The operating framework for the NHS in England 2010/11, the white paper NHS 2010–2015: from good to great and the Chancellor’s Pre-Budget Report (PBR) were all published in December 2009. These documents set out the financial environment for the NHS and the Department of Health’s (DH) priorities for the years ahead. This Briefing details the key points of the documents.

Key points

- National priorities remain the same as last year.
- Average funding growth for PCTs will be 5.5 per cent for 2010/11.
- There will be a real-terms freeze in funding for frontline services – defined as 95 per cent of the NHS budget – with cuts to the remainder in the following two years.
- £10bn of efficiency savings are required by 2012/13, as an interim milestone towards £15bn–£20bn of efficiencies by 2013/14. These savings will be recycled back into the NHS.
- PCTs are required to agree proposals for the future organisational structure of PCT-provided community services with SHAs by March 2010.
- The government is consulting on adding legal rights to maximum waiting times – or the offer of alternative providers – to the NHS Constitution. PCTs will need to ensure these rights are delivered from 1 April 2010.

Background

The scale of the public sector deficit and record levels of borrowing mean the NHS will be operating in the context of severe restraint on spending across the public sector in the years ahead, although it will see funding growth in line with recent years for 2010/11.

But the operating framework, the white paper NHS 2010–2015, and the PBR make clear that NHS organisations must prepare now for a freeze on funding for frontline services and reductions to the remainder of the health budget in 2011/12 and 2012/13; “standing still is not an option.”

The three documents between them set out a rapidly changing funding environment, but offer continuity in the NHS’s key priorities, which remain unchanged from 2009/10. However, a requirement for efficiency savings of £10bn by 2012/13, and £15bn–£20bn by 2013/14, is accompanied by a renewed push from the DH for a more preventive approach and for more patients to be treated at home or in community settings.

The timing of the next general election adds a layer of uncertainty. The Conservatives have pledged to introduce an emergency budget within 50 days if they form the next government, and policy changes would also be likely.

NHS organisations will also be working in a context where public and political attention is likely to be focused on levels of public spending and borrowing as well as the traditional election battlefield of health service delivery – a particularly challenging environment.
The financial framework

Allocations and surplus in 2010/11
Primary care trust (PCT) allocations will increase by 5.5 per cent on average in 2010/11. But this will be the last year of significant growth for some time.

The 2009/10 strategic health authority (SHA) and PCT surplus will be carried forward to 2010/11 and SHAs will need to agree with the DH how this is drawn down in 2010/11. SHAs and PCTs are expected to end 2010/11 with an aggregate surplus of £1bn, to be spent during the next spending review period.

The operating framework makes clear that all NHS organisations should prepare for a period of capital constraint.

In order to manage risk and volatility, PCTs should, on aggregate, ensure that at least 2 per cent of recurrent funding is only committed on a one-off, non-recurrent basis. This approach is expected to remain through the next spending review period.

Budgets for ophthalmic services and pharmacy will be devolved to PCTs, with primary dental service resources – already devolved – also to be included within unified allocations. These budgets will be allocated separately in 2010/11, at 2009/10 levels. Growth in these areas for 2010/11 is expected to come from lower like-for-like tariff prices.

2011/12 and 2012/13
For this period, the PBR sets out a real-terms freeze in funding for

Fitting the pieces together
The operating framework, the white paper NHS 2010–2015 and the PBR are closely inter-related, but run to different timescales.

The PBR
The PBR sets out the NHS funding envelope, within the context of the public finances as a whole, for the next three years.

It outlines a requirement for £10bn of efficiency savings – to be recycled into the NHS – by 2012/13, as part of £15bn–£20bn savings to be made by 2013/14. These savings are to be detailed in the 2010 Budget.

The PBR was not accompanied by a new spending review package, which would have been expected to outline funding until 2014, and Chancellor Alistair Darling has not indicated when a review might be published.

The white paper
The white paper, NHS 2010–2015: from good to great – preventative, people-centred and productive, sets out the direction for the NHS over the next five years.

It outlines a plan to build on Lord Darzi’s Next Stage Review. There is a strong stress on services becoming more productive: “This will mean change on an unprecedented scale for patients and staff. It will mean hard choices about resources and priorities.”

Funding for the first three years of the five-year plan is outlined in the PBR. But the document makes clear that its aims are to be delivered in “a new financial era.” The final chapter sketches the system measures intended to make this happen.

The operating framework
The NHS operating framework for England 2010/11 should be seen in the context of both the PBR and the white paper. It ‘operationalises’ the first year of the five-year vision.

