Trust Board Meeting: Thursday 12 January 2012

<table>
<thead>
<tr>
<th>Title</th>
<th>Operating Framework 2012/13</th>
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<tr>
<td>Status</td>
<td>A paper for information</td>
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<tr>
<td>History</td>
<td>This paper is designed to provide the Board with key documents associated with the 2012/13 planning round</td>
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| Board Lead(s)    | Mr Andrew Stevens, Director of Planning and Information  
|                  | Mr Mark Mansfield, Director of Finance and Procurement  
|                  | Mr Paul Brennan, Director of Clinical Services |
| Key purpose      | Strategy | Assurance | Policy | Performance |
Summary

<table>
<thead>
<tr>
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<th>The annual planning process within the NHS has recently commenced.</th>
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<tr>
<td>2</td>
<td>A number of key documents have been published during late November 2011 and December 2011. These documents include:</td>
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<tr>
<td></td>
<td>2.1. The Operating Framework for the NHS in England 2012/13 (Attached to this document as Appendix A) - published on 24 November 2011.</td>
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<td>2.2. Primary Care Trust allocations 2012/13 - published on 14 December 2011.</td>
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<td>2.3. Operating Plan for NHS South of England 2012/13 - published on 19 December 2011 (Attached to this document as Appendix B)</td>
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<td>2.4. Payment by Results “road test” tariff 2012/13 (The draft tariff prices for 2012/13) - published on 15 December 2011.</td>
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<td>3</td>
<td>The Board in Committee meeting on 15 December received an informal briefing paper on the content of the Operating Framework (Appendix A), referred to in point 2.1 above. Items 2.2 - 2.4 above have been published since that meeting. Trust Management Executive received a similar briefing at its meeting on 22 December 2011.</td>
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Operating Framework 2012/13

Introduction
1. The NHS has recently commenced the process of planning for the forthcoming year 1 April 2012 to 31 March 2013. As part of this process a number of key documents have been published. This brief paper introduces these documents and attaches the most important publications as Appendices A and B.

Overview
2. The Department of Health published three key documents associated with the 2012/13 planning round during November and December. These were:
   2.2. Primary Care Trust allocations for 2012/13.
   2.3. Payment by Results draft (or “road test”) tariff 2012/13.
NHS South of England subsequently published the local Operating Plan on 19 December.
The Operating Framework for the NHS (the key national document) is attached as Appendix A to this paper. The NHS South of England Operating Plan is attached as Appendix B to this paper.

Commentary
3. The attached documents provide essential guidance for the development of 2012/13 plans at national, local health economy and Trust level. The Trust is presently engaged in the development of plans for 2012/13 within the organisation and with its key partners in the Primary Care Trusts, Clinical Commissioning Groups and Strategic Health Authorities.
4. The Trust has addressed the key content of these documents in its internal management processes. The Board in Committee received a briefing at its meeting on 15 December and the Trust Management Team discussed the Operating Framework on 22 December.
5. The Board will receive regular briefings on progress in the development of 2012/13 plans in the period up to the agreement of contracts and the submission of plans to the Strategic Health Authority in February and March.

Conclusion
6. The national and local planning frameworks attached to this document provide essential guidance for the development of Trust plans for 2012/13. The Board will be kept informed of developments as the planning process continues over the forthcoming months.

Recommendations
7. The Board is asked to receive the attached documents and note the contents.
Mr Mark Mansfield, Director of Finance and Procurement

January 2012
The Operating Framework
for the NHS in England 2012/13
<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Action</th>
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<tbody>
<tr>
<td>Gateway reference</td>
<td>16890</td>
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<tr>
<td>Title</td>
<td>The Operating Framework for the NHS in England 2012/13</td>
</tr>
<tr>
<td>Author</td>
<td>DH/NHS Finance, Performance and Operations</td>
</tr>
<tr>
<td>Publication date</td>
<td>24 November 2011</td>
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<tr>
<td>Target audience</td>
<td>PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communications Leads, Directors of Performance</td>
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<td>Circulation list</td>
<td>Voluntary Organisations/NDPBs</td>
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<tr>
<td>Description</td>
<td>This document outlines the business and planning arrangements for the NHS in 2012/13. It describes the national priorities, system levers and enablers needed for NHS organisations to maintain and improve the quality of services provided, while delivering transformational change and maintaining financial stability.</td>
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<td>Cross-references</td>
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<td>Superseded documents</td>
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<td>Timing</td>
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| Contact details | David Flory CBE  
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Richmond House  
79 Whitehall  
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For recipient’s use
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Foreword by Sir David Nicholson KCB CBE

Introduction

2012/13 is the second year of the quality and productivity challenge and the final year of transition to the new commissioning and management system for the NHS. It is therefore a vital period during which NHS leaders will have to respond to four inter-related challenges: the need to maintain our continued strong performance on finance and service quality; the need to address the difficult changes to service provision required to meet the QIPP challenge in the medium term; the need to complete the transition to the new delivery system set out in Liberating the NHS; and the urgent need to ensure that elderly and vulnerable patients receive dignified and compassionate care in every part of the NHS.

Getting the basics right every time

The scale of the changes we need to manage in the coming period mean that we need to focus more than ever on what the NHS is here to do. Recent reports by the Care Quality Commission and the Health Service Ombudsman have shown that some parts of the NHS are still failing to provide elderly and vulnerable patients with dignified and compassionate care, or to offer good basic standards in areas such as nutrition, continence and communication. The ongoing Mid Staffordshire Inquiry should act as a stark reminder of the consequences if we fail to focus on the fundamental quality of care and to listen to the concerns of patients and relatives. Many areas of the NHS are performing well on these issues, but too often variations in standards between and even within organisations remain.

The causes of shortcomings in dignity and basic care are complex and deep-rooted, often as much to do with culture and behaviour as with resourcing and prioritisation. But while local leadership is critical to addressing these issues, there is a clear role for the centre in supporting improvement and tackling poor performance. This NHS Operating Framework therefore includes requirements on clinical audit in key areas of basic care, a further programme of inspections by the Care Quality Commission, a renewed push on implementation of the national dementia strategy and increased support for carers. This issue resonates with the public and patients because it touches on the very purpose of the health service, in the words of the NHS Constitution, to support people “at times of basic human need, when care and compassion are what matter most”. We lose sight of this mission at our peril.
Maintaining a grip on performance

In spite of these important issues, overall performance to date in 2011/12 has been strong, building on our successful track record of delivery in recent years. Waiting times remain low and stable, although we must retain a focus on dealing with the longest waiters, quality improvements in areas such as infection control and reducing the use of mixed-sex accommodation have continued, and financial control remains firm at national level, despite some local exceptions. There are also encouraging early signs that we are making the sustainable changes needed to deliver the QIPP challenge as referral rates and emergency admission rates have stabilised. Given the complexity and uncertainty of the environment in which we are operating, this performance record is impressive: a testament to the commitment and professionalism of managers and clinicians across the NHS.

Maintaining strong day-to-day performance remains our over-riding priority for the remainder of 2011/12, including the difficult winter period we are now entering, and throughout 2012/13. That means keeping a strong financial grip, continually improving quality in priority areas, and maintaining operational resilience. Existing accountability arrangements, with PCT clusters and SHA clusters at their heart, will remain in place for the whole of 2012/13 and this NHS Operating Framework sets out clear performance expectations as well as the finance and business rules to support delivery. It seeks to maintain stability and balance risk between commissioners and providers, while recognising the need to shift to a greater focus on outcomes in future years and to accelerate our response to the QIPP challenge.

Meeting the quality and productivity challenge

The scale and nature of that challenge, requiring us to make up to £20 billion of efficiency savings by 2014/15 to invest in meeting demand and improving quality, mean that all parts of the NHS will need to take bold, long term measures in 2012/13 to secure sustainable change. The role of innovation, too often the forgotten element of QIPP, will be critical. Rapidly spreading changes that improve quality and productivity to all parts of the NHS will be crucial: a clear example is the use of telehealth to improve services for patients with long term conditions. We must also create the right conditions for rapid diffusion of good practice and the forthcoming Innovation Review will set out specific measures to achieve this.

Achieving sustainable improvement will also mean taking on the challenge of service change, to provide services closer to patients wherever appropriate, to create centralised networks of clinical care where necessary, and to improve integration between services. The recent agreement on several significant service reconfigurations and the creation of a number of newly integrated organisations through the Transforming Community Services programme show that real change can be achieved where managers and clinicians work together with courage and skill. Where change is needed in the interests of patients and taxpayers,
for example to the organisation of care for long term conditions, to the configuration of stroke or trauma services, or to integration between different sectors of care, we must be prepared to take on the challenge during 2012/13. Failure to do so will mean we are forced to rely on short-term fire-fighting measures, and that is why this NHS Operating Framework makes clear that blanket restrictions on procedures or minimum waiting times that do not take account of healthcare needs of individual patients are not acceptable. We must continue to focus on quality and productivity together and to plan for the long term if we are to succeed.

Building the new delivery system

2012/13 will also be the critical year in building the new system envisaged in Liberating the NHS. This will mean a great deal of technical and project work, and this NHS Operating Framework sets out clear expectations for delivering the changes. In taking this forward it is critical that we maintain a focus on our core purpose and build a system that will support us to deliver, particularly in difficult areas such as service change. That means developing clinical commissioning groups with a clear focus on improving long term conditions care, building on the role of GPs as navigators of the wider system. It means developing clinical networks and clinical senates which can support service redesign across wider areas where this is needed. And it means developing an NHS Commissioning Board with a relentless focus on improving outcomes and delivering value for money.

On the provider side, we must recognise the importance of the NHS Foundation Trust process not just as an end in itself, but as the means for ensuring we have the clinically and financially sustainable provider organisations we need to realise the QIPP challenge. And as we continue the roll-out of Any Qualified Provider during 2012/13, focusing on areas where patients themselves have told us there is a need for change such as wheelchair services and wound care, we need to recognise the role that choice and competition can play in driving improvement in service areas that have not always received a high priority.

As well as truly clinically led commissioning and a robust and diverse provider sector, service change requires the right environment at local level, an environment in which patients, the public and communities are highly engaged. That is why the focus on giving patients more information, choice and power is of such importance. And it is why Health and Wellbeing Boards have such a key role in integrating local commissioning and overseeing a clear local strategy across the NHS, public health and social care. Getting these aspects of the change right can help to create real pull for service change where to date there has too often been conflict.
Conclusion

Each of these four areas represents an exacting challenge in its own right. Taken together, they constitute a truly formidable leadership agenda. This is not a time for the faint-hearted: we must sink our teeth into these issues if we are to have any chance of success. I recognise that this is particularly challenging given the personal and professional uncertainty that many across the NHS continue to face.

Subject to the passage of the Health and Social Care Bill, this will be the final NHS Operating Framework for the current delivery system of Primary Care Trusts and Strategic Health Authorities. This management system – whatever its imperfections – has been at the cornerstone of the successful delivery in recent years of continuously improving care for our patients and strong stewardship of financial resources for taxpayers. I want to take this opportunity to thank once again all those who have contributed to a track record of which we can justifiably be proud. 2012/13 will test our mettle once again, but it is safe to say that the next evolution of the NHS commissioning and oversight system already has a lot to live up to.

