



briefing

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Commissioning for quality – delivering national priorities

The demands on commissioning are greater than ever before as primary care trusts are relied upon by policymakers and taxpayers to improve health and health services, assure quality and deliver value for money in an NHS faced with more stringent financial circumstances and increasing public scrutiny.

This *Briefing* highlights some actions commissioners can take to ensure they secure best value for patients and taxpayers when commissioning for two NHS priorities in 2010/11: delivering same-sex accommodation (DSSA) as part of the thrust towards high-quality care; and improving cleanliness and further reducing healthcare associated infections (HCAI).

Key points

- Drafting effective contracts supports the delivery of key HCAI and DSSA objectives as well as offering a solid foundation on which to build sound commissioner and provider relationships.
- Clinically-driven service specifications that include HCAI and DSSA add value to the commissioning process and support the achievement of desired outcomes.
- Building in robust yet proportionate assurance frameworks contributes to the effective management and quality improvement of services without sacrificing effective clinical care of patients.

Background

Faced with new challenges brought on by changing demographics and stronger demands for increased efficiency and productivity while delivering high-quality care, robust commissioning has never been more crucial for the NHS and its partners.

While national priorities remain unchanged from last year, specific objectives and quality indicators have been updated, such as those around delivering same-sex accommodation (DSSA) and reducing healthcare associated infections (HCAIs), which are detailed further in this *Briefing*.

Developing the appropriate architecture for carrying out its commissioning functions, and the contract between primary care trusts (PCTs) and providers, are central to managing these challenges to deliver optimum service performance.

Policy context

The white paper *NHS 2010–2015: from good to great*, the operating framework 2010/11 and the Chancellor's Pre-Budget Report set out the priorities and parameters for NHS commissioners over the next few years. These documents also highlight the expectations placed on commissioners in transforming services.

The recently published NHS standard contracts for 2010/11 provide the framework for commissioning services across acute, community, ambulance and mental health and learning disability services. Commissioners face tight timelines as contracts need to be agreed by 1 March, signed by providers by 15 March, and final plans submitted to their strategic health authorities (SHAs) on or before 26 March 2010.

Under these constraints, commissioners have the task of interpreting the new templates, matching the terms against the services of their providers, and amending the generic documents to produce relevant and bespoke contracts for their providers. They then need to enter discussions with providers to agree terms, levers and incentives before 15 March 2010.

The varying social, geographic and financial landscapes in which PCTs operate mean there are variations in how individual service specifications are written to meet the needs of the commissioners. There are, however, a few actions that all commissioners can take to ensure a strong commissioning process as outlined below. In addition, this *Briefing* provides further insight into commissioning for HCAI (see box on page 3) and DSSA (see box on page 4).

Drafting effective contracts

Contracts are the cornerstones on which commissioners and providers build their relationships and ensure quality care for patients. As such, the contract provides more benefits when used to encourage performance rather than to levy penalties. PCTs should focus on what the provider can do to manage risk and aspire to better service provision.

The financial imperative often takes precedence in the contracts rather than a more operational focus. However, including clinical and quality indicators as well will ensure the focus remains on the provision of effective and quality care of patients.

Contracts are more effective when they provide clear, concrete requirements and set out exactly what is expected of the provider. This includes the minimum standards required for the provision of services along with relevant local and national targets. PCTs should ensure the clauses and quality requirements set out in the Schedules are backed up with the relevant information requirements.¹

The contract should also reflect the specific circumstances and realities of the provider, taking into consideration the care settings and unique requirements for community-based organisations, acute services, mental health and learning disability services as well as requirements of the providers.

Making service specifications work

A relevant, detailed, clinically-driven service specification can reinforce contractual obligations and support the achievement of desired outcomes. HCAI and DSSA commissioners should consider an overarching content for service specifications that can be added to all other contract areas that feed into the delivery of these objectives.

A strong service specification will:

- describe the nature and parameters of the service to be bought, with identified minimum and measurable standards for each, rather than national objectives alone
- define the people (patients or service users) for whom the service is to be provided
- set the clinical and quality outcomes that are required
- set standards to which the service should be delivered
- describe a clear mechanism for auditing and measuring performance

Foundation trust requirements

Commissioners should be familiar with the requirements placed on all NHS foundation trusts, in particular the requirements detailed in Monitor's Compliance Framework, along with:

- the terms of authorisation and statements of standards in relation to the provision of healthcare published by the Secretary of State under section 46 of the Health and Social Care (Community Health and Standards) Act 2003 as may be amended from time to time
- Monitor's inclusion of the operating framework's national requirements on reducing methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (*C.diff*) infection rates and the retention of a number of the existing healthcare targets within the Compliance Framework applicable through Monitor's regulatory regime
- the requirement to cooperate with other healthcare bodies, including PCTs under their terms of authorisation.

