Appendix 2

Additional Information on the NHS Annual Operating Framework 2011-12

The NHS Annual Operating Framework (AOF) sets out the main national priorities for the NHS in the coming year, as well as detailing planned changes to NHS managerial structures, payment regimes, staff terms and conditions, quality initiatives etc. 2011-12 is likely to be a particularly significant year in terms of NHS structures, as a radical Health and Social Care Bill (due to be presented to parliament in early 2011) will seek to make significant changes to the way in which the NHS operates. In addition, the requirement to find around £20 billion in 'efficiency' savings in the next four years presents the NHS with very major financial challenges.

1 Organisations

1(a) NHS Commissioning Board/SHAs

The forthcoming Health and Social Care Bill will propose introducing a national NHS Commissioning Board (NHSCB). Essentially, the NHSCB will take over many of the current strategic/monitoring functions of Strategic Health Authorities (SHAs), whilst also directly commissioning services which are unsuitable for localised commissioning by GP consortia, such as primary care (where there would be an obvious clash of interests for GP commissioners), specialised care (i.e. low volume treatments provided on a regional or national basis), and aspects of prison/military care. The NHSCB will be launched in shadow form in 2011, but will not become operational until April 2012. In the meantime, SHAs will continue to exercise authority over regional health planning, quality assurance etc.

1(b) PCTs

Primary Care Trusts (PCTs) will remain in existence until at least April 2013, but the DH expects there to be a significant reduction and/or transfer of staff (i.e. into GP consortia, local authorities, the NHSCB) before this date. This is likely to mean that the current system of 152 discrete PCTs will quickly become unsustainable, and the DH consequently expects PCTs to form regional or sub-regional 'clusters' by June 2011. Clusters will each be managed by a single executive team.

1(c) Health and Wellbeing Boards

Health and Wellbeing Boards (HWBs) will bring together GP commissioners and local authorities to plan local health and social care strategies. In formal terms, HWBs will be responsible for the local Joint Strategic Needs Assessment (JSNA) and for the local Joint Health and Wellbeing Strategy (JHWS). HWBs will need to be in place by April 2012, and 2011 will see a network of 'early adopters' piloted in parallel with some of the pathfinder GP consortia. The Health and Social Care Bill is expected to define a minimum membership for HWBs, with localities free to add to this core if they choose. The minimum representation will be: local GP consortium representative,

Director of Public Health, Director of Adult Social Care, Director of Children's Social Care, local authority elected member, Healthwatch representative.

1(d) Foundation Trusts

The AOF confirms that all NHS trusts must become Foundation Trusts by 2014.

2 Commissioning Community Services

By April 2011 all PCTs must have separated their commissioning activities from any 'provider arm' community services (this is not directly relevant to Brighton & Hove, as NHS Brighton & Hove has never provided services directly).

During 2011-12 PCTs are expected to promote the "Any Willing Provider" policy, encouraging a range of providers to participate in community healthcare services. Particular attention should be provided to encouraging social enterprises and the voluntary and community sectors.

3 Pay and Reward

The AOF confirms that there will be a general pay freeze for NHS staff from 2011-13. The DH is also actively negotiating with unions over plans to freeze pay increments across the same period, with savings used to mitigate the impact of redundancies.

4 Transparency and Accountability

The NHS will begin publishing an Outcomes Framework in 2011. This will set out the NHS plans for service improvement in terms of specific outcomes measures, and will become the main tool to measure improvements within NHS-funded healthcare.

Patient experience and feedback will also be prioritised, with PCTs and GP commissioners encouraged to engage with patients and use patient-recorded information to inform commissioning decisions.

5 Choice

From April 2011, patients will be offered a greater degree of choice in their treatment, including a wider choice of diagnostic options and the choice of a named consultant-led team to carry out procedures. People with long term conditions should also be offered more involvement in the management of their conditions.

"Any Willing Provider" – e.g. the ability for patients to choose any healthcare provider willing to operate within NHS tariffs and at NHS quality – will be phased in, starting with community care.