Sir David Nicholson KCB CBE
NHS Chief Executive
1. Overview

A year for improvement and transition

1.1 This NHS Operating Framework sets out the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which they will be held to account. The current NHS reforms set out a clear strategic vision around transforming service delivery so that it is focused on better outcomes for patients with real decisions increasingly being taken by patients and their GPs and services being held to account by them. We welcome the NHS Future Forum’s interim advice on the importance of integrated care for patients. Delivery of high-quality services, based on clinical decision making and integrated care for patients and service users, will provide a strong platform for future years.

1.2 To improve services for patients, there will be four key themes for all NHS organisations during 2012/13:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;

- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;

- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and

- maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.

In doing so, PCT clusters should support local authorities in establishing Health and Wellbeing Boards so that they become effective local system leaders across health, social care and public health.

1.3 It is imperative that all NHS organisations prepare themselves for the reforms that come into place for 2013/14 and as such this NHS Operating Framework sets out the steps to allow that to happen. From 2013/14, the Secretary of State will hold the NHS Commissioning Board to account on the basis of a “mandate”, with the NHS Commissioning Board itself holding
CCGs to account for their performance. The Secretary of State will use the NHS Outcomes Framework as the basis for the mandate to the NHS Commissioning Board so PCT clusters and emerging CCGs need to ensure that they are in a position to publish data when available and certainly from 2013/14. All indicators within the NHS Outcomes Framework will be published on an ongoing basis.

1.4 It will be equally important that, as more decision making is taken locally to reflect the needs of patients and the clinicians who support them, the NHS does more to integrate service delivery, not only across primary and secondary care between mental and physical health but also with social care organisations. Each sector needs to look at where it can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users rather than institutions. PCT clusters should actively promote the NHS Constitution in their localities so that the public can be fully informed when they exercise choice.

Putting patients at the centre of decision making

1.5 The experience of patients, service users and their carers should drive everything the NHS has to do. This NHS Operating Framework puts patients at the centre of decision making with their experience of health and supporting care services central to the drive for further improvements. There will be no hiding place for those organisations that cannot provide basic levels of dignity and humanity in the delivery of service, and nor should meeting minimum standards be regarded as good enough. Throughout this NHS Operating Framework are expectations and enablers to support the NHS in improving patients’ experiences of care. This includes a new national CQUIN goal that will incentivise use of the NHS Safety Thermometer to help keep patients safe from four areas of harm.

Development of the new system for delivery

1.6 It will be imperative that CCGs are supported so that the NHS Commissioning Board is in a strong position to authorise them as ready, willing and able to take on statutory responsibilities from April 2013.

1.7 Section 3 of this NHS Operating Framework sets out the technical requirements to support the development of CCGs. Within that, any decision going forward that does not incorporate a genuine viewpoint from local clinical leaders of emerging CCGs will be open to challenge.

1.8 Transparency, as well as integration and joint working across the health and social care sector, continues to be of vital importance as we move to a system with an emphasis on local accountability, supporting Health
and Wellbeing Boards and a new public health system. This document sets out the measures for national accountability in the Annex. However, performance against all existing quality indicators must be maintained or improved with local accountability required where performance may have slipped or require explanation.

Quality, innovation, productivity and prevention

1.9 While funding over the Spending Review period will increase in real terms, the QIPP challenge has identified the need to achieve efficiency savings of up to £20 billion over the same period, to be reinvested in services to provide high-quality care. The NHS is on track in 2011/12 to meet QIPP objectives. Currently this is weighted towards central actions, including pay and administrative cost reductions and local efficiency programmes. For future years, delivering the additional efficiency savings and quality improvements will require the NHS to focus on delivering transformational change through clinical service redesign. For 2012/13, we need to build on the progress made in delivering efficient organisations and, through the reinvestment of those efficiencies, start to deliver transformational service change while maintaining the gains already made. Where cost improvement programmes are required, these must be agreed by Medical Directors and Directors of Nursing, involve patients in their design and include in-built assurance of patient safety and quality. A single national process is being developed so that all SHA clusters take a consistent approach to their quality assurance of cost improvement plans. This will be part of a broader common operating model for quality and safety that is being developed by the National Quality Team.

1.10 The NHS must prioritise the adoption and spread of effective innovation and best practice. The NHS Chief Executive’s Innovation Review will be published in December 2011 and make further recommendations on how this can be taken forward.

1.11 CCGs will need to take on the QIPP challenge within their local community. The milestones for each PCT cluster described in Section 5 of this NHS Operating Framework, supported by the indicators in the Annex, will provide ongoing national assurance that progress against the QIPP challenge is being made. SHA and PCT clusters can and should supplement these with additional measures that reflect their own local circumstances and ambitions.
Maintaining and improving performance

1.12 The agenda set out above in terms of efficiency and productivity savings, as well as reform of the commissioning regime, will be challenging but must be with the overall aim of improving quality of services. This NHS Operating Framework aims to limit the key performance measures that will be subject to national assessment in order to support more local decision making on priorities. The national measures are set out in the Annex and can be grouped in three categories:

Quality: those indicators of safety, effectiveness and patient experience that provide an indication that standards are being maintained or improved;

Resources: those indicators of finance, capacity and activity that demonstrate the robustness of organisations; and

Reform: indicators that demonstrate commissioner and provider reform, with more information and choice provided to patients.

1.13 This NHS Operating Framework provides a solid basis for a new health service that builds on current successes and patients, clinicians and local communities with the opportunity to take greater responsibility for local services that remain available to all on the basis of the key NHS principle of provision based on need and not the ability to pay.

1.14 The Government’s Spending Review for 2011/12 to 2014/15 protected the total health budget with real terms increases in each of those years. This document is set out in four distinct but inter-related sections which amount to the basis on which success will be judged during 2012/13:

Quality: the national priorities to be delivered in 2012/13 to improve services for patients and to support the NHS Constitution and meet a more outcomes-based approach.

Reform: what needs to be done during 2012/13 to deliver a different architecture for delivery from April 2013, improving patient choice and local accountability.

Finance and business rules: where the quantum of resources is set out, together with incentives, enablers and business rules for the year.

Planning and accountability: a single planning process that brings together the above components, describing how local plans should be developed and assured, as well as how this information will be used nationally to hold NHS organisations to account.
2. Quality

Improving services and patient experiences during 2012/13

2.1 Section 1 of this NHS Operating Framework sets out the context of a challenging year of transformation for the NHS. These changes will bring about a more devolved system to allow for decisions to be taken by local patients and their GPs, with local system leadership by Health and Wellbeing Boards to drive forward quality improvements.

2.2 The NHS is moving to a system where quality and outcomes drive everything we do. Our model of delivery needs to be overhauled and 2012/13 is the year to make that change happen. The NHS Outcomes Framework\(^1\) will act as a catalyst for driving quality improvements and outcome measurement throughout the NHS. It defines and supports a focus on clinical outcomes, including the reduction of health inequalities, to drive a change in culture, behaviour and the way we deliver clinical services.

2.3 These changes give real power to clinicians to exercise their judgement on the best way of improving outcomes for their patients. Our clinicians are our best judges of clinical quality and, where survey results suggest that the staff believe the quality of services in their organisation needs to improve, then that must happen. The staff survey asks whether staff would recommend their hospital to patients. This is a key indicator of quality and the results of the staff survey should be monitored locally and nationally.

2.4 At a time of change, NHS organisations must act responsibly in fulfilling ongoing statutory and other core duties. All NHS organisations must comply with the Equality Act 2010 and its associated public sector Equality Duty. The NHS Equality and Diversity Council has developed an Equality Delivery System\(^2\) so that NHS organisations may have a systemic approach to supporting quality performance. The promotion and conduct of research continues to be a core NHS function and continued commitment to research is vital if we are to address future challenges. Further action is needed to embed a culture that encourages and values research throughout the NHS.

2.5 Medical revalidation is central to improving the quality and safety of care. NHS organisations must be ready in 2012 (as indicated by their organisational readiness self-assessment returns) with clinical governance arrangements including appraisals for doctors in place, to support responsible officers in fulfilling their duties.

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2.6 NHS bodies should ensure that they have arrangements in place to ensure that any person they appoint to a post has the knowledge of English necessary to perform their duties in line with the existing requirements under the Performers List Regulations 2004 and Health Circular 1999/137.

Areas requiring particular attention during 2012/13

2.7 There are a number of key areas that require particular attention during 2012/13 to provide the bedrock for a health service driven by patients and clinicians.

Dementia and care of older people

2.8 Caring for patients with dignity and humanity goes to the heart of the purpose of the NHS. The Care Quality Commission’s report *Dignity and Nutrition for Older People*³ set out good examples of NHS providers treating patients with dignity and respect as well as other more worrying examples where the standards are not acceptable in a modern health service. An outcomes focused approach provides us with incentives we can use to improve services for older people. There is a systemic set of things we need to do which will require organisations to work together. These include:

- 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;

- ensuring participation in and publication of national clinical audits that relate to services for older people;

- 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;

- improving diagnosis rates, particularly in the areas with the lowest current performance;

- the continued drive to eliminate mixed-sex accommodation;

- the use of inappropriate emergency admission rates as a performance measure for national reporting; and

2. Quality

2.9 In addition to national leadership and incentives to support high-quality personal interactions between clinicians and patients, PCT clusters should ensure that all providers have a systematic approach to improving dignity in care for patients, to giving staff appropriate training and to incorporating learning from the experience of patients and carers into their work.

2.10 For the first time to support local accountability in 2011/12, PCTs were asked to work with their local authorities and publish dementia plans which set out locally the progress they were making on the National Dementia Strategy. That requirement will also apply for 2012/13 with the additional expectation that any local or national CQUIN goals should be included.

Carers

2.11 Carers play a vital role in our system and must receive help and support from local organisations. Following a joint assessment of local needs, which should be published with plans, 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.

Military and veterans’ health

2.12 SHAs should maintain and develop their Armed Forces Networks to ensure the principles of the Armed Forces Network Covenant are met for the armed forces, their families and veterans. The Ministry of Defence/NHS Transition Protocol for those who have been seriously injured in the course

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4 http://www.dh.gov.uk/health/category/policy-areas/dementia
6 http://www.mod.uk/NR/rdonlyres/0117C914-174C-4DAE-8755-0A010F2427D5/0/Armed_Forces_Covenant_Today_and_Tomorrow.pdf
of their duty should be implemented, meeting veterans’ prosthetic needs and ensuring improvement in mental health services for veterans. NHS employers should be supportive towards those staff who volunteer for reserve duties.

Health visitors and Family Nurse Partnerships

2.13 SHA and PCT clusters should work together to deliver the number of health visitors required as part of the Government commitment to increase the number by 4,200 by April 2015. Commissioners should ensure that new health visitors coming through the expanded training pipeline are effectively supported and deployed. The increased number of health visitors will ensure improved support for families through the delivery of the Healthy Child Programme and the Family Nurse Partnership programme. PCT clusters are expected to maintain existing delivery and continue expansion of the Family Nurse Partnership programme in line with the commitment to double capacity to 13,000 places by April 2015, to improve outcomes for the most vulnerable first time teenage mothers and their children.