Addressing healthcare associated infections issues in commissioning

Action taken locally and nationally has assisted in driving down rates of infection of two serious HCAs – *C.diff* and MRSA. There is still a considerable challenge for commissioners to observe the provisions of the Code of Practice on HCAI under the Health and Social Care Act 2008.

NHS priorities

The NHS Operating Framework has a great emphasis on infection control and prevention within the wider health economy and sets out a number of priorities for improving cleanliness and reducing HCAI in 2010/11 (namely no avoidable MRSA by 2011 and a 30 per cent reduction in *C.diff* by 2011).

The National Quality Board has also issued objectives on MRSA bloodstream infections for 2010/11 and the Department of Health (DH) will issue new minimum standards for *C.diff* in the Spring.

Actions to reduce HCAI

The HCAI and Cleanliness team at the DH has identified four critical factors that reinforce a whole systems approach to combating HCAs. These are:

- **people:** having the correct staff trained, with appropriate skills and behaviours
- **processes:** having systematic methods, procedures and ways of working
- **practices:** having consistent individual, clinical and organisational practices
- **performance:** having assurance of delivering on policies, procedures and standards.

When commissioning for HCAI reduction, PCTs should consider the following:

- providing clear guidance on competencies, appropriate skills and behaviours required of key staff (for example, Director of Infection Prevention and Control (DIPC), clear communication channels, board and individual commitment to achieving HCAI objectives)
- establishing an information system which collects data on both community and acute associated infections to support appropriate system, process and behavioural changes, so they can be avoided in future
- putting systems in place to foster closer working across all health and social care organisations (for example, cross-sector HCAI working group)
- clearly laying out the monitoring criteria through the service specifications
- highlighting relevant national good practice for providers to emulate, and effective assurance systems to ensure policies and good practice are adopted
- recommending specific tools and resources for the provider to use to improve processes, such as the Root Cause Analysis (RCA) toolkit, High Impact Interventions care bundles and *C.diff* care pathway toolkits
- requesting monthly infection surveillance reports with trend analysis from providers to be discussed in monthly performance meetings
- specifying environmental and cleaning standards, audit tools and a system for collecting performance data
- outlining the assurance mechanisms expected of providers to act on infection control, including:
 - discussions and challenge at board level
 - external reviews and compliance with national standards
 - peer reviews and clinician to clinician meetings
 - PCT membership of trust infection control committees
 - all MRSA bacteraemias reported as serious untoward incidents (SUI) and are subject to an RCA.

Commissioning to ensure delivery of same-sex accommodation

The need to deliver the highest standards of privacy and dignity applies equally to all areas of a hospital as well as mental health and learning disability settings. Achieving these standards will mean ensuring men and women do not have to sleep in the same room or share toilet and washing facilities.

NHS priorities

The NHS has put patient safety and patient experience at the centre of delivering high-quality care. Patients now have higher expectations of the environment in which they are treated and more say about how and where healthcare is provided.

The 2010/11 Operating Framework requires all NHS providers to have published, before the end of March 2010, a 'declaration of compliance' that they have virtually eliminated mixed-sex accommodation, undertaken a self-assessment of same-sex accommodation (SSA) provision and have robust plans in place to ensure continued delivery of this commitment. Providers of mental health services are required to have women-only day space. In addition, the 2010/11 standard contracts require that providers must have a DSSA plan.

After March 2010, PCTs will need to report to SHAs on an exception basis those organisations that have failed to provide SSA and have had funds retained as a result.

SSA definitions, along with the declaration process, can be found in the professional letter issued to trusts in early February 2010. Additional guidance can be found at www.dh.gov.uk/samesexaccommodation

Four key areas to be considered in relation to the DSSA agenda are patient experience, estates, systems and processes and staff culture.

When commissioning for DSSA consider the following:

- gain a clear understanding of the provider's current position against the required goals and standards for DSSA especially as it relates to the four key areas outlined above
- ensure contracts and service specifications take into account local challenges and reflect stretching objectives set out in the provider's action plan with clear guidance on monitoring, reporting outputs and delivery dates where services are below minimum requirements
- gaining clarity, using the guidance around what is SSA, what constitutes a breach and what the full cost of occurrences in accordance with the contract requirements are
- agree with providers how patient views on DSSA and overall privacy and dignity will be obtained, monitored, recorded and discussed in monthly performance monitoring meetings, and outline any actions or improvements
- utilise support systems to help providers in the delivery of SSA, such as capacity and demand modelling systems, bed management systems and data collection split by gender.

to determine whether or not all the requirements are being met

- clearly relate to the contract control mechanisms and incentives and any 'stretch goals' identified
- set expectations for compliance with key policies, communicating and reinforcing specific elements (for example, hand hygiene, dress codes, environmental cleanliness and antimicrobial prescribing) and identifying or responding to non-compliance.