The operating framework also sets some milestones for the following two years and includes pointers towards the way further policy aims might be put into practice.

Putting the front line first
A further cross-government document, Putting the front line first: smarter government, outlines expectations on benchmarking and reducing back-office costs. It points to greater joint planning and pooled budgets across local areas in line with the government’s Total Place initiative.
frontline services – defined as 95 per cent of the NHS budget. Because of the very low level of public spending growth overall and planned increases in some areas of spending, the remaining 5 per cent of the NHS budget is set to see a cut.

The PBR does not specify what is covered by the 95 per cent, nor does it indicate what the scale of the cut to the remaining 5 per cent of the budget might be. We await confirmation of what might be included in the 5 per cent and what the net effect of this will be in terms of overall NHS funding.

This trend should be seen in the context of potentially harsher cuts across much of Whitehall: NHS allocations will be relatively protected.

The PBR brings an additional pressure as employers National Insurance will increase by 1 per cent from 2011.

Efficiency savings
A drive for efficiency savings is highlighted in the PBR, white paper and the operating framework – in particular the need for NHS organisations to "bear down" on their back-office management, procurement and estates costs in the coming years.

As part of meeting its commitment to make £2.3bn of efficiency savings in 2010/11, as set out in the 2009 Budget, the DH will pass responsibility for funding £500m of previously centrally funded activity to the NHS, to be paid for through an additional 0.5 per cent efficiency requirement in service tariffs.

The PBR requires the NHS to make £10bn of efficiency savings by 2012/13

The PBR requires the NHS to make £10bn of efficiency savings by 2012/13, as part of £15bn–£20bn savings to be made by 2013/14. These savings will be detailed in the 2010 Budget.

The efficiency savings will be recycled back into the NHS. This money is expected to fund continuing improvement in the absence of funding growth from 2011 onwards. Some of this will be needed to fund outgoings from other pressures.

The operating framework says all NHS organisations should "rigorously consider how to reduce their back-office costs", pointing to the cross-government Smarter government document, published just before the PBR, which sets out an aim to cut spending on consultancy by 50 per cent, communications by 25 per cent and IT project costs by 10 per cent, along with reductions in estate and procurement costs. The white paper estimates that all this could produce £1.8bn of savings.

Productivity gains, through ensuring all organisations meet the staff productivity levels achieved by the best, could produce annual savings of up to £3.5bn, while preventive work and moving treatment out of hospitals could release an annual £2.7bn, the white paper says.

Management and agency costs
The operating framework says management and administrative support costs in PCTs and SHAs (but not trusts) must be reviewed and reduced by 30 per cent by 2013/14 to maximise resources to the front line. SHAs will determine how this is managed across PCTs.

Despite concerns among NHS organisations that most of this would be required in 2010/11, the framework does not set a target for that year, although it states the expectation that most progress should be made in 2010/11 and 2011/12. Provider arms are included in the aggregate requirement.

The tariff
In line with the NHS 2010–2015 white paper’s aim to incentivise cost efficiency, the operating framework sets out a "zero per cent uplift" in national tariff prices. The uplift for the following three years will be "a maximum of zero per cent" – allowing for a potential reduction.

The 2010/11 tariff ‘uplift’ includes an efficiency requirement of 3.5 per cent to cover pay and prices inflation. It is expected that the efficiency requirement will increase over the following three years.

The framework also confirms predictions that the tariff would include incentives to reduce emergency activity. Any emergency activity above the value of the contracted baseline will only attract 30 per cent of the tariff price for providers.

It adds: “SHAs will be expected to remove the savings accruing from the triggering of this business rule from PCTs to create a regional pool
The operating framework leaves the five national priorities unchanged from last year. These remain:

- improving cleanliness and reducing healthcare-associated infections
- improving access through achievement of the 18-week referral to treatment pledge, and improving access to GP services (including at evenings and weekends)
- keeping adults and children well, improving their health and reducing health inequalities
- improving patient experience and staff satisfaction and engagement
- preparing to respond in a state of emergency, such as an outbreak of a new pandemic.

Future decisions should be seen “in the context of delivering cash-releasing strategies while sustaining and improving the quality of services.” The main characteristics of a system that can achieve this require:

- more care closer to home
- fewer acute beds
- reduced unit costs
- reduced variation
- more standardisation of pathways
- early and more upstream intervention
- greater co-production, with people taking greater ownership of their health.

The white paper 

*NHS 2010–2015* gives renewed emphasis to overarching themes of prevention and a shift in services to the community. These are both linked to greater productivity and efficiency. The productivity drive “will mean change on an unprecedented scale for patients and staff.”

Its message to the public focuses on the planned enshrinement of maximum waiting times in legislation and a need for responsibility in their use of services and in looking after their own health.

Key priorities

**Quality**

Commissioning for Quality and Innovation (CQUIN) will have a more significant impact on provider income in 2010/11. The income quantum earned under agreed CQUIN schemes will treble to 1.5 per cent of contract income. All CQUIN schemes will be required to include a patient experience element and a requirement to improve compliance with guidance on venous thromboembolism (VTE) (see NHS Confed *Briefing* issue 183, May 2009).

From 2011/12, PCTs will be able to withhold a significant proportion of contract payment, rising to 10 per cent over time, if providers fail to meet agreed patient satisfaction goals on a service by service basis.

In primary care, there will be no changes to the Quality and Outcomes Framework (QOF) in recognition of the pressures arising from pandemic flu. But “significant reform” of the QOF is signalled from 2011/12.

Changes to the market forces factor introduced in 2009/10 will continue in 2010/11. A new currency for adult mental health services will be made available for local use in 2010/11.
Pay restraint is emphasised in the PBR, operating framework and white paper, which says: “Sustained pay restraint... must begin immediately and be led by our most senior managers and clinicians.”

This is linked explicitly to job security in the operating framework; Health Secretary Andy Burnham has announced that the government will consult unions and employers about the pros and cons of offering frontline staff an employment guarantee locally or regionally in return for flexibility, mobility and sustained pay restraint.

This more complicated pay and jobs bargaining context provides a potential challenge for NHS organisations as they consider service changes and efficiency measures.

The 2.25 per cent pay award for the majority of NHS staff set for 2010/11 in the existing three-year deal will be honoured, the government has said. But the DH has recommended that there be no increase for consultants or very senior managers.

The PBR explicitly states the government will seek a 1 per cent cap on basic pay uplifts across the public sector for 2011/12 and 2012/13. It also announced reforms to very senior managers’ pay, with new transparency and scrutiny measures for pay levels above £150,000 and any bonus payments of over £50,000.

Changes for community services and service integration

Both the NHS 2010–2015 white paper and the operating framework raise the prospect of organisational change, with particular emphasis on integrating services and – speedily – setting out a future structure for the community services now provided by PCTs.

The drive for both greater productivity and quality improvements will “require new service delivery models, greater cooperation between providers and different commercial partnerships within the NHS and with the independent and third sector, delivered at pace.”

NHS chief executive David Nicholson says this drive must come not within individual NHS organisations but at the interfaces between primary and secondary care, between health and social care, and between empowered patients and the NHS. He continues: “At the heart of this is the importance of transforming patient pathways, leading to the integration of services and, in some cases, the integration of organisations.”

NHS organisations face a balancing act, as Nicholson says: “Success requires bold and thoughtful leadership; re-thinking how we work; challenging current practice and thinking outside of our own organisational and professional interests.” But he adds: “This not a time for rash, short-term decisions.”

The white paper gives a possibly stronger indication that integration is the direction of travel, saying: “We will greatly increase the integration of services.”

Community services

The operating framework gives a tight timescale for setting out the future shape of community services. PCTs must have agreed with SHAs proposals for the future organisational structure of all current PCT-provided community services by March 2010.

They will be required to demonstrate that any provider changes are needs and pathway driven and will provide more integrated and sustainable primary, community and secondary care services.

But the framework explicitly avoids prescribing a solution. Instead, the DH will set "demanding national standards" for provider reform which will leave PCTs to create a system that best meets local needs.

Using the independent and third sectors "where they can contribute best", is an option along with horizontal or vertical integration with other NHS bodies. Direct provision by PCTs will remain an option where it meets DH tests and is partnered by strong commissioning. Social enterprise ‘right to request’ schemes are also an option, while strong proposals for community NHS foundation trust status will be considered.

The white paper offers a slightly more detailed indication of how integrated services are envisaged, giving more emphasis to the potential integration of community services with existing hospital providers or with mental health trusts and practice-based commissioning consortia.
It adds: “Community foundation trusts may be an option for a few areas, if the proposals meet the demanding criteria we will set out. Only a small number of community foundation trusts, however, are likely to be approved, since we believe that in many places other options will be more appropriate.” It also points to social enterprise ‘right to request’ schemes as a possibility.

But the white paper states: “For most of the NHS we do not believe that creating new organisations is the right solution.”

The DH is due to provide more guidance on the options and the approvals process shortly. This will build on Transforming community services: enabling new patterns of provision.