An outcomes approach

2.14 The NHS Outcomes Framework will set out the improvements against which the NHS Commissioning Board will be held to account from 2013/14 and NHS organisations should be preparing for this approach in 2012/13. Each of the five domains within the NHS Outcomes Framework will be supported by a suite of NICE quality standards which will provide authoritative definitions of what high-quality care looks like for a particular pathway of care.

2.15 To provide a strong base on which to introduce the NHS Outcomes Framework, we have identified outcomes measures or proxies for them for 2012/13 as set out below under the domains of the NHS Outcomes Framework. 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. In addition, all deadlines for the full roll-out of programmes highlighted in previous NHS Operating Frameworks, such as abdominal aortic aneurysm screening, should be completed within the established timescale.

Domain 1: Preventing people from dying prematurely

2.16 In addition to the outcomes strategies, NHS organisations should continue to support the other clinical strategies aimed at reducing early mortality from cardiovascular disease, including heart disease, stroke, kidney disease and diabetes.
2.17 There is strong evidence that early treatment supports better clinical outcomes. There are a number of key areas where commissioners and providers can work together to ensure earlier diagnosis and treatment.

The Summary Hospital Mortality Indicator

2.18 There are a number of different aggregate measures available for measuring hospital performance including Hospital Standard Mortality Rates and the Summary Hospital Mortality Indicator (SHMI). The SHMI has been developed through consensus and the methodology published on the Information Centre website. All hospital trusts, regardless of whether they are outliers, need to examine, understand and explain their SHMI and identify and act where performance is falling short. Should a trust be an outlier on any mortality measure it should scrutinise the underlying data to understand the reason and take appropriate action. Where any trust is identified as a high outlier on any published measure, SHA clusters must ensure that they have investigated the underlying reasons.

Ambulance services

2.19 Responsive ambulance services are critical for emergency patients. We expect the operational standards of 75 per cent of Category A calls resulting in an emergency response arriving within eight minutes and 95 per cent of Category A calls resulting in an ambulance arriving at the scene within 19 minutes to continue to be met or exceeded.

Cancer

2.20 Early treatment secures better outcomes where patients have cancer symptoms. We expect all four of the 31 day operational standards and all three of the 62 day operational standards to continue to be met or exceeded.

Domain 2: Enhancing quality of life for people with long term conditions

Long term conditions

2.21 Transforming care for long term conditions is a critical challenge central to delivering better quality and productivity. People with long term conditions are significant users of NHS services and for national performance purposes we shall track progress in improving their quality of life using the following key indicators:

• the proportion of people feeling supported to manage their condition;
2. Quality

- unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); and
- unplanned hospitalisation for asthma, diabetes and epilepsy (in under 19s).

2.22 Telehealth and telecare offer opportunities for delivering care differently but also more efficiently. Use of both of these technologies in a transformed service can lead to significant reductions in hospital admissions and lead to better outcomes for patients. Using the emerging evidence base from the Whole System Demonstrator programme\(^7\), PCT clusters working with local authorities and the emerging CCGs should spread the benefits of innovations such as telehealth and telecare as part of their ongoing transformation of NHS services. They should also take full consideration of the use of telehealth and telecare as part of any local reconfiguration plans.

Mental health services

2.23 The mental health outcomes strategy, *No Health Without Mental Health*\(^8\) sets out that mental health should have parity of esteem with physical health and six objectives for improvement. PCT clusters need to consider the strategy to support local commissioning. For 2012/13 particular focus is needed on improving:

- access to psychological therapies as part of the commitment to full roll-out 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;

- 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.

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2.24 Meeting the QIPP challenge includes a continued focus on investment in high-quality mental health services, and we shall judge progress using the indicators in the Mental Health Performance Framework\(^9\), monitoring nationally:

- 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.

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

Emergency admissions and readmissions

2.25 Emergency readmissions need to continue to reduce as patients receive better planned care and are supported to self-care more effectively. Commissioners need not reimburse hospitals for admissions within 30 days of discharge following an elective admission with locally agreed thresholds for other readmissions. The savings made need to be invested in clinically driven initiatives to support improved outcomes through reablement and post-discharge support. Commissioners should work with local providers, GPs, local authorities and Local Involvement Networks (LINks) to ensure those initiatives are understood and used by their patients.

2.26 For performance reporting, we shall monitor emergency admissions for acute conditions that should not usually require hospital admission and seek confirmation on the deployment of savings.

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

Patient experience

2.27 Each patient’s experience is the final arbiter in everything the NHS does. The Health Service Ombudsman’s report, *Listening and Learning*\(^10\), set out an inconsistent and at times unacceptable approach by some NHS organisations to complaints handling. Good complaints handling is vital in ensuring a culture in the NHS where patients are listened to and organisations learn from mistakes. NHS organisations must actively seek out, respond positively and improve services in line with patient feedback.

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2. Quality

This includes acting on complaints, patient comments, local and national surveys and results from “real time” data techniques. Patients and carers should feel that services are integrated and co-ordinated and this should form part of survey questions. The Government announced in its response to the NHS Future Forum on 20 June 2011 that it would introduce a “Duty of Candour”, a new contractual requirement on providers of NHS funded care to be open and transparent with patients and service users in admitting mistakes.

2.28 Commissioners should ensure their contracts allow for providers to complete central returns on mistakes, never events, incidents and complaints and use sanctions if they are not compliant. The national patient experience surveys should continue to be monitored and acted upon. In addition, as part of the National Standard Contract we shall expect each local organisation to carry out more frequent local patient surveys, including using “real time” data techniques, to publish the results – including data on complaints – and to respond appropriately where improvements need to be made.

2.29 Commissioners should also look to identify local measures of integrated care that will support improved delivery such as patient reported experience of co-ordinated care.

Access to services

2.30 The NHS Constitution provides patients with a right to access services within maximum waiting times, including the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. If this is not possible, the NHS Constitution requires the NHS to take all reasonable steps to offer patients a range of suitable alternative providers. PCT clusters should publicise this right and the options available to local people where treatment within 18 weeks is at risk. It is the responsibility of the trust to ensure patients have the information they need to exercise those options if need be. Pilots will be carried out during 2012/13 in order to identify the best way(s) in which trusts can meet that responsibility in the best interests of patients. The pilots will focus especially on orthopaedics and the lessons will be available for full roll-out from April 2013.

2.31 The operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits as set out in the NHS Constitution 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 referral to treatment (RTT) operational standards should be achieved in each specialty by every organisation and this will be monitored monthly. We also expect less than 1 per cent of patients to wait longer than six weeks for a diagnostic test. Patients should
have access to Choose and Book for planned treatments 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.

2.32 The NHS Constitution also provides patients with a right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. Patients need to know that services are responsive when their GP recommends urgent specialist attention and we expect this and the standard for two week waits from GP referral for breast symptoms to be met.

2.33 Decisions on appropriate referrals should be made by clinicians in line with best clinical evidence. PCT clusters should ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits (that one or more providers are required to comply with) that do not take account of healthcare needs of individual patients.

2.34 Patients should be added to planned waiting, pending or review lists only if there are clinical or personal reasons why they cannot have a procedure or treatment until a specified time. Trusts must have systems in place to review such lists regularly to ensure that safety and standards of care are not compromised to the detriment of outcomes for these patients. All organisations must have reviewed planned waiting lists for all specialties and diagnostic services by no later than the end of December 2011.

2.35 Decisions on appropriate treatment should be made by clinicians in line with best clinical evidence. Commissioners must be clear whether they have strong evidence that a procedure is genuinely of low clinical value to patients or whether they believe there is evidence that a treatment may be of high value if given to the correct patient but achieves poor results by being used inappropriately on patients who will not benefit from it. PCT clusters should ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of blanket bans that do not take account of healthcare needs of individual patients.

2.36 2011/12 saw the introduction of a set of clinically led indicators to allow a rounded view to be taken of the performance of Accident and Emergency services. Those indicators will continue to be in place during 2012/13 for local use, and this information should be published locally for patients and the public. The ability for local commissioners to impose fines through the national contract will continue. In judging performance nationally, we shall use the operational standard of 95 per cent of patients being seen within four hours.
NHS 111

2.37 The development of the NHS 111 service will improve the quality, efficiency and coherence of our urgent care system. To support more effective access to urgent care, SHA clusters will need to be satisfied that roll-out is complete by April 2013 using a range of different systems and solutions, such as:

- proceeding to full local procurement, using Any Qualified Provider (AQP) principles;
- establishing services initially through pilots, using single or multiple providers; or
- an “opt-in” model involving a consortium of NHS Direct, ambulance services and other local providers.

2.38 The design of urgent care service provision accessible in each area through NHS 111 and the choice of provider and clinical assessment services must be led by CCGs. In any solution there must be demonstrable evidence of local clinical approval and the service must be compliant with the high-level national NHS 111 Service Specification.

Maternity

2.39 Continuity in all aspects of maternity care is vital, from antenatal care through to support at home. Mothers and their families should feel supported and experience well co-ordinated and integrated care.

Eliminating mixed-sex accommodation

2.40 The NHS has made significant progress in reducing mixed-sex accommodation over the last year and we expect this to be maintained or improved. We shall continue to track progress through the numbers of breaches of sleeping accommodation as set out in national guidance. Breaches 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

Healthcare associated infections (HCAIs)

2.41 Protecting the safety of our patients is of paramount importance. The zero tolerance approach to all avoidable HCAIs will continue. All NHS commissioners and providers should identify and agree plans for reducing MRSA bloodstream and *Clostridium difficile* infections in line with the national objectives.
Venous thromboembolism (VTE)

2.42 Patients need to be risk assessed for hospital-related venous thromboembolism and national monitoring will take place to oversee improvement.

Safeguarding

2.43 PCT clusters will need to ensure a sustained focus on robust safeguarding arrangements, including work in partnership through Local Safeguarding Children Boards (LSCBs) and Local Safeguarding Adult Boards, and to ensure ongoing access to the expertise of designated professionals in line with local need. They will need to work with CCGs as they develop to ensure they are well prepared for their safeguarding responsibilities and that robust local arrangements, including future input to LSCBs and Local Safeguarding Adult Boards, are put in place.

Public health

2.44 During 2012/13, PCT clusters will be working with local authorities on the transfer of responsibility for public health commissioning. It will be incumbent that PCT clusters maintain appropriate investment in public health services throughout transition, for instance continuing with screening and immunisation programmes as well as monitoring progress with obesity and alcohol-related harm. We will monitor the following areas nationally:

- number of four week smoking quitters; and
- NHS healthchecks.

