Operating Framework for the NHS in England 2012/13

Key points
- A range of outcome measures are set out under the domains of the NHS Outcomes Framework.
- PCT allocations will grow by at least 2.5 per cent in 2012/13 and PCT clusters must ensure all patients are seen on the basis of clinical need.
- The running cost of clinical commissioning groups (CCGs) will be £25 per head and the tariff price adjuster will see a reduction of at least 1.5 per cent.
- All NHS trusts are expected to achieve NHS foundation trust (FT) status by April 2014 other than by exceptional agreement.
- There are key areas for improvement of dementia and care of older people, carers support, and military and veteran health.
- CQUIN (Commission for Quality and Innovation) will be increased to 2.5 per cent on top of actual ‘outturn’ value.

The Operating Framework for 2012/13, published on 24 November 2011, aims to help the NHS implement the necessary changes in the Government’s health reform programme. Focusing on quality, reform, finance and business rules, and planning and accountability, the full document describes the national priorities, system levers and enablers the NHS needs to change services while maintaining and improving quality and finance. Supplementary outcomes measures, to ‘temperature check’ patients’ experience of services, were published on 7 December.

This Briefing sets out the key points of the Operating Framework, alongside our reaction to its publication, and some of the specific points our members asked for the Framework to include.

Background
In their meeting with NHS deputy chief executive David Flory back in September 2011, a group of our members requested that the 2012/13 Framework set limited and achievable key national priorities. So we were pleased to see a Framework that will both assist the NHS through the huge structural reform set out in the Health and Social Care Bill and help existing commissioners and providers to focus on the main tasks at hand.

Sir David Nicholson emphasises the need to get the basics right, alongside the importance of maintaining a grip on performance, meeting the QIPP (Quality, Innovation, Productivity and Prevention) challenge and building the new system.

The 2012/13 Framework sets out to improve services for patients by:
- putting patients at the centre of decision making
The Operating Framework identifies a set of systemic areas that organisations need to work together on, including:

- commissioners need to ensure providers comply with relevant NICE standards
- commissioners should work with GPs to improve general practice and community services so that patients only go into hospital if that will secure the best clinical outcome
- organisations are to ensure information is published in providers’ quality accounts.

PCT clusters should also ensure all providers have a systematic approach to improving dignity in care, staff training and incorporating learning from patients and carers. PCTs need to work with local authorities to set out progress on the national dementia strategy with local or national CQUIN goals included in 2012/13.

Carers

PCT clusters need to agree policies, plans and budgets with local authorities and voluntary groups to support carers where possible with personal budgets. Plans should be in line with the national carers strategy and published on PCT websites by 30 September 2012.

Military and veteran health

Strategic health authorities (SHAs) need to maintain and develop their armed forces networks to ensure principles of the Armed Forces Network Covenant are met. The MoD/NHS Transition protocol for those seriously injured in the course of duty must be implemented, as well as improving mental health services for veterans.

Health visitors and family nurse partnerships

SHA and PCT clusters need to work together to increase the number of health visitors, and PCT clusters are to expand family nurse partnerships so that capacity is doubled to 13,000 places by April 2015.

Outcomes across the Framework domains

The full Operating Framework document goes into some detail on a range of measures in the NHS Outcomes Framework with outcome measures or proxies for each of the domains, that will be underpinned by a suite of NICE quality standards.

NHS organisations should continue to work to meet expectations in service-specific outcomes strategies published for services such as mental health services, cancer and long-term conditions associated with premature mortality.

Outcomes Framework – the five domains

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.
Particularly welcome is that the Operating Framework specifically mentions the national No health without mental health strategy, and asks PCTs to consider it in supporting local commissioning of mental health services. Our members requested that the Framework referred explicitly to the national strategy, particularly on the target to increase access to psychological therapies by 2014/15 and targeted support for children and young people at particular risk, so we are pleased to see this included.

The Operating Framework highlights examples of good practice to support the delivery of the QIPP challenge.

Reform

This key part of the Framework sets out detailed information on what commissioners and providers need to do during 2012/13 to prepare for implementation of the health and social care reforms.

The new commissioning landscape

PCTs and SHAs will remain statutory organisations throughout 2012/13. They will be held to account on delivering ongoing performance and supporting development of new organisations and clinical leadership for commissioning. Further guidance will be published in 2012/13 on the transfer of responsibilities from PCTs to the NHS Commissioning Board. Clinical senates and networks are expected to be established in 2012/13.