Management costs will be a factor in these decisions. The white paper pledges to reduce overheads and transaction costs in the provider sector, to maximise resources for frontline care, and the DH will set clear limits on the number of new organisations created in the community sector, although it is not clear whether this would apply to social enterprises or on what basis these limits will be calculated.

Commissioners and providers
A revised suite of standard national NHS contracts will be published by 16 January 2010. These will cover hospital services, community services, mental health services and ambulance services. A separate national NHS contract for care homes will be published by July 2010. Contract models that move away from funding episodic hospital care and reward the provision of integrated care will be developed for 2011/12.

Contracts are to be agreed by 1 March 2010 and signed by 15 March 2010. Final SHA plans for 2010/11 are to be submitted to the DH by 26 March 2010.

All PCTs are expected to have achieved a green World Class Commissioning assurance rating for governance, and at least seven out of 11 competencies in each PCT should be rated three or above by April 2011.

All remaining acute and mental health trust boards are expected to plan for foundation status by the end of 2013/14.

Confederation viewpoint

Although the overall priorities have not changed there is a long list of areas where it is suggested that organisations will want to consider action. This is a large agenda when associated with a big reduction in management costs. There are some substantial areas for action prior to April 2010 in addition to the usual annual deadlines: provider registration; developing plans for foundation trust status; and plans for the future of PCT provider arms.

This is the operational plan required for the business of the next three years and to deliver existing priorities. In parallel, David Nicholson has already made it clear that there is the challenge of saving £15 to £20 billion, to be recycled into the NHS to meet cost pressures and increasing demands, and to do this while holding on to quality gains.

The framework will give providers and commissioners very little room for manoeuvre. This implies that some new solutions will need to be developed quickly; simply doing more of the same faster and cheaper is unlikely to be adequate. Hospitals may need to find ways to get upstream to improve demand management; commissioners will need to create environments to encourage experiment and innovation; and mental health can help to unlock productivity in other sectors, for example through work on dementia, medically unexplained symptoms etc. In many cases very different service delivery models will be required. A theme that permeates the framework is the need for new behaviours, joint working with a purpose and more focus on pathways.

The scale of the task and of the redesign of service that is required is daunting. There are significant risks of delay and of re-centralisation or of being distracted by the prospect of further large-scale organisational change. The overall goal of redesigning the way that services operate to improve quality and releasing significant efficiency savings will be paramount.

For more information on the issues covered in this Briefing, contact Nigel Edwards, Director of Policy and Communications, at nigel.edwards@nhsconfed.org
# Planning timetable

The timetable below sets out the main stages and decision-making points for commissioners to be aware of during the planning discussions.

<table>
<thead>
<tr>
<th>Event</th>
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<tr>
<td>Applications for registration submitted to CQC</td>
<td>29 January 2010</td>
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<tr>
<td>Initial SHA plans for finance, informatics, vital signs, workforce and NSR refreshed visions shared with DH</td>
<td>29 January 2010</td>
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<tr>
<td>DH feedback on the component part of SHA plans</td>
<td>February 2010</td>
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<tr>
<td>Contracts to be agreed</td>
<td>1 March 2010</td>
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<tr>
<td>Final LAA submitted to Department for Communities and Local Government</td>
<td>Early March 2010</td>
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<tr>
<td>Contracts to be signed</td>
<td>15 March 2010</td>
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<tr>
<td>Final SHA plans for 2010/11 submitted</td>
<td>26 March 2010</td>
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<tr>
<td>NHS providers publish declaration on elimination of mixed-sex accommodation</td>
<td>31 March 2010</td>
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<tr>
<td>PCTs to agree with SHAs future structures of PCT-provided community services</td>
<td>March 2010</td>
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<tr>
<td>Plans for future of non-foundation trusts</td>
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<tr>
<td>DH/SHA bilaterals to sign off plans</td>
<td>April 2010</td>
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<tr>
<td>Providers delivering services on behalf of the NHS to publish quality accounts</td>
<td>June 2010</td>
</tr>
<tr>
<td>National NHS contract for care homes published</td>
<td>July 2010</td>
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Further information

www.dh.gov.uk/en/Publicationsandstatistics (Gateway ref 13232)

www.dh.gov.uk/en/Publicationsandstatistics (Gateway ref 13179)

Pre-Budget Report 2009
www.hm-treasury.gov.uk/prebud_pbr09_index.htm

PCT allocations:
www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/index.htm

Putting the front line first: smarter government.
www.hmg.gov.uk/frontlinefirst.aspx

The NHS Confederation

The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS. Our ambition is a health system that delivers first-class services and improved health for all. We work with our members to ensure that we are an independent driving force for positive change by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.