Emergency preparedness

2.45 Emergency preparedness, resilience and response across the NHS continues to be a core function of the NHS, required in line with the Civil Contingencies Act 2004. Accountability arrangements should be clear at all times throughout the transition and organisations must continue to test and review their arrangements. All NHS organisations are required to maintain a good standard of preparedness to respond safely and effectively to a full spectrum of threats, hazards and disruptive events, such as pandemic flu, mass casualty, potential terrorist incidents, severe weather, chemical, biological, radiological and nuclear incidents, fuel and supplies disruption, public health incidents and the 2012 Olympic and Paralympic Games. PCT commissioners must also ensure that they maintain the current capability and capacity of existing Hazardous Area Response Teams (HARTs) in ambulance trusts.
Good practice to support delivery of the QIPP challenge

2.46 As service improvement continues, the NHS should learn from initiatives that are successful elsewhere, adapting and improving their own plans. NHS organisations are encouraged to draw on a wide range of sources and evidence bases, such as the NHS Evidence website\(^\text{11}\), which provides a range of case study examples demonstrating how innovative local action can deliver real quality and productivity improvements. Some current examples that demonstrate the four key elements of QIPP are set out in the table below.

### QIPP good practice examples

<table>
<thead>
<tr>
<th>Quality</th>
<th>Innovation</th>
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<tr>
<td>Tools such as patient decision aids, health</td>
<td>Innovative service models such as the RAID (Rapid Assessment</td>
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<tr>
<td>investment packs, the atlas of variation and</td>
<td>Interface and Discharge) 24/7 psychiatric liaison service</td>
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<tr>
<td>approaches such as programme budgeting</td>
<td>have been shown to generate significant cost savings and</td>
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<tr>
<td>support a focus on offering the right</td>
<td>health improvements.</td>
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<td>treatment to the right patient. These tools</td>
<td>The Innovative Technology Adoption Procurement Programme</td>
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<td>should help shared decision making with</td>
<td>(iTAPP) identifies innovative technologies that can be</td>
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<td>patients about care options, as well as</td>
<td>adopted by local organisations. A small number of evidence</td>
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<td>supporting commissioning for increased</td>
<td>based technologies, including the Oesophageal Doppler</td>
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<td>value to address unwarranted variation.</td>
<td>Monitoring, are suggested for wide adoption by local health</td>
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<tr>
<td>Tower Hamlets and South East Essex have</td>
<td>economies.</td>
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<td>worked with third sector partners on more</td>
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<td>effective procurement and flexible use of</td>
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<td>staffing in services to provide wheelchairs</td>
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<td>for children. This has been shown to deliver</td>
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<td>significantly reduced waiting times and</td>
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<td>better quality equipment at no extra cost or</td>
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<td>even while delivering financial savings.</td>
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<td>Commissioners should consider whether this</td>
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<td>is a service that could benefit locally from</td>
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<td>patient choice, as part of ensuring that</td>
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<td>they deliver timely and cost effective</td>
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<td>access to good quality wheelchairs for</td>
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\(^{11}\) http://www.evidence.nhs.uk/
### Productivity

- The NHS Institute’s Productive Series has supported NHS teams to redesign the way they work. It has allowed staff to spend more time directly caring for patients and demonstrated improvements in patient experience, quality of care and productivity.

- Consolidation of pathology services can improve productivity and deliver increased standardisation and quality services.

### Prevention

- Risk stratification, care planning, patient involvement and supported self-care can transform the care of people with long term conditions and prevent the need for some reactive, expensive acute based care. This is particularly true where there is strong integration between the NHS and Social Care and existing resources, such as specialist community based nurses, are effectively used to meet the needs of patients with multiple long term conditions. Providing services supported by telehealth and telecare delivered at scale can maximise benefits for individual patients.

- Tools such as the Safety Thermometer can be used to prevent avoidable harm and deliver safer care by measuring progress against ambitious improvement goals, looking at a bundle of measures such as reducing falls, pressure ulcers, catheter acquired urinary tract infections, and venous thromboembolisms.
3. Reform

The challenge

3.1 The NHS at the end of 2012/13 will look and feel very different to that at the beginning of the year. By the end of the year, the NHS will have transformed the commissioning landscape into one focused on local clinical decision making, with the development and authorisation of CCGs, assisted by commissioning support vehicles and overseen by the NHS Commissioning Board. Local authorities will take on the lead role in public health, alongside the new Public Health England.

3.2 Central to the new system will be the establishment of Health and Wellbeing Boards, who will provide local systems leadership across health, social care and public health. Communities, patients and their GPs will be empowered to improve their local health services, with choice and better information. PCT clusters must support this cultural shift as we move to an outcomes approach.

3.3 Alongside this, developments will continue to the provider landscape, through the extension of Any Qualified Provider, progress with the NHS Foundation Trust pipeline and the establishment of the new NHS Trust Development Authority. There will also be developments to the health education system, with new education and training partnerships and Health Education England.

3.4 The need for good systematic engagement with staff, patients and the public is essential so that service delivery and change is taken forward with the active involvement of local people. Our staff and patients provide essential insights into the quality of services. Organisations should listen closely and act on any information from staff about where services need to improve. Organisations should also listen closely to patient feedback and complaints, using this information to improve services.

3.5 Throughout 2012/13, PCTs and SHAs remain statutory organisations. To make the best use of our management capability, as well as creating space for new organisations, they will be held to account on a clustered basis. PCT clusters will deliver the requirements of this NHS Operating Framework, under the supervision of SHA clusters who themselves will be accountable through to the NHS Chief Executive. In doing so, there should be no trade off between delivering ongoing performance and supporting and facilitating the development of new and emerging organisations and clinical leadership for commissioning.
The new commissioning landscape

NHS Commissioning Board

3.6 The NHS Commissioning Board has been established as a special health authority to allow it to prepare for taking on its full statutory duties from April 2013. Its broad responsibilities will be to provide leadership and hold CCGs to account for delivering their statutory responsibilities, and to commission services such as primary care, specialised services, prison/offender health and military health. There will be further guidance during 2012/13 on the operational requirements for the transfer of these responsibilities from PCTs to the NHS Commissioning Board.

Clinical commissioning groups

3.7 PCT clusters must:

- support all CCGs in making progress to full authorisation by the NHS Commissioning Board;

- support exploration and the development of commissioning support offers from a range of suppliers, which might include the independent sector, voluntary organisations and local authorities, that will be responsive to the needs of CCGs;

- establish an effective transition to the NHS Commissioning Board for a common model for commissioning services for which the NHS Commissioning Board will be directly accountable;

- prepare for formal transfer of staff to the new commissioning architecture;

- demonstrate that they are allocating both non-pay running costs and staff to support emerging CCGs, commensurate with the level of budgets for which emerging CCGs have delegated responsibility; and

- work with GP practices to undertake a full review of practice registered patient lists, ensuring patient anomalies are identified and corrected by March 2013.

3.8 SHA clusters will be held to account for the delivery of plans to support the development of the new commissioning architecture, whether for the establishment of CCGs, commissioning support or the transfer of commissioning responsibilities to the NHS Commissioning Board.
3. Reform

Health and Wellbeing Boards

3.9 Health and Wellbeing Boards will operate in shadow form from April 2012 and will be statutorily operational from April 2013. Health and Wellbeing Boards will act as the local system leader through work on Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS), and NHS organisations need to be active leaders within this process. The JHWS sets shared priorities and a plan for what the NHS and local authorities can do individually and collectively to deliver seamless care, improved outcomes and reduced health inequalities. The JSNA and JHWS inform CCGs’ commissioning plans and support integration of delivery.

3.10 SHA and PCT clusters should support shadow Health and Wellbeing Boards and encourage CCGs to play an active part in their formation, including participation in the programme of accelerated learning sets. Health and Wellbeing Boards will contribute to the authorisation process and will play a part in supporting the NHS Commissioning Board in holding CCGs to account.

CCG development and authorisation

3.11 We shall support the development of CCGs during 2012/13, helping them to become the best they possibly can. Specific guidance on the process for authorisation will be issued in due course. As far as possible CCGs should be coterminous with a single local Health and Wellbeing Board.

3.12 Ahead of that, SHA clusters should be working to support practices and emerging CCGs to resolve configuration issues. By 31 January 2012, SHA clusters need to be confident that any outstanding configuration issues can be resolved by the end of March 2012. Where this is not the case, the timetable for authorisation means that discussions on alternatives will need to take place. SHA clusters will be responsible for oversight of the readiness of CCGs for authorisation.

3.13 Almost half of available budgets have already been delegated to emerging CCGs and we expect the rate of delegation to continue to increase. In preparation for becoming a statutory clinical commissioning group, CCGs will need to:

- build a track record:
  - manage those budgets well and play an active role in the planning round for 2012/13, taking ownership of those parts of a PCT cluster’s plan which it will inherit;
3. Reform

- develop relationships with local partners, including social care, and engage with the local community, in particular playing an active role in the emerging Health and Wellbeing Boards;

- deliver the relevant share of the QIPP agenda for the PCT cluster;

- prepare for establishment:
  - address any issues arising from the configuration risk assessment by the end of March 2012;
  - prepare an application in line with the forthcoming guidance;
  - identify how they wish to secure commissioning support and plans to utilise the running costs allowance;

- become a successful organisation:
  - undertake the development plan agreed with the PCT cluster in 2011/12 as a result of the self-assessment diagnostic, and agree governance plans locally, including relationships with the Health and Wellbeing Board.

Commissioning support

3.14 Effective commissioning support will be critical to the quality and affordability of the future commissioning system. Commissioning support must be commercially viable, customer focused and develop distinctly and separately from the PCT cluster. It may occupy a different geographic and service footprint to that of clusters or their constituent PCTs. Opportunities to aggregate demand from CCGs in aspects of commissioning support should be facilitated by PCT and SHA clusters.

Clinical networks and senates

3.15 Work is ongoing to design the role and function of clinical senates. There will be a process of widespread engagement with stakeholders and it is expected that clinical networks and senates will be established in 2012/13. One of their key roles in 2012/13 will be to contribute to engagement on clinical service redesign across wider health communities.

The new public health landscape

3.16 Public Health England (PHE) will be in a shadow year of operation in 2012/13, and a statutory Executive Agency from April 2013. Significant functions from the current NHS commissioning infrastructure will need to transfer to PHE.
3.17 The NHS will be accountable for delivering a successful public health transition and it will need to do so in co-production of the new system with local authority colleagues. PCT clusters and SHA clusters will need to include robust local plans for the public health transition, as set out in Section 5.

3.18 In 2012/13, PCT clusters 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 systems are in place;
- prepare for formal transfer of staff; and
- test the new arrangements for emergency planning, resilience and response.

The new provider landscape

NHS Foundation Trust pipeline

3.19 Progress on the NHS Foundation Trust (FT) pipeline is not an end in itself but a critical means for creating clinically and financially sustainable organisations across the provider sector. NHS trusts are expected to achieve NHS FT status on their own, as part of an existing NHS FT or in another organisational form by April 2014, with a few concluding beyond this date by exceptional agreement. Plans for all NHS trusts have been agreed under Tripartite Formal Agreements (TFAs), which codify the locally owned issues, actions and processes and set out the journey each organisation must take going forward.

3.20 Local actions will ultimately drive the transition to an all NHS FT sector. However, for a small number of NHS trusts, there will be areas of development where additional support may be required. These potentially include support on underlying financial issues, including PFI and liquidity issues, and Board assurance development. Options for national support will only be considered where solutions are beyond the capacity of local organisations and the pre-defined criteria for these solutions are met.

Any Qualified Provider

3.21 In 2012/13, PCT clusters should start to offer patients choice of AQP in at least three services which are local priorities. PCT clusters should work with CCGs and patients to set outcome-based specifications that encourage
providers to deliver high-quality services. Commissioners may find it useful to refer to the published implementation packs and other material on NHS Supply2Health\textsuperscript{12}. We expect that commissioners will use the national qualification process and questionnaire to qualify providers.

Empowering patients

Choice and personal health budgets

3.22 Choice is critical to giving patients more power in our system. PCT clusters should drive forward improvements in patient choice so that there is a presumption of choice for most services from 2013/14. During 2012/13 this means continuing the implementation of:

- choice of named consultant team;
- 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.

3.23 Patients’ rights under the NHS Constitution continue, including the right to treatment within 18 weeks from referral, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible. From April 2012, all patients referred for a first consultant-led outpatient appointment will be able to choose a named consultant-led team. Providers’ obligations are set out in standard contract guidance to accept patients who are referred to a clinically appropriate named consultant-led team and list their services on Choose and Book in a way that allows users to book appointments with named consultant-led teams.

3.24 PCT clusters should work collaboratively with GP practices to establish new outer areas to enable patients who move house locally to stay with their existing practice. The NHS will also pilot in three areas new arrangements to open up patient choice beyond traditional practice boundaries. PCT clusters will need to support the pilots, including ensuring that patients who register with a practice beyond their local area have appropriate access to local urgent care services.

\textsuperscript{12} http://www.supply2health.nhs.uk/default.aspx
3.25 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. The NHS will need to consider how to deliver personal health budgets locally and include this as part of transition planning.

Information Strategy for the NHS

3.26 Choice will be of little value to patients without meaningful information. NHS organisations need to prepare for the forthcoming Information Strategy for Health and Social Care and work to:

- give patients better access to their records;
- provide information on outcomes to support choice;
- support integrated care through enabling the appropriate sharing of information between organisations; and
- allow for better use of aggregated information.

3.27 On 7 July 2011, the Prime Minister set out a number of key NHS datasets that have been identified for public release\textsuperscript{13} and these will be added to during 2012/13. NHS organisations must ensure the availability and quality of these data sets.

3.28 Patients who have been written to about the Summary Care Record should have a record created by March 2013 at the latest. Data is being published on the proportion of patients with greater control of their care records and we are considering the feasibility of making this an entitlement from 2013/14.

3.29 No single technical change has greater power to improve the integration of services than the consistent use of the NHS number. NHS organisations are expected to use the NHS number consistently in 2012/13 and commissioners should link the use of the NHS number to contractual payments in line with the guidance. There will be punitive contract sanctions for any organisation not compliant by 31 March 2013.

3.30 The protection of sensitive patient information remains a top priority for the NHS. Incidences of data loss continue to occur and in some cases these are both significant and clearly in breach of national guidelines. Data loss is not acceptable where adherence to agreed national policies would have

\textsuperscript{13} http://www.number10.gov.uk/news/letter-to-cabinet-ministers-on-transparency-and-open-data/
3.31 The reforms set out above require changes to the NHS workforce. NHS values, clinical leadership and working together are fundamental when decisions are taken that have an impact on our staff and the safety and quality of patient outcomes. It is essential that all NHS and their partner organisations work together to create and sustain the talent pipeline for critical posts. At national level, the new NHS Leadership Academy will provide a talent management and development focus for all those involved in the leadership of healthcare services.

3.32 Our staff continue to be our most vital resource. All organisations should use the results from the NHS staff survey to improve continuously staff experience and services to patients.

3.33 Organisations can take a number of steps to support work to improve staff health and wellbeing. These include ensuring their occupational health services are accredited to the Faculty of Occupational Medicine Standards, implementing recommendations set out in the NICE public health guidance, making pledges through the Public Health Responsibility Deal in relation to food, alcohol, physical activity and health at work and working to promote improved programmes of flu vaccination for staff.

3.34 Healthy Staff, Better Care for Patients\textsuperscript{14} and the NHS Health & Well-being Improvement Framework\textsuperscript{15} provide a model for improvement, detailing how organisations can ensure their staff have access to appropriate health interventions when required and, overall, support better staff health at work. This will contribute to achieving the Boorman ambition of reducing sickness absence levels towards 3 per cent and will contribute towards meeting the QIPP challenge.

Education and training

3.35 In the future, Health Education England will provide sector-wide leadership and oversight of workforce planning, education and training in the NHS. During 2012/13, SHA clusters remain accountable for education funding, commissioning decisions, medical recruitment and working with healthcare providers, and will be responsible for setting up provider-led partnerships to take on these responsibilities from April 2013. SHA clusters

\textsuperscript{14} http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128692
\textsuperscript{15} http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691
should work with healthcare providers and the education sector on education commissioning for 2012/13 and 2013/14 as well as 2012 medical recruitment, supported by the recommendations of the Centre for Workforce Intelligence (CfWI).

3.36 SHA clusters will be responsible for ensuring a level of business continuity during the reforms. They will need to plan for the novation of education and training contracts and other agreements, both formal and informal to their successor bodies.

3.37 During 2012, SHA clusters should plan for the implementation of the revised education and training tariffs resulting from the Multi Professional Education and Training (MPET) review in relation to undergraduate medical and non-medical clinical placement rates. In doing so, SHA clusters should plan transition based on a safe pace of change to minimise disruption from funding changes.

Pension and pay

3.38 On pension reform, the NHS will be required to implement increased employee contributions from April 2012 and the NHS Pension Agency (NHS PA) will provide the necessary administrative arrangements to support employers delivering this legal requirement. Additionally, there will be a Pension Charter clarifying the roles and responsibilities of employers and the NHS PA to ensure that there is effective administration of pensions for all NHS employees as required.

3.39 This is the second year of the Government’s two-year pay freeze for public sector workers. To protect the low paid, the Government will again recommend that staff earning £21,000 or less receive a flat rate increase of £250 from April 2012.
4. Finance and business rules

4.1 The finance and business rules are in place to help ensure that there is consistency and transparency across NHS organisations in the way the financial framework is applied. In particular, for 2012/13, they are designed to enable continued financial stability with no part of the new system inheriting problems not of their own making and going further and faster on QIPP delivery, including driving up value for the taxpayer.

Surplus strategy and financial control 2012/13 onwards

4.2 Strong financial management and control during 2012/13 will be crucial to ensure successful delivery through transition and into the reformed NHS landscape.

4.3 As with previous years, the aggregate 2011/12 SHA and PCT surplus will be carried forward into 2012/13. We shall continue to draw down the surplus generated from previous years in a planned and managed way. The expected level of the national SHA and PCT surplus drawdown will be £150 million, based on the 2011/12 quarter one forecast. It is expected that the surplus deployment will be primarily available to SHA clusters to support the successful delivery of transition.

4.4 It is a requirement that no PCT or SHA will plan for a deficit in 2012/13. PCTs carrying legacy debt into 2012/13 must clear it.

4.5 CCGs will not be responsible for resolving PCT legacy debt that arose prior to 2011/12. It is expected that aspirant CCGs will continue to work closely with PCTs and PCT clusters in 2012/13, to ensure that no PCT ends 2012/13 in a deficit position.

4.6 NHS trusts are expected to plan for a surplus consistent with their NHS Foundation Trust pipeline plan and their TFA. Breakeven or operating deficit plans will only be countenanced where an NHS trust is in formal recovery, it has been agreed with its SHA cluster, and it is consistent with the TFA.

4.7 The final year-end aggregate surplus generated by SHAs and PCTs in 2012/13 will be carried forward to the NHS Commissioning Board in 2013/14, with an expectation that PCT originated surpluses will be made available to the relevant local health systems in future years.
4.8 As in 2010/11 and 2011/12, the requirement for all PCTs to set aside 2 per cent of their recurrent funding for non-recurrent expenditure purposes only will continue. It is expected that SHA clusters will hold these funds for this expenditure until appropriate business cases for the expenditure have been approved. The non-recurrent cost of organisational and system change during 2012/13 will need to be met from the 2 per cent.

4.9 The requirement to identify a quantum of recurring funds that are only committed on non-recurrent expenditure each year is an important component of the NHS financial strategy. It provides flexibility and mitigates financial risk. It is expected that this approach to financial risk management will continue into the new health system to underpin continued financial control and support QIPP delivery.

PCT allocations

4.10 The total amount allocated through PCTs’ recurrent allocations in 2012/13 will grow by at least two and a half per cent. The PCT 2012/13 revenue allocations will be announced in December 2011 and will be reviewed in light of the Office for Budget Responsibility’s forecast for inflation.

4.11 Transfers of funding between PCTs and local authorities were included in the NHS Operating Framework 2011/12. This includes £622 million in 2012/13 for social care services to benefit health. In making decisions about use of this funding in 2012/13, local authorities and their NHS partners should be aware that financial support from the health system for social care will continue in 2013/14 and 2014/15. Allocations for primary dental care, pharmaceutical services and primary ophthalmic services will also be announced in December 2011.

4.12 The 2012/13 shadow allocations for CCGs, the shadow allocation for the NHS Commissioning Board and shadow grants for local authorities’ new public health responsibilities will be published after PCT allocations.

Running costs

4.13 The target running cost savings for 2012/13 will be set at the SHA cluster level, but with an assumption that there will be no further savings at the SHA organisation level during 2012/13. This recognises the impact of the decision to extend the life of the SHAs for another year, as part of the strategy to deliver effective transition to the new system.

4.14 From 2013/14, the running cost allowance for CCGs is expected to be £25 per head of population per annum: this is before any entitlement to a quality premium.
4.15 By 2014/15 the overall running costs of the new NHS superstructure will be, on average, one third lower than the running costs of the NHS in 2010/11. The running cost allowance for the core functions of the NHS Commissioning Board will be at least £492 million.

Capital

4.16 NHS trusts must continue to ensure that they provide a clean and safe environment that is fit for purpose, based on national best practice. A key factor in delivering such an environment is that backlog maintenance and upgrading work must be managed effectively, with an emphasis on eliminating any backlog maintenance that affects safety or the provision of high-quality healthcare. To support the elimination of mixed-sex accommodation, improve patients’ privacy and dignity, and provide increased isolation facilities for infection control, capital investment to provide additional single en-suite rooms needs to be considered as part of the capital planning process.

4.17 Capital expenditure plans for NHS trusts and PCTs will be agreed by SHA clusters. In 2012/13, any capital funding for community services will follow the regime applicable to the organisation into which they transfer. As with previous years, any unspent capital allocation in 2011/12 will not be carried forward.

Tariff

4.18 Developments of the payment system in 2012/13 are intended to increase the links with the quality of care, to drive integration of services and to incentivise delivery of the QIPP challenge. Increasing the scope of a more transparent rules-based funding system will be a priority in 2012/13. To this end, Payment by Results (PbR) will expand and develop to incentivise best clinical practice and better patient outcomes.

4.19 In 2012/13, we 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.
4.20 In 2012/13, we shall expand the scope of tariff to:

- require that the recently developed currency is used when contracting for adult mental health services;
- introduce mandatory currencies for use when contracting for chemotherapy delivery, external beam radiotherapy and ambulance services;
- introduce non-mandatory currencies for HIV outpatient services and some community podiatry services;
- introduce a “quality increment” which may apply to patients being treated at regional major trauma centres, designed to reward high-quality care and facilitate the move to trauma care being delivered in designated centres;
- introduce national “pathway” tariffs for services such as 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.

4.21 In 2012/13, we shall continue to:

- retain the 30 per cent marginal rate, which will continue to apply for increases in the value of emergency admissions; and
- apply the policy of non-payment for emergency readmissions, subject to some exemptions.

4.22 The Department is jointly sponsoring with the Foundation Trust Network a number of sample audits of emergency readmissions, designed to help to inform more detailed guidance on the operation of the policy in 2012/13.

4.23 The PbR guidance and accompanying Code of Conduct will describe one system and one set of rules for England that are mandatory. Where commissioners and providers find the rules prevent them doing the best for patients, then local variation is permitted. However, variations which in effect enable the continuation of poor-quality, inefficient models of care or restrict patient choice are not valid.

4.24 In response to concerns about the “cherry picking” of patients, commissioners will now 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.
4.25 Commissioners are required to pay the appropriate rate of Market Forces Factor to the organisation providing treatment. This must not impede free choice of provider for the patient.

4.26 The national efficiency requirement for 2012/13 is 4 per cent. This will be offset by pay and price inflation. The tariff price adjuster will be a reduction of at least 1.5 per cent, and this will also be applied to non-tariff services. This will be confirmed in the 2012/13 PbR Guidance following allocations.

4.27 Some best practice tariffs for 2012/13 have an in-built efficiency assumption, allowed for in the overall tariff price adjuster. Some best practice tariffs will lead to reduced payments where best practice is not achieved and this is not allowed for in the tariff price adjuster.

4.28 For 2013/14, we shall continue to work with the NHS and social care providers and commissioners on existing long term condition tariffs and so support the development of higher-quality primary and community-based services to deliver better care and outcomes for patients with long term conditions.

CQUIN framework

4.29 Commissioners are reminded that CQUIN is a quality increment that applies to a level of service over and above the standard contract. In 2012/13, CQUIN will be developed so that, for all standard contracts, the amount that providers can earn will be increased to 2.5 per cent on top of actual outturn value. The two national goals on VTE risk assessment and on responsiveness to personal needs of patients will continue to be in place. With the additional quantum that is now available for local determination, three new requirements will be brought in:

- a third national goal on improving diagnosis of dementia in hospitals;
- a fourth national goal to incentivise use of the NHS Safety Thermometer; and
- where CQUIN funding has been used previously to achieve a higher standard of quality, that funding may be made recurrent through CQUIN only where the commissioner is satisfied it is the necessary means to maintain the improvement.

4.30 The national goals must continue to be linked to around one fifth of the 2.5 per cent value of schemes unless commissioners decide there is negligible room for improvement. Commissioners must share agreed schemes on the NHS Institute website.
4.31 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”. The CQUIN scheme will reward submission of data generated from use of the NHS Safety Thermometer. While all data collected through the Safety Thermometer will be published, there will be a particular emphasis on pressure ulcer prevalence data, which will be presented alongside pressure ulcer data from Hospital Episode Statistics and national incident reporting for all providers, to support the wider Government Transparency Agenda.

4.32 Commissioners and providers should have due regard to the NHS Chief Executive’s Innovation Review, due to be published in December 2011, when developing local CQUIN schemes for 2012/13. This will be used as a pre-qualification criterion for CQUIN in 2013/14 and during 2012/13 commissioners and providers should be preparing for it.

Clinical audits

4.33 The current contract states that providers will participate in the national clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) relevant to the services they provide.

4.34 Preparatory work is under way to transfer the cost of established national clinical audits within NCAPOP to providers of relevant and tariffed services from 2012/13. The intention is to do this on a subscription basis, with the aim of providing stability in funding for audit and to provide financial headroom in the central programme budget to support the development and commissioning of new audits. The clinical audit subscription will be recognised in an adjustment to the tariff for the services associated with the subscription.

SHA bundle

4.35 The proposed value of the bundle of central initiative budgets devolved to SHAs for local management is £6,394 million, including MPET, administration costs and the National Programme for IT Local Ownership Programme (NLOP). This is the same amount as in 2011/12 and takes account of changes to the bundle after the NHS Operating Framework 2011/12 was issued. The detail will be issued with the financial planning guidance. Clinical networks will also continue to be funded through the SHA bundle in 2012/13.
Joint working with local authorities

4.36 PCT clusters will need to work together with local authorities to agree jointly on priorities, plans and outcomes for investment of the monies allocated for reablement in 2012/13. This could include:

- current services such as telecare\textsuperscript{16}, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services;

- new services such as:
  - funding the social care aspects of the National Dementia Strategy; and
  - actively impacting on Delayed Transfers of Care, using local opportunities to develop the provision of post-discharge care and support services which are the responsibility of social services.

4.37 PCT clusters will need to continue to transfer the social care funding within allocations to local authorities to invest in social care services to benefit health and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the NHS Act 2006.

Procurement

4.38 Trusts’ non-pay expenditure typically accounts for 30 per cent of their expenditure, therefore in the current economic climate it is vitally important that this expenditure is managed efficiently and effectively. We know trusts can do more to generate savings through better procurement and all organisations need to look at how they can do this better, individually and collectively. This is an important part of meeting the QIPP challenge.

4.39 The Department is preparing a procurement strategy to be launched by April 2012, to help trusts improve their procurement performance. We will expect trusts that spend more on goods and services than their peers and do not use national frameworks where they exist, to justify why they are doing so under a comply or explain regime.

Contract management arrangements

4.40 The 2012/13 NHS Standard Contracts will see the implementation of the first phase of the fundamental review of the contracts signalled in the NHS Operating Framework 2011/12.

\textsuperscript{16} Further evidence on the effectiveness of telecare as part of a holistic response to managing long term conditions will be available shortly as part of the Whole System Demonstrator sites.
4.41 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. Commissioners must enforce the standard terms, in particular the financial penalties for under performance.

4.42 PCT clusters should ensure that providers use the Secondary Uses Service (SUS) for performance monitoring, reconciliation and payments and may use contract sanctions if they are not satisfied over the completeness and quality of a provider’s data.

4.43 Introduction of a single agreement recognises that the delivery of care is now in a range of different settings. The restructured contract is more “user friendly” and easier to follow. The revised supporting guidance will further assist organisations and new commissioners.

4.44 Contracts and variations to contracts must be signed prior to the start of the financial year and before service commencement.

4.45 Contracts, in general, will be limited to 12 months for 2012/13. Anything beyond that time period would be by exception and would have to meet defined criteria.

4.46 During 2012/13, further review will take place to ensure that, subject to the passage of the Bill and Regulations, the contract drafting reflects the revised requirements for CCGs and the NHS Commissioning Board.

4.47 The 2012/13 contract will be published with accompanying guidance to support the commissioners and providers. The standard variation documents to reflect the policy requirements covering prior year standard contracts will be published shortly afterwards.

4.48 The involvement of local clinicians in the contracting round for 2012/13 will be essential, as PCT clusters will be mindful that contracts with providers of NHS funded services must transition smoothly to CCGs, the NHS Commissioning Board or local authorities.

4.49 It is planned to integrate the interim care homes and the High Secure Services contract terms into the 2013/14 standard contract, and engagement with stakeholders will take place as part of this process.
4.50 During 2012/13, work will continue on the preparation of the transfer of the clinical contracts from current commissioners to the new commissioning authorities as planned as part of the NHS reforms. Guidance on the initial phases of this work has been published, and further guidance on the later stages of the transfer process will be issued during 2012.

The principles and rules for cooperation and competition (PRCC)

4.51 PCT clusters are required to review their practices in light of the Cooperation and Competition Panel’s report on the operation of any qualified provider in elective care, and the Department’s response, to ensure they are compliant with the PRCC.

4.52 Any decisions that would restrict patient choice must be taken at Board level and published annually, including the rationale, impact and period of operation. SHA clusters will have oversight of the PRCC locally in 2012/13 and should ensure compliance by local commissioners and NHS trusts.
5. Planning and accountability

Overall context

5.1 In 2012/13, the Department of Health will work through SHA clusters to hold PCT clusters to account for delivery of the requirements set out in this NHS Operating Framework. The accountability arrangements in 2012/13 are:

Throughout the year, NHS organisations must maintain or improve the quality of services provided, while delivering transformational change and maintaining financial stability. Under performance will trigger proportional action that may include intervention from the centre.

5.2 From 2013/14, the NHS Commissioning Board will be held to account by the Department of Health and NHS commissioners should anticipate the introduction of a more outcomes-based approach through the NHS, Public Health and Social Care Outcomes Frameworks. Local publication and benchmarking should take place for all available quality measures, in addition to those set out in this NHS Operating Framework for national reporting.

5.3 The accountability arrangements described in this NHS Operating Framework sit within an overall context of the NHS system during 2012/13, key to which continue to be:

- the current statutory framework, where PCTs and SHAs continue to be the statutory units of accountability;
- the NHS Constitution, which secures patient and staff rights;
- contracts, which form the means of doing business between commissioners and providers;
- the Care Quality Commission, who carry out inspections and other activity to regulate NHS providers against essential standards of safety and quality; and
- Monitor, who ensure NHS Foundation Trusts are meeting their terms of authorisation, including their contribution to delivery against the national priorities set out in this NHS Operating Framework.
Planning arrangements

5.4 Each PCT cluster is required to have an integrated plan, consisting of a narrative supported by data trajectories for each PCT. PCT clusters should build on the plans that were in place for 2011/12 to 2014/15, reviewing and refreshing as necessary, for the period 2012/13 to 2014/15.

5.5 The integrated plan should have a clear focus on quality and the national priorities set out in this NHS Operating Framework, bringing together QIPP, finance, activity, workforce, informatics and transition to the new structures. This plan should include robust milestones for transformational change for QIPP and reform, and should align with the data trajectories for quality indicators, activity, finance and workforce at PCT level. There should be a clear read across between planned transformational change and the impact the planned change will have on data trajectories.

5.6 The technical planning guidance will be published in December 2011 and will set out the national expectations of key milestones for reform, to deliver the requirements set out in this NHS Operating Framework. Financial planning guidance will be issued in January 2012 and will include the detailed rules underpinning the financial strategy, control and plans for 2012/13.

Providing a base for the reformed system

5.7 As a minimum, PCT clusters must ensure that their emerging CCGs explicitly support the plan for 2012/13 and beyond so that they have a strong base on which to build their own planning from 2013/14. Plans should be clinically sound and agreed by Medical Directors and Directors of Nursing.

5.8 Plans should reflect the outcomes of the local Joint Strategic Needs Assessment and PCT clusters need to ensure that the public health transition elements of their plan are supported by local authorities, again to ensure that those organisations have a good understanding of the basis on which they will take on responsibilities from 2013/14.

5.9 The contracts agreed with local providers need to be consistent with the integrated plan to allow for alignment with Tripartite Formal Agreements for NHS trusts.
Performance monitoring and assessment

5.10 The Annex to this NHS Operating Framework sets out the indicators that will be used nationally to assess how SHA clusters and PCT clusters are delivering during the year. The indicators are grouped under three domains:

- **quality**, covering safety, effectiveness and experience;
- **resources**, covering finance, workforce, capacity and activity; and
- **reform**, covering commissioning, provision and patient empowerment.

5.11 Alongside these indicators, PCT clusters will be held to account against the key milestones for the transformational change elements of QIPP and reform, agreed with SHA clusters as part of the planning round. These milestones should reflect the relevant national milestones, set out in the technical planning guidance. Success against these milestones as well as national indicators set out in the Annex mean that NHS organisations will be providing high-quality services within the current financial envelope, whilst achieving the transformational change that creates the platform for delivery in the future.

System requirements and timetable

5.12 By the end of March 2012, all PCT clusters should have an integrated plan as specified above, which has been assured by SHA clusters, through a process overseen by the Department of Health. There will be two stages of submissions by SHA clusters, with the first set of submissions in draft format on 27 January 2012 and the second in final format on 5 April 2012. From each SHA cluster, the Department of Health will require:

- data trajectories for all PCTs for the relevant indicators set out in the Annex to this NHS Operating Framework;
- milestones for each PCT cluster (drawn from their integrated plan), covering transformational change elements of QIPP and reform;
- milestones for each SHA cluster about the transition of the functions within the SHA to new bodies; and
- a short narrative outlining the SHA cluster’s assurance process and the SHA cluster’s assessment of key risks and mitigating action within the region (both geographical and programme based).
5.13 The Department of Health’s External Gateway function serves to assure that all national communications to NHS and social care audiences from the Department are fit for purpose in terms of content and policy governance. This includes compliance with the NHS Operating Framework as well as other key aspects such as ensuring financial affordability, creating space for local decision making, meeting our obligations in terms of better regulation, and supporting equality and inclusion. All communications requiring the attention of NHS management during 2012/13 will include a Gateway reference number.
### Annex – National performance measures

#### Quality

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<td>Cancer 31 day, 62 day waits</td>
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<tr>
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<td>Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)</td>
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<td>Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)</td>
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<th>Helping people to recover from episodes of ill health or following injury</th>
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<td>Referral to Treatment and diagnostic waits (incl. incomplete pathways)</td>
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<td>A&amp;E total time</td>
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<td>Cancer 2 week waits</td>
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<td>Incidence of MRSA</td>
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<td>Risk assessment of hospital-related venous thromboembolism (VTE)</td>
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#### Resources

- Financial forecast outturn & performance against plan
- Financial performance score for NHS trusts
- Delivery of running cost targets
- Progress on financial aspects of QIPP
- Acute bed capacity
- Activity (eg Elective and non-elective consultant episodes; Outpatients; Referrals)
- Numbers waiting on an incomplete Referral to Treatment pathway
- Health visitor numbers
- Workforce productivity
- Total pay costs
- Workforce numbers (clinical staff and non-clinical)

#### Reform

- **Commissioning Development**
  - % delegated budgets
  - Measure of £ per head devolved running costs
  - % authorisation of clinical commissioning groups
  - % of General Practice lists reviewed and “cleaned”

- **Public Health**
  - Completed transfers of public health functions to local authorities

- **FT pipeline**
  - Progress against TFA milestones

- **Choice**
  - Bookings to services where named consultant led team was available (even if not selected)
  - Proportion of GP referrals to first outpatient appointments booked using Choose and Book
  - Trend in value/volume of patients being treated at non-NHS hospitals

- **Information to Patients**
  - % of patients with electronic access to their medical records

#### Public Health

- Smoking quitters
- Health checks
Appendix B

Our ref: IC/GJU/gju

Chief Executives of all NHS organisations in the South of England

19 December 2011

Dear Colleague

The framework for preparing The Operating Plan for NHS South of England 2012/13


The development of The Operating Plan for NHS South of England 2012/13 is a shared process involving all organisations responsible for delivering NHS services: Primary Care Trust clusters, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts, Social Enterprises, the independent and voluntary sectors and close working with Local Authorities is expected.

The Operating Framework for the NHS in England 2012/13 sets out the practical steps that need to be taken to carry the NHS through a strong and stable transition over the next year. These steps will ensure that high quality standards and financial grip are maintained and the reformed NHS envisaged in the Health and Social Care Bill is built to deliver improvements in outcomes for patients.

It is essential that during 2012/13 headroom is achieved to ensure that safe, high quality services which meet national standards are delivered within the resources available, together with the delivery of reform to enable the NHS Commissioning Board, Clinical Commissioning Groups, the NHS Trust Development Authority, Public Health England, Health Education England and the Regulators to inherit a strong position to take forward the leadership of the NHS from 1 April 2013.

The main submission dates for Operating Plans for 2012/13 are set out below.

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<td>West</td>
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Further details of the full timetable including other submissions required are set out in Section 5.

Chair: Dr Geoffrey Harris

Chief Executive: Sir Ian Carruthers OBE

NHS South of England comprising South Central, South East Coast and South West Strategic Health Authorities
If you have any queries or require clarification on any aspect of the preparation of The Operating Plan for NHS South of England 2012/13, please contact the Director of Performance for your area:

- Central: Jane Dale      jane.dale@southcentral.nhs.uk
- East:   Guy Boersma     guy.boersma@southeastcoast.nhs.uk
- West:   Lisa Manson     lisa.manson@southwest.nhs.uk

I look forward to discussing your plans for the important year ahead.

Yours sincerely

Sir Ian Carruthers OBE
Chief Executive
The framework for preparing
The Operating Plan for NHS
South of England 2012/13

19 December 2011
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<td>Charlotte Moar, Deputy Chief Operating Officer and Director of Finance (South)</td>
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<tr>
<td><strong>Responsible Director</strong></td>
<td>Andrea Young, Chief Operating Officer Bob Alexander, Director of Finance</td>
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<td>People in the protected groups have helped develop the strategies underpinning this document</td>
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NHS South of England

The framework for preparing
The Operating Plan for NHS South of England 2012/13

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Assessment sheet

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Preface

This paper sets out the requirements for the development of The Operating Plan for NHS South of England for 2012/13 and should be read in conjunction with The Operating Framework for the NHS in England 2012/13.

The key challenges facing NHS South of England include:

- the quality challenge covering safety, effectiveness, experience and access;
- the service challenge of meeting national standards;
- the financial challenge, to deliver services within the resources available and achieve the national £20 billion savings requirement;
- the people challenge in terms of reducing management costs, retaining and developing talent and treating people fairly;
- the reform challenge in terms of creating the new architecture, focusing on health care outcomes, sharing decision-making with patients and users, empowering clinicians, increasing local democratic legitimacy, establishing NHS Foundation Trusts whilst increasing choice, competition and services closer to home.

The Operating Framework for the NHS in England 2012/13 sets out the practical steps that need to be taken to carry the NHS through a strong and stable transition over the next year. These steps will ensure that high quality standards and financial grip are maintained and the reformed NHS envisaged in the Health and Social Care Bill is built to deliver improvements in outcomes for patients.

It is essential that during 2012/13 headroom is achieved to ensure that safe, high quality services which meet national standards are delivered within the resources available, together with the delivery of reform to enable the NHS Commissioning Board, Clinical Commissioning Groups, the NHS Trust Development Authority, Public Health England, Health Education England and the Regulators to inherit a strong position to take forward the leadership of the NHS from 1 April 2013.

Sir Ian Carruthers OBE
Chief Executive
19 December 2011
Section 1

Introduction

This section sets out the overall expectations of Primary Care Trust clusters, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts, Social Enterprises and the independent and voluntary sectors when developing their Operating Plans for 2012/13.
1. **Introduction**

1.1 The proposals set out in the Health and Social Care Bill aim to:

- put patients and the public first, giving greater choice and control to patients through shared decision-making and transparency of information;

- improve health care outcomes, through implementation of the NHS Outcomes Framework;

- increase autonomy, accountability and democratic legitimacy by empowering professionals and providers, and making them more accountable to patients and the public for the results achieved and encouraging close working between the NHS and Local Authorities on the reform programme;

- improve public health through implementing the strategy for public health in England;

- cut bureaucracy and improve efficiency, reducing the number of NHS bodies and functions in the Department of Health to maximise investment in frontline services;

- integrate health and social care through improved joint commissioning and incentives and more flexible organisational forms.

1.2 These aims have been further developed in *The Operating Framework for the NHS in England 2012/13* which confirms that there will be four key themes for all NHS organisations during 2012/13, in order to improve services for patients:

**Getting the basics right every time**

- putting patients at the centre of decision-making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;

**Maintaining a grip on performance**

- maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met;

**Meeting the quality and productivity challenge**

- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge;
Building the new delivery system

- completion of the last year of transition to the new system, building the capacity of emerging Clinical Commissioning Groups and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS.

1.3 In 2011/12, the three separate Strategic Health Authorities, which are now clustered into NHS South of England, continued to improve quality, safety and financial performance and drive forward the reform agenda. Their ambitions were set out in: Towards a Healthier Future’ (Central), Healthier people, excellent care (East), and The Strategic Framework for Improving Health and Healthcare (West). The Operating Plan for NHS South of England for 2012/13 will build on these ambitions and encompass the benefits and opportunities available from working collaboratively across NHS South of England.

1.4 The Board of NHS South of England has identified the following priorities for delivery during transition:

- improving quality of care through improved patient safety, clinical effectiveness, patient experience and access to care;
- ensuring services are delivered within the resources available so that taxpayer value is achieved;
- ensuring the reformed NHS is established and its benefits are realised;
- ensuring strategic issues are addressed in the reformed NHS;
- managing the human consequences of the reform programme and supporting staff through the transition.

1.5 Significant further progress across NHS South of England must be made on all aspects of services during 2012/13 to ensure achievement of these priorities in a challenging financial environment.

1.6 This document sets out the proposed planning process for Primary Care Trust clusters, Clinical Commissioning Groups, NHS Trusts, the independent and voluntary sectors which will support delivery of these priorities.

1.7 Headroom will be secured to ensure that safe, high quality services that meet national standards are delivered within the resources available, to enable the NHS Commissioning Board, Clinical Commissioning Groups, the NHS Trust Development Authority, Public Health England, Health Education England and the Regulators to inherit a strong position as they take on the leadership of health services from 1 April 2013.
1.8 The financial position will remain challenging in 2012/13. Initial planning assumptions have been shared with Primary Care Trust clusters and NHS Trusts and these have been confirmed following the publication of The Operating Framework for the NHS in England 2012/13. The Director of Finance will lead the development of a financial framework for NHS South of England which will set out requirements in terms of control totals for the Strategic Health Authorities and individual organisations, use of the 2% headroom and use of Strategic Health Authority financial flexibility.

1.9 The year 2012/13 will be the second year for the QIPP plans of each Primary Care Trust and the plans for 2012/13 will be expected to include a refresh of the initial plans, incorporating new plans where appropriate. This will include detailed QIPP plans for 2012/13 and detailed QIPP milestones for 2013/14 and 2014/15.

1.10 The statutory bodies responsible for delivery remain the individual Primary Care Trusts and those organisations with NHS contracts including NHS Trusts, NHS Foundation Trusts, Social Enterprises, the independent and voluntary sectors. Finance and activity plans will be submitted on a Primary Care Trust basis. Operating Plans for 2012/13 will be submitted to the Department of Health at Primary Care Trust cluster and Strategic Health Authority cluster level. However within this, Primary Care Trust clusters will be given flexibility to present the content of plans at Primary Care Trust or health community level to support clarity of understanding and focus on key issues.

1.11 Strategic Health Authorities are the statutory bodies for providing assurance and oversight of the process, ensuring plans meet national and local priorities and the requirements of The Operating Framework for the NHS in England 2012/13.

1.12 The year 2012/13 will be the last year for Primary Care Trusts and Strategic Health Authorities. As part of the planning process it will be important that milestones towards a safe transition to the NHS Commissioning Board, Clinical Commissioning Groups, the new public health structures commissioning support organisations and other structures in the new architecture are planned and delivered.

1.13 In summary, 2012/13 will be the most challenging and critical year for NHS South of England. NHS South of England has a strong track record and has made good progress in 2011/12. Primary Care Trust clusters, Clinical Commissioning Groups, providers of NHS services and NHS South of England will harness their collective strength to ensure delivery of the ambition to provide the very best in care and a confident reformed system for the future.
Section 2

Priorities for delivery in
The Operating Plan for NHS South of England 2012/13

This section sets out the national and local priorities for delivery in The Operating Plan for NHS South of England 2012/13.

2.1 The key challenges facing NHS South of England include:

- the quality challenge covering safety, effectiveness, experience and access;
- the service challenge of meeting national standards;
- the financial challenge, to deliver services within the resources available and achieve the national £20 billion savings requirement;
- the people challenge in terms of reducing management costs, retaining and developing talent and treating people fairly;
- the reform challenge in terms of creating the new architecture, focusing on health care outcomes, sharing decision-making with patients and users, empowering clinicians, increasing local democratic legitimacy, establishing NHS Foundation Trusts whilst increasing choice, competition and services closer to home.

2.2 The Operating Framework for the NHS in England 2012/13 sets out the priorities for delivery. These priorities include:

- improving quality through better health outcomes;
- delivering the reform agenda;
- developing a robust financial framework.

2.3 The 2012/13 planning process for NHS South of England will deliver an Operating Plan for each Primary Care Trust cluster for 2012/13, agreed by NHS South of England by 31 March 2012. The Operating Plan, which is developed jointly with Clinical Commissioning Groups, is expected to meet the key challenges and delivery priorities in The Operating Framework for the NHS in England 2012/13, including:

**Improving quality through better health outcomes**

- introduction of the NHS Outcomes Framework 2012/13;
- preventing people from dying prematurely, including having a responsive ambulance service, early identification and treatment of cancer and improvement in mortality indicators;
- enhancing quality of life for people with long term conditions including mental health;
- helping people to recover from episodes of ill health or following injury;
ensuring that people have a positive experience of care, including a continued reduction in the number of incidents of mixed sex accommodation breaches;

treating and caring for people in a safe environment and protecting them from avoidable harm;

ensuring people have quicker access to services through delivery against the NHS Constitution patient rights. In addition to achievement of these targets for waiting times of 90% admitted, 95% non-admitted and 92% incomplete pathways within 18 weeks we also expect NHS organisations to:

* comply with best practice guidance and report to their Board the reasons for patient breaches classified as choice, complexity and capacity;

* analyse on a monthly basis all patients reported as waiting over 35 weeks;

* review all planned waiting lists monthly to ensure compliance with Department of Health policy;

* ensure 18 week delivery is sustainable by reviewing the current pathway wait for surgical patients and reduce the diagnostic or outpatient waits as appropriate.

implementing good practice to support the delivery of the QIPP challenge;

an outcomes focussed approach to improve care for patients with dementia and care for older people;

supporting carers through the agreement of policies, plans and budgets with local authorities and voluntary groups;

improved support for families through the delivery of the Healthy Child Programme through an increase in the number of Health Visitors and Family Nurse Partnerships;

designing an urgent care service provision accessible in each area through NHS 111;

robust emergency preparedness and resilience planning, including the requirements to provide effective health services to support the Olympic 2012 plans;

ensuring development of Armed Forces Networks and that the principles of the Armed Forces Network covenant are met.
Innovation

- reducing variation and strengthening compliance by implementing the Compliance Regime of the National Institute for Health and Clinical Excellence;
- creating a system for delivery of innovation through the establishment of a number of Academic Health Science Networks;
- alignment of financial, operational and performance incentives to support the adoption and diffusion of innovation including the development of tariffs and the extension of the Never Events regime;
- implementing the NHS procurement strategy to support the achievement of improved quality and productivity and the delivery of efficiency savings;
- developing the capacity and capability of staff including ‘hard wiring’ innovation into educational curricula, training programmes and leadership development;
- promoting the leadership of innovation through setting the right expectations and the use of the recommendations as a pre-qualification for local Commissioning for Quality and Innovation (CQUIN) schemes;
- implementing the first phase of high impact innovations including assistive technologies, oesophageal doppler monitoring, child in a chair in a day, international and commercial activity, digital by default and carers for people with dementia.

Delivering the reform agenda

- developing the new commissioning landscape, including the NHS Commissioning Board, Clinical Commissioning Groups, Health and Wellbeing Boards and clinical networks and senates;
- supporting the development and authorisation of Clinical Commissioning Groups through:
  * devolved relevant commissioning budgets from 1 April 2012;
  * provision of commissioning support;
  * active involvement in the planning round, taking ownership of those parts of a Primary Care Trust cluster plan which it will inherit;
developing the new public health landscape, including establishment of Public Health England in shadow form in 2012/13 and delivering a successful public health transition through close working with local authorities;

developing the new provider landscape, including progress on the NHS Foundation Trust pipeline through delivery of agreed Tripartite Formal Agreement milestones;

empowering patients, including choice over how, where and when they receive treatment, choice of Any Qualified Provider in at least three services and improving the transparency of information and outcomes;

developing the workforce including the establishment of Health Education England and supporting staff through the transition;

preparation for the transfer of functions from Primary Care Trust clusters and Strategic Health Authorities to the organisations in the new architecture by 1 April 2013.

Developing a robust financial framework

strong financial management and control during 2012/13 will be crucial to ensure successful delivery through transition and into the reformed NHS landscape. A detailed financial framework for NHS South of England has been prepared and is included in Section 4 of this report.

Cancer

2.4 The Operating Framework for the NHS in England 2012/13 highlights the need to focus on early diagnosis and treatment and to continue to meet the 62, 31 and 14 day waiting time standards and screening programme quality and performance standards. Primary Care Trust clusters will be expected to work with cancer networks and providers on improving survival in line with the Improving Outcomes Strategy for Cancer, in particular increasing diagnostic capacity to support delivery of the early diagnosis agenda. The new headline measure concerning diagnostic waits supports this.

Dementia

2.5 The Operating Framework for the NHS in England 2012/13 sets out the systematic set of actions for the local NHS and partners to work together to continue to implement the National Dementia Strategy, the need for Primary Care Trusts to publish their plans, the use of funding for social care aspects of implementing the national strategy and the introduction of the new national CQUIN on improving diagnosis of dementia in hospital.
2.6 The letter from Sir David Nicholson with the report, Innovation Health and Wealth (December 2011) also highlights that compliance with the provision of breaks for those carers looking after people with dementia is one of the High Impact Changes that are a pre-requisite for national CQUIN schemes from 1 April 2013.

2.7 NHS South of England has undertaken a stocktake of progress on the delivery of improvements in dementia services which has identified a significant number of areas for improvement in 2012/13, especially increasing diagnosis rates and reducing the inappropriate prescribing of antipsychotic medication. These are closely aligned with the actions identified in The Operating Framework for the NHS in England 2012/13. The stocktake will be circulated separately and Primary Care Trust clusters are expected to include actions to improve performance in this area within their Operating Plans for 2012/13.

Learning disabilities

2.8 In addition to the requirements on child and adult safeguarding in The Operating Framework for the NHS in England 2012/13, Primary Care Trust clusters will be expected to work with providers to continue to develop comprehensive services to support people with learning disabilities in line with the national assurance framework. Specifically they will be expected to implement the initial lessons following the events at Winterbourne View and those Primary Care Trusts with people still in campus accommodation will be expected to ensure that campus accommodation is replaced by more appropriate alternatives in line with the agreed timetable.

Mental health

2.9 The Operating Framework for the NHS in England 2012/13 highlights the need for Primary Care Trust clusters to progress the implementation of the mental health strategy, No health without mental health (February 2011) and the need to improve performance on the indicators set out in the Mental Health Performance Framework. Across the South, Primary Care Trust clusters will be expected to work with mental health providers to make significant progress on patient safety through learning the lessons from Serious Untoward Incidents and specific reviews, and on significantly improving performance in the four indicators in the Performance Measures (Appendix 5 details the Performance Measures).

Safeguarding

2.10 The Operating Framework for the NHS in England 2012/13 requires Primary Care Trust clusters to have a sustained focus on adult and child safeguarding and to work to ensure an effective transition to the new arrangements in 2013. Primary Care Trust clusters in the South of England will be expected to provide assurance that they have designated professionals supporting all local safeguarding boards and that they have internal systems to escalate and intervene as required in response to safeguarding alerts.
Equality and diversity

2.11 NHS South of England is fully committed to the Government Equality Strategy, Building a Fairer Britain, and its underpinning principles of equal treatment and equal opportunity.

2.12 The Equality Delivery System for the NHS has been designed to support the delivery of services that are personal, fair and diverse. The Equality Delivery System will be a key mechanism through which the NHS delivers its commitment to equality, doing so through the active involvement of staff and the public in the setting of objectives and monitoring of performance for equality.

Local priorities in NHS South of England

2.13 In addition to the delivery of all national priorities, there are a number of local priorities which NHS South of England expects to be agreed and incorporated into Operating Plans for 2012/13. These cover the following areas and the specific requirements are included as Appendix 1 to this document.

- commissioning intentions;
- referral to treatment waiting times;
- provider efficiency;
- tertiary providers;
- information to support Clinical Commissioning Group commissioning;
- community care;
- primary care;
- improving health care.

Commissioning intentions

2.14 The aim of requiring commissioners to prepare commissioning intentions in January 2012 is to ensure that:

- commissioners go into contract negotiations with a clear set of goals which align across the system, which deliver performance measures and which enable clear activity and finance plans to be set which are deliverable and affordable;
- Clinical Commissioning Groