The operating framework for the NHS in England 2011/12

Key points
- NHS organisations have an extra year to achieve the efficiency savings target of £20 billion.
- £89 billion will be allocated to PCTs next year – an increase of £2.6 billion.
- PCTs will remain statutorily accountable in 2011/12 and 2012/13, but more clusters of PCTs will form next year.
- Some PCT staff will be allocated to emerging GP consortia.
- Alterations in tariff and non-tariff prices for providers are outlined.
- SHAs will hold back 2 per cent of PCTs’ allocations to ensure funds are available to meet the costs of change.
- An outcomes framework has been published containing outcome goals to help focus on health improvements achieved.

On 15 December 2010 the Department of Health published the operating framework for the NHS in England for 2011/12, the first full year of the transition to the proposed new structure for the NHS. The overarching goal is to build strong foundations for the new system by: maintaining and improving quality; keeping tight financial control; delivering on the quality and productivity challenge; and creating energy and momentum for transition and reform. This Briefing outlines the key points from the operating framework.

Background
The operating framework sets out what NHS organisations should focus on in 2011/12 to prepare for transition to the new system of GP-led commissioning that will be fully in place by 2013, as outlined in the white paper Equity and excellence: liberating the NHS. As the NHS moves towards this new system, there is a need to meet rising demand while also continuing to improve performance and outcomes for patients. To achieve this, the NHS is being asked to cut waste, reduce bureaucracy and simplify NHS structures.

In October 2010, the government’s spending review for the period 2011/12 to 2014/15 confirmed that the total NHS budget would increase by £10.6 billion over four years. This is, however, in the context of the government’s expectation for reducing management costs and Quality, Innovation, Productivity and Prevention (QIPP) productivity gains to release up to £20 billion which can be reinvested in front-line services over the four-year period.

The new NHS landscape
The role of PCTs
Primary care trusts (PCTs) will undergo significant change during 2011/12 as GP consortia and the NHS Commissioning Board develop.
Action is needed to prevent the risk of unplanned loss of capacity and capability in the current commissioning system. The Department of Health (DH) therefore has decided that, while PCTs will continue to be the statutory unit of accountability during 2011/12, they will increasingly discharge their responsibilities through cluster arrangements.

PCT staff (including finance managers and experts in governance and commissioning) will be assigned to emerging GP consortia to support their development. This will help the 52 GP consortia announced in December 2010 as ‘pathfinders’, involving 1,860 GP practices covering around 25 per cent of the population.

The responsibilities of clusters will include: delivery of medium-term QIPP objectives; delivery of operational plans for 2011/12 and 2012/13; overseeing PCT closedown; commissioning of all services not delegated to GP consortia; PCT statutory obligations; staff engagement; and stakeholder relationships.

Hard budgets should be delegated to the consortia when they are in a position to take control of such resources. PCTs are also expected to help consortia become involved in the joint strategic needs assessment (JSNA) processes.

PCTs should involve all GP practices in the 2011/12 commissioning process. All commissioner-provider contracts should be in place before the start of the new financial year. They must also ensure that GPs, existing practice-based commissioners and developing consortia are involved in these negotiations.

PCTs are still expected to publish local plans for 2011/12 “where appropriate”.

The NHS Commissioning Board will be created in shadow form as a special health authority, in advance of its official establishment in April 2012.

**Aspirant foundation trusts**

All NHS trusts will become NHS foundation trusts by the end of 2013/14, including newly established NHS trusts formed out of PCT provider arms. In January 2011, the DH will advise trusts still seeking foundation trust status on the necessary actions. Community service dataset will be developed in 2011/12.

**Health and wellbeing boards**

Commissioners will need to work closely with local authorities to establish shadow health and wellbeing boards in 2011/12, prior to full implementation from April 2012. ‘Early implementer’ boards are expected, with close links to the pathfinder GP consortia.

**Standard contracts**

Standard contracts for acute and mental health trusts that have integrated with PCT provider arms will be revised during 2011/12 and 2012/13. The bespoke contract for the care homes sector will also be reviewed.
The operating framework for the NHS in England 2011/12

Accountability

Local health services need to become more transparent and understandable for local people, and patient experience “must be a key arbiter of all NHS services.” The operating framework outlines some of the mechanisms to support this “revolution in patient power”. Further proposals will be published early in 2011.

A new outcomes framework

The first NHS outcomes framework has been published. This will be used to hold the NHS Commissioning Board to account for improving quality and delivering better health outcomes.

The outcomes framework consists of a small set of outcome goals or domains. Each domain will be supported by a suite of NICE quality standards. Priority areas include improvements in relation to healthcare associated infection rates and progress on cancer access indicators.

Other mechanisms for increasing accountability to patients include:

- better collection of and timely action on patient experience and feedback
- better information, helped by a new information strategy setting out how local commissioners and the people they serve can be better supported in decision making
- quality accounts being extended to cover community services
- greater clarity of how expenditure translates into local achievements.

Key priorities

Key priorities in the operating framework for 2011/12 include:

- continuing to reduce healthcare associated infections
- reducing the emergency admission rate
- eliminating mixed-sex accommodation
- ensuring good and timely cancer screening services
- being prepared to respond in a state of emergency, such as a pandemic flu outbreak
- maintaining quality in public health
- improving healthcare for people with a learning disability
- paying greater attention to the physical and mental health needs of children and young people
- ensuring good services for people with diabetes
- addressing violence against women and girls
- delivering good respiratory disease services
- increasing access to psychological therapies
- commissioning improvements in dentistry services
- improving mental health services
- improving stroke outcomes
- ensuring good end-of-life care.
“It will be challenging to bring about the necessary changes in the NHS in 2011/12 while maintaining service quality”

The NHS Constitution will continue to play an important role. The promotion and conduct of research is also a crucial function. An evidence base should be used for both the delivery and design of NHS services.

Increased choice
Patients should be able to choose a named consultant-led team for outpatient appointments by April 2011.

Further choice guidance is expected in the New Year. It is currently anticipated that choice should be offered during 2011 for: some mental health services, diagnostic testing and post-diagnostic support; long-term conditions, and a number of community services. Choice of GP practice is also expected from April 2012.

Choice in maternity services is a key commitment. Further work is expected on the development of a maternity tariff.

The roll-out of personal health budgets will be continued, informed by the lessons learned from pilot programmes.

Quality accounts
Providers need to illustrate how they perform in relation to patient priorities, how they engage with patients and the public, and the ways in which they measure their performance compared to others.

Service quality
It will be challenging to bring about the necessary changes in the NHS in 2011/12 while maintaining service quality. The operating framework gives a list of key indicators and milestones against which PCTs and clusters will be held to account during 2011/12 and which should be used to assess how strategic health authorities (SHAs) and PCTs are delivering on plans during the year of transition.

Key new commitments

**Health visitors** – the number of health visitors will be increased by 4,200 by April 2015.

**Family nurse partnerships** – programme capacity to be doubled by April 2015.

**Cancer Drugs Fund** – to come into operation from April 2011, with £200m annual funding.

**Military and veterans’ health** – SHAs are expected to ensure the implementation of the Murrison Report and to maintain armed forces networks.

**Autism** – new guidance will require NHS commissioners and providers to assess the needs of people with autism in their areas.

**Dementia** – NHS organisations should focus on: early diagnosis and intervention; increased quality of hospital care; care home standard of living; and the usage of antipsychotic medication.

**Carer support** – NHS organisations are expected to pay heed to the recent *Recognised, valued and supported: next steps for the carers strategy* document which highlighted early identification of carers; supporting carers with education and employment opportunities; personalised support; and maintaining mental and physical wellbeing. PCTs should agree policies and budgets for carer support for 2011/12.

Efficiency savings
The £20bn efficiency challenge has been extended by one year, up to the end of 2014/15. This adjustment follows the spending review, the two-year pay freeze and the “deeper than originally modelled reductions in management and administration costs.” However, the operating framework warns against any loss of focus on this agenda. Single operational plans should outline how organisations will deliver on their QIPP objectives for 2011/12 while managing the transition and reinvesting savings.
Public health

The NHS is expected to continue to provide leadership for public health in 2011/12. The operating framework confirms many of the proposals in Healthy lives, healthy people, last month’s public health white paper, including:

• Public Health England will assume responsibility for delivering public health services from 2012. Local authorities will receive shadow funding allocations in 2012/13, with full resources expected the following year.

• PCTs will assume responsibility for the hazardous accident response teams (HARTs) in ambulance trusts, following the reallocation of funding.

• PCTs should continue to progress their NHS health check programmes – complete coverage of abdominal aortic aneurysm screening is anticipated by the end of 2012/13.

• PCTs should examine ways in which they can help to reduce prevalence of fragility fractures among the elderly in their community.

• Plans should be in place within all organisations for efficiently dealing with any exceptional rises in service demand. Pandemic influenza remains a serious threat.

The Government is consulting on the public health white paper until 8 March 2011.

Finance issues

Surplus strategy

Aggregate surpluses for 2010/11 among SHAs and PCTs will continue to be made available to these organisations during the following year. The drawdown of surplus is projected at £150m.

No PCT should plan for an operational deficit in 2011/12. Every PCT should ensure that 2 per cent of recurrent funding is only committed to non-recurrent spending. However, SHAs will hold these resources, with PCTs required to submit business cases to access them.

GP consortia will not be responsible for tackling PCT debt that accrued prior to 2011/12. PCTs and clusters should ensure that “all existing legacy issues are dealt with” between 2011 and 2013. PCTs and consortia should collaborate on delivering financial control.

PCT allocations

Average growth in PCT recurrent allocations is 2.2 per cent, with minimum growth at 2.0 per cent. The allocations are made on the basis of a revised weighted capitation formula.

Additional allocations for social care, primary dental services, general ophthalmic services and pharmaceutical services result in overall PCT allocations increasing by £2.6bn (3.0 per cent), with rises to trusts varying between 2.5 and 4.9 per cent.

Running costs

From 2011/12, PCTs and SHAs must report running costs, rather than merely management costs. The definition will be finalised in the financial planning guidelines but will include “any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.”

By 2014/15 the overall running costs of the ‘NHS superstructure’ will reduce by one third. This includes the more than 45 per cent reduction in management costs detailed in the white paper.

The expectation is that GP consortia will have an allowance for running costs in the range of £25 to £35 per patient by 2014/15.

Capital funding

Any unspent capital allocation will not be allowed to be carried forward. PCTs will no longer receive capital funding automatically, with any applications being evaluated on a case-by-case basis.

NHS trusts are advised to prioritise any urgent backlog maintenance work. They should also evaluate the need for any single rooms that may be required to fulfil their obligations regarding mixed-sex accommodation and infection control.

Social care

PCTs will receive £648m to support the delivery of social care in 2011/12, in addition to the
Providers will now be allowed to offer services below the published mandatory price, if both commissioners and providers concur

£150m for reablement services which is in the baseline funding.

Further allocations of £622m and £300m respectively for social care and reablement are expected for 2012/13. PCTs and local authorities should work together on determining the most appropriate areas for investment, as part of the joint strategic needs assessment process.

Tariff

The development of the national tariff for 2011/12 is driven by the following priorities: quality and outcomes; efficiency; integration and patient responsiveness; and expanding tariff scope. Health Resource Group version 4 (HRG4) will be implemented in 2011/12.

A 2 per cent efficiency requirement has been embedded into the tariff, with the introduction of a five-day trim point floor (to ensure shorter hospital stays do not incur a long-stay payment), the setting of all tariffs at 1 per cent below average and the expansion of best practice tariffs.

National efficiency assumption for 2011/12 is set at 4 per cent. Once 2.5 per cent for pay and prices is included, this results in an adjustment of a 1.5 per cent reduction to be applied when negotiating prices outside national tariffs. Tariff prices for 2011/12 are subject to a final adjustment of 0.5 per cent.

Hospitals will no longer be reimbursed for emergency readmissions within 30 days of discharge following an elective admission in 2011/12. All other readmission rates will be subject to locally determined thresholds, with a 25 per cent decrease desired where achievable.

PCTs, providers, GPs and local authorities should jointly manage the savings arising from this initiative on reablement and post-discharge support. PCTs have received £70m in 2010/11 in an attempt to offer greater support in that 30-day period. They have been required to devise local plans in an effort to prevent unnecessary readmissions.

During 2011/12 the DH will work with ‘early implementer’ areas on tariff increases to be introduced from 2012/13. New currency and tariff development should be led locally by the NHS. The DH also believes this process should not hamper service integration where this is found to be in the interest of patients.

Providers will now be allowed to offer services below the published mandatory price, if both commissioners and providers concur. It is intended to significantly broaden the scope of the mandatory tariff after 2012.

CQUIN and ‘never events’

Existing Commissioning for Quality and Innovation (CQUIN) goals around venous thromboembolism (VTE) risk assessment and responsiveness to patient needs should be included in acute CQUIN schemes in 2011/12. CQUIN will also be extended to care homes.

The NHS standard contract has expanded the list of ‘never events.’ Commissioners can recover costs of care when one of these occurs.

SHA bundle

2011/12 is the final year for the SHA bundle of funding. It is proposed that this resource should decrease slightly to £6.243bn. While funding for some policy programmes has declined, the funding for prison drug treatment has increased.

Long-term plans

The operating framework wants to ensure that PCTs and SHAs maintain standards and a long-term vision for the NHS.

In 2011/12, for accountability arrangements, it expects one integrated plan that brings together all of the major requirements across quality, resources and reform. These plans should be geographically based, and NHS organisations should start working closely with existing and emerging GP consortia to help shape the development of PCT plans.

The plans will outlive the lifespan of SHAs and PCTs, so have to be drawn up with a long-term agenda in mind and need to describe the overall improvements envisaged over the next four years in terms of quality, productivity, management of resources and capacity building for the new system.
Plans will be collected in two stages. A first draft is due on 28 January 2011, covering the full scope of the plan, and a final draft will be due on 25 March 2011.

Between March and June 2011, NHS leadership will visit each SHA to carry out a ‘transition assurance process’ seeking assurance that the authority has a suitable agenda for quality, productivity and reform.

Confederation viewpoint

The operating framework for 2011/12 contains a very large number of tasks and imperatives and a daunting delivery agenda: the reforms, QIPP and a long list of new and existing policies to implement.

Some attempt has been made to ameliorate this, but the scale of the requirements seems to be at odds with the need to reduce management costs by a very large amount relatively quickly and will be a major challenge even with PCT clustering – itself a significant management task.

The proposal to find ways to stabilise PCTs and to ensure that there is some continued system management is welcome, but it will be very important that this is implemented in a way that is sensitive to local issues. This will constitute a further significant management burden.

We await with interest the remaining elements of the policy which will outline the range of responsibilities required of the existing and new commissioners as they embed into the local systems. However, the challenges are not just focused on commissioners – the changes in tariff, the continued move to foundation trust status, and preparation for any willing provider markets will also maintain the need to focus on efficiency for NHS providers of care.

The changes to the tariff will be challenging, and there are particular concerns in services where the majority of income is non-tariff that they will suffer disproportionately. The embedding of efficiency improvements in the tariff also brings a risk that some providers will experience particularly challenging additional cost reduction targets.

The hint at a further move to price competition is an issue that will require further discussion as without strong commissioning and quality measurement there is a concern that this can have a deleterious impact on quality.

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

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