

The Operating Framework for the NHS 2012/13 November 2011

On 24 November 2011 the Department of Health (DH) published the Operating Framework for the NHS in England for 2012/13, the first full year of the transition to the proposed new structure for the NHS.

We believe its focus will help the NHS shift into implementation mode and away from the political debate, and we are pleased it does not contain lots of new initiatives.

This briefing outlines the key points from the Operating Framework and what we see as the challenges and opportunities for members.

Key announcements in the Operating Framework include:

- key areas for improvement of dementia and care of older people, carers support, and military and veterans health
- a range of outcome measures or proxies for them under the domains of the NHS Outcomes Framework
- new measure for referral to treatment so that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks
- PCT clusters to ensure all patients are seen on the basis of clinical need with no justification for the use of minimum waits
- the running cost of clinical commissioning groups (CCGs) to be £25 per head
- all NHS trusts expected to achieve NHS foundation trust (FT) status by April 2014 other than by exceptional agreement
- PCT allocations to grow by at least 2.5 per cent
- tariff price adjuster will be a reduction of at least 1.5 per cent. This will also be applied to non-tariff services
- CQUIN (Commission for Quality and Innovation) to be increased to 2.5 per cent on top of actual 'outturn' value.

OPERATING FRAMEWORK OVERVIEW

Sir David Nicholson's introduction emphasises the importance of getting the basics right, in light of recent Care Quality Commission and Health Service Ombudsman reports, alongside the importance of maintaining a grip on performance, meeting the QIPP (Quality, Innovation, Productivity and Prevention) challenge and building the new system.

The Framework for 2012/13 is set out in four chapters that cover: quality; reform; finance and business rules; and planning and accountability.

Its stated goals are to improve services for patients by:

- putting patients at the centre of decision making
- successfully completing the last year of transition to the new system and building CCG capacity
- increasing the pace of delivery of the quality and productivity (QIPP) challenge
- maintaining strong control over service and financial performance.

QUALITY

Improving services and patient experiences

- the staff survey results should be monitored locally and nationally
- all NHS organisations must comply with the Equality Act 2010 and its associated Public Sector Equality Duty
- the NHS needs to be ready in 2012 with clinical governance arrangements for medical revalidation
- NHS bodies must ensure staff have knowledge of English necessary to perform their duties.

Dementia and care of older people

- the Operating Framework identifies a systemic set of 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 including:
 - ensuring participation in and publication of national clinical audits for services for older people
 - reducing inappropriate prescribing of antipsychotic drugs for people with dementia
 - improving diagnosis rates
 - continuing to eliminate mixed-sex accommodation
 - use of inappropriate emergency admission rates as a performance measure
 - non-payment of emergency readmissions within 30 days of discharge following an elective admission.
- PCT clusters should 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 and local or national CQUIN goals should be included in 2012/13.

Carers

- PCT clusters 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 veterans health

- SHAs to maintain and develop their armed forces networks to ensure principles of the Armed Forces Network Covenant are met.
- Implementation of the MoD/NHS Transition protocol for those seriously injured in the course of duty, 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
- PCT clusters are to maintain existing delivery and expand family nurse partnerships to double capacity to 13,000 places by April 2015.

Outcomes across the domains of the framework

The Operating Framework makes significant reference to a range of measures in the NHS Outcomes Framework, which we have summarised below.

- NHS organisations are expected to prepare to use the NHS Outcomes Framework to hold the NHS Commissioning Board to account in 2013/14
- The Operating Framework identifies outcome measures or proxies for each of the domains of the Outcomes Framework which are set out below
- 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
- Each domain is to be underpinned by a suite of NICE quality standards.

Outcomes Framework Domain 1: preventing people from dying prematurely

- the NHS is to support clinical strategies aimed at reducing early mortality from cardiovascular disease, including heart disease, stroke, kidney disease and diabetes. Commissioners and providers need to work together to ensure earlier diagnosis and treatment
- all hospital trusts should examine and explain their Summary Hospital Mortality Indicator and identify and act where performance is falling short
- existing operational standards in ambulance services should continue to be met or exceeded
- all four of the 31 day operational standards and all three of the 62 day operational standards for early cancer treatment should continue to be met or exceeded.

