- Having arrangements for risk management, quality assurance and clinical governance
- Keeping records of the provision of care and treatment
- Checking that workers are safe and competent to give people the care and treatment they need
- Having enough competent staff to give people the care and treatment they need
- Supporting workers to give people the care and treatment they need
- Working effectively with other services

43. Where a provider is in breach of these requirements the CQC will have the power to take enforcement action and, in extreme cases, will be able to close services in order to ensure patient safety. The CQC may also carry out investigations

where it has concerns regarding quality and safety, and the learning from such investigations is a potentially powerful lever for driving improvements in quality. The NHS Performance Regime needs to harness this potential and ensure that appropriate action is taken in response to investigations for the benefit of patients.



Chapter 3: The role of Primary Care Trusts as commissioners, accountable to their local communities

Overview

44. Providers are responsible for the performance of services and for addressing underperformance. However, a key objective in publishing this vision for developing the NHS Performance Regime is to reinforce the role of PCTs as the bodies responsible for commissioning NHS services. At the local level, there is only one organisation responsible for the totality of NHS services and that body is the local PCT.
45. PCTs are statutorily responsible for the quality and accessibility of the services that they commission on behalf of their populations and for securing value for public money. Moreover, unlike many of the organisations that provide NHS services (eg NHS Foundation Trusts and GP practices), PCTs are public bodies accountable to the Secretary of State for Health. Where people have concerns or complaints about the

range of NHS services available locally, or any particular aspect of the care they receive, these may be directed to the local PCT. In particular, where a person's care involves contributions from several different providers the commissioning PCT is responsible for the overall package.

46. The role of commissioners is paramount in our vision for developing the NHS Performance Regime, and the contract that a PCT holds with a provider is the key line of accountability for service performance. We should be able to expect PCTs to intervene effectively when a provider underperforms, as illustrated by our stated ambition for WCC under Competency 10:

*'Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvement in quality and outcomes and value for money.'*³

47. But, we need to do more to support PCTs in identifying underperformance, intervening to support recovery and, in a small minority of cases, managing failure and/or provider exit. The WCC programme has set out the organisational development agenda for PCTs, of which the commissioner assurance process is a key driver. It will help identify development needs and target interventions aimed at improving organisational competency. In addition, the Department is working with the service to develop tools to support PCT commissioning, including national contracts, performance metrics and a new 'performance dashboard' of information on key indicators.

National standard contracts

48. The Department is committed to developing national standardised contracts across a range of health services, including mental health, ambulance and community services. The national standard contract for acute care establishes a standardised framework for holding providers accountable for service delivery, a consistent basis for identifying underperformance and a defined series of escalations, aimed initially at supporting recovery.

³ *Commissioning Assurance Handbook*, Department of Health, June 2008, Competency 10, p. 84

Monitoring service performance

49. A common approach to measuring service performance is an important tool for commissioners (ie PCTs) in identifying underperformance consistently and in providing a transparent basis for intervention under contracts. In turn, this information can be used to populate a performance framework for PCTs and inform the role of SHAs as their performance managers, accountable to the Department.
50. We are working with the service to develop a 'performance dashboard' as a tool for the Department, SHAs and PCTs to use in monitoring service performance. The 'dashboard' will utilise the national performance data supplied by providers under the terms of their contracts and therefore enable SHAs and PCTs to both aggregate performance data and 'drill down' below aggregate data to identify underperformance at provider level.
51. The national performance dashboard will incorporate indicators from the 'Vital Signs', introduced under the 2008/09 Operating Framework,⁴ which are intended to support local target setting and performance monitoring against both national and local priorities. The 'Vital Signs' incorporate relevant components of the National Indicator Set (NIS) for local authorities.⁵ The 'Vital Signs' include indicators of overall health and health inequalities (ie health outcomes); performance against operational standards and targets; and user experience.
52. The Operating Framework requires PCTs – as commissioners, in contracting with providers – to secure services that meet national standards of access, quality and value for money⁶ and

4 The Vital Signs indicators are structured around three 'tiers', according to how they will be used in performance management. A subset, Tier 1 indicators, is subject to performance management by the Department of Health and represents national requirements (ie 'must dos'). See *Operational Plans 2008/09–2010/11*, Department of Health, January 2008.

5 The NIS of 198 indicators includes those 'Vital Signs' indicators that PCT will expect to achieve by working with local government and its partners.

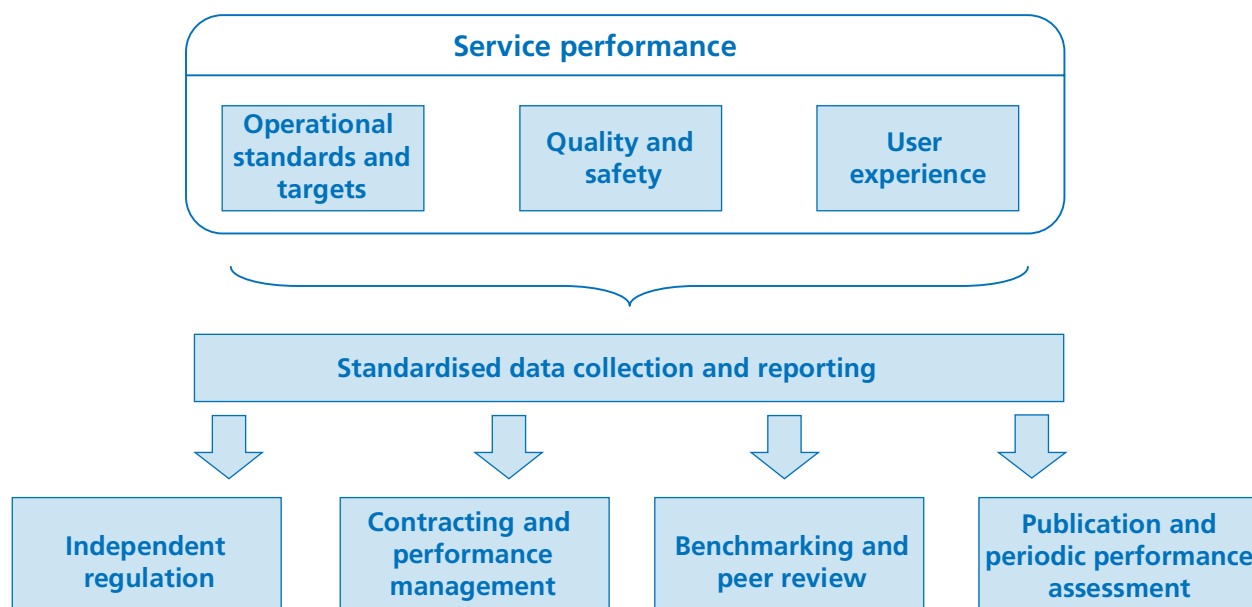
6 National standards include compliance with minimum standards of quality and safety such as *Standards for Better Health* – to be replaced in future by CQC 'Registration Requirements' (A consultation on the framework for the registration of health and adult social care providers, Department of Health, March 2008). In addition, providers are required to maintain performance against existing, operational standards such as, in primary care, guaranteeing access to an appointment with a GP within 48 hours (*Operational Plans 2008/09–2010/11*, Department of Health, January 2008, Annex B, pp. 22-3).

to deliver specific improvements against national and local priorities. These improvements will be specified in terms of measurable targets and will be underpinned by a combination of both nationally (eg 'Vital Signs') and locally determined indicators.

53. Enshrining standards and key indicators under contracts in this way will enable commissioners to monitor service performance in terms of:
 - operational standards and targets;
 - quality and safety; and
 - user experience.
54. This is consistent with WCC competencies at Level 2, for example:
 - the PCT benchmarks itself against national targets and other PCTs on local health needs status (Competency 5);
 - there is clear identification of quality and outcomes metrics to monitor (Competency 8); and
 - the PCT considers patient experience data for each provider (Competency 9).⁷
55. Moreover, the performance information supplied by providers under their contracts with commissioners is a key enabler of the system in driving performance improvement, as shown in Figure 5.

⁷ *Commissioning Assurance Handbook*, Department of Health, June 2008, Appendix IV.

Figure 4: Measuring service performance enables the system to drive improvements



56. Table 2 provides examples of how performance is measured in each of the three areas shown in Figure 4.

Table 2: Measuring service performance by its domains

	Example	Performance metrics and data collection
Operational standards and targets	Access standards: • primary care • elective care • A&E	National waiting times data collections and publications (including 'Vital Signs')
Quality and safety	CQC registration requirements Clinical outcomes	Declaration of compliance with core standards Targeted audit/assessment of compliance Clinical indicators (eg survival rates) Annual Health Check scores ⁸
User experience	Patient satisfaction Patient reported outcomes	Patient and public experience scores (including 'Vital Signs' and survey results) Feedback/complaints monitoring

Identifying underperformance

57. Regular monitoring and active contract management will enable providers and commissioners to identify early signs of underperformance and target where remedial action is required including the need to target action on behalf of population groups according to age, gender, disability or race. When a provider underperforms systematically or persistently then the commissioner will need to intervene under contract. For example, the national contract for acute services includes definitions of underperformance and corresponding sanctions in relation to national targets on reducing MRSA and achieving a maximum 18-week waiting time in elective care.⁹
58. This is a core requirement of WCC under Competency 10, whereby to achieve Level 2 a PCT must demonstrate:
- data is accessible and used to monitor provider performance; and
 - contracts indicate when intervention is required.