Patients will be able to choose to register with any GP practice (providing it has spaces on its list) from April 2012.

6 QUIPP

The current commitment to finding £15-20 billion savings via the QUIPP programme is reiterated in the AOF, but the time-frame has been relaxed somewhat – savings must now be found over four rather than three years.

7 Key New Commitments

The AOF makes a number of commitments to improve particular aspects of NHS services. These include:

7(a) **Health Visitor Services** - increasing the number of health visitors and changing the way in which they are utilised.

7(b) **Family Nurse Partnerships** - providing dedicated support for teenage mothers and their families via expanding the current family nurse initiative.

7(c) **Cancer Drugs Fund** - £200 million p.a. to help buy cancer treatments recommended by doctors.

7(d) **Military and Veterans' Health** – ensuring that good quality services are available, particularly in terms of prosthetics and mental health. Also ensuring that NHS organisations support staff with commitments as reservists.

7(e) **Autism** – ensuring that the NHS acts in accordance with the 2009 Autism Act guidance (to be published in 2011).

7(f) **Dementia** – improving services, particularly in terms of: early diagnosis and intervention, better care in general hospitals, care homes, and reduced use of antipsychotic medications. Better co-ordination between health and social care via S75 agreements.

7(g) **Support for Carers** – better support, particularly in terms of: early identification of carers, supporting carers to fulfil their educational and employment potential, personalised support for carers, looking after carers' physical and mental wellbeing.

7(h) **Maintaining Quality Improvements** – ensuring that achievements in reducing waiting times (e.g. 4 hour wait for A&E, 18 week wait for planned treatment) are not lost as the NHS moves from a process target culture to one focused on outcomes.

7(i) **A&E Services** – general improvement across a range of indicators.

7(j) **Ambulance Services** – general improvement across a range of indicators.

7(k) **Mixed Sex Accommodation** – working to implement the programme to eliminate mixed sex accommodation in hospitals.

7(l) **End of Life Care** – continuing to implement the End of Life Care strategy.

7(m) **Cancer Care** – working to improve access to diagnostics and to improve the efficacy of radiotherapy; better data collection re: survival rates.

7(n) **Stroke** – implementing the stroke strategy, particularly in terms of improving prevention; acute care at the point of admittance (i.e. ensuring that those patients who would benefit from thrombolysis receive it); long term care/re-ablement.

7(o) **Mental Health** – better integration of mental and general health services; improved early intervention in MH (with targeting of 'at risk' groups such as offenders); reducing hospital admissions and length of stay via improved community services; (subject to consultation) introducing "Any Willing Provider" to MH services; expanding the "Improving Access to Psychological Therapies" programme.

7(p) **Safeguarding Children** – implementation of the Munro Review (to be published spring 2011.

7(q) **Dentistry** – working to improve access to dental services and to develop children's services.

8 Areas for Improvement

The AOF identifies a number of areas in which NHS services urgently need to be improved. these include:

8(a) **Healthcare for Learning Disabled People** – improving services, with particular focus on: staff making reasonable adjustments for LD patients, involving LD people in making decisions about their care; providing annual health checks for LD people.

8(b) **Children and Young People's Health** – with particular attention to transition services; CAMHS; palliative care; disabled children; children in care and families with multiple problems.

8(c) **Diabetes** – better screening; improved patient information; better management of diabetes in-patient services.

8(d) **Sharing Non-Confidential Information to Tackle Violence** – initiative for A&E services to collect and share data on violent incidents resulting

in hospital attendance with local Community Safety Partnerships. (This is essentially a national roll-out of the 'Cardiff' pilot on reducing alcohol-related harm. The recently completed BHCC intelligent commissioning pilot on alcohol also recommended adopting this initiative.)

8(e) **Violence Against Women and Girls** – ensuring that the NHS has effective systems for identifying women and girls who have experienced violence or abuse (e.g. domestic abuse) when they present for healthcare treatments and that appropriate pathways are in place to guarantee that they receive the help they need.

8(f) **Regional Trauma Networks** – implementing regional trauma networks (locally the Royal Sussex County Hospital is to become the SE region trauma centre as part of the '3T' programme)

8(g) **Respiratory Disease** – particular focus on earlier diagnosis of COPD (chronic obstructive pulmonary disease).

9 Other Areas of Importance

The AOF also identifies other areas as being of importance. These include:

- managing the transfer of public health responsibilities from PCTs to local authorities;
- improving pharmacy services; improving emergency preparedness and resilience;
- promoting physical activity for children and adults; better screening for major illnesses (heart disease, diabetes, stroke, kidney disease);
- better abdominal aortic aneurysm screening;
- and a focus on improving care for and reducing the incidence of fragility fractures (particularly in older women).

10 Finance

GP consortia will not inherit historic PCT debt - i.e. debt incurred prior to 2011-12. However, consortia will be responsible for debts accrued after this date, and so will be expected to work with PCTs to minimise the risk of budget deficits during the transition period.

There will be a 45% reduction in the costs of NHS management (i.e. PCTs and SHAs) by 2014-15. At the same time as these reductions are being implemented, PCTs and SHAs will need to realise reductions in order to fund the establishment of GP consortia managerial/administrative and commissioning support (which will eventually be funded at a rate of £25-35 per head of population).

Capital funding for NHS projects has been reduced, although not drastically so. Urgent maintenance spending should be prioritised, as should short term capital investment likely to realise significant medium term savings.

11 Social Care

There is approximately £1 billion in the NHS budget to be passed over to local authority social care services. Some of this funding is specifically for re-ablement, but the bulk can be spent on general social care investment. Spending plans must be jointly agreed by PCTs and local authorities.

12 Tariff

The AOF announces a number of changes to the NHS tariff system. Some of the more noteworthy include:

- A reduction in tariff price of 1.5% for 2011-12 (e.g. providers working to tariff will be paid 1.5% less than in 2010-11).

- In 2011-12, hospitals will not be reimbursed for the costs of treatment for patients who have emergency re-admissions within 30 days of being discharged following an elective admission. This measure is designed to incentivise acute providers to ensure that they do not discharge patients inappropriately. Payment for re-admissions within 30 days following other discharges (i.e. discharges after unplanned admissions) is to be negotiated locally, with the intention of reducing re-admissions by 25%.

- In 2011-12 the DH will pilot initiatives to increase specific tariffs to include payment for a period of re-ablement following hospital discharge.

- Extension of tariff scheme to include elements of treatment for long term conditions, community services, mental health care etc.

- Continuation of 30% marginal tariff rate initiative for emergency admissions above agreed baseline (i.e. hospitals are only paid 30% of tariff for every emergency admission beyond an agreed annual baseline rate). This initiative is intended to encourage acute providers to manage emergency admissions effectively.

- 'Never-events' (e.g. catastrophic failures in care which should never have been allowed to happen) will no longer be reimbursed by commissioners.

- In 2011-12, and for the first time, providers will be able to offer services to commissioners at less than the published tariff rate. This is potentially significant, as tariffs were introduced, in part, to ensure that competition within the NHS internal market was focused on quality rather than price. Currently, providers in the tariff-controlled market (i.e. mainly planned hospital care) cannot offer their services at anything

other than the tariff rate - the fear presumably being that price competition would drive down quality.

The bar on price competition may also have had the effect (although perhaps not the intention) of limiting the penetration of core NHS markets by the independent sector. New entrants into any market will typically struggle to gain business based on their reputation for quality, as they have no local reputation to rely upon, in contrast to existing providers. Therefore unless the existing provision is clearly sub-standard or lacks the capacity to cope with demand, new entrants to the market need to compete on price. By barring price competition, the tariff system has effectively discouraged the independent sector from competing with existing NHS providers – given the costs associated with establishing health infrastructure, relatively few providers are likely to gamble that commissioners will refer into their services if they have no levers to ensure they can compete with existing providers.

It is unclear whether the radical implications of this change in the tariff rules were intended – this is a measure published in the ‘small print’ of the AOF rather than a headline initiative. Nonetheless, it has created considerable interest.