

PSA Delivery Agreement 18:

Promote better health and
wellbeing for all

Revised June 2009

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1

Vision

1.1 Government is committed to delivering the best possible health and well-being outcomes for everyone, helping people to live healthier lives, empowering them to stay independent for longer and tackling inequalities. This PSA, and more broadly the Department of Health's (DH) 'Better Health and Well-being for all' strategic objective sits alongside the DH's other two strategic objectives of better care for all and better value for all. This reflects the ambitions set out in *Our health, our care, our say*¹ to create a health and adult social care service that genuinely focuses on prevention and promotion of health and well-being informed by what people have said they want. It provides a new direction for the whole health and adult social care system and the way in which services are delivered – ensuring they meet people's aspirations for independence and well-being.

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

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

1.3 The health of the population has improved substantially in recent years. Life expectancy is at its highest recorded level. The premature mortality rate from cardiovascular disease has fallen by 40% since 1996 and from cancer by almost 17 per cent in the same period.

1.4 But, whilst significant progress has been made in treating ill-health and the causes of premature death, changes in society create new challenges and problems still exist:

- of deaths that occurred in 2006, 24 per cent were of people below the age of 70;
- death rates from coronary heart disease in people aged 35-64 in the lowest social classes were almost double that of those in the highest;

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

- 4,000 people still commit suicide each year and suicide is the second commonest cause of death in men under 35;
- men in the highest social class live on average eight years longer than those in the lowest;
- evidence shows that smoking is the principal avoidable cause of premature death and ill-health in England today; killing an estimated 86,500 people a year; equivalent to one-fifth of all deaths;
- evidence shows that people value cost-effective health and social care support that enables them to live independent lives and to play their full part in society. This is particularly true of older people, currently the largest group of users of health and social care, in a population that is ageing demographically. By 2026, 20 per cent of the population will be over 65 and numbers over 85 are set to increase by two-thirds;² and
- a large number of people suffer from common mental health problems. Past surveys³ have suggested that 1 in 6 adults were assessed as having a neurotic disorder. More recent reports have shown that the scale of the challenge in meeting the needs of large sections of the community remains high.

1.5 This PSA aims to respond to these challenges by:

- continuing to increase life expectancy in England by tackling the biggest killer diseases, with an emphasis on ill health prevention and promotion of good health, and sustaining the drive to promote equality and to reduce inequalities in health;
- reducing smoking prevalence;
- supporting people to meet their aspirations for independence and well-being; and
- improving the well-being and inclusion of people with depression and / or anxiety disorders through improved access to psychological therapies.

² See also PSA 17.

³ 2001 Psychiatric Morbidity Survey (Psychiatric morbidity among adults living in private households, 2000, Singleton et al, Office for National Statistics, 2001).

2

Measurement

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

Indicator 1: All Age All Cause Mortality (AAACM) rate

Indicator 2: Difference in All Age All Cause Mortality (AAACM) between England average and spearhead areas¹

- Improving people's overall life expectancy and tackling the inequalities gap is key to achieving better health and well-being for all. A focus on ill health prevention and promotion of good health, and tackling health inequalities will help people to live healthier lives for longer and take more control over their own health.
- Indicator 1 will track progress in reducing mortality rates and Indicator 2 will track progress in reducing inequalities in mortality rates. Mortality rates provide a good proxy for life expectancy. Both indicators have national targets attached.

Indicator 3: Smoking prevalence

- Reducing smoking prevalence is crucial to delivering reductions in health inequalities, and to tackle health problems in poorer communities. This indicator monitors smoking among all adults and among routine and manual groups, and has a national target attached.

Indicator 4: Proportion of people supported to live independently (all ages)

- This provides a high-level indicator signalling the importance of cost-effective, evidence-based, innovative approaches to supporting people to live independently in the community. The indicator covers people receiving any amount of care / support including that provided through organisations that are grant funded. It indicates how much lower-level care / support is provided and is consistent with the wider direction of *Our health, our care, our say* of providing treatment and support in community settings and preventing or postponing need for more intensive care packages or residential care.

Indicator 5: Access to psychological therapies.

- There is evidence that even a short course of psychological therapy is effective in restoring people with mental health problems to well-being, inclusion and meaningful activity, which is best indicated through return to, or retention of, work. This indicator will monitor improved access to psychological therapies, especially for those with mild to moderate depression and anxiety disorders.

¹ The 20 per cent of areas with the worst health and deprivation indicators.

3

Delivery strategy

3.1 The strategic framework for delivering this PSA¹ combines a balanced set of levers and incentives, including greater transparency, plurality and patient choice, supported by better commissioning and a new outcomes and performance framework. For the specific aspects of this PSA, further details of how they will be delivered are set out below².

Life expectancy

3.2 The introduction of local data for local authorities and Primary Care Trusts (PCTs) on all age all cause mortality provides an incentive for partnership working and gives flexibility for organisations to focus on the interventions that are most important to their local population in delivering improvements in life expectancy, supported by best practice such as that produced by national clinical directors.