Intervening to support recovery

59. PCTs are responsible for monitoring service performance under contracts with providers and may need to intervene to address underperformance. Interventions should be proportionate to risk and will initially be aimed at supporting recovery. But where a provider underperforms seriously or persistently then the commissioner's intervention may be aimed at safeguarding patient safety and/or initiating action to procure services from elsewhere.
60. Contractual interventions to address underperformance include:
- **contractual notices** (eg 'Performance Notice') – requiring a response by the provider to address underperformance;
 - **contractual remedies** (eg. remedial action) – requiring the parties to agree, implement and monitor a remedial action plan to address persistent underperformance;

8 The Healthcare Commission publishes a periodic assessment of 'Quality of Care' for all NHS organisations as part of its *Annual Health Check* publication. From 2009 onwards, responsibility for the annual assessment will transfer to the new Care Quality Commission.

9 *Standard NHS Contract for Acute Services*, Department of Health, January 2008.

- **financial sanctions** (if applicable) – providing rights for the commissioner in consideration for breaches of contract by the provider; and
 - **suspension and termination provisions** – rights for the commissioner to suspend or terminate all or part of a contract in response to a material breach by the provider.
61. In the first instance, underperformance is likely to occur at service level, for example where a provider underperforms against operational standards on waiting times within a single specialty only. However, persistent or systematic underperformance is likely to be an indicator of problems at an organisational or system level. The determining of an appropriate intervention will need to take account of the level at which underperformance occurs. For example, it will not be necessary to terminate contracts for all services where failure to address underperformance occurs at service level.
 62. An effective remedial action plan is likely to include responsibilities for the commissioner or its agents, as well as for the provider. These responsibilities may be operational, for example where the commissioner takes action to ensure compliance with referral protocols as part of a plan to reduce elective waiting times.
 63. However, in more challenging cases, systematic or persistent underperformance may be the result of problems at a strategic level, for example where a service is not financially viable due to over-capacity, or where it fails to meet clinical standards because it does not treat sufficient volumes of patients (ie it is 'too small to be safe').
 64. In such cases, intervention by the commissioner may involve some form of additional non-tariff income (ie short to medium-term) and/or consultation on service change aimed at addressing unsustainable configurations. This illustrates how the local NHS functions as an integrated 'system' rather than a true 'market' – it is not necessarily as simple for the commissioner as terminating a contract with one provider and taking its business elsewhere. The role of the commissioner in supporting recovery may involve making strategic decisions about how best to secure value for money on behalf of the local population and balancing considerations of local access, quality and cost.

65. This 'system management' role for commissioners within the NHS Performance Regime is consistent with the ambitions of WCC, including that:
- the PCT has an understanding of:
 - provider economics (eg. scale, finances, performance)
 - provider market dynamics;¹⁰
 - the PCT implements specific changes to provider capacity driven by needs modelling, including long-term structural changes, and forecasts based on actual risk analysis;
 - the PCT has clear investment and disinvestment processes, which lead to a mix of providers based on clinically defined cost/quality trade-offs.¹¹
66. In more extreme cases, termination provisions are a potentially powerful lever and essential for ensuring that the commissioner is not forced to tolerate persistent failure by the provider to meet contractual requirements. In such circumstances, we would expect commissioners to be engaged in ongoing dialogue with the SHA and that decisions to initiate termination would not be taken unilaterally.
67. Ultimately, contract termination should be used as a last resort. In the vast majority of cases, commissioners and providers will be able to work together to resolve performance issues successfully.
68. However, where a provider occupies a dominant position in the local health economy (eg an NHS Foundation Trust providing acute hospital services), the commissioner may utilise a 'Notice of Termination' in order to establish a defined period within which the provider must demonstrate recovery.
69. The revenue consequences of termination, for the provider, are likely to be significant and cannot be taken lightly. For example, the national contract for acute services requires the commissioner to adhere to an agreed payment schedule and ensures a degree of revenue stability regardless of fluctuations in activity. Without this revenue security, the provider would be forced to invoice the commissioner for Non-Contract

10 *Commissioning Assurance Handbook*, Department of Health, June 2008, Competency 9, Level 2, p. 83.

11 *Commissioning Assurance Handbook*, Department of Health, June 2008, Competency 7, Level 4, p. 81.

Activity, with payment in arrears.¹² This would put significant pressure on working capital and could trigger regulatory intervention by Monitor, where the provider is an NHS Foundation Trust, or by the responsible SHA, for NHS Trusts.

Managing failure

70. Developing a more consistent and transparent approach to managing failure depends upon defining clear thresholds for intervention and taking action against providers that fail to address underperformance within a reasonable timeframe.
71. Where a provider fails to comply with the requirements of its registration with the CQC, and there is a risk to patient safety, then we can expect the regulator to take enforcement action, as described in Chapter 1. In such cases, it will be important for the commissioner and the regulator to work together to ensure minimal disruption to patients.
72. The role of PCTs, as commissioners, in managing failure involves taking action under contracts to suspend services where patient safety may be at risk and initiating action to procure services from elsewhere. Where a provider is unable to demonstrate recovery, the commissioner will need to consider disinvesting. This may invariably require the commissioner to give notice of contract termination for all or part of the services, as a necessary step towards procuring an alternative. However, the commissioner would need to have regard to its statutory obligations to consult on any significant service change and may therefore need to continue funding services – for example through the Non-Contract Activity mechanism – during a transitional period.

Primary care

73. The majority of primary medical and dental care services are provided by independent contractors (ie GP and dental practices). Primary care providers are thus held to account for performance through contracts with the PCT and are not subject to performance management by SHAs.
74. The PCT has a clear role in assessing whether practices are meeting their contractual obligations. Firstly, the PCT can

¹² Guidance on claiming payment for non-contract activity is set out in *Who Pays? Establishing the Responsible Commissioner*, Department of Health, September 2007.

draw on existing information sources to define expectations of performance and develop metrics to assess performance. These can come from the Quality and Outcomes Framework, clinical governance systems and patient feedback, in addition to wider indicators relevant to the local healthcare community.

75. Secondly, the PCT is responsible for actively commissioning primary care services in line with local needs and managing existing contracts to take action against failing practices. The WCC programme aims to develop PCT skills in managing contracts and to embed best practice in commissioning primary care services, building on existing examples.
76. Thirdly, all individual GPs and other primary care professionals are subject to professional regulation, and PCTs manage NHS performers lists, which confirm the individual suitability of GPs, dentists and optometrists to work in NHS services. In addition, the consultation on the regulation of health and social care published on 25 March has proposed that primary medical and dental care providers should in future be required to register with the CQC. The CQC would be able to enforce essential quality and safety requirements at an organisational level through a range of sanctions or (ultimately) withdrawal of registration – without which the GP or dental practice (or other provider organisation) would not be able to practise.
77. PCTs have a complementary role in raising quality above the minimum standards by actively using their commissioning levers, by promoting patient choice and by supporting professional accreditation schemes which can drive quality improvements through peer assessment and provide data to measure performance.
78. For community pharmaceutical services, the Pharmacy White Paper published in April 2008 sets out proposals for future commissioning arrangements through which contractors will in time come to be judged on safety, quality and outcomes achieved.
79. Further details of the development of the NHS Performance Regime for primary care will be published in the Primary and Community Care Strategy in June 2008.



Chapter 4: Strategic Health Authorities – the local headquarters of the NHS

Overview

80. SHAs are the local headquarters of the NHS and are directly accountable to the Department. SHAs are responsible for performance management of PCTs and NHS Trusts¹³ within their regions, including:
- PCT performance against the requirements of the Operating Framework;
 - financial performance of PCTs and NHS Trusts;
 - implementation of the Commissioner Assurance regime;
 - supporting NHS Trusts to achieve Foundation Trust status; and
 - recovery of 'challenged' PCTs and NHS Trusts.

¹³ NHS Foundation Trusts and independent sector providers are not subject to performance management by SHAs.

81. In addition, SHAs are responsible for system management across their regions, including:
- managing co-operation and competition in accordance with NHS governing principles, including the use of additional non-tariff income to encourage service development and market entry;
 - co-ordinating action by commissioners to disinvest from unsustainable service configurations (eg where existing configurations represent poor value for money or fail to meet clinical standards ('too small to be safe'));
 - ensuring continuity of services by co-ordinating funding for a provider during a period of transition (ie pending the closure of services, or their transfer or franchising from a 'failed' organisation to a third party);
 - ensuring that services which cross boundaries are part of their system management;
 - ensuring that SHAs share information about poor practice/incidents and good practice; and
 - liaising with CQC on areas of concern identified by the regulator and ensure that action is taken to rectify service failings.
82. The role of SHAs within the NHS Performance Regime spans both of these sets of responsibilities. But, where the Operating Framework focuses on the SHA role in ensuring delivery for the region as a whole, this document is concerned with the performance of individual organisations.
83. SHAs are accountable to the Department for ensuring delivery against SHA-level plans for improvement in the national priorities areas, as set out in the Operating Framework and accompanying planning guidance. In turn, SHAs are responsible for sign-off and performance management against PCT Operational Plans, which underpin the SHA-level plan.
84. However, successful delivery against the SHA-level plan can sometimes hide poor performance by a small minority of individual organisations in the region. And over time there is a risk that such organisations are allowed to 'drift along', while high-performing organisations in the region are delivering more than their 'fair share' of performance improvement at SHA-level.
85. For example, in the past PCTs that were successful in delivering against their priorities and live within their financial resource limits sometimes had to 'bail out' poorer performers

in financial deficit. Similarly, an SHA may achieve its aggregate target on reducing MRSA, but there may be significant variation in performance among NHS Trusts in the region. In both of these examples there is a risk that local patients may lose out, despite an acceptable level of performance being achieved for the SHA-region as a whole. This highlights the importance of the SHA's role in performance managing individual organisations (ie PCTs and NHS Trusts) as an end in itself, so that local communities and local patients are not let down.

