The Operating Framework for the NHS 2011/12
December 2010

On 15 December 2010 the Department of Health (DH) published the Operating Framework for the NHS for 2011/12, the first full year of the transition to the proposed new structure for the NHS. It states that 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
- creating energy and momentum for transition and reform.

This briefing for members outlines the key points from the Operating Framework and what we see as the challenges and opportunities for members as they implement the framework in this period of financial restraint.

Operating Framework overview

Key points in the Operating Framework include:

- PCTs will receive on average 2.2% recurrent growth with additional 0.8% growth in non-recurrent funding (mainly for investment in social care).
- The £20bn efficiency challenge has now 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”.
- The national efficiency requirement in 2011/12 is 4% with an uplift for pay and price inflation of 2.5%. Prices for off-tariff services will be reduced by 1.5%.
- Tariff prices for 2011/12 also reflect the 4% efficiency requirement: 2% is embedded in tariff design with the remaining 2% offsetting the pay and prices uplift resulting in a final tariff adjustment of 0.5%.
- 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.
- Providers will now be allowed to offer services below the published mandatory price, if both commissioners and providers concur.
• PCTs are expected to develop formal ‘cluster’ arrangements to help mitigate against a risk of “unplanned loss of capacity and capability in the current commissioning system”.
• 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.
• GP consortia are expected to have running costs of between £25 and £35 per head by 2014/15.
• The document calls for extra vigilance in relation to: the transition; QIPP; ensuring sustainability of improvements such as waiting times; and delivery of Government priorities in areas such as health visitor recruitment.
• New commitments are announced on health visitors, family nurse partnerships, the cancer drugs fund, military and veterans’ health, autism, dementia and carer support.
• Areas recognised as needing improvement include learning disabilities, child health, diabetes, violence, regional trauma networks and respiratory disease.

Transition and reform

Role of PCTs

The Operating Framework notes a risk of “unplanned loss of capacity and capability in the current commissioning system.” In an attempt to mitigate this, PCTs are expected to develop formal ‘cluster’ arrangements, while also assisting the fledgling GP pathfinder consortia and gradually devolving more commissioning responsibility.

Strategic health authorities should ensure that PCT clusters are established within their region by June 2011 and hold them to account for the remainder of that financial year.

The clusters are intended to be a transitional vehicle with responsibilities including: delivery of medium term Quality, Innovation, Productivity and Prevention (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.

The clusters will also be tasked with assisting with GP consortia development. A development fund of up to £2 per head, largely funded from the Mutually Agreed Resignation Scheme (MARS) savings (estimated at more than £70m in 2011/12) will be utilised. They are also expected to provide a senior finance manager and experts in organisational development, governance and commissioning. 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 to gain awareness of and become involved in the Joint Strategic Needs Assessment (JSNA) processes.

PCTs should be involving 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. PCTs should enable their providers to assume responsibility for
demand management. 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”, with specific reference to dementia and carer support.

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

Reconfiguration of services
The previously announced ‘four tests’ continue to apply. PCTs must also continue to consult with overview and scrutiny committees about substantive changes during transition.

The Operating Framework contains a list of key indicators to hold PCTs and clusters to account during 2011/12: key performance indicators relating to QIPP; new commitments and reform; and clinical indicators for current measures.

QIPP
QIPP value for money projections should be recalculated to reflect consortia areas, with developing consortia also urged to assume responsibility for QIPP delivery when they are best placed to do so.

The DH is currently examining the level of support that will be made available to GP consortia for leadership development.

Transition timetable
The transition timetable from now until the full establishment of GP consortia and the abolition of PCTs in April 2013 is set out. The authorisation process for GP consortia will commence in April 2012.

Aspirant foundation trusts
In January 2011, the DH will advise trusts still seeking foundation trust status on the necessary actions. A Provider Development Authority should have been established by April 2012 to support the achievement of an all foundation trust sector by 2014. Community service data set will be developed in 2011/12.

Shadow health and well-being boards
Shadow health and well-being boards should be established 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.
**Human resources issues**

The DH will work with NHS Employers on material to help organisations engage their staff. It is hoped that this project will help to avoid unnecessary costs resulting from staff moving from current organisations into GP consortia.

Employers are urged to maintain awareness among their staff of pay, rewards and available benefits at a time when pay is being frozen for those earning more than £21,000 per annum. Total reward statements should be introduced from 2012.

The document also highlights the proposals being developed between NHS Employers and trade unions through the NHS Staff Council, aimed at providing enhanced employment security while foregoing pay increments for 2011/12 and 2012/13. Any savings from this scheme would be held by employers to protect staff from ‘avoidable compulsory redundancies.’

The Operating Framework confirms that a consultation on education and training will be published shortly, aimed at providing employers with ‘greater autonomy and accountability’ as well as enhanced ownership by the professions. Local arrangements should be in place by April 2012.

**Transparency and local accountability**

**New outcomes framework for the NHS**

The first NHS Outcomes Framework will be published in December 2010. This will be used to hold the NHS Commissioning Board to account for improving quality and delivering better health outcomes for people using NHS services.

Each domain of the Outcomes Framework will be supported by a suite of National Institute for Health and Clinical Excellence (NICE) Quality Standards.

**Patient experience and feedback**

The Operating Framework stipulates that patient experience “must be a key arbiter of all NHS services.” The patient survey programme will continue, but alongside real-time feedback methods, analysis of complaints data and Patient Reported Outcome Measures (PROMs). Guidance for the latter will be revised in 2011.

The Government’s plans for a “revolution in patient power” are expected early in the new year. The NHS Constitution will continue to play an important role. The promotion and conduct of research is also defined as a crucial function. An evidence base should be used for both the delivery and design of NHS services.

**Information and choice**

An Information Strategy will be published in the new year once feedback from the consultation and further reviews of areas such as data returns has been taken into account.
NHS organisations should include a number of mechanisms in plans for the forthcoming year, including digital technology and greater integration of informatics systems.

Patients should be able to choose a named consultant-led team for outpatient appointments by April 2011. The standard NHS contracts will be amended to reflect these changes to ensure providers are required to: accept patients referred to a named team; list services on Choose and Book; and publish information to empower patients.

Further choice guidance is expected once the current consultation closes. 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. PCTs are tasked with developing and implementing plans covering shared decision-making and information provision.

The Operating Framework states: “Choice in maternity services is a key Government commitment.” The Government encourages participation in the maternity and children’s dataset by providers. Further work is expected on the development of a maternity tariff.

The Government confirms its wish to continue the roll-out of personal health budgets, informed by the lessons learned from pilot programmes.

**Quality Accounts**

Quality Accounts for 2010/11 are expected to meet the requirements around expectations and the expansion of the initiative into community services. 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 and compare to others.

**Service quality**

The Operating Framework recognises the challenge of maintaining and improving quality while delivering significant efficiencies and changing the architecture of the health and care system.

**QIPP**

The £20bn efficiency challenge has now 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 re-investing savings.
**Key new commitments**
The Operating Framework sets out a number of new commitments including:

- **Health visitors** – The Operating Framework confirms the Government’s commitment to establish an ‘expanded and stronger’ health visiting service for new or expanding families. It hopes to increase the overall number of health visitors by 4,200 by April 2015.
- **Family Nurse Partnerships** – This programme should have more than doubled its capacity by April 2015. At least 13,000 clients should be able to benefit by that date.
- **Cancer Drugs Fund** – The fund should come into operation from April 2011, with £200 million annual funding.
- **Military and veterans’ health** – SHAs are expected to ensure the implementation of the recent 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** – The Operating Framework says that NHS organisations should focus on four main priorities of the National Dementia Strategy: 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 also 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 well-being. PCTs should agree policies and budgets for carer support for 2011/12.

**Maintaining progress**
The Operating Framework also identifies areas where progress needs to be maintained including:

- **Referral to treatment** – Commissioners are expected to ensure that referral to treatment performance does not decline. Providers should offer patients maximum waiting times, with monitoring of median and maximum waits.
- **A&E services** – A&E departments should deliver performance improvements across all indicators drawn up by the Department of Health with the College of Emergency Medicine and Royal College of Nursing. Providers are also encouraged to “redesign urgent and emergency care services” as more clinicians in this area complete training.
- **Ambulance services** – Ambulance trusts should drive improvements across all indicators developed by the national ambulance director. All trusts should be achieving the waiting time standards for responding to Category A cases.
- **Cleaner facilities** – A zero tolerance approach to all healthcare association infections (HCAIs) continues to apply. Improvement plans must ensure performance at least meets the level set by HCAI indicators.
- **Mixed sex accommodation** – From April, all providers of NHS care should be taking steps to eliminate mixed sex accommodation, with rare exceptions.
Breaches must be routinely reported, with organisations completing annual declarations on whether they are compliant with national definitions.

- **End-of-life care** – Strategy implementation should continue during 2011/12 and commissioners should pay particular attention to providing 24/7 community services.

- **Cancer reform** – NHS organisations will be tasked with implementing the forthcoming *Improving Outcomes Strategy for Cancer*. Cancer waiting time standards continue to apply. Commissioners should formulate plans to deliver appropriate access to radiotherapy treatment and collaborate with cancer networks on attainment of NICE Improving Outcomes Guidance for Cancer and the maintenance of screening services.

- **Stroke** – The following areas are highlighted for improvement: prevention (best practice tariff for outpatient transient ischaemic attack patients to be launched in April); acute care (prompt admissions and thrombolysis assessments); and post hospital care.

- **Mental health** – The imminent mental health strategy will centre on the objectives of delivering improvements to public mental health and well-being and the provision of high quality care. NHS organisations are urged to collaborate with local partners on commissioning drug services. There is also an expectation that all young people should be able to access evidence-based, early intervention community services. Subject to consultation, choice for many service users should be introduced in 2011. The NHS is expected to continue expanding access to the Improving Access to Psychological Therapies (IAPT) programme in 2011/12, leading to full roll out by 2014/15. This includes training programmes to develop the workforce and a choice of NICE-approved therapies. The DH and NHS will extend talking therapies to children and young people, older people, for people with severe mental illness and people with co-morbid mental and physical health long term conditions.

- **Safeguarding children** – The Munro child protection review is expected to be completed in April 2011.

- **Dentistry** – A new dental contract is to be developed, with pilot proposals to be announced during 2011/12. PCTs will be asked to identify and offer support to possible pilots.

**Areas for improvement**

A number of areas for improvement are also set out including:

- **Learning disabilities** – PCTs should take necessary action to alleviate concerns in this area. Annual health checks are advocated.

- **Child health** – NHS organisations should focus particular attention on specific groups such as disabled children, CAMHS service users and children in care.

- **Diabetes** – Screening should be offered to all people with diabetes and insulin pumps should be more widely available. PCTs are tasked with commissioning patient education services and NHS providers are expected to improve the overall management of diabetic inpatients.

- **Violence** – Appropriate care pathways should be in place for women and girls who have been victims of violence.
- **Regional trauma networks** – All regions should be making the transition to these networks during 2010/11. Tariff changes will come into play from April, with major trauma hospitals planning for continuous consultant-led team provision and access to necessary scans and radiology services.

- **Respiratory disease** – PCTs should continue to deliver against the recommendations coming out of the public consultation on chronic obstructive pulmonary disease (COPD) and adult asthma.

**Public health**
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.

- The NHS is expected to continue to provide leadership for public health in 2011/12, “ensuring that public health services are in the strongest possible position” for the transition. PCTs will now assume responsibility for the Hazardous Accident Response Teams (HARTs) in ambulance trusts, following the reallocation of funding.

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

- PCTs should continue to progress their NHS health check programmes and complete coverage of abdominal aortic aneurysm screening is anticipated by the end of 2012/13. PCTs should be examining ways in which they can help to reduce prevalence of fragility fractures among the elderly in their community.

**Finance and business rules**

**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 be planning for an operational deficit in 2011/12. Every PCT should be ensuring 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 over 45% 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 head by 2014/15. The exact amount will be determined as further work is done by the pathfinders.

Capital
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 £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 (JSNA) process.

Tariff
The development of the national tariff for 2011/12 is driven by 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 thrombo-embolism (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.

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 is the most significant to increase.
Accountability

Planning arrangements for 2011/12 are about maintaining a grip on current performance levels while delivering quality and productivity improvements.

One integrated, geographically-based plan for each locality should be developed in 2011/12, which should “evolve from the regional visions and subsequent QIPP plans.” Furthermore these documents should outline short-term commitments aimed at meeting longer-term expectations. PCTs should ensure GP consortia are involved in the development of plans ‘as fully as possible’, while also taking full account of local arrangements such as JSNAs.

By the end of March 2011 the DH will have reviewed all plans with each SHA, and between March and June a transition assurance process will be undertaken in each region.

Further guidance on the centrally monitored indicators will be issued shortly.