Tackling the biggest killers

3.3 Continuing to tackle the biggest killers, with a focus on areas where inequalities exist, is particularly key to improving life expectancy and reducing health inequalities. This includes tackling cancer, cardiovascular disease (CVD), suicide and smoking, which all have a major impact. The DH will continue to drive improvement in these areas through delivery of a number of existing commitments as part of its wider performance framework:

- reducing the mortality rate by 2010 for cancer by at least 20 per cent in people under 75, with a reduction in the inequalities gap by at least 6 per cent;
- reducing the mortality rate by 2010 for heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a reduction in the inequalities gap by at least 40 per cent;
- reducing mortality rate by 2010 for suicide and injury of undetermined intent by at least 20 per cent; and
- reducing health inequalities by 10 per cent by 2010 as measured by infant mortality and life expectancy at birth.

3.4 These are underpinned by delivery strategies that set out comprehensive programmes of action for the whole system.

¹ See paragraphs 3.22-3.36 below.

² The Delivery strategies for a number of other PSAs will also help to deliver the PSA vision – see also PSAs 12, 14, 15, 16, 17, 25 and 28.

Cancer

3.5 The *NHS Cancer Plan*³ sets out the Government's strategy for cancer. This includes the key actions needed by every part of the system to improve cancer prevention, such as reducing smoking prevalence, the single biggest preventable risk factor for cancer, and by promoting a healthier diet, which is another important factor in reducing the risk of cancer. The programme is in a strong position to deliver its ambition for cancer due to historic action on smoking cessation and early achievements from the Cancer plan, for example including:

- implementation of NICE guidance for treatment and models for the delivery of cancer services;
- faster access to specialists and treatment where cancer is suspected and, or diagnosed;
- improved workforce and equipment capacity and capability for both diagnosis and treatment;
- continued action to reduce smoking prevalence;
- expanding the established cancer screening services to detect cancer earlier; and
- raising public awareness of symptoms and promotion of earlier presentation through some targeted campaigns.

3.6 To build on the progress made through the NHS Cancer Plan, a new cancer reform strategy is being developed which will set out how further improvements can be achieved in a reformed system, focusing on improving access, quality, equality and value for money.

CVD

3.7 The Vascular Programme is underpinned by three National Service Frameworks (NSFs) for coronary heart disease (CHD), Diabetes and Renal Disease.⁴ In addition, the DH has just launched a consultation on a National Stroke Strategy⁵. The NSFs provide comprehensive guidance on how the system locally can raise standards of care, covering the entire patient pathway in cardiovascular disease, from action in primary prevention through long-term conditions management, to supportive and palliative care.

3.8 The Department of Health will continue to strengthen the work across all four disease areas by drawing together common elements, specifically on risk assessment and risk management, which aims to prevent a significant proportion of the existing burden of disease particularly for the most deprived areas.

3.9 Other examples of specific action going forward include:

- continued work on emergency care, with paramedical thrombolysis and work on primary angioplasty driving ever faster and more effective care; and
- continuing to work through the GP contract negotiations to drive further improvements in disease management.

³ *The NHS cancer plan: a plan for investment, a plan for reform*, DH, 2000.

⁴ National Service Framework for Coronary Heart Disease (2000), National Service Framework for Diabetes: Standards (2001) and Delivery Strategy (2003), National Service Framework for Renal Disease (2004).

⁵ The Department of Health launched the consultation on the development of a National Stroke Strategy on 9 July inviting views on meeting the challenges facing stroke services, the consultation will close on 12 October 2007.

Suicide

3.10 The *Suicide Prevention Strategy*⁶ sets out ways in which commissioners can reduce risk in key risk groups, for example, young men or people who have recently self-harmed, promoting mental well-being in the wider population, and reducing the availability of suicide methods. The Strategy going forward involves a wide range of initiatives including:

- improving mental health promotion for young men;
- coordination by DH of better monitoring of, and research into, those who have self-harmed;
- PCTs undertaking population-based suicide audits in their local areas;
- early follow up by mental health providers of patients discharged from psychiatric in-patient care; and
- early intervention for psychosis for young people.

Health inequalities

3.11 *Tackling Health Inequalities: A Programme for Action*⁷ is the cross-government strategy to meet the target for 2010 which is attached to indicator 2. Cardiovascular disease (mainly coronary heart disease), cancer and respiratory disease account for about two-thirds of the inequalities gap, so the delivery strategies for these will help to drive progress in tackling health inequalities. Specifically:

- the Health Inequalities Intervention Tool (available on the London Health Observatory website)⁸ will assist Spearhead areas to establish the size of their life expectancy gap, the diseases responsible for it and the key interventions to ensure rapid impact;
- action by PCTs and practices to reduce smoking prevalence, control blood pressure and cholesterol will have a quick impact on cardiovascular diseases;
- for cancer, symptom awareness and promoting early presentation with symptoms in deprived and under-served populations is important; and
- effective primary care in disadvantaged areas and case finding to find people with untreated disease underpin the approach.