86. But, as we said in the previous chapter, it will not always be entirely within the gift of an individual PCT or NHS Trust to address the root causes of underperformance. An organisation can be well run, but still unable to address underperformance because of structural problems – for example, where a PCT is too small to be able to invest in sufficient informatics and analytical capacity within the organisation itself; or where an NHS Trust cannot maintain a sustainable financial position because of over-capacity in the region. That is why the role of SHAs as system managers is particularly important within the NHS Performance Regime. Where organisations have had long-standing difficulties, the SHA contribution as system manager may be an essential factor in achieving recovery.

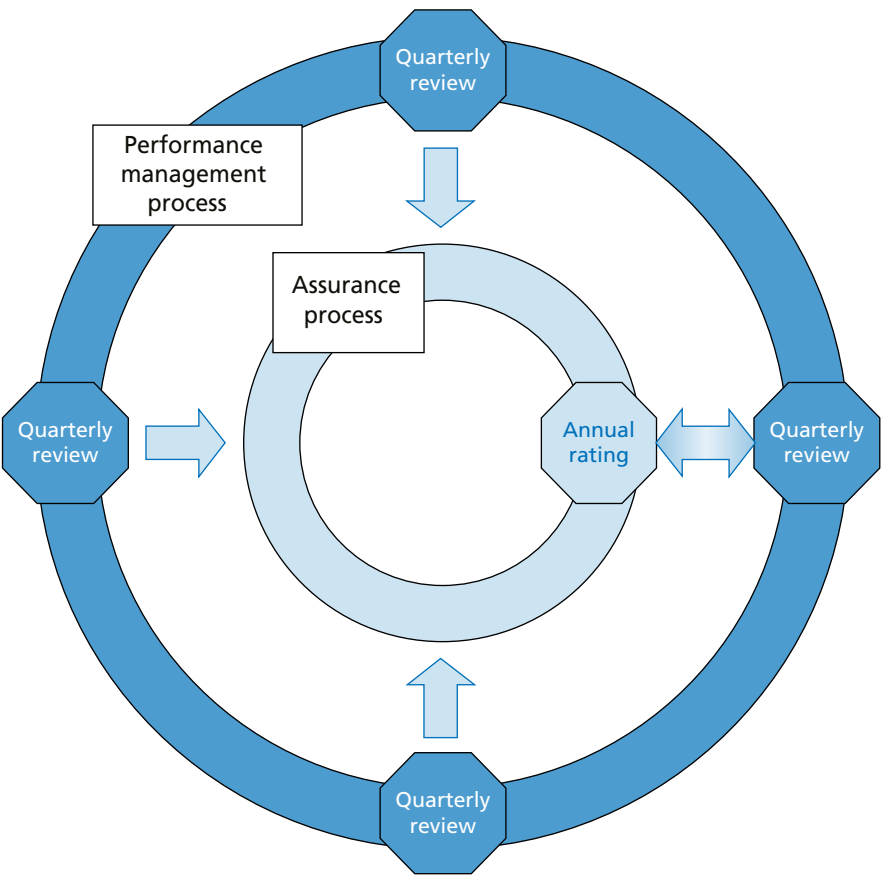
Supporting organisational development

87. A longer-term objective of SHAs as the local headquarters of the NHS is the development of world class organisations across their region, by supporting:
- PCTs to become world class commissioners; and
 - NHS Trusts to become Foundation Trusts.
88. Working with colleagues from within the service, the Department has developed tools to support this agenda: a commissioner assurance regime for PCTs; and an 'FT diagnostic' for NHS Trusts.
89. There is an important relationship between this organisational development agenda and the role of the NHS Performance Regime, and the tools used for each must be complementary.
90. For example, outputs from the commissioner assurance process will help identify development needs for PCTs against the WCC competencies and will be available locally from March 2009. The competencies encompass key

commissioning skills and organisational capabilities such as health-needs assessment, patient and public engagement, information systems, analytical capability, procurement and contract management. In turn, performance management information will inform the commissioner assurance process by helping to identify where questions need to be asked about the underlying causes of underperformance.

91. In this way, commissioner assurance and performance management form part of an ongoing cycle and should work together to support both short-term and medium-term objectives of delivering specific targets on improving services for patients and the longer-term aim of developing world class commissioners for the future.

Figure 5: Commissioner assurance and performance management form part of an ongoing cycle



92. There is a similar relationship between the SHA role in leading the Foundation Trust programme within their regions and their performance management of NHS Trusts. The Foundation Trust programme aims to support all NHS Trusts to become

Foundation Trusts, operationally independent and accountable to Monitor for complying with their terms of authorisation.

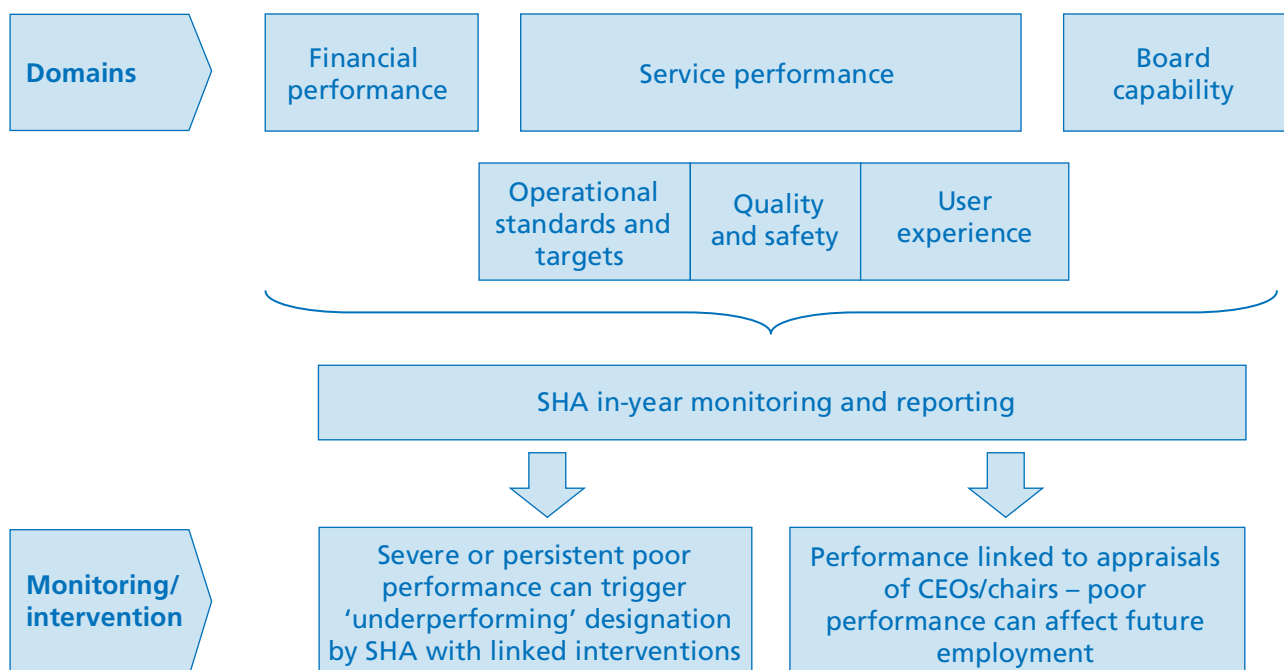
93. The 'FT diagnostic' exercise ran in 2005/06 and has helped to achieve authorisation of 99 Foundation Trusts as of 1 June 2008. In a similar role to the commissioner assurance process, the outputs from the 'FT diagnostic' identified development needs for NHS Trusts against the requirements of authorisation as Foundation Trusts. However, unlike commissioner assurance, national roll-out of the 'FT diagnostic' was a one-off exercise and it is for SHAs locally to determine when and how the outputs need to be refreshed for NHS Trusts that they are still unable to recommend for the Secretary of State's approval to apply for Foundation Trust status.
94. But again, there will be a relationship between performance management and organisational development. For example, where an NHS Trust fails to address persistent underperformance over time this may indicate the need for an external review of board capability and governance using a similar approach to how Monitor assesses this for NHS Foundation Trusts and was adapted for use as part of the 'FT diagnostic' exercise.

Identifying underperformance

95. Greater transparency and consistency is our overarching objective in developing the NHS Performance Regime. In the previous chapter we described the role of national contracts, performance indicators and tools such as the 'performance dashboard' in supporting PCTs, as commissioners, to take a more consistent approach in tackling underperformance through contracts. For SHAs, as performance managers, we propose to work with colleagues in the service to develop a performance framework for PCTs and NHS Trusts as a nationally consistent basis for identifying underperformance and triggering intervention.
96. In determining our approach, we propose to draw upon Monitor's compliance framework for NHS Foundation Trusts, which may be characterised by:
 - use of metrics and criteria as a consistent basis for identifying financial and governance risk or underperformance in service delivery;

- risk-based judgements by performance managers; and
 - escalation in proportion to risk: through staged interventions and increasing loss of autonomy for boards.
97. This proposal would utilise a balanced approach to measuring performance, at organisational level, across three domains:
- financial performance;
 - service performance; and
 - board capability.
98. The approach would need to be consistent across PCTs and NHS Trusts – as well as for PCTs as commissioners and as providers – although some of the detail would need to vary in order to reflect the different roles of commissioners and providers. For example, the performance framework for PCTs would need to encompass their role as providers of community services.¹⁴ In addition, we would expect the detail of the service performance domain to vary according to the range of services that the organisation commissions or provides.

Figure 6: Developing a performance framework for PCTs and NHS Trusts



¹⁴ Further details on plans for developing community metrics are set out in the Annex.

99. In developing a performance framework for PCTs and NHS Trusts we need to ensure coherence with the way PCTs are assessed through the commissioner assurance process and, for NHS Trusts, how Monitor's compliance framework assesses the risk of Foundation Trusts breaching their authorisation. For example, the three domains we are proposing for the performance framework would correspond to the governance domain of the commissioner assurance regime and the finance and governance domains of Monitor's compliance framework.¹⁵
100. Moreover, we must have a coherent approach to performance assessment across the system. For example, we cannot have the same organisation being identified as 'weak' by the CQC and not identified as 'underperforming' by SHAs as performance managers. We therefore need to ensure that the performance indicators, thresholds and relative weightings used by SHAs to identify underperformance are consistent with:
- compliance with minimum standards of quality and safety (note that, subject to legislation, these will be enshrined as national 'registration requirements' and used to underpin regulation by the CQC);
 - the requirements of the Operating Framework and the approach to performance management described in the accompanying planning guidance;
 - the responsibilities of PCTs in securing delivery of their contribution to LAAs, in particular their duty to co-operate to deliver locally agreed targets;
 - the Audit Commission's 'Use of Resources' assessment of PCTs that will be introduced from 1 April 2009 as part of the Comprehensive Area Assessments (CAAs); and
 - the CQC's approach to assessing the performance of NHS organisations includes their assessment of quality and of financial performance. Our expectation is that the CQC will continue to work closely with the Audit Commission on the latter.

15 Under both the PCT commissioner assurance regime and Monitor's compliance framework for Foundation Trusts, 'service performance' impacts upon the governance domain (ie poor service performance is an indicator of potential weaknesses in the board's capability and/or the competency of internal management systems).

101. An illustration of how we may be able to achieve these requirements of coherence in developing a performance framework for PCTs and NHS Trusts is described in the table below.

Table 3: Ensuring coherence in performance assessment across the system

Domain		Possible approach to performance assessment
Finance		Financial metrics For NHS Trusts the metrics would be based on Monitor's financial risk assessment used for Foundation Trusts, adjusted to reflect their statutory duties and the requirements of the Operating Framework. For PCTs, the starting point would also be a Monitor style of risk assessment, with further metrics developed to recognise the commissioning role of the PCTs, statutory duties and the requirements of the Operating Framework.
Service Performance	Operational Standards & Targets	'Vital Signs', including Tier 1 indicators (ie. national requirements) and existing operational standards
	Quality & Safety	Compliance with minimum requirements of quality and safety or 'registration requirements' (ie. a development of the 'core standards' that underpin the current role of the Healthcare Commission) Performance against clinical indicators (TBD)
	User Experience	'Vital Signs' indicators, based on survey results
Board Capability		For PCTs, outputs from the annual commissioner assurance process. For NHS Trusts, outputs from the FT diagnostic, refreshed on a risk basis, according to evidence of underperformance in other domains.

102. We know from our conversations with SHA colleagues that some individual SHAs have developed their own 'balanced scorecard' approaches to performance and financial management of PCTs and NHS Trusts in their regions. Indeed, these innovations are a key inspiration behind our vision for developing the NHS Performance Regime. We therefore propose to work with SHA Directors of Performance, Directors of Finance and representatives from organisations within their regions in developing a national model – building upon existing examples of good practice – and aim to afford greater consistency and transparency of approach to identifying underperformance across the 10 SHA regions.

Intervening to support recovery

103. The previous chapter focused on the role of the commissioner in intervening to support recovery. However, the system also needs mechanisms for providing assurance that commissioners are doing everything they can to hold providers accountable and are intervening to address underperformance and support recovery. This is a key component of the role of SHAs as performance managers of PCTs in their regions.
104. In addition, during this transitional stage in the development of the system, SHAs continue to have an important role in intervening to address serious underperformance by NHS Trusts.
105. Responsibility for addressing underperformance would continue to rest with the Board of the organisation and, ultimately, intervention on behalf of the NHS Chief Executive would be at Board-level. In accordance with the overarching principles we have set for developing the NHS Performance Regime, the system would expect SHAs to intervene in proportion to risk aiming initially at supporting recovery.
106. The table below describes three stages of escalation and intervention:
- 'Underperforming';
 - 'Seriously Underperforming'; and
 - 'Challenged'.

The timescales associated with the first two stages are included for illustration only and will be tested with stakeholders prior to implementation under the 2009/10 Operating Framework.

Table 4: Defined stages of escalation and intervention

	Intervention		Escalation
	PCT	NHS Trust	
Underperforming (thresholds for intervention triggered under the Performance Framework)	SHA-led PCT given a defined period (eg 3 months) to improve	Commissioner-led Provider given a defined period (eg 3 months) to improve	Persistent underperformance within a defined (eg 3-month) period may result in escalation
Seriously underperforming	Performance management against remedial action plan SHA reports to NHS Chief Executive after 6 months		Insufficient evidence of progress against remedial action plan within a defined (eg 6-month) period or significant risk to patient safety may result in escalation
Challenged	NHS Chief Executive publicly designates PCT or NHS Trust as 'Challenged' and subject to intervention at Board-level SHA commissions an external review of governance and board capability Acting on behalf of the NHS Chief Executive, the SHA may: • impose temporary appointments; and • initiate action to suspend or remove members of the Board. 'Turnaround' plan is agreed with SHA		SHA reports to NHS Chief Executive after 12 months and makes recommendations based on evidence of recovery: • removal of 'challenged' status; • Review after further agreed period; or, • 'Under Directions'

107. SHAs would utilise the performance framework to identify underperformance by PCTs and NHS Trusts, as described in the previous section. For NHS Trusts, intervention would be commissioner-led to ensure consistency of approach across different types of provider as described in the previous chapter. However, at this initial stage, intervention would be limited to giving notice to the board that it must take action to address underperformance and demonstrate recovery within a defined period (eg three months).

108. In most cases, escalation and further intervention would only result where the organisation fails to address underperformance within the defined period. However, where there is clear evidence of 'serious underperformance', intervention may be appropriate from the outset. Therefore,

the performance framework would need to define a criteria-based threshold for intervention, based on evidence of either:

- serious underperformance against **individual** 'key' indicators or domains; or
- systematic underperformance against a **range** of indicators or domains.

109. For example, where an organisation is not complying with minimum standards of infection control – a likely condition of its registration with the CQC – the performance framework would need to identify the provider as 'seriously underperforming'.
110. Where a PCT or NHS Trust is 'seriously underperforming' it may be subject to intervention at service level by the CQC; (eg where a service is suspended or terminated due to a risk to patient safety). In addition, the organisation would be required to implement a remedial action plan, which would be subject to performance management by the SHA. After six months the SHA would submit a report to the NHS Chief Executive providing evidence as to whether the organisation had demonstrated recovery. The SHA's report would include its recommendation on designating the PCT or NHS Trust as 'challenged' and therefore subject to intervention at Board level.

Designating PCTs or NHS Trusts as 'challenged'

111. The concept of a 'challenged' organisation was introduced in Chapter 1 where we described the stages of escalation for a PCT, as commissioner, intervening under contract to address underperformance.
112. However, there comes a point at which commissioner-led intervention may be insufficient and effective escalation requires an additional response from the wider system. For example, where in future the CQC may impose conditions on a provider's registration or take action to suspend or close individual services.
113. Moreover, where the commissioner itself underperforms persistently then the SHA has a responsibility to intervene on behalf of local patients and the wider community.
114. Furthermore, for state-owned organisations (ie PCTs, NHS Trusts and Foundation Trusts) there is a clear public interest in intervening to support recovery and/or maximising value

for money from public assets. In such circumstances, the system needs to do more than simply take action to procure services from elsewhere. For example, where an NHS Trust or Foundation Trust is failing financially then the system needs to respond by taking action to address weaknesses in leadership and governance, as well as putting in place a robust financial recovery plan.

115. For NHS Foundation Trusts, Monitor maintains a risk rating for each organisation under its compliance framework and has powers to intervene in proportion to risk. Where an NHS Foundation Trust is rated as a 'red' risk of significantly breaching the terms of its authorisation, Monitor will intervene at Board level, aiming to support recovery. Monitor routinely publishes details of its risk ratings and any interventions undertaken through its compliance framework to ensure transparency. Further details of the role of Monitor as the independent regulator of NHS Foundation Trusts and how it will work together with the CQC are set out in Chapter 6.
116. Drawing upon the example of Monitor and NHS Foundation Trusts, we propose that the NHS Chief Executive will be able to publicly designate PCTs and NHS Trusts as 'challenged' and subject to intervention at Board level. The NHS Chief Executive would exercise discretion as to whether and how the SHA would lead such intervention on his behalf.¹⁶
117. Intervention in 'challenged' PCTs or NHS Trusts would be aimed at supporting recovery through successful 'turnaround'. For recovery to be sustainable, turnaround must include action to address weaknesses in leadership and governance. In addition, it may involve action to address structural issues – such as excess capacity or sub-optimal configurations – where these are the root cause of financial problems or poor clinical outcomes.
118. In all cases, 'challenged' PCTs or NHS Trusts would be subjected to an external review of governance and board capability. The purpose of this external review would be to:
 - identify capability and competency gaps at board level;
 - identify weaknesses in governance (eg. gaps in accountability);

¹⁶ To avoid doubt, SHAs would not have the power to intervene in NHS Foundation Trusts.

