National Voices

People shaping health
and social care

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Members’ briefing: November 2011

THE NHS OPERATING FRAMEWORK 2012-13

Introduction

The NHS Operating Framework is an annual document issued by the centre, to instruct the NHS on how it will be performance managed for the next financial year.

The framework for 2011-12 will be the **last** of these documents. The reformed NHS is expected to be in place from April 2013 and will be governed instead by a three-year ‘mandate’ from the Secretary of State to the NHS Commissioning Board, which will then have the operational ‘autonomy’ to decide how it will work with the system to achieve the mandate’s objectives.

Overview

The NHS Operating Framework for 2011-12 tries to do three things:

- make full use of the last year of this kind of performance management to bear down on costs and get these reconciled before the NHS Commissioning Board and clinical commissioning groups take over
- drive transition by cajoling current NHS structures to prepare for the new NHS
- highlight particular areas of patient care, choice and involvement to which PCTs in particular must pay attention

National Voices would point members’ attention to two overall challenges here. First, demanding that the current system doesn’t slip in its management of both quality and finance while at the same time working to abolish itself.

Second, maintaining real financial stringency while at the same time telling everybody not to ration or restrict access and treatments inappropriately.

In a quote given to hsj we have noted:

> “Tightly restricting the finance lines while telling everyone not to ration or restrict choice is a circle that will be hard to square. Patients and patient groups will need to be watchful of any attempts to restrict treatments inappropriately, for example by not prescribing NICE-recommended treatments, stopping referrals for some treatments, or cleansing patients from GP lists.”

That said, there is welcome focus on improving the care of older people, people with dementia, people with mental illness, and carers.

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Financial context

In line with the ‘Nicholson challenge’ the NHS enters its second year of trying to find new 4% efficiencies from its budget.

It must aim to reduce management costs: by 2014-15 these should be one third lower than in 2010-11, with the NHS Commissioning Board holding a budget of at least £492 million.

PCTs will be allocated money for 2011-12 at a level at least two and a half per cent higher than this year (may vary following Chancellor’s statement). But they cannot plan for deficits and must clear all debts before handing over to CCGs at April 2013.

NHS provider trusts will be further squeezed. Both tariff and non-tariff services will be charged at 1.5% less than this year. Penalties for early readmissions will continue.

Providers have the chance to ‘earn back’ some of this lost income by meeting CQUIN standards. CQUIN will be raised to maximum 2.5% of contract price. (CQUIN is the system of commissioners paying extra on top of the contract if additional quality is achieved.)

CQUIN can be used as now to reward VTE risk assessment and ‘responsiveness to personal needs of patients’; and three new areas are added:

- improving diagnosis of dementia
- use of the NHS Safety Thermometer
- a ‘quantum’ that can be decided locally

(The NHS Safety Thermometer is an improvement tool that allows NHS organisations to measure harm in four key areas (pressure ulcers, urine infection in patients with catheters, falls and VTE) and the proportion of patients who are “harm free”. See link.)

The DH says it will “expand best practice tariffs to:

- incentivise more procedures being performed in a less acute setting;
- incentivise 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.

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Priorities for patient care

It is notable that the DH is insisting that national strategies still apply and must be implemented. These strategies appear to be at risk from the reforms. The document says:

> "NHS organisations should also continue to work to meet the expectations in service specific outcomes strategies that have been published for mental health services, cancer, chronic obstructive pulmonary disease, asthma and long term conditions associated with premature mortality."

1. *Older people and people with dementia*

Commissioners should ensure that providers are compliant with relevant NICE quality standards and ensure information is published in providers' quality accounts.

Commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome.

NHS must ensure participation in and publication of national clinical audits that relate to services for older people.

There will be initiatives to reduce inappropriate antipsychotic prescribing for people with dementia to improve quality of life with a view to achieving overall a two-thirds reduction in the use of antipsychotic medicines.

There will be initiatives to improve diagnosis rates for dementia, particularly in the areas with the lowest current performance.

A continued drive to eliminate mixed-sex accommodation and to performance manage this.

Inappropriate emergency admission rates continue to be used as a performance measure for national reporting.

There will be continuing use of non-payment for emergency readmissions within 30 days of discharge following an elective admission.

As this year, PCTs must work with their local authorities and publish dementia plans which set out locally the progress they are making on the National Dementia Strategy

2. *Mental health*

particular attention must be given to improving:

- access to psychological therapies as part of the commitment to full rollout by 2014/15 so that services remain on track to meet at least 15 per cent of disorder prevalence, with a recovery rate of at least 50 per cent in fully established services. During 2012/13 this will mean increased access for black and minority ethnic groups and older people, and increased availability of psychological therapies for people with severe mental illness and long term health problems;

- the physical healthcare of those with mental illness to reduce their excess mortality;

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- offender health, working in partnership with the National Offender Management Service; and

- targeted support for children and young people at particular risk of developing mental health problems, such as looked after children.

National monitoring will judge progress using the indicators in the Mental Health Performance Framework:

- the number of new cases of psychosis served by early intervention teams;

- the percentage of inpatient admissions that have been gatekept by Crisis Resolution/Home Treatment Teams; and

- the proportion of people under adult mental illness specialties on the Care Programme Approach (CPA) who were followed up within seven days of discharge from psychiatric inpatient care.

3. Carers

PCT clusters need to agree policies, plans and budgets with local authorities and voluntary groups to support carers, where possible using direct payments or personal budgets. For 2012/13 this means plans should be in line with the Carers Strategy and:

- be explicitly agreed and signed off by both local authorities and PCT clusters;
- identify the financial contribution made to support carers by both local authorities and PCT clusters and that any transfer of funds from the NHS to local authorities is through a section 256 agreement;
- identify how much of the total is being spent on carers' breaks;
- identify an indicative number of breaks that should be available within that funding; and
- be published on the PCT or PCT cluster's website by 30 September 2012 at the latest.

4. Access

The DH is clearly aware of recent examples of restrictions of access and is robust in declaring these are not acceptable. In particular:

- if patients are at risk of not being treated within 18 weeks PCTs must publicise list of alternative provider options
- less than 1 per cent of patients should wait longer than six weeks for a diagnostic test
- no justification for the use of minimum waits that take no account of clinical need
- no justification for the use of blanket bans of certain treatments (eg those of low clinical value)
- all rights in the NHS constitution on waiting times should be upheld

Patient choice

PCTs expected to drive forwards choice in the following areas:

- choice of named consultant team – from April 2012;
- choice of diagnostic test provider;
- choices post-diagnosis including choice of treatment;
- choice of treatment and provider in mental health services;
- choice in care for long term conditions as part of personalised care planning; and
- choice about maternity care.

Under a compromise agreed with the BMA, the NHS will also pilot in three areas new arrangements to open up patient choice of GP beyond traditional practice boundaries.

Personal health budgets

PCT clusters should prepare for wider roll-out of personal health budgets, following the completion and evaluation of the pilot programme, due to end in October 2012. Subject to evaluation, this should include preparation for all patients with NHS continuing care to be offered a personal health budget for relevant aspects of care by April 2014 at the latest.

Other items of interest

Clinical senates and networks will be established during 2012-13. Still no clarity on what they are but there will be 'widespread engagement' first.

PCTs will be expected to cleanse GP practice lists of 'ghost patients' by the end of 2012-13.

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