PCTs must support the clinical commissioning group (CCG) authorisation processes, the development of commissioning support offers, the establishment of effective transition for services and staff, while demonstrating they are allocating both non-pay running costs and staff to support emerging CCGs. Before March 2013, they need to work with GP practices to review practice registered patient lists.

SHAs and PCTs must support shadow health and well-being boards and encourage CCGs to take an active part in their formation. Further specific guidance on the CCG authorisation process is awaited, but CCGs should be coterminous with a single health and well-being board as far as possible.

By 31 January 2012, SHAs should be confident that any CCG configuration issues can be solved by the end of March 2012. SHA clusters are responsible for overseeing CCGs’ readiness for authorisation.

Almost half of available budgets have already been delegated to emerging CCGs, and this is expected to increase. CCGs will need to:

- manage budgets well and play active roles in 2012/13 planning
- develop relationships with local partners including social care, local community and be active on the shadow health and well being boards
- deliver their relevant share of the QIPP agenda
- address configuration issues by end of March 2012
- prepare application for authorisation
- identify how to secure commissioning support and plans to use their running cost allowance.

Commissioning support must be commercially viable and distinctly separate from the PCT cluster. It may occupy a different geographic service footprint to PCT clusters and their PCT constituents.

The new public health landscape

Public Health England is to operate in shadow form in 2012/13 and as a statutory executive agency from April 2013. The NHS will be accountable for delivering successful public health transition with local authorities. PCT and SHA clusters will need robust transition plans for public health.

PCTs will need to work with local authorities to develop the vision and strategy for the new public health role, prepare local systems for new commissioning arrangements, ensure new clinical governance arrangements are in place and test the new arrangements for emergency planning, resilience and response.

The new provider landscape

The Operating Framework confirms that NHS trusts are expected to achieve FT status on their own or as part of an existing NHS FT, or in another organisational form by April 2014. It says that national support will be considered for a small number of NHS trusts where “solutions cannot be found locally.”

In 2012/13, PCTs should start to offer patients the choice of Any Qualified Provider (AQP) in at least three services. They should work with CCGs and patients to set outcomes-based
specifications for providers to deliver high-quality services.

**Choice and personal health budgets**

PCTs need to continue to implement choice of:

- named consultant team
- diagnostic test provider
- post-diagnosis treatment
- treatment and provider in mental health
- care for long-term conditions
- maternity care.

From April 2012, providers will have to accept patients referred to a clinically-appropriate, named consultant-led team and list their services on the Choose and Book system.

PCTs are asked to work with GPs to establish new ‘outer areas’ to enable patients to stay with their existing practice. Three pilots will take place looking at opening up choice beyond traditional practice boundaries. PCTs will need to ensure patients who register with a practice beyond their local area have appropriate access to local urgent care services. PCTs should prepare for wider roll out of personal health budgets.

**Information**

Better information for patients is a key part of the Government’s reform programme. In 2012/13 the NHS will need to prepare for the forthcoming information strategy to give patients better access to their records, provide information on outcomes to support choice, support integrated care through sharing of information, and allow for better use of aggregated information.

NHS organisations will need to ensure that key NHS datasets (published by the Prime Minister1) are available and of good quality and patients written to about the summary care record should have one created by March 2013.

Organisations need to use the NHS number consistently in 2012/13 and commissioners should link the use of the NHS number to contractual payments. Punitive contract sanctions will be in place for any organisations not compliant by 31 March 2013.

Appropriate governance policies and guidelines for protecting information must be implemented. This is particularly important during the transition to the new system.

**Workforce**

NHS and partner organisations must sustain a ‘talent pipeline’ for critical posts and nationally the new NHS Leadership Academy will provide talent management for all those involved in healthcare leadership.

Organisations should improve staff health and well-being, including ensuring occupational health services are accredited and promoting flu vaccination for staff. NHS staff survey results should be used to improve staff experience and services.

**Education and training**

During 2012/13, SHAs will remain accountable for education funding, commissioning decisions, medical recruitment and working with healthcare providers. They are required to set up provider-led partnerships to take on these responsibilities from April 2013.

SHAs need to ensure business continuity and plan for transfer of education and training contracts. They need to plan for implementation of revised education and training tariffs.