Role of other government departments

3.12 Successful delivery relies on shared priorities across Government Departments so that local services are encouraged to work together to achieve common outcomes in housing, education, social care and all the other elements that help to build sustainable communities. This includes:

⁶ *The Suicide Prevention Strategy for England*, DH, 2002.

⁷ *Tackling Health Inequalities: A programme for action*, DH, 2003

⁸ http://www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

- **Communities and Local Government (CLG):** through taking action set out in strategies including: the Race Equality in Mental Health Care programme;⁹ *Improving Opportunity, Strengthening Society on race equality*¹⁰ and community cohesion; and the National Strategy for Neighbourhood Renewal.¹¹ National programmes and local delivery via local authorities will also support better quality local environments, including parks and leisure and recreation services;
- **Department for Children, Schools and Families (DCSF):** through the health promotion activities of Children's Centres and other early years settings, schools and other education settings, youth services and the opportunities they provide for young people and their families to access health services;¹²
- **Ministry of Justice (MoJ):** supporting the reduction in suicide rate in prisons through partnership working with the Safer Custody Group on a range of policy and practice issues to improve prisoner mental health and well-being. The Safer Custody programme seeks to mitigate the risk of an increase in suicides and deaths in cells or failure to reduce levels of deaths, assaults and self-harm;
- **Department for Environment, Food and Rural Affairs (Defra):** action to reduce fuel poverty among vulnerable groups, for example the elderly, families with children, disabled people and those with long-term illness;
- **Department for Transport (DfT):** local authorities can look at (transport) access to healthcare facilities (hospitals / GPs) as part of the accessibility planning process. This requires joint effort and partnership with health transport planning and healthcare location to make this happen. Also through initiatives on road traffic accidents, which is the greatest single cause of mortality in young men;
- **Department for Work and Pensions (DWP):** through its programmes to tackle poverty, reform welfare and promote employment, DWP will help to reduce incidence of long-term worklessness, deprivation and consequent health inequalities. Meanwhile, DWP's contribution to the Health, Work and Well-being Strategy and the activity of the Health and Safety Executive will help to ensure that people in employment are healthier and that fewer people fall out of work onto benefits, with resultant poorer health outcomes; and
- **Food Standards Agency (FSA):** in order to reduce incidences of food-borne illness, improving food safety and hygiene control was agreed as one of the five national priorities for local authority regulatory services by the Cabinet Office Rogers Review, accepted in full by the Government as part of its March 2007 budget.

Smoking

3.13 The Comprehensive Tobacco Strategy¹³ has six strands based on international evidence of effective tobacco control. The Strategy covers:

⁹ *Delivering race equality in mental health care*, DH, 2005

¹⁰ *Improving opportunity, strengthening society*, Home Office, 2005

¹¹ *National strategy for neighbourhood renewal*, Neighbourhood Renewal Unit, 2001

¹² See also PSA 12

¹³ More information on the tobacco strategy can be found on the DH website.

- help for smokers to quit through NHS stop-smoking services;
- stop-smoking aids on NHS prescription and national quit-lines / electronic support;
- comprehensive bans on tobacco advertising, promotion and sponsorship;
- protection for people from harm from secondhand smoke;
- regulation of tobacco products through pack-warnings, information on packs, age of sale and restricting under-age sales; and
- reducing consumption through increased price by HMRC action to tackle smuggling and HMT action on tax / duty rates.

3.14 There are a range of measures to help build on progress made including:

- comprehensive smoke-free legislation to eliminate health risks from secondhand smoke;
- introducing picture warnings;
- the introduction of new powers to ban retailers from repeatedly selling tobacco products to under-age children; and
- supporting international work to develop a framework for controls on global smuggling of tobacco.

Role of other government departments

3.15 Successful delivery relies on shared priorities across Government Departments so that local services are encouraged to work together to achieve common outcomes. This includes action by:

- **Her Majesty's Revenue and Customs (HMRC):** continued action in tackling tobacco smuggling and reducing the illicit market share of hand-rolled tobacco is crucial as the availability of cheap tobacco undermines the high rate of duty on cigarettes, and has a particular effect in groups more sensitive to price – such as routine and manual workers. Partnerships between HMRC, local authorities and PCTs are key to providing a cohesive local tobacco control approach, for example Trading Standards Officers working closely with HMRC to tackle the counterfeit problem and local authorities (LAs) enforcing tobacco legislation; and
- **Her Majesty's Treasury (HMT):** which leads on tobacco duty. At Budget 2007 tobacco duties were increased in line with inflation. Maintaining high levels of tax helps to reduce overall tobacco consumption.

Proportion of people supported to live independently¹⁴

3.16 Independent living will be driven by the system incentives set out at paragraph 3.22-3.36 below, including:

- choice and control: for example through promoting the use of direct payments, which acts as a powerful incentive for providers to respond to patients' and users' preferences;
- duties on commissioners for joint strategic needs assessment and commissioning jointly for health and well-being; and

¹⁴ All ages

- developments towards a Common Assessment Framework that will build outcomes into each individual's assessment and a review process.

National service framework for older people

3.17 Older people are the largest group of users of health and social care. A framework of actions to support local commissioners of older people's services have been set out in *Next Steps in Implementing the National Service Framework for Older People*¹⁵. These include a number of actions that can be taken locally, for example:

- to improve physical fitness through encouraging and communicating the benefits of moderate regular exercise for older people;
- to overcome barriers to active life for older people through giving attention to equipment, foot-care, oral health, continence care, low-vision and hearing services;
- to improve access to health care and health promotion services for older people who are socially isolated, living in poverty, have mental health problems and those from black and minority ethnic groups, and protect vulnerable older people from cold and heat-related illness; and
- to extend healthy active life expectancy through disease prevention and modifying health behaviour through life checks and social marketing techniques.

3.18 DH will also work with local authorities and their partners to:

- increase the effectiveness of rehabilitation;
- share learning from the evaluation of the thirteen individual budget pilot sites and work with In Control, a research and development partnership, working with local authorities and other partners to learn and share approaches to and delivery of self-directed support; and
- share learning from the Partnerships for Older People Projects (POPP) pilot sites led by councils with social services responsibilities in partnership with PCTs, the voluntary, community and independent sector through 2008/09.

Role of other government departments

3.19 Action to support local delivery includes the Supporting People programme. Supporting people's key performance indicator 1 measures people maintaining independent living, and action by CLG is closely linked to Department of Health outcomes in areas such as single assessment processes, user choice and control, joint commissioning; third sector service provision and local partnership working, including through Local Area Agreements (LAAs), Local Strategic Partnership (LSPs) and supporting people commissioning bodies.

Access to psychological therapies

3.20 The Department of Health is rolling out further pilot sites to create effective local incentives to ensure the right number of people who can benefit and receive prompt access to evidence-based psychological therapies in a timely and cost-effective way. The evidence from the pilots will define the most cost-effective and deliverable service models to support commissioners and service providers, and to help further national rollout during the CSR period, with an emphasis on developing psychological resilience through early intervention and improving the mental well-being of the general population.

¹⁵ *A new ambition for old age: Next steps in implementing the National Service Framework for Older People*, DH, April 2006.

Partnership with Jobcentre Plus

3.21 The Improving Access to Psychological Therapies (IAPT) system locates the provision of effective psychological treatment within an integrated set of social supports designed to enable people to stay in and return to employment. Key partnerships include developing referral pathways with Job Centre Plus as part of the development of the Pathways to Work Condition Management Programme. Central to this will be developing the role of employers through the development of stress management standards, which will strengthen their role in supporting employees who may be struggling to remain in work with depression or anxiety disorders.

Strategic delivery framework

3.22 Reform tools and levers, implemented and delivered locally, provide a range of incentives, centred around patients and users, to drive improvement in a more devolved system, and are the means by which the vision for this PSA and the Department of Health's strategic objectives will be delivered.

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

- enabling more choice and a stronger voice for patients and service users who will be able to choose the highest quality of care appropriate for their needs, helping them to take better control of their health and care needs;
- empowering patients, public and staff through the provision of information and sharing of good practice;
- strengthening commissioning, as practices, PCTs and LAs use their knowledge of local communities, extensive public and patient involvement, particularly with seldom heard groups, service reviews and robust joint needs assessment to secure services within available resources;
- supporting a richer landscape of diverse providers, including Social Enterprises (SEs) and the wider third sector (including charities and the voluntary and community sector), to play an important role in providing choice, increasing quality and fostering innovation;
- money following service users, rewarding the best and most efficient providers, giving others the incentive to improve; and
- a framework of system management, regulation and decision making which guarantees safety and quality, fairness, equity and value for money.

Roles and responsibilities

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

- **local boards** will need to be well organised to take greater ownership for continuous service improvement, and be accountable to their local communities for the outcomes they achieve;
- **practice-based commissioners** can use delegated indicative budgets and their role in the commissioning process to better design services for their patients;

- **PCTs and Local Authorities (LAs)** are responsible for undertaking joint strategic needs assessments in order to understand the needs and meet the expectations of their population. World-class commissioning will deliver the best possible health outcomes, including reduced health inequalities, and the best possible healthcare, within the resources available. Strategic planning will be based on high quality information and evidence, and will include all partners including patients, users and clinicians. Commissioners will specify outcomes and then work with providers to design services to best deliver these outcomes. Commissioners will then hold providers to account for delivery of the agreed outcomes. Strong local partnerships between PCTs and local authorities are critical to commissioning better services, using their commissioning muscle to deliver better outcomes;
- **Local Strategic Partnerships** which will be underpinned by a legal framework, ensure all of the relevant statutory partners are participating in the production of sustainable community strategies and co-operate to agree local targets which will feed into local plans and Local Area Agreements (LAAs);
- **providers**, whether public or private, are responsible for providing the very best care for patients and users;
- **Regional Public Health Group (RPHGs)** provide the leadership at regional level on LAAs and all other local delivery issues. RPHGs currently work with the Care Services Improvement Partnership (CSIP) who provide support and advice on adult social services, mental health and learning disabilities. In future, DH's regional presence will be strengthened to deliver crosscutting issues. This will be the support mechanism for developing the place specific levers to enable local partners to respond more flexibly to local needs, enabling local communities to play a full part in the bottom-up process;
- **Government Offices** are responsible for co-ordinating central Government's relationship with each region, working closely with Strategic Health Authorities. This will include leading on the negotiation of improvement targets in LAAs, reviewing progress and, where necessary, co-ordinating action to respond to underperformance;
- **Strategic Health Authorities (SHAs)** are responsible for actively ensuring that patients have access to sustainable primary, secondary and specialist care, and that across the regional health care economy, there is equity of access to choice and quality for all. SHAs will use the reform tools, liaising with RPHGs and Government Offices, to their best effect to improve local services in the best interests of their patients, users and citizens. PCTs will be supported and performance managed by SHAs on the extent to which they measure and meet the needs of their population, and whether they deliver what they say they will do. SHAs will be held to account by the Department of Health and Secretary of State for Health;
- **independent regulation of health and adult social care services** is important to make sure that organisations are meeting national requirements for quality and safety, and are using taxpayers' money in an efficient and effective way. Currently, the Commission for Social Care Inspection (CSCI) and the Healthcare Commission (HCC) monitor compliance with standards and assess performance, providing public accountability and incentivising improvement; and

- the **Local Government White Paper *Strong and Prosperous Communities***¹⁶ set out proposals for an approach to independent external challenge and assurance from inspectorates. From April 2009, Comprehensive Performance Assessment (CPA) will be replaced with a Comprehensive Area Assessment (CAA). CAA will look at risk and the management of risks to outcomes in local areas rather than at the performance of local institutions and will focus more on citizens' experiences and perspectives. As part of the new local performance framework, CAA will relate to anything done by local authorities working alone or in partnership.

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

- implementing and managing the new performance framework for PCTs and LAs, outlined below;
- providing better information to service users (for example through the NHS Choices and Community Profiles, which are designed to show the health of people in a Local Authority);
- spreading best practice through issuing guidance to encourage improvement, and provide support, for example through improvement teams, to help local bodies tackle poor performance;
- supporting excellence, for example through the NHS Institute, NHS Employers, "Skills for Care", Social Care Institute for Excellence and the Improvement and Development Agency;
- maximising the value gained from the work done by LINKs [DN: spell out] achieving community engagement on the ground and building on the contribution made by health and social care Overview and Scrutiny Committees to the improvement of services delivery; and
- intervening to tackle poor performance where necessary, for example, when performance has been significantly off track for prolonged periods of time.

A new outcomes and accountability framework

Moving beyond top-down targets

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

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

¹⁶ *Department for Communities and Local Government: Strong and prosperous communities: The Local Government White Paper (Oct 2006).*

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

3.29 The indicators are designed in a way that:

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

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

Direct accountability to the public and patients

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

- be able to set local "stretch" targets in relation to the indicators based on their local joint strategic assessment of need, taking account of national (and where appropriate, international) benchmarks of best practice, and national targets. This would also inform the content of the LAAs to which local priorities will be set to meet place based needs in their local community; and
- publish a prospectus setting out their local priorities. For example, The PCT prospectus will signal the strategic direction for local services, highlighting commissioning priorities, needs and opportunities to service providers, offering a focus for discussion with patients and local community and an opportunity to open dialogues with potential providers.

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

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

Tackling poor performance

3.34 The relationship between DH and SHAs, and Local Government (through our presence in the Government Offices of the Regions) will increasingly focus on tackling significant underperforming / unacceptable variations.

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

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

Consultation and user engagement

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

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

- the White Paper *Our health, our care, our say* was informed by a major public engagement exercise to support the next stage of reform and improvement in the NHS and social care. *Our health, our care, our say* also incorporated the findings of the adult social care Green Paper *Independence, Well-being and Choice: Our Vision for the future of adult social care in England*;¹⁷
- DH's consultation on *The Future Regulation for Health and Adult Social Care in England*¹⁸, which outlines how the new regulator could best work alongside other bodies in the health and adult social care system to fulfil its duties and powers, closed at the end of February this year. This would help the development of a regulatory framework that will support health reform;
- a consultation on a commissioning framework for health and well-being, which builds on the White Paper *Our health, our care, our say* and is a framework about action, with a particular focus on partnerships; and

¹⁷ *Independence, well-being and choice: our vision for the future of social care for adults in England*, DH, 2005.

¹⁸ *The future regulation of health and adult social care in England*, DH, 2006.

- an extensive engagement process with stakeholders on the Department of Health's new performance approach, the objectives and the underpinning indicators. The programme of engagement has provided an opportunity for real clinical engagement, helping to identify the right balance of indicators that are meaningful at a local level.

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

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

Accountability and governance

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

3.42 The Senior Responsible Officer within Government for the PSA will be agreed by the end of 2007, and will chair a Senior Official PSA Delivery Board, comprising senior officials from DH and CLG. The Board will also monitor progress and review delivery regularly, and report to the relevant Cabinet Committee/s.

A

Measurement annex

Indicator 1	All-age all-cause mortality (AAACM) rate
National target	By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women monitored using mortality rates as a proxy (see national targets section below).
Data provider	Office for National Statistics (ONS) (mortality rates calculated by DH based on ONS data).
Data set used	3 year rolling average directly age-standardised mortality rates (standardised to European Standard Population), calculated from ONS mortality statistics from death registrations, and mid-year population estimates. Data for males and females are monitored separately.
Baseline	As the target is set in absolute not relative terms, there is no baseline. The latest available data, for 2003-05, on life expectancy for England are: 76.9 years (Male); and 81.1 years (Female).
Frequency of reporting	Annual (provisional rolling 12 month averages can be updated more frequently, subject to availability of data from ONS – quarterly/monthly to track performance).
95 per cent confidence interval	Males: +/- 1.8 deaths per 100,000 population. Females: +/- 1.3 deaths per 100,000 population.
Data quality officer	Health Improvement Analyst, Health Improvement Directorate, Department of Health.
Minimum movement required for performance assessment	Ultimate success will be measured by life expectancy at birth, but AAACM will be used as a proxy to monitor progress. At present this would be mortality reducing to 660 per 100,000 for males and to 470 per 100,000 for females. The precise numbers however will change as demographics evolve.

Definition of key terms

- *Directly Age-Standardised Rates:*

Directly age-standardised mortality rates are calculated to adjust for differences in the age structure of different populations. The Direct Method of standardisation describes the rate of events that would occur in a chosen standard population by applying the age-specific rates of the subject population to the age structure of the standard population – in this instance, the European Standard Population.

- *European Standard Population:*

The European Standard Population is used to compute directly age-standardised rates. The same population is used for males and females.

Age group	European Standard Population
0	1,600
1-4	6,400
5-9	7,000
10-14	7,000
15-19	7,000
20-24	7,000
25-29	7,000
30-34	7,000
35-39	7,000
40-44	7,000
45-49	7,000
50-54	7,000
55-59	6,000
60-64	5,000
65-69	4,000
70-74	3,000
75-79	2,000
80-84	1,000
85+	1,000
Total	100,000

National target

- By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women monitored using mortality rates as a proxy (see national targets section below).

A.1 Ultimate success will be measured by the life expectancy at birth measure but AAACM will be used as a proxy to measure progress. AAACM is a more locally relevant measure, closely related to life expectancy and based on the same death data. The measure will enable local areas to focus on the causes of mortality and therefore the interventions that are most important to their local population. Provisional AAACM rates can be updated quarterly/monthly (subject to availability of data from ONS), enabling local areas to track progress in-year.

A.2 Final assessment of achievement will be assessed using the life expectancy measure, published by ONS, based on 3 year rolling averages.

A.3 Further details of the life expectancy measure are set out at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065226.

Indicator 2	Gap in all-age all-cause mortality (AAACM) rate, between Spearhead Group and national average
National target	Reduce health inequalities by 10% by 2010 as measured by life expectancy at birth (monitored using AAACM as a proxy) (see national targets section below).
Data provider	Office for National Statistics (ONS) (mortality rates and gap calculated by DH based on ONS data).
Data set used	3 year rolling average directly age-standardised mortality rates (standardised to European Standard Population), calculated from ONS mortality statistics from death registrations, and mid-year population estimates. Data for males and females are monitored separately.
Baseline	1995-97. ¹ Life expectancy for England: 74.6 years (Male); 79.7 years (Female). Life expectancy for Spearhead areas (average): 72.7 years (Male); 78.3 years (Female). Relative gap (% difference): 2.57% (Male); 1.77% years (Female).
Frequency of reporting	Annual (provisional rolling 12 month averages can be updated more frequently, subject to availability of data from ONS – quarterly/monthly to track performance)
95 per cent confidence interval	Approximate confidence intervals for the absolute gap in AAACM rates between the Spearhead Group and England average at last outturn are: Males: +/- 3.2 deaths per 100,000 population; Females: +/- 2.3 deaths per 100,000 population.
Data quality officer	Health Improvement Analyst, Health Improvement Directorate, Department of Health.
Minimum movement required for performance assessment	Ultimate success will be measured by life expectancy at birth and infant mortality, but AAACM will be used as a proxy to monitor progress. The AAACM rates in Spearhead areas will be assessed relative to the movement in the England average rate and taking account of the specific gaps of different Spearhead areas and their progress towards target.

Definition of key terms

- *Directly Age-standardised rates and European Standard population*: see Indicator 1.
- *Gap*

The absolute gap in AAACM rates between the Spearhead Group and England average, i.e. the difference between the average mortality rates for the Spearhead Group and England as a whole.

- *Spearhead Group*:

The Spearhead Group 70 Local Authority areas (which following the NHS reconfiguration, overlap with 62 Primary Care Trusts) that are in the bottom fifth nationally for 3 or more of the following 5 factors:

- Male life expectancy at birth;
- Female life expectancy at birth;

¹ Note: all figures may be subject to revision as a result of revision of population estimates by ONS.

- Cancer mortality rate in under 75s;
- Cardiovascular disease mortality rate in under 75s; and
- Index of Multiple Deprivation 2004 (Local Authority Summary), average score.

National target

- Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth i.e.
 - Starting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the "worst health and deprivation indicators" and the population as a whole
 - Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between the "routine and manual" socioeconomic group and the population as a whole

A.4 Ultimate success will be measured by the life expectancy at birth and infant mortality measures but AAACM will be used as a proxy to measure progress. AAACM is a more locally relevant measure, closely related to life expectancy and based on the same death data. The measure will enable local areas to focus on the causes of mortality and therefore the interventions that are most important to their local population. Provisional AAACM rates can be updated quarterly/monthly (subject to availability of data from ONS), enabling local areas to track progress in-year.

A.5 In order to achieve the increased life expectancy to meet the target, the ages at which people die in the areas with the worst health and deprivation is important as well as the number dying prematurely. Lives will have to be prolonged across the age range, not just in the elderly. The decline in AAACM required is sufficiently large that prolonging lives across the ages is the only way to achieve it. Spearhead areas can also use the Health Inequalities Intervention Tool to see at what ages excess mortality is occurring and from what diseases, enabling them to focus local action.

A.6 Final assessment of achievement will be assessed using the life expectancy and infant mortality measures, published by ONS, based on 3 year rolling averages. The baseline for the targets is 1995-97 for the gap in life expectancy. Further details of these are set out at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065226.

Indicator 3	Smoking prevalence
National target	To reduce reducing adult (16+) smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.
Data provider	Office for National Statistics.
Data set used	General Household Survey. This survey is due to be incorporated into the Integrated Household Survey during 2008.
Baseline	The percentage of the overall population in 2005, aged 16 or over, who smoke is 24% and in the routine and manual occupations is 31% Source – 2005 General Household Survey
Frequency of reporting	Annual.
95 per cent confidence interval	+/- 0.7 percentage points. +/- 1.4 percentage points.
Data quality officer	Tobacco analytical lead, Health Improvement Directorate, Department of Health.
Minimum movement required for performance assessment	We can be confident of achievement if the recorded levels are below 20.3 per cent and 24.6 per cent respectively. Conversely, we can be confident that they have not been met if the recorded levels are above 21.7 per cent and 27.4 per cent respectively. Falls between two years greater than 0.9 and 1.6 percentage points respectively are statistically significant (at the 95% one-tailed level).

Definition of key terms

- *Smoking prevalence:*

Respondents who replied "yes" to the question "Do you smoke cigarettes at all nowadays?" The results are weighted to take account of non-response.

- *Routine and manual occupations:*

Consists of the following categories from the National Statistics Socio-Economic Classification (NS-SeC): lower supervisory and technical occupations, semi-routine occupations and routine occupations. For comprehensive information on NS-SeC see http://www.statistics.gov.uk/methods_quality/ns_sec/default.asp

National target

- To reduce reducing adult (16+) smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.

A.7 Results from the General Household Survey are published around 10 months after the end of the fieldwork period. The smoking results from the Integrated Household Survey are expected to become available after a similar period. The results for the 2010 calendar year are expected to be published towards the end of 2011.

A.8 Overall success for this measure will be achieving both elements of this target by 2010, which is to reduce reducing adult smoking rates to 21 per cent or less, with a reduction in prevalence among routine and manual groups to 26 per cent or less.

Indicator 4	Independence - Proportion of adults (18+) supported directly through social care community care assessment, to live at home²
Data provider	Local Authorities through statistical returns to the Information Centre for health and social care.
Data set used	Referrals, Assessments and Packages (RAP) data Grant Funded Services (GFS1).
Baseline	Robust data for these lines will be available in November 2008, following data quality issues with one of the data returns (Grant Funded Services) and baselines should be produced shortly afterwards. Partial data for part of this metric will be available in November 2007 and a proxy baseline produced soon thereafter.
Frequency of reporting	Annual.
95 per cent confidence interval	Data not yet available to establish confidence interval (see above).
Data quality officer (name and/or post)	Section Head, Adult Social Care Statistics, Information Centre for health and social care.
Minimum movement required for performance assessment	To be determined on establishment of baselines – (see above).

Definition of key terms

- *Supported to live Independently:*

Number of adults (18+) supported directly through social care community care assessment, to live at home. Source:³

- RAP Table P2s Page 1 line 1 (Physical disability frailty and sensory impairment) column 1.
- RAP Table P2s Page 1 line 9 (Learning Disability) column 1
- RAP Table P2s Page 1 line 6 (Mental Health (total)) column 1
- RAP Table P2s Pages 3 and 5 line 11 (people over 65) column 1
- RAP Table P2s page 1 line 8 (Vulnerable People)
- RAP Table P2s Page 1 line 10 (Substance Misuse)
- *Grant Funded Services:*

The number of adult clients (aged 18+) who are receiving services (within a sample week) outside of the formal care management process that are equivalent to the services reported in the RAP return, but that are provided by organisations external to the council (Borough and District councils count as external for this definition) as a result of council funding. This covers those clients that are not at the time in receipt of services as a result of a community care assessment. (<http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections>).

² Indicator to be expressed as a proportion of age/need weighted and adjusted population data aged 18+ 1,000 / 10,000.

³ <http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information>.

A.9 Mechanisms within the system such as Eligibility Criteria and user/population expectations as expressed through the Joint Strategic Needs Assessment and individually through the development of the Common Assessment Framework would act to ensure that support provided would meet the various levels of support needed by the local population. A lack of sufficient focus on intensive support can be tested through related indicators including:

- Achieving independence through rehabilitation;
- Delayed transfers of care;
- Number of emergency bed days;
- Self reported experience of social care service users; and
- People over 65 receiving the support they need to live independently (Later Life PSA indicator included in Local Government Framework).

Indicator 5	Proportion of people with depression and/or anxiety disorders who are offered psychological therapies
	<p>This is a comparison of:</p> <p>(A) the number of people who have depression and/or anxiety disorders;</p> <p>(B) the number of people who are diagnosed with depression and/or anxiety disorders; and</p> <p>(C) the number of people who are offered psychological therapies.</p>
Data provider	Data will be provided by PCTs (including access to GP-based QOF data)
Data set used	<p>(A) The psychiatric morbidity survey will give a sound estimate of the number of people with depression and/or anxiety disorders (both diagnosed and undiagnosed) – available in mid-2008.</p> <p>(B) A new dataset will count the number of people who are diagnosed with depression and/or anxiety disorders. This should capture all who are diagnosed, regardless of whether they proceed to psychological therapy services or not (e.g. if they are treated with medication). It will be based on use of the GAD7 indicator (to signify caseness in anxiety disorders) and the PHQ9 indicator (to signify caseness in depression). Again, this number should, if feasible, be broken down by gender, sexuality, age, disability, ethnicity and race. This data will be collected by GPs, local services and acute services. For depression, data are already available through the QOF – this can be used to help determine the baseline for the depression element in 2008/09.</p> <p>(C) A new dataset will capture the number of people who receive psychological therapies. It will be a count of the number of individual patients who commence a course of evidence-based psychological therapy. This number should be broken down by gender, sexuality, age, disability, ethnicity and race. These data will be collected via a single point of access, or similar entry points, with a standard assessment process. As datasets (B) and (C) are new, the descriptions above are at this stage aspirational. From 2008/09 every PCT is expected to provide a minimum set of data for IAPT – however the exact composition of this dataset is currently to be determined. The collection of this data will build on existing work – for example, the 10 IAPT pathfinder sites will be able to provide the majority of these data from shortly after their inception, with the first quarterly round of data in December 2007. The PHQ9 (depression indicator) is linked with the QOF and already collected at national level.</p>
Baseline	This is a new dataset. As such, baselines will be determined by winter 2008/09.
Frequency of reporting	These data should be reported on a three-monthly basis. (This coincides with frequency of reporting for the Pathfinder sites).

95 per cent confidence interval at last outturn	To be determined when the baseline data is established, by winter 2008/9.
Data Quality Officer	IAPT Data Analyst, Mental Health Programme, DH.
Minimum movement required for performance assessment	<p>To be determined when the baseline data is established, by winter 2008/9. We will seek an increase in (i) the proportion of people diagnosed with depression and/or anxiety disorders who are offered psychological therapies (i.e. C/B must increase) and (ii) the proportion of all people with depression and/or anxiety disorders who are offered psychological therapies (ie C/A must increase).</p> <p>This is a comparison of: (A) the number of people who have depression and/or anxiety disorders; (B) the number of people who are diagnosed with depression and/or anxiety disorders; and (C) the number of people who are offered psychological therapies.</p>

Definition of key terms

- *Progress:*

progress against the indicator will be measured by looking at the increase in the proportion of people with anxiety disorders and depression who get prompt access to evidence-based psychological therapies.

- *Case:*

a patient suffering from depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire (PHQ9) for depression and/or the Patient Health Questionnaire (GAD7) for anxiety disorders.

- *Evidence-based psychological therapy:*

low or high intensity brief Cognitive Behavioural Therapy (CBT), Computerised CBT (cCBT), which may include large group CBT, self-help support groups, and telephone support and guidance.

A.10 The number of people who are diagnosed with depression and/or anxiety disorders includes:

- people diagnosed by a GP;
- people who self-refer for treatment and are diagnosed as a case by local services; and
- people who are referred from elsewhere and have already been diagnosed as a case or are diagnosed as a case by local services.