# Revision to the Operating Framework for the NHS in England 2010/11

Department of Health

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# Revision to the Operating Framework for the NHS in England 2010/11


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# Foreword by Sir David Nicholson KCB CBE

The NHS Operating Framework for 2010/11 set out the challenge facing the NHS over the coming year. While many of these challenges remain, the political landscape has changed and this Government has communicated clear objectives and ambitions for the NHS to deliver, and we must now respond.

This revision to the NHS Operating Framework for 2010/11 sets out which changes need to happen in-year and those areas where change can be expected in the NHS Operating Framework for 2011/12. It centres on five areas:

- revisions to Vital Signs and Existing Commitments;
- new rules on reconfiguration;
- future direction and next steps on transforming community services;
- finance and efficiencies; and
- accelerating development of the payment system.

This revision document makes clear that the NHS is expected to deliver against the 2010/11 NHS Operating Framework in all areas not explicitly mentioned. Standards and quality are also expected to be maintained where existing targets are removed or adjusted pending the development of more outcome-focused measures. Patients would not expect a return to long waiting times for operations.

The NHS must also maintain a relentless focus on achieving the £15-20 billion efficiency savings over the next four years by improving quality and productivity so that this can be re-invested back into the service.

In essence, this revision to the NHS Operating Framework 2010/11 sets a clear way forward on a small number of areas and highlights further issues where change can be expected. It aims to give certainty to the NHS about the new Government's objectives and plans so that we are prepared to respond and adapt as we have shown we can.

**Sir David Nicholson, KCB CBE**
**NHS Chief Executive**

# Revisions to Vital Signs and Existing Commitments

1. The agenda for the NHS for 2010/11 has been set by the NHS Operating Framework 2010/11, which was published on 16 December 2009. In now moving towards a health service which puts patients at the heart of decision-making, which focuses on quality and outcomes not processes and with more devolved responsibilities, this document sets out areas subject to immediate change. The NHS Operating Framework for 2011/12 will include substantive systemic changes and in developing it, we shall review the clinical relevance of all existing indicators with the removal of those that have little or no clinical relevance.

2. SHAs will continue to hold PCTs to account on the basis of the operational plans submitted in March 2010 as well as achieving the milestones set out in the quality, innovation, productivity and prevention plans. There should be no re-opening of agreements beyond those set out below. The arrangements for joint planning between the NHS and social care must remain, and will be crucial for managing services over the winter. Joint working and commissioning between PCTs and Local Authorities will be of increased importance in order to deliver better outcomes for patients, service users and their carers.

3. Building a service that is personal, fair and diverse requires recognition of the differing needs and skills offered by groups within our communities. There are real opportunities presented by the implementation of the Equality Act in developing such a service, where everyone counts.

4. PCTs must put a stronger emphasis on using Secondary Uses Services as their data source, which requires providers to improve the quality and completeness of data, in line with the information transparency agenda.

5. The Department will work to ensure that the regulators and system managers have a consistent view of how changes set out below should be applied. Changes required to Standard Contracts will be implemented through a centrally prepared Deed of Variation and circulated to PCTs shortly.

## Access

6. We intend to remove some process targets. This is not a signal that clinically unjustified waits are acceptable. Patients should still be able to expect the NHS to continue to deliver improvements in access and quality. It will remain important, for example, for patients with cancer or its symptoms, to be seen by the right person, with appropriate expertise, within the current performance standard timescales.

### 18-weeks waiting times

7. NHS organisations have made significant improvements in access to elective care. Average waiting times now need to be reduced, in line with international experience. Accountability to patients and greater information transparency, through patient choice and the move towards GP-led commissioning, should now make long waits unacceptable. Performance management of the 18 weeks waiting times target by the Department of Health will cease with immediate effect.

8. To maintain progress during 2010/11:

   - commissioners should maintain the contractual position and GPs and commissioners will want to ensure that any flexibility to improve access reflects local clinical priorities; and

   - referral to treatment data will continue to be published and monitored. Commissioners will want to use the median wait as an additional measure for performance managing providers.

9. Patients' rights under the NHS Constitution will continue, as will the accompanying legal requirements to ensure that providers are achieving the waiting time rights. We are considering to what extent amendments are required, and if so, we shall carry out a full consultation in due course.

### Access to primary care

10. The Vital Sign and Existing Commitment relating to access to primary care will no longer be performance managed. This is not a signal that a deterioration of patients' experiences is acceptable and commissioners must ensure access reflects local need.

### Four-hour A&E waiting times

11. Work is being accelerated to identify more clinically relevant indicators for emergency care, which we intend to introduce in pilot form during this year with a view to them being fully embedded from 2011/12. In the meantime, the four-hour A&E standard will continue to apply during 2010/11. However, on clinical advice, the threshold will now change from 98 per cent to 95 per cent with median times in A&E to be performance managed.

## Reporting the reduction in healthcare-associated infections

12. NHS organisations have achieved significant reductions in MRSA bacteraemias and *Clostridium difficile* infections. Organisations should demonstrate continuous improvement as per the new standards, while pursuing a zero tolerance approach to infections. There are no changes to how we expect each organisation to deliver and, as

part of opening up data to the public, the Health Protection Agency has been asked to publish data on a weekly basis from 5 July 2010.

### Local prioritisation

13. During the recent sign-off of SHAs plans, two areas stood out as not being given sufficient emphasis. The first is ensuring that military veterans receive appropriate treatment. Here, ensuring a smooth transition for injured personnel into NHS care is important as well as providing priority treatment for conditions relating to their service. The second area is dementia. NHS organisations should be working with partners on implementing the National Dementia Strategy. People with dementia and their families need information that helps them understand their local services, and the level of quality and outcomes that they can expect. PCTs and their partners should publish how they are implementing the National Dementia Strategy to increase local accountability for prioritisation. This is to support a move away from central command to local determination and as such PCTs will not be subject to requirements on how or what they publish, neither will there be any national performance requirements put on them.

14. The emphasis has changed for a third area discussed as part of the sign-off of SHA plans. Mixed-sex accommodation needs to be eliminated, except where it is clearly in the overall best interests of the patient. We shall explore for implementation in the autumn the options on how commissioners might refine the sanctions in the standard contracts with the aim of imposing additional sanctions on those services not meeting these requirements. To further this initiative, guidance on capital schemes will be amended to improve the provision of single rooms and achieve better dignity and privacy for patients.

## New rules on reconfiguration

15. A moratorium is in place for future and ongoing reconfiguration proposals. This does not mean that there is no longer a need for service redesign and robust proposals should continue to be developed. For example, the National Audit Office report published in February 2010 set out the need to improve the planning and design of major trauma networks. Proposals to raise the standard of trauma care should proceed this year. The "Safe and Sustainable" review of paediatric cardiac surgery will also continue, with the intention of developing proposals for consultation in the autumn. These and any other current and future reconfiguration proposals must meet four new tests before they can proceed. These tests are designed to build confidence within the service, with patients and communities.

16. The tests will require reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;

- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

17. SHAs should revisit planned, ongoing and completed consultations, and respond to external requests for the same to ensure they are consistent with these tests for service change. This does not necessarily mean that formal consultation and implementation plans should be unpicked. Where there is insufficient assurance that the four tests have been properly applied, the Secretary of State for Health may ask the Independent Reconfiguration Panel to review the case and make recommendations to him.

# Future direction and next steps on transforming community services

18. Separating PCT commissioning from the provision of services remains a priority. This must be achieved by April 2011, even if this means transferring services to other organisations while sustainable medium-term arrangements are identified and secured. PCTs should therefore continue to develop and review proposals for the divestment of their directly-provided community services, but in doing so ensure that:

    - they have been tested with GP commissioners and local authorities;
    - final proposals are consistent with the aims of the forthcoming NHS Strategy in strengthening the delivery of public health services and health services for children;
    - they consider the implications for choice and competition;
    - they consider a wide range of options, including the development and early delivery of Community Foundation Trusts and Social Enterprises, providing employee leadership and ownership;
    - there has been effective engagement of staff and their representatives when considering options;
    - previous proposals for continued direct provision are reviewed and alternative options developed which secure separation; and
    - proposals should be capable of being implemented, or substantial progress made towards implementation, by April 2011.

19. Guidance on the approval process and timescale will follow publication of the forthcoming NHS Strategy. This may include an additional option of a staff membership Foundation Trust model for community services, where viable. Existing approved

applicants for Community Foundation Trusts, however, should continue to prepare for the first step of being established as NHS Trusts.

20. Looking forward, we shall develop proposals for a phased move towards an 'Any Willing Provider' model for community services, addressing barriers to entry to greater participation by the independent and voluntary sector.

# Finance and efficiencies

21. The coalition agreement commits to increases in health spending in real terms in each year of the Parliament, enabling us to plan for the future with more certainty. Final departmental spending plans will be announced in the Spending Review in the autumn. Then the NHS Operating Framework for 2011/12 will spell out the detail of both revenue and capital allocations in this revised funding context. In setting capital allocations for 2011/12 particular consideration will need to be given to reducing the high levels of Backlog Maintenance. Any new major hospital schemes will be assessed in the context of the Spending Review, to ensure that they are affordable and represent the highest possible value for money. Only priority schemes should go forward.

22. The £15-20 billion efficiency challenge up to 2014, which the NHS is planning to meet, remains absolutely critical for the future. The national workstreams and local plans which are now in place to address quality, innovation, productivity and prevention will need to deliver at least the level of savings required to meet the increasing demands on the NHS and to release resources to meet demographic and demand pressures, and invest in any new priorities that emerge from the Spending Review process later this year.

23. As a result of the increases in SHA and PCT Management Costs reported in the draft 2009/10 accounts and the commitment to reduce costs in bureaucracy and administration, each SHA region must now go further and faster to achieve the following reductions. The overall ceiling for Management Costs in PCTs and SHAs will now be set at two thirds of the 2008/09 Management Costs (£1,509 million), the ceiling will therefore be £1,006 million. It will be for SHAs to determine how this is managed across PCTs and the SHAs, but the expectation is that most of the reductions need to be realised in 2010/11 and 2011/12. SHAs should ensure that plans are not limited to simply achieving the ceiling and should aim to go further to ensure all possible efficiencies are realised.

24. The Management Costs reduction plans for 2010/11 and 2011/12 will need to be revisited. In aggregate, PCTs and SHAs will need to save at least £222 million in 2010/11 and a further £350 million by the end of 2011/12. Achieving these reductions will significantly narrow down the variation in per capita management costs between the SHA areas. For 2011/12, we will explore how to take this further to address the variation at PCT level. As part of the ongoing reduction in SHA and PCT Management Costs, the

NHS Operating Framework for 2011/12 will set out how resources will be released from the infrastructure and running costs of SHAs and PCTs in order to provide a running cost allowance for the GP Commissioning Consortia.

25. In order to deliver additional efficiencies in 2010/11, the Government has recently undertaken a review of capital spending and announced new spending controls, including a freeze on new consultancy, marketing and ICT spend, a freeze on civil service recruitment and centralised procurement for goods and services. This will be overseen by a new Efficiency and Reform Group. While these controls do not formally apply to the NHS, organisations should ensure that they can demonstrate similar discipline across these areas, and prepare for a period of capital constraint, particularly as they progress their quality and productivity plans.

26. These actions should be additional to the existing requirements for the SHA and PCT sector to end 2010/11 with £1bn of aggregate surplus and for SHAs to ensure that two per cent of recurrent funding is only committed non-recurrently at the aggregate regional level.

# Accelerating the development of the payment system

27. The payment system should reward excellent performance and be tough on poor quality. We are developing a range of mechanisms, which will include more transparent reporting of quality information to patients and the public. Competition and choice are key mechanisms to create a patient-centred and quality-focussed NHS, so we are committed to publishing detailed data about the performance of healthcare services online.