**Pension and pay**

The NHS is required to implement increased employee contributions from April 2012. A pensions charter will clarify roles and responsibilities.

2012/13 is the second year of a two-year pay freeze for public sector workers. The Government recommends that staff earning £21,000 or less receive a flat rate increase of £250 from April 2012.

**Finance and business rules**

**Surplus strategy**

Aggregate surpluses for 2011/12 in SHAs and PCTs will continue to be made available to these organisations during 2012/13. The ‘drawdown’ of surplus is projected at £150 million.

No PCT or SHA should be planning for an operational deficit in 2012/13 and PCTs carrying a legacy debt will be required to clear it. CCGs will not be responsible for PCT legacy debt arising prior to 2011/12 and are expected to work closely with PCTs and clusters to ensure no PCT ends 2012/13 in deficit. NHS trusts must plan for a surplus consistent with their pipeline plan and their tripartite formal agreement (TFA).

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The running cost allowance for CCGs from 2013/14 is expected to be £25 per head of population per annum before any entitlement to a quality premium, and the running cost allowance for the core functions of the NHS Commissioning Board will be at least £492 million.

Capital
NHS trusts must ensure they have a clean and safe environment by prioritising any urgent backlog maintenance and upgrading work. They should also evaluate the need for any single en-suite rooms that may be required to fulfil their obligations on mixed sex accommodation, patients’ dignity and infection control.

SHA clusters will agree capital expenditure plans for NHS trusts and PCTs and any unspent capital allocation will not be carried forward.

Tariff
National tariff development for 2012/13 is driven by increasing the quality of care and outcomes, driving integration of services and incentivising delivery of QIPP. In 2012/13 the scope of the tariff will be extended to:

- require the recently developed currency to be used when contracting for adult mental health services
- introduce mandatory currencies for chemotherapy delivery, external beam radiotherapy and ambulance services
- introduce non-mandatory currencies for HIV outpatient services and some community podiatry
- introduce a ‘quality increment’ for patients at regional major trauma centres, to facilitate the move to trauma care being provided in designated centres
- introduce national ‘pathway’ tariffs for maternity care, cystic fibrosis and paediatric diabetes
- introduce tariffs for post-discharge care for some procedures, which will be mandatory where acute and community services are integrated in one trust.

Best practice tariffs will be expanded to:

- incentivise more procedures in a less acute setting and same-day emergency treatments where clinically appropriate
- increase the payment differential between standard and best practice care for fragility hip fracture care and stroke
- promote the use of interventional radiology procedures.

The 30 per cent marginal rate will continue to apply for increases in the value of emergency admissions, as will the policy of non-payment for emergency readmissions following elective surgery. The Department of Health (DH) is working with the Foundation Trust Network to produce more detailed guidance on the operation of this policy in 2012/13. Commissioners will be required to adjust the tariff price if...
The national efficiency requirement for 2012/13 is set at 4 per cent and will be offset by pay and price inflation.

the type of patients that a provider treats results in it incurring lower costs than the average of the tariff category (intended to respond to concerns about ‘cherry picking’).

The national efficiency requirement for 2012/13 is set at 4 per cent, which will be offset by pay and price inflation. The tariff price adjuster will be a reduction of at least 1.5 per cent and will also be applied to non-tariff services. This will be confirmed in the 2012/13 Payment by Results guidance following allocations.

Some best practice tariffs have a built-in efficiency assumption, allowed for in the overall tariff price adjuster. Others will lead to reduced payments where best practice is not achieved and this is not allowed for in the tariff price adjuster.

For 2012/13 the DH will continue to work on existing long-term condition tariffs to support the development of higher-quality primary and community-based services.

CQUIN framework
Our members had asked that CQUIN becomes a stronger incentive to deliver QIPP objectives, improve quality and drive service transformation. The Operating Framework says that CQUIN will be developed in 2012/13 so that, for all standard contracts, the amount providers can earn will be increased to 2.5 per cent.

National goals on venous thrombo-embolism (VTE) risk assessment and on responsiveness to personal needs of patients will continue alongside two new national goals:

- improving diagnosis of dementia in hospitals
- increasing use of the NHS Safety Thermometer.

Where CQUIN funding has been used to achieve higher quality, funding may be recurrent but only when the commissioner is satisfied it is necessary to maintain any improvement.

Commissioners and providers should refer to the NHS Chief Executive’s Innovation Review, published in December 2011 when developing CQUIN schemes for 2012/13.

Clinical audits
Work is underway to transfer the cost of established clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) to providers of relevant and tariffed services from 2012/13.

SHA bundle
The proposed value of the SHA ‘bundle’ of funding is £6.4bn, the same amount as in 2011/12. Further detail will be released with financial planning guidance. Clinical networks will continue to be funded through the SHA bundle in 2012/13.

Joint working with local authorities
PCT clusters need to work with local authorities to jointly agree priorities around investment of

funds allocated for reablement in 2012/13. This could include funding new services such as the social care aspects of the national dementia strategy and impact actively on delayed transfers of care.

PCT clusters will need to continue to transfer social care funding within allocations to local authorities to invest in social care services.

Procurement
The DH is preparing a procurement strategy to be launched by April 2012 to help trusts improve their procurement performance. Trusts that spend more on goods and services than the benchmark will have to justify why they are doing so.

Contract management arrangements
The 2012/13 NHS Standard Contract will be a single agreement for use by commissioners when commissioning services from providers that are seeking to deliver NHS-funded secondary and community services. Contracts will be limited to 12 months for 2012/13.

Work will continue on the transfer of clinical contracts from current commissioners to the new commissioning authorities. Guidance on the later stages of the transfer process will be issued during 2012.

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Principles and rules for cooperation and competition (PRCC)
PCT clusters must review their practices in line with the Cooperation and Competition Panel report on AQP in elective care to ensure they are compliant with the PRCC. Any decisions restricting patient choice must be taken at board level and published annually.
with the associated rationale, impact and period of operations. SHA clusters will have oversight of the PRCC locally in 2012/13.

Planning and accountability
In 2012/13, SHAs will continue to work through SHA clusters to hold PCT clusters to account. From 2013/14, the NHS Commissioning Board will be held to account by the Department of Health, and commissioners should anticipate a more outcomes-based approach.

Each PCT cluster is required to have an integrated plan for 2012/13 to 2014/15, building on previous plans. Integrated plans should have a clear focus on quality and the national priorities set out in the Operating Framework. Technical planning guidance with key milestones is awaited, and we expect financial planning guidance in January 2012.

At a minimum, PCT clusters must ensure that CCGs explicitly support plans for 2012/13 and beyond to ensure a strong base on which to build their own planning from 2013/14. Plans should reflect the outcomes of local Joint Strategic Needs Assessments and the public health transition elements should be supported by local authorities.

Performance monitoring and assessment

Three groups of indicators will be used to nationally assess the performance of PCT and SHA clusters:

- quality (covering safety, effectiveness and experience)
- resources (covering finance, workforce, capacity and activity)
- reform (covering commissioning, provision and patient empowerment).

PCT clusters will also be monitored against the key milestones for the transformational change elements of QIPP and reform, agreed with SHA clusters as part of the planning round.

Confederation viewpoint
At a time when the NHS is going through huge structural reform, and its most challenging financial period, we were relieved to see a document that will help commissioners and providers keep focused on the main tasks at hand and build on existing priorities.

In their meeting with NHS deputy chief executive David Flory back in September 2011, a group of our members specifically asked that the 2012/13 Framework set a limited and achievable number of key national priorities, and we believe the end product reflects this.

Also encouraging is the emphasis on the importance of dignity in care for older people, which chimes with our joint Commission on dignity in care with Age UK and the Local Government Association, set to publish draft recommendations in January 2012.

The additional outcome measures set out by the health secretary in December undoubtedly present the whole NHS with a genuine opportunity to deliver better healthcare for patients. But making them work will require significant investment in data collection to allow useful and consistent comparisons between providers. We have said that a discussion with NHS leaders about the practicalities is necessary if the Department of Health is to guarantee the measures do not add another burden to trusts.

The political noise in Whitehall during 2011 had its place, but we believe the Operating Framework for next year will help the NHS to move away from the political debate and start to implement the reforms. Of course transition to the new system will not be easy, not least for PCT and SHA clusters which are still running the system and have significant responsibilities and targets to meet. As the 2012/13 Framework highlights, the enormous range of responsibilities for all parts of the system over the next year cannot be underestimated.

Further information


Cooperation and Competition Panel www.ccpanel.org.uk/index.html
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