Outcomes Framework Domain 2: enhancing quality of life for people with long-term conditions

- the NHS needs to track progress in improving quality of life for people with long-term conditions through indicators including the proportion of people feeling supported to manage their condition and unplanned hospitalisation for certain patients
- PCTs with local authorities and emerging CCGs should spread the benefits of telehealth and telecare
- PCTs should consider the *No Health Without Mental Health* strategy to support local commissioning, with a particular focus on: access to psychological therapies as part of the full roll-out by 2014/15 with an increase in access for black and minority ethnic groups, older people and people with severe mental illness and long term health problems; physical healthcare of those with mental illness; offender health; and targeted support for children and young people at particular risk, such as looked after children.
- NHS organisations need to meet the QIPP challenge with a continued focus on investment in high-quality mental health services, with national monitoring of:
 - number of new cases of psychosis served by early intervention teams
 - percentage of inpatient admissions gate-kept by crisis resolution/home treatment teams
 - proportion of people under adult mental illness specialities on the Care Programme Approach (CPA) who were followed up within seven days of discharge from inpatient care.

Outcomes Framework Domain 3: Helping people to recover from episodes of ill-health or following injury

- the Operating Framework makes clear that commissioners need not reimburse hospitals for admissions within 30 days of discharge following elective admission, but that savings are to be invested in clinically driven initiatives through reablement and post-discharge support. Commissioners are to work with partners to ensure initiatives are understood and used by patients
- the DH will monitor emergency admissions for acute conditions that do not normally require admission and seek confirmation on the deployment of savings.

Outcomes Framework Domain 4: Ensuring that people have a positive experience of care

- a Duty of Candour is being introduced – a new contractual requirement on providers to be open and transparent regarding mistakes
- commissioners are to ensure contracts allow for central returns on mistakes, ‘never events’, incidents and complaints, and use sanctions if providers are not compliant
- in addition to existing national surveys, each local organisation is expected to carry out more frequent patient surveys, including the use of real-time data, and to respond appropriately where needed
- commissioners need to identify local measures of integrated care that will support improved delivery such as patient-reported outcomes
- PCT clusters should publicise the NHS Constitution right for a maximum 18-week wait for treatment from referral for non-urgent conditions, as well as the options

available where there is a risk that treatment will not be provided within 18 weeks. It is the provider trust's responsibility to ensure patients have the information. Pilots focused on orthopaedics especially will be carried out in 2012/13 to identify the best ways trusts can meet this responsibility

- the referral to treatment (RTT) operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks
- the RTT standards should be achieved in each speciality and will be monitored monthly. Less than 1 per cent of patients should wait longer than six weeks for a diagnostic test
- patients should have access to Choose and Book and commissioners should take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers, if the patient makes such a request
- patients need to continue to be informed that the two week wait is standard from GP referral for urgent referrals where cancer is suspected and the standard for two week waits from GP referral for breast symptoms should be met
- PCT clusters must ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits
- all organisations must have reviewed planned waiting lists for all specialities and diagnostic services no later than December 2011. Patients should be added to planned waiting lists only if there are personal or clinical reasons
- The Operating Framework stipulates that there is no justification for the use of blanket bans for treatments that do not take account of healthcare needs of individual patients
- clinically led indicators for accident and emergency will remain in place during 2012/13 and information on this is to be published locally. The ability of local commissioners to impose fines will continue. Operational performance will be judged nationally using the current operational standard that 95 per cent of patients are seen within four hours
- SHAs are to complete the roll-out of NHS 111 by April 2013 using solutions such as: Any Qualified Provider (AQP) principles for procurement; establishing services initially through pilots; and an 'opt-in' model involving a consortium of NHS Direct, ambulance services and other providers
- CCGs need to lead the design of urgent care service provision through NHS 111. In any solution reached, there must be evidence of local clinical approval and compliance with national service specifications.
- breaches of mixed-sex sleeping accommodation will continue to attract contract sanctions through the NHS contract.

Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm

- providers and commissioners need to identify and agree plans for reducing MRSA bloodstream and CDiff infections
- there will be national monitoring for hospital-related venous thrombo-embolism

- PCTs need to ensure a sustained focus on safeguarding to ensure access to the expertise of designated professionals and to work with CCGs to ensure they are prepared
- PCTs need to work with local authorities on the transfer of public health commissioning, and PCT clusters must maintain appropriate investment in public health services throughout transition. The number of four week smoking quitters and NHS healthchecks will be monitored nationally
- accountability arrangements for emergency preparedness, resilience and response should be clear at all times through the transition. PCTs must ensure they maintain current capability and capacity of existing Hazardous Area Response Teams in ambulance trusts.

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

REFORM

The new commissioning landscape

- the Operating Framework reiterates that 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
- PCTs must support the CCG authorisation processes, development of commissioning support offers, establish effective transition for services and staff, and demonstrate they are allocating both non-pay running costs and staff to support emerging CCGs. They will work with GP practices to review practice registered patient lists by March 2013
- SHAs and PCTs must support shadow health and well-being boards and encourage CCGs to take an active part in their formation
- specific guidance on the CCG authorisation process will be issued, but CCGs should be coterminous with a single health and wellbeing board as far as possible
- by 31 January 2012 SHAs should be confident that any CCG configuration issues can be solved by end of March 2012. SHA clusters are responsible for oversight of the readiness of CCGs for authorisation
- almost half of available budgets have already been delegated to emerging CCGs, and delegation 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 wellbeing boards
 - deliver relevant share of QIPP agenda
 - address configuration issues by end of March 2012
 - prepare application for authorisation and identify how to secure commissioning support and plans to use running cost allowance

- commissioning support must be commercially viable and distinctly separate from the PCT cluster and may occupy different geographic service footprint to PCT clusters and their PCT constituents
- it is expected that clinical senates and networks will be established in 2012/13.

The new public health landscape

- Public Health England will operate in shadow form 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 part of an existing NHS FT or in another organisational form by April 2014
- 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 choice of 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 implementing choice of: named consultant team, diagnostic test provider, post-diagnosis treatment, treatment and provider in mental health, care for long-term conditions and maternity care
- from April 2012 providers will accept patients referred to a clinically appropriate named consultant-led team and list their services on Choose and Book
- PCTs are 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 an appropriate access to local urgent care services
- PCTs need to prepare for wider roll out of personal health budgets. Subject to programme evaluation this should include offers to all patients with NHS continuing care for relevant aspects of care by April 2014.

Information

- 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 ensure availability and quality of key NHS datasets published by Prime Minister David Cameron¹
- patients written to about the summary care record should have one created by March 2013
- organisations are to use the NHS number consistently in 2012/13 and commissioners should link the use of the NHS number to contractual payments. There will be punitive contract sanctions 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 transition.

Workforce

- NHS and partner organisations must sustain a talent pipeline for critical posts. Nationally the new NHS Leadership Academy will provide talent management for all those involved in leadership of healthcare
- the NHS should use the NHS staff survey to improve staff experience and services
- organisations should improve staff health and well-being, including ensuring occupational health services are accredited, following NICE public health guidance, making pledges through the Public Health Responsibility Deal and promoting flu vaccination for staff.

Education and training

- In 2012/13, SHAs remain accountable for education funding, commissioning decisions, medical recruitment and working with healthcare providers. SHAs are to set up provider-led partnerships to take on these responsibilities from April 2013 and work on education commissioning for 2012 to 2014, as well as medical recruitment in 2012
- SHAs need to ensure business continuity and plan for transfer of education and training contracts
- SHAs need to plan for implementation of revised education and training tariffs.

Pension and pay

- The NHS will be required to implement increased employee contributions from April 2012. A pensions charter will clarify roles and responsibilities.
- This is the second year of a two-year pay freeze for public sector workers and 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 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

¹ <http://www.number10.gov.uk/news/letter-to-cabinet-ministers-on-transparency-and-open-data/>

- 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)
- PCTs will continue to set aside 2 per cent of recurrent funding for non-recurrent spending. SHAs will hold these funds, with PCTs required to submit business cases to access them. The non-recurrent cost of organisational and system change will need to be met from the 2 per cent.

PCT allocations

- PCT recurrent allocations will grow by at least 2.5 per cent. PCT 2012/13 revenue allocations will be announced in December 2011 and will be informed by the Office for Budget Responsibility's inflation forecast. Additional allocations for primary dental services, general ophthalmic services and pharmaceutical services will also be announced in December 2011
- transfers of funding between PCTs and local authorities included in the NHS Operating Framework 2011/12 will continue, including £622 million in 2012/13 for social care services to benefit health
- financial support from the health system for social care will continue in 2013/14 and 2014/15.

Running costs

- targets for running cost savings will be set at SHA cluster level, with the assumption that there will be no further savings at the SHA organisation level during 2012/13
- 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
- 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 regarding mixed sex accommodation, patients' dignity and infection control
- capital expenditure plans for NHS trusts and PCTs will be agreed by SHA clusters. Any unspent capital allocation will not be carried forward.

Tariff

- the development of the national tariff for 2012/13 is driven by increasing the quality of care and outcomes, driving integration of services and incentivising delivery of QIPP
- 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; and 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 being performed 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; and 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 admissions. The 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 type of patients that a provider treats results in it incurring lower costs than the average of the tariff category. This is 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 adjusted. 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

- 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 and increasing using of the NHS Safety Thermometer
- where CQUIN funding has been used to achieve higher quality, funding may be made recurrent 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 (due 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 will 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 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.

Principles and rules for cooperation and competition (PRCC)

- PCT clusters must review their practices in line with the Cooperation and Competition Panel's report on the operation of 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 DH, and commissioners should anticipate a more outcomes-based approach

- each PCT cluster is required to have an integrated plan for the period 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 will be published in December 2011, setting out key milestones and financial planning guidance is due to be published 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); and 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.