28. The forthcoming NHS Strategy will set out proposals for further development in 2011/12 and beyond. The payment mechanism will be an increasingly vital means of supporting quality and efficiency; to achieve this, payments for performance must be structured around outcomes, be capable of aggregation along patient pathways, extend across service sectors, be benchmarked for quality and cost; and incentivise for quality. We are continuing to develop contractual quality requirements, expanding the number of best practice tariffs where payment is linked to best practice care, and expanding the list of never events so that no payment is made for services which compromise patient safety. These changes for 2011/12 will be detailed in the tariff guidance we issue later this year. In 2011/12, we intend to make available a number of pathway (or year of care) tariffs in appropriate areas. To support the development of pathway tariffs, a number of ‘commissioning packs’ are in production, starting with cardiac rehabilitation, which is to be published shortly. Other commissioning packs will be published later this year and

could include dementia, diabetes, chronic obstructive pulmonary disease, end of life care and stroke rehabilitation.

## Re-ablement and post-discharge support

29. For 2011/12, we are planning changes to the tariff to cover re-ablement and post-discharge support, including social care. Re-ablement services help people with poor physical or mental health accommodate their illness by learning or re-learning the skills necessary for daily living. Such an approach creates real opportunities for acute providers to work with GPs and Local Authorities and would require the full engagement of the wider health and care economy before discharging patients. It should encourage the use of services such as community health services; social care; home adaptations (including telecare), and extra-care housing. These services should contribute to improved patient outcomes and significantly reduce the risk of emergency re-admission into hospital, which increased by 50% from 1998/99 to 2007/08.[1]

30. We should like to invite organisations to come forward to help us develop best practice before April 2011. We should particularly welcome expressions of interest from GPs and Local Authorities, who have prioritised this area in their local quality, innovation, productivity and prevention plans and have a positive approach to health and social care integration.

31. Alongside this, there is now an intention to ensure that hospitals are responsible for patients for the 30 days after discharge. If a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment. This strengthens an existing expectation that avoidable readmissions due to poor quality care are not reimbursed[2]. From 1 December 2010, we expect providers and commissioners to apply the provisions of this guidance if they are not already doing so. Making hospitals responsible for a patient's ongoing care after discharge will create more joined-up working between hospitals and community services and may be supported by the developments in re-ablement and post-discharge support. This will improve quality and performance and shift the focus to the outcome for the patient. We are leaving the exact method for determining how non-payment should occur up to health economies' discretion in consultation with GPs and local authorities - this will allow the local NHS to come up with a solution that fits its circumstances.

[1] source "Compendium of clinical and health indicators", NCHOD October 2009
[2] Payment by Results Guidance 2010-2011 paragraphs 402-405

# Summary

32. This revision to the NHS Operating Framework 2010/11 makes significant changes in-year, and signals substantial changes in future years as to how the NHS will function as it develops to drive up standards, support professional accountability, deliver better value for money and creates a healthier nation.

33. Increasingly NHS staff will be freed from central micro-management and become more accountable to the patients they serve. To maintain a minimum burden approach, all national communications will be subject to a Gateway process, so that they are consistent with both the messages in the NHS Operating Framework and wider statutory responsibilities. All communications requiring the attention of NHS management will include a Gateway reference.

# Annex

## Summary of how the Revision to the Operating Framework for the NHS in England 2010/11 impacts on Existing Commitments and Vital Signs

### Existing Commitments

The following indicator is removed:

- Guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours

The following indicator will now be subject to a 95% threshold:

- A four-hour maximum wait in A&E from arrival to admission, transfer or discharge

### Vital Signs Tier 1

The following indicators are removed:

- Percentage of patients seen within 18 weeks for admitted and non-admitted pathways (and supporting measures)
- Patient experience of access to primary care (and supporting measures)

There are no changes to Vital Signs Tiers 2 or 3.