- identify weaknesses in management information systems;
 - identify weaknesses in financial management systems;
 - and
 - make recommendations on remedial action.
119. The outputs from this external review would then inform the SHA's recommendations to the Department on potential changes at Board level, including:
- appointment of advisors (eg NHS IMAS);
 - suspensions; and
 - removals.
120. In addition, the SHA would sign off a turnaround plan for the 'challenged' organisation, which would then be subject to additional performance management. At his discretion, the NHS Chief Executive may also require that the turnaround plan be signed-off by the Department. The SHA could provide support to the 'challenged' organisation as part of the turnaround plan, including:
- support business cases for cash advances or loans;
 - co-ordinating action by commissioners to address financial sustainability issues;
 - support with business cases for major service or organisational change.
121. After a maximum of 12 months, the SHA would submit a report to the NHS Chief Executive and make recommendations – based on evidence of recovery – for approval to:
- remove the 'challenged' designation;
 - review after a further agreed period; or
 - place an organisation 'Under Directions'.

'Under Directions'

122. Where a 'challenged' PCT or NHS Trust fails to demonstrate recovery the NHS Chief Executive may place the organisation 'Under Directions'.¹⁷ We are exploring options to grant similar powers to Monitor in relation to NHS Foundation Trusts to the extent this may not be already provided for in existing legislation.
123. Placing an organisation 'Under Directions' will involve action to take control of the Board (ie suspensions/removals/appointments), possibly through an Intervention Order under

¹⁷ The NHS Chief Executive would be acting under delegated authority from the Secretary of State.

the National Health Service Act 2006. Such intervention is also likely to include removing the incumbent Chief Executive's Accountable Officer status and designating a new member of the Board as Accountable Officer, either on an interim or permanent basis.¹⁸ The purpose of this intervention is to ensure service continuity for a transitional period pending further management and/or organisational change and make recommendations on a sustainable solution going forward.

124. The role of the SHA during a period where an organisation is 'Under Directions' will be different in relation to commissioners and providers respectively and may include:
- working with the NHS Appointments Commission on implementing changes at board level;
 - coordinating action by commissioners to provide transitional funding in order to ensure essential service continuity;
 - coordinating action by commissioners to consult on planned service change;
 - developing a business case for merging the organisation with another PCT or NHS Trust; and
 - working with the board and local commissioners to manage transactions for either closure of services, disposal of assets, management franchising, or acquisition by an NHS Foundation Trust.

Managing commissioner failure

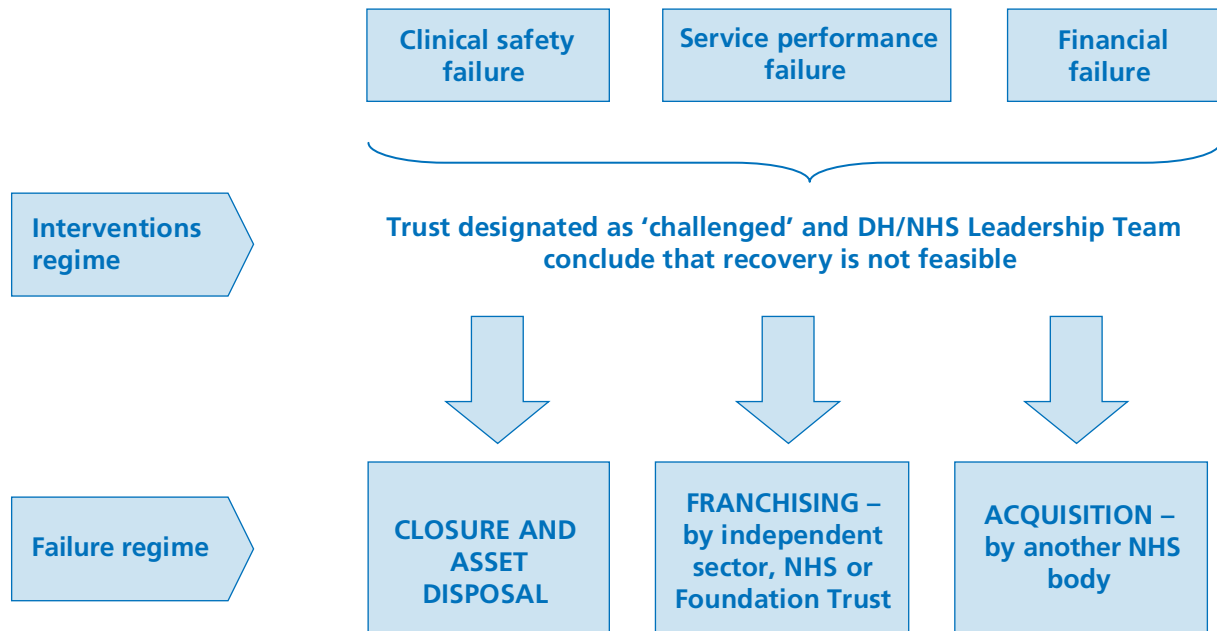
125. The process for managing failure by commissioners will necessarily be different from that for providers. Unlike provider organisations, PCTs as commissioners do not hold substantial capital assets. In addition, PCTs have a standing responsibility to commission services on behalf of their local population.
126. Given these considerations we envisage that the options available to the SHA, acting on behalf of the NHS Chief Executive, in the event of PCT failure will include:
- replacement of the PCT board;
 - outsourcing of some or all of the PCT's functions; and
 - takeover of the organisation by another PCT.

¹⁸ Removal of the Chief Executive from the Board, or removal of Accountable Officer status, would not terminate his/her employment, which would be a matter for the new Board to resolve.

Managing provider failure

127. Managing failure by providers is potentially more complex than managing failure by commissioners, due to the larger numbers of staff and substantial capital assets involved, particularly in the case of NHS Trusts and Foundation Trusts where staff are employed under NHS contracts and the capital assets are public assets. Furthermore, the underlying causes of a provider's failure to demonstrate recovery may be more fundamental than a failure of leadership, governance or internal management. For example, a provider may be operating service configurations that are not sustainable in their current form, in either financial or clinical terms.
128. We therefore need to establish a failure regime for state-owned providers that reflects the Government's obligations to ensure service continuity and protect public assets. This stands in contrast to the private sector, where maximising the value to creditors is of primary concern. The provider failure regime will be rules-based and transparent. It will reflect the obligation to provide service continuity and protect publicly owned assets. As such, it will reflect the following objectives and principles:
- the local NHS would maintain provision of services during a period of 'transition';
 - the Secretary of State would secure control of public assets, to be made available for reprovision of services or dissolution;
 - local commissioners would define the services to be re-provided following a provider's exit; and
 - assets, liabilities and staff may be transferred as part of a transaction for the reprovision of services or dissolution.
129. Following the period during which the organisation is 'Under Directions' the new Board would consider and make recommendations for re-provision or dissolution of services. These include:
- Closure/asset disposal;
 - Franchising of individual services and/or management (ie. outsourcing); or
 - Acquisition by another NHS organisation.

Figure 7: Developing a failure regime for state-owned providers



130. We will learn from previous government experience in the financial restructuring of failed organisations and the effectiveness of administration regimes in public-sector utilities such as rail and energy.
131. Where public assets are to be retained in public ownership and made available for the reprovision of services, opportunities for involving the private sector will be limited to the first two options. For example, independent-sector organisations could bid for a franchise to run NHS services (where assets and staff would remain the responsibility of the NHS).
132. The Department will work with stakeholders, including Monitor and the CQC, to develop the regime. We will publish proposals later this year, and if necessary we will pursue primary legislation.

Strategic Health Authority assurance

133. The NHS Performance Regime will remain incomplete without an assurance system for SHAs. Developing an SHA assurance system will involve further defining the role and responsibilities of SHAs and subjecting each SHA to a capability review aimed at identifying development needs. The SHA assurance system will need to include an element of performance assessment

and afford greater consistency and transparency as to how the Department holds SHAs to account as the local headquarters of the NHS.

134. The SHA assurance system will inform performance appraisal of SHA chairs and chief executives and will encompass all the key dimensions of the SHA role, including:
 - performance management;
 - commissioner assurance;
 - system management; and
 - commissioning of training and education.
135. Specifically, SHA assurance will need to include assessment of the SHA's performance in supporting recovery and managing failure, as described earlier in this document.
136. We propose to develop the SHA assurance system, working jointly with colleagues in the service, for implementation under the 2009/10 Operating Framework.



Chapter 5: Holding people to account

137. Strong leadership and good human resources (HR) practice in the NHS are necessary not just to enable and maintain high standards of care but also to transform services to achieve even higher levels of excellence. They are also crucial to obtaining and retaining a high-performing workforce. NHS workforce requirements need to be considered strategically in order to help deliver national priorities as set out in local delivery or business plans.
138. Boards and senior leaders within NHS organisations play a key role in ensuring organisations perform. Outlined below are some of the key principles related to the main stages of the employment of senior managers and terms in office of Chairs and non-executive directors assuring the public, patients and staff of the quality of Board members' performance.

Figure 8: NHS board executive and non-executive human resources framework: key stages

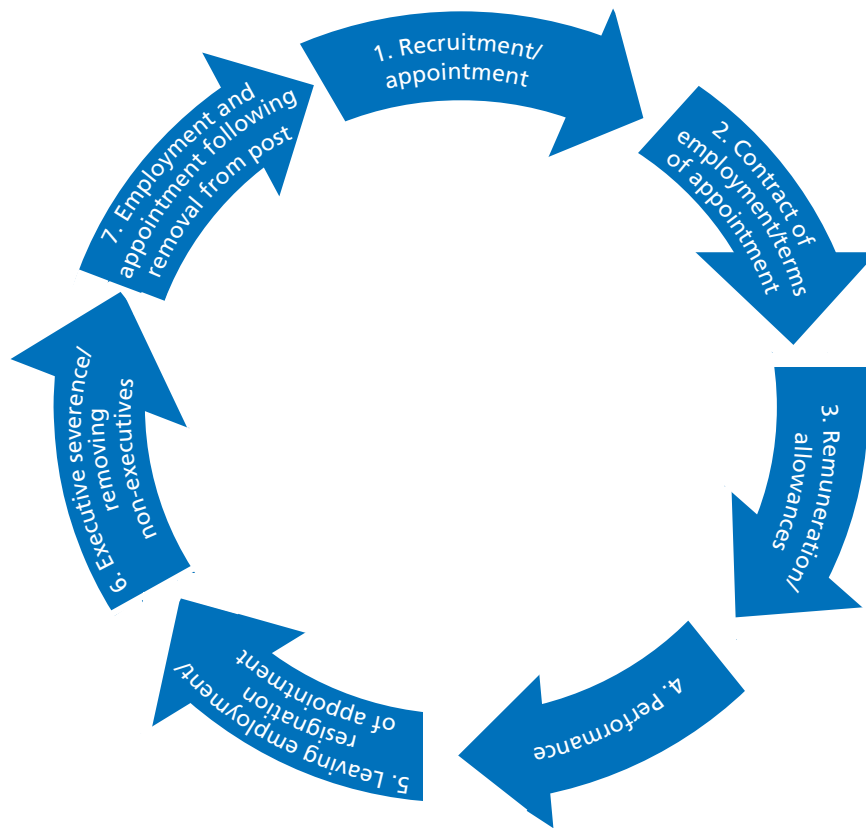


Table 5: Some key principles in support of board members' performance

Recruitment/ appointment	• To follow robust selection and recruitment processes to ensure that the best people from a diverse range of backgrounds are appointed as board members • To ensure appropriate checks are done, including references being taken, to make sure that the appointed candidate warrants public confidence and represents value for taxpayers' money
Contract of employment/ terms of appointment	• To pay particular attention to elements of the contract which relate to accountability of the individual and which help to ensure that the individual will maintain public confidence, such as codes of conduct, and clarity about conflicts of interest or probity issues • To consider any specific contractual clauses which may be relevant to the post and/or senior grade of the individual being employed, such as termination payments or length of notice period
Remuneration/ allowances	• Executive pay and allowances should represent value for money and bear in mind the prospects of success as well as failure of individuals, helping to guarantee public confidence in the organisation and the NHS
Performance support/ management	• To enable board members to perform to a high standard and ensure they are supported in doing so • To recognise good performance and deal with poor performance swiftly and effectively
Leaving employment/ end of appointment	• To ensure appropriate processes are followed if an individual is leaving on grounds of capability or conduct • To have systems in place for succession planning
Executive contract severance/ removing non- executives from office	• To consider key factors such as risk to patients or staff, business continuity, public confidence and value for money • To ensure that severance payments for executives should be an exception. They should not be treated as a soft option, eg to avoid management action, disciplinary processes, unwelcome publicity or reputational damage • Executives and non-executives can be suspended or dismissed/removed from office if deemed necessary, for instance when they fail to meet the requirements of public office • Cases should be handled sensitively to maintain public confidence in the organisation and the NHS

Employment and appointment following removal from post or office	• An effective and full appraisal of the circumstances of re-employment/reappointment is required by local management, for executives, and by the Appointments Commission, for chairs and non-executive directors. Both the legal and contractual angle as well as the public/patient safety and public confidence perspective need to be considered
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139. The Department is taking a number of important steps (as shown in Table 6) to strengthen the way that the healthcare system not only supports leaders but also holds the people who work in it to account throughout their employment life when they fail to meet the requirements of public office.

These developments are important in order to:

- command a high degree of confidence on the part of our patients, our staff and the public, particularly in relation to the use of public resources;
- ensure that organisations are well-led and well-managed; and
- make individuals accountable for their actions.

Table 6: Strengthening the way people are held to account: current and forthcoming initiatives

NHS Board HR Framework	Document highlighting core HR principles and providing references to high-level existing HR guidance and legislation impacting on board members' management
NHS Interim Management and Support service	To support NHS organisations when they need additional capacity or expertise at a senior level. It aims to provide an internal turnaround and development service for all parts of the NHS. The NHS will be able to draw down individuals or whole teams with expertise across a whole range of disciplines, including financial, clinical and general management
New powers to suspend chairs and non-executive directors of NHS Trusts, PCTs, SHAs, special health authorities and other national organisations	From mid-June 2008, non-executive directors of PCTs and NHS Trusts can be suspended by the Appointments Commission, on behalf of the Secretary of State, when they fail to meet the requirements of public office. Non-executive directors of SHAs, special health authorities and other national organisations (eg arms-length bodies) cannot currently be suspended, but work is under way to create primary powers to allow this to happen
Notice periods for senior managers	The NHS Bodies Employment Contract Directions 2008 require NHS bodies to ensure that the period of notice which a senior manager is entitled to receive when his/her contract of employment is terminated is not more than six months, limiting the size of potential payouts in severance cases
Revised guidance on executive severance	Revised guidance that would require boards and their professional advisors to consider wider impact on the reputation of the NHS, with the aim of avoiding decisions being made solely on the basis of economic criteria and the impact upon one organisation
Pre-appointment hearings	As part of increasing democratic scrutiny of key public appointments, Parliamentary Select Committees will be given the opportunity to hold pre-appointment hearings with candidates recommended for appointment. This new process was recently used for the appointment of the new CQC chair



Chapter 6: Independent regulation

140. Regulation shapes and governs the structure, conduct and performance of healthcare providers to safeguard patients and the public through the delivery of high-quality care.
141. There are broadly speaking two forms of regulation: regulation of organisations providing health and social care, and regulation of individual professionals working in these organisations or providing care as self-employed practitioners. These forms of regulation are complementary, and between them give assurance that care will be safe and of acceptable quality. Additionally, the CQC will be able to carry out reviews of services commissioned and provided, thereby following the pathway of care across health and social care organisations.
142. Subject to the passage of legislation, the safety and quality of health and adult social care provided by all types of provider in England will be regulated by the CQC. Monitor remains the independent regulator for NHS Foundation Trusts. The two organisations will work closely together. Individual health professionals are regulated by professional bodies such as the General Medical Council and the Nursing and Midwifery Council.

143. The organisational regulators take an active role in ensuring that healthcare providers meet their respective regimes. The CQC will have enforcement powers to protect patient safety (eg to suspend or close a service) whereas Monitor has intervention powers (eg to specify what action an NHS Foundation Trust should take to rectify a problem or to remove board members).
144. The regulators of health professionals fulfil their role principally by setting standards; ensuring the quality of initial and postgraduate professional education; overseeing the quality of systems of professional appraisal; and investigating specific concerns brought to their attention. In carrying out this role, they rely to a large extent on the quality of the internal clinical governance systems within healthcare organisations to ensure that any concerns over individual healthcare professionals are speedily identified and, where necessary, referred to them for action.

Governing conduct to deliver high-quality care

145. To deliver the key principles of consistency, proportionality and fairness, regulators will adopt an approach to organisations that is based on their level of performance. Broadly, as set out in previous chapters, an organisation may be considered to be performing, underperforming, systematically and persistently underperforming or failing. This chapter describes the role of regulation for organisations that are underperforming or worse.
146. The regulators will be responsible for identifying the thresholds that will trigger regulatory intervention. These will be applied according to the key principles of consistency and transparency. That said, transition of an NHS provider from one performance level to another will not be mechanistic; context is important.
147. Information on which decisions on regulatory intervention would be taken will be drawn from a variety of sources, including measures of existing standards and targets, financial measures, registration requirements, 'Vital Signs', patient reported outcomes (PROMs) and clinical indicators (when these are developed).

Taking action to deliver high-quality care

148. As stated above, the regulators will apply their own compliance and enforcement regimes to safeguard requirements, including reporting, inspection and compliance monitoring. Where requirements are not met, the regulators can take action, and can apply sanctions to organisations.
149. Subject to the passage of legislation, the CQC will monitor compliance with the registration requirements for healthcare providers, including NHS Foundation Trusts. It will have a broad range of powers and will be able to take the most appropriate action in response to failures.

Regulation and the role of the Care Quality Commission

150. The main responsibilities of the CQC are to:
- register health and social care providers;
 - carry out a periodic assessment of all NHS providers and commissioners;
 - carry out special reviews of services, along patient pathways or into other areas of concern or risk in terms of patient safety;
 - carry out investigations into specific organisations where CQC believes that user safety is seriously at risk; and
 - gatekeeping and proportionate regulation.
151. However, the principal role of the CQC will be to register health and adult social care providers. Providers will need to demonstrate that they can meet the essential levels of safety and quality required for registration and will need to continue to meet them to maintain their registration.
152. The Department is currently consulting on the scope of registration, and the content of the registration requirements. As part of this, the Department is consulting on the proposal that the CQC's role be expanded in the future to include primary care services.
153. The registration system will be a key function of the CQC. In operating this, the regulator will **register, monitor compliance** and **take action** in relation to healthcare providers' adherence to the registration scheme. The CQC's This is described in more detail in Table 7. But, it must be emphasised that it will be for CQC itself to develop the detail of its approach.

154. The CQC will also drive quality improvement by publishing comparative information on the performance of both providers and commissioners.

Table 7: Key roles of the Care Quality Commission

The CQC registration process will:

- be coherent across providers from both independent and public sectors (including NHS Trusts and Foundation Trusts);
- require providers to manage key risks to the safety and quality of the care they provide;
- seek to address the concerns of people using health and adult social care services, and cover the topics on which they want assurance;
- provide clarity about what is required to deliver essential levels of safety and quality and so to achieve compliance, without being prescriptive about how compliance is achieved; and
- allow the CQC to take a light-touch, risk-based approach to judging compliance, and if necessary, take a range of enforcement actions against non-compliance.

The CQC will take action by:

- increasing the frequency of monitoring or inspection;
- issuing formal warning notices;
- issuing simple cautions;
- issuing penalty notices in lieu of prosecution;
- imposing conditions that place additional restrictions on registration;
- suspending registration for a fixed period; and
- in the most extreme cases, initiating prosecution or cancelling registration.

The CQC, will also:

- encourage quality improvement by publishing comparative information on the performance of both providers and commissioners.

155. The CQC will operate a single enforcement regime designed to:

- be consistent across providers from independent and public sectors (including NHS Trusts and Foundation Trusts);
- be fair to all types of provider;
- enable the CQC to respond promptly where it has concerns;
- support providers to correct problems themselves;
- enable the CQC to choose the most appropriate action in individual circumstances; and
- ultimately, allow the CQC to close services that put patients at substantial risk.

156. When taking enforcement action, the CQC will work with different partners, depending on the provider's status – eg with Monitor for NHS Foundation Trusts and with SHAs for NHS Trusts and PCT-provided services. The CQC will keep relevant bodies, such as PCTs, SHAs and Monitor, notified of the action it is taking. In addition, the CQC will publish its successful enforcement action.
157. For example, when the CQC responds to a safety or quality failing with a warning notice, the provider will be responsible for delivering the necessary improvements. Monitor or the SHA will work with the NHS provider to ensure compliance, and their powers of intervention will be available if required.

Monitor's compliance framework for NHS Foundation Trusts

158. The principal role of Monitor is to 'authorise' NHS Foundation Trusts and then regulate delivery on the terms upon which they are authorised ('Terms of Authorisation'). If satisfied that certain criteria are met, Monitor will authorise an applicant NHS Trust, allowing them to operate as an NHS Foundation Trust, monitor compliance with their Terms of Authorisation and take such action as is required to ensure that Boards of NHS Foundation Trusts take action to remedy any breach of these terms.
159. The main responsibilities of Monitor are to:
- assessment of FTs: to assess applications for FT status and issue authorisations (including approval of mergers between FTs);
 - ensuring that FTs deliver in accordance with the terms of their Authorisation (compliance);
 - intervening as appropriate in order to ensure that significant breaches in the terms of Authorisation are rectified (section 52 of 2006 Act) or to act on third party (eg: Healthcare Commission) findings;
 - if necessary, requiring an FT to obtain a moratorium or make a proposal for a voluntary arrangement (section 53 of 2006 Act);
 - establishing and updating the reporting and regulatory framework within which NHS Foundation Trusts operate, and then reporting consolidated accounts and performance data; and
 - providing support on NHS Foundation Trusts development (eg: Governance Code, service line management) and

contributing to the development of DH guidance (eg: Operating Framework, standard contracts, PbR etc).

160. This information describes the *Compliance Framework*¹⁹ and outlines a risk-based approach to regulating NHS Foundation Trusts. A key principle guiding Monitor as regulator of NHS Foundation Trusts is proportionality. Monitor takes a 'risk-based approach to regulation, intervening only when necessary. The intensity of its monitoring of an NHS Foundation Trust is guided by the risk of a significant breach of their Authorisation.' This approach means that, for successful and well-governed NHS Foundation Trusts, the regulatory regime will require 'very limited specially-generated information and only infrequent contact with Monitor'. However, where NHS Foundation Trusts are experiencing major financial or service problems, oversight will be more intensive and Monitor will 'intervene rapidly to ensure services to patients are safeguarded'. Monitor has extensive powers in law to intervene when an NHS Foundation Trust is failing to comply with its authorisation.
161. There are three main components to the *Compliance Framework*: annual risk assessment, in-year monitoring and intervention. For both annual risk assessment and in-year monitoring, Monitor will assign a risk rating in three areas – finance, governance and mandatory goods and services ('mandatory services'). Monitor will use these risk ratings to guide the intensity of its monitoring and signal to the NHS Foundation Trust its degree of concern with the specific issues identified and evaluated. The risk ratings and implications are described in Table 8.

¹⁹ *Compliance Framework*, Monitor, 2008

Table 8: Risk ratings for NHS Foundation Trusts from Monitor's *Compliance Framework*

Financial risk rating	Description	Implications
Rating 5	Achieving weighted average of 5 across assessed components and no overriding rules applied	• Quarterly/six-monthly monitoring • Maximum debt: capital ratio (MDCR) is 40%
Rating 4	Achieving weighted average of 4 across assessed components and no overriding rules applied	• Quarterly monitoring • MDCR is 25%
Rating 3	Regulatory concerns in one or more components. Significant breach is unlikely	• Quarterly monitoring; however, monthly monitoring in case of deteriorating trend or recovering from a 2 rating • Supplementary information if required • MDCR is 15%
Rating 2	Risk of significant breach in the medium term, eg 12 to 18 months in the absence of remedial action	• Monthly monitoring with supplementary information and service line information • Remedial plan may be required • Potential for intervention under section 52 of the NHS Act 2006 • MDCR is 10%
Rating 1	High probability of significant breach of authorisation in the short term, eg <12 months, unless remedial action is taken	• Likely intervention under section 52 of the Act • MDCR decided case-by-case

Governance risk rating	Description	Implications
Green	NHS Foundation Trust's governance arrangements comply with authorisation: • service performance score less than 1.0; • self-certification complete and satisfactory; and • where exception reports or third-party reports are received: any issues are being addressed; no potential or actual significant breach; no significant broader concerns/raised.	• Self-certification (except membership) • Exception reporting of issues, and actions taken to resolve third-party reports
Amber	Concerns about one or more aspects of governance, eg: • service performance score is between 1.0 and 2.9 or failure of the same target weighted 0.5 in three consecutive quarters; • key element of self-certification is either incomplete or unsatisfactory and requires investigation; and • exception reports or validated third-party reports raise significant issues, which remain unresolved or require further investigation.	• For issue of concern: – supplementary information may be required; – specific reporting on progress in resolving issue as agreed; and – potential for investigating relevant aspects of self-certification • For all other issues: – as for green
Red	Concern that one or more issues significantly breach authorisation: • service performance score is more than 3.0 or failure of the same target weighted 1.0 (where it is a national requirement) in three consecutive quarters; • previously reported significant issue remains substantially unresolved; or • newly reported issue causes grave concern.	• As for amber, plus: – potential for intervention under section 52 of the NHS Act 2006

Mandatory services risk rating	Description	Implications
Green	NHS Foundation Trust's mandatory services arrangements comply with authorisation: • self-certification is complete and satisfactory • 'variation of authorisation' and 'asset protection' processes used as needed • where exception reports or third-party reports are received, any issues being addressed by board and/or third parties.	• self-certification • 'variation of authorisation' process to manage changes to mandatory service provision • 'asset protection' process to manage disposals of protected assets • exception reporting of issues, and actions taken to resolve • third-party reports
Amber	Concerns about one or more aspects of mandatory services, eg: • key element of self-certification either incomplete or unsatisfactory and requires investigation; or • exception reports or validated third-party reports raise significant issues, which remain unresolved or require further investigation.	• For issue of concern: – supplementary information may be required; – specific reporting on progress in resolving issue as agreed; – potential for investigating relevant aspects of self-certification • For all other issues: – as for green
Red	Concern that one or more issues significantly breaches authorisation: • 'variation of authorisation' or 'asset protection' processes misused or not used; • previously reported significant issue; • remains substantially unresolved; • newly reported issue causes grave concern; or • three consecutive amber ratings due to failure to meet the same target.	• As for amber, plus: – potential for intervention under section 52 of the NHS Act 2006

162. As set out in Table 8, Monitor has the potential to intervene when there is a high-risk rating in any domain. Monitor's intervention framework is drawn from the National Health Service Act 2006²⁰ and is described in Table 9.

20 National Health Service Act 2006, HMSO.

Table 9: Monitor's intervention framework

Trigger	Actions
Significant contravention of/ failure to comply with Terms of Authorisation and Monitor exercises its discretion to intervene	Monitor can: • require directors or board of governors to do • or not do specified things • remove or suspend directors or governors and replace with interim members
The financial position of the NHS Foundation Trust reaches a position where Monitor determines it is necessary or expedient to start insolvency proceedings	Monitor can require the directors to: • take steps to obtain a moratorium • make a proposal for a voluntary arrangement [The regulations relating to these powers have not yet been laid before Parliament]
In the case of: • Contravention of/failure to comply with a requirement imposed by Monitor under its powers of intervention • Failure of voluntary arrangement • Monitor considers that further exercise of its powers of intervention would not be likely to secure the provision of the services required in the NHS Foundation Trust's ToA	Following consultation by Monitor the SoS can by order: • transfer any property or liabilities to another NHS Foundation Trust, NHS Trust, PCT or Secretary of State • dissolve the NHS Foundation Trust

Regulation and the role of professional regulators

163. The regulation of healthcare professionals has changed considerably in recent years, partly in response to a series of high-profile cases such as that of Harold Shipman, and partly as a result of changes in public expectations and patients' awareness of health issues. A major programme of reform was set out in a recent white paper *Trust, assurance and safety* and in the Government's response to the Shipman Inquiry's fifth report *Safeguarding patients*.

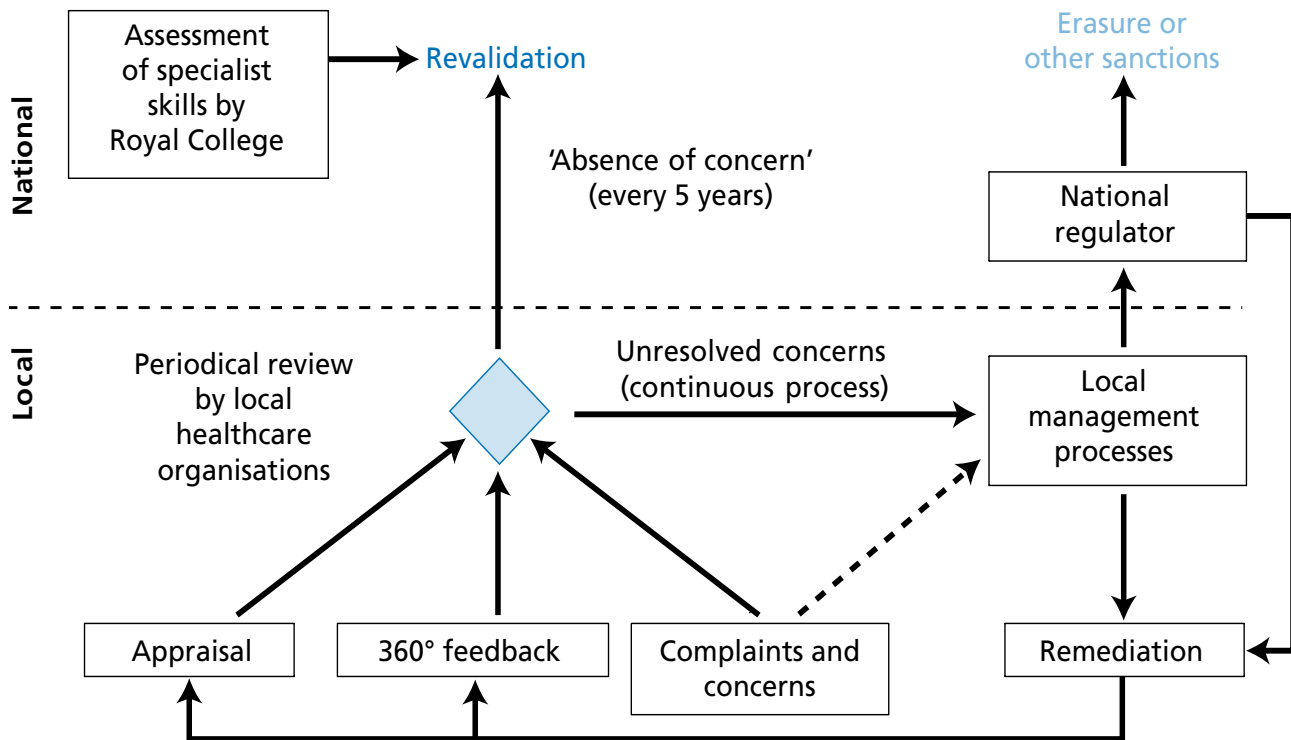
164. The principles underlying this programme can be summarised as follows:

- The protection of patients and of the general public should be the overriding priority.
- Regulation should minimise any potential impact on the delivery of patient care and affirm and support health professionals who aspire to do the best for their patients.
- Additional safeguards should build on existing processes in the NHS for ensuring clinical quality and safety.
- Additional safeguards should apply on a proportionate basis across all sectors of healthcare and to all health professionals.
- The reforms should be carried out in a way that wins the trust of both patients and the general public, and of healthcare professionals.

165. The core of professional regulation consists of two overlapping sets of arrangements which have the dual purpose of protecting patients and supporting professionals:

- **Appraisal and revalidation:** annual appraisal defines specific goals for improvement for the individual professional, while revalidation is a process in which the national regulator gives an assurance that the healthcare professional remains fit to practise. Revalidation should draw on the information from an enhanced process of appraisal, as well as on other sources of information.
- **Investigation of specific concerns:** whenever a concern is raised over the conduct or performance of a healthcare professional, it is investigated so that, if it is validated, action can be taken to protect patients and, if possible, help the healthcare professional to address the area of concern.

Figure 9: How it all fits together: regulators' appraisal, intervention, and investigation



166. In both elements, the national professional regulator is to a large extent dependent on the quality of the local systems of clinical governance, including appraisal, analysis of clinical indicators, handling of complaints, investigations and local disciplinary processes. Wherever possible, the emphasis should be on local intervention and remediation as soon as issues emerge, with referral to the national regulator only as a last resort. The professional regulators will therefore need to work increasingly closely with healthcare organisations and with the organisational regulators such as the CQC to ensure that all healthcare providers have the clinical governance processes needed to support effective professional regulation.



Chapter 7: Next steps

167. This document represents the first of two stages of work in developing the NHS Performance Regime.
168. The second stage will involve working with colleagues in the service and across Government to develop the detail of our proposals, for implementation under the 2009/10 Operating Framework. This programme of work will consist of three related projects:
- Developing the performance framework for PCTs and NHS Trusts (see Paragraphs 95-102);
 - SHA Assurance System (see Paragraphs 133-136); and
 - Failure regime for state-owned providers (see Paragraphs 127-132).
169. The NHS Finance, Performance and Operations Executive Group (ie. sub-committee of the NHS Management Board) will provide leadership of the work. This group is chaired by David Flory (Director General – NHS Finance, Performance and Operations).
170. This programme of work will be taken forward over the Summer and tested with stakeholders prior to implementation from April 2009.



Annex: Metrics in development

1. Alongside existing metrics, we are developing a number of new metrics and metrics frameworks in support of the NHS Performance Regime. These new metrics will fill existing gaps in the system, ensuring that our approach to performance is consistently evidence-based. Both for organisations and for individual clinical services, the use of metrics will drive improvement by informing patient choice, commissioning, regulation and performance management. The main developments are:
 - detailed plans for an assurance framework for PCTs as part of the World Class Commissioning programme;
 - plans for an assurance framework for SHAs;
 - new registration requirements for all healthcare providers, to be assessed by the new CQC;
 - work to develop new metrics to measure the performance of community care providers and GP practices;
 - plans to develop metrics, improvement standards and indicator sets to measure and compare the performance of individual clinical teams; and

- renewed efforts to improve the quality and accessibility of performance metrics by increasing the use of PROMs and by developing performance dashboards.
2. These wide-ranging developments will ensure that a number of existing gaps are filled, allowing us to take a consistent and evidence-based approach to assessing performance across the NHS.

Metrics in primary and community care

3. Many of our existing metrics focus on the performance of secondary care providers, even though a large and growing proportion of NHS care is provided in primary and community care settings. One of our ambitions is to redress this balance by developing and piloting new performance metrics for out-of-hospital care. Current work in this area includes:
- a project to develop a range of metrics for **community services**, including performance measures and health outcome measures. These metrics will cover a range of services include district nursing, community physiotherapy and health visiting services. We will publish a strategy and timetable for developing community care metrics as part of the 2009/10 Operating Framework; and
 - initiatives to develop **balanced scorecards** to measure performance and outcomes in GP practices. A number of PCTs are using these at local level and we will work closely with PCTs to develop them further.

Local clinical indicators

4. We are also developing metrics for local clinical services and specialties. In this context, the role of metrics is to enable comparison and benchmarking, rather than as a tool for performance management. Over the coming months, a suite of clinical and nursing outcome and quality indicators will be assessed and developed nationally, to allow ready comparison of the outcomes and quality of key clinical services and specialties.
5. The purpose of the clinical and nursing indicators is to allow benchmarking of local services against national comparators, in order to support local improvement efforts. An extensive trawl of existing clinical indicators within the NHS and of international best practice is commencing, and this will

include opportunities for direct engagement with clinicians. We envisage identifying the first tranche of the indicator suite in time for the 2009/10 Operating Framework, for introduction next year. Additional indicators will be added to the suite over time, as new data sources allow new indicators to become viable.

Patient-Reported Outcome Measures

6. As we develop the use of metrics to measure performance, we will shift increasingly from measuring inputs and outputs to measuring health outcomes. In order to achieve this, we intend to expand the use of PROMs within new and existing metrics frameworks. PROMs offer an excellent mechanism for making variations in clinical outcomes transparent to patients, regulators and system managers. This will help to drive improvements in performance, particularly through the choice and commissioning processes.

Performance dashboards

7. As well as designing new metrics, one of the aims of the Performance Regime is to improve the presentation of performance information. In order to achieve this, we are working to create 'performance dashboards' which will present performance metrics in an accessible and visually striking fashion.
8. Performance dashboards are being piloted at a national level but we hope to make them available to SHAs and local Trusts in due course. During the recent Department of Health Informatics Review, a prototype dashboard was created to demonstrate how clearer presentation of information can aid interpretation and understanding of performance metrics. The prototype dashboard offered a graphical representation of some of the information that was presented in the monthly NHS Management Board performance report. Key indicators from the report were displayed using dials and graphs. The main focus of the prototype was a detailed representation of performance against targets for reducing hospital-acquired infections. The prototype solution allowed users to drill down into the detail of the MRSA performance from a national position to Trust level.



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