Building in robust assurance frameworks

As well as promoting ongoing quality improvement, commissioners need to assure themselves that services meet acceptable standards. Robust assurance frameworks and effective performance management mechanisms ensure continued and sustained focus on achieving desired objectives.

The standard contracts for NHS services provide a framework for commissioners to focus on quality issues. Commissioners are required to agree a schedule of quality standards (some of which are nationally specified) with providers, and to develop Commissioning for Quality Improvement and Innovation (CQUIN) schemes with financial incentives to reward performance well above baseline standards.

An effective system of performance management has the following characteristics:

- linked to corporate objectives
- clear benefits realisation
- defined responsibilities and objectives

- relevant and proportionate metrics
- regular review of delivery and performance improvement.

The assurance framework should be proportionate and realistic, ensuring it supports clinical care of patients. It should be fully linked into the corporate risk management process.

All of the above work together to build a framework for effective commissioning.

PCT Network viewpoint

This *Briefing* sets out how commissioners can use contract specifications and performance monitoring to support the delivery of two specific national priorities. Similar approaches can be taken for other local and national priority areas. It is important to emphasize that commissioners' use of these formal contractual approaches needs to be backed up by effective relationships with provider organisations and feedback from patients and the public.

For more information on the issues covered in this *Briefing*, please contact elizabeth.wade@nhsconfed.org

Questions for boards

Delivering same-sex accommodation

- Do our contracts and service specifications clearly set out the SSA standards that individual providers are required to meet (including the requirement for self-assessment, the provision of a declaration and an action plan re delivering SSA and assurance frameworks)?
- Do our contracts clearly identify the conditions that would give rise to financial sanctions and what these sanctions will be?
- How do we monitor whether the accommodation we contract for complies with SSA and does this factor in patient experience data?
- Do we take into account gender, age and vulnerabilities along with SSA issues when planning for future capacity and demand?
- Are we assured that our contracts are robust to deliver same-sex accommodation in the future?

Healthcare associated infections

- Do our contracts and service specifications clearly identify the standards that providers are required to meet (such as staff skills and behaviours, the use of RCA, isolation protocols and screening and decolonisation, environmental cleaning, High Impact Interventions, hand hygiene, assurance frameworks, surveillance reports and antibiotic compliance)?
- How are we monitoring for HCAI risks across all provider sectors, and how is this information being reported to the board?
- What support do we have in place for our providers to assist them to deliver on their standards?
- Do we have systems in place to foster closer working across all health and social care organisations to ensure a zero tolerance approach to HCAs?

References

1. Standard NHS contracts and supporting guidance www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

Further information

Same-sex accommodation – your privacy, our responsibility. NHS Confederation Briefing 186, June 2009

Delivering same-sex accommodation in mental health and learning disability services. NHS Confederation Briefing 195, January 2010

The NHS Operating Framework for England 2010/11.
www.dh.gov.uk/en/Publicationsandstatistics (Gateway ref 13232)

The HCAI and Cleanliness Division

The HCAI and Cleanliness Division was set up by the DH to provide support and improve knowledge, skills and practice in infection prevention and control across the NHS. Improving cleanliness and reducing HCAI is one of the top priorities for the NHS as all patients have a right to clean and safe treatment wherever and whenever they are treated in NHS funded care. The Division works with trusts and healthcare organisations to embed sustainable systems to reduce HCAI, and deliver clean, safe care to patients.

For further information visit www.clean-safe-care.co.uk or contact the HCAI support team at reducinghcai@dh.gsi.gov.uk

The Delivering Same-Sex Accommodation (DSSA) Programme

The Delivering Same-Sex Accommodation (DSSA) Programme is a time-limited initiative launched by the DH in January 2009. It will run until March 2010 and it aims to support the NHS to virtually eliminate mixed-sex accommodation in NHS settings for all patients or service users, at every stage in their care journey.

The DSSA Programme has provided resources and support to acute, mental health and learning disabilities commissioners and service providers. A toolkit is available on the DH website.

For more information visit www.dh.gov.uk/samesexaccommodation
To contact the DSSA support team, email DSSA@dh.gsi.gov.uk

The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs.

The Network aims to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The PCT Network is one of these.

For further details about the work of the PCT Network, please visit www.nhsconfed.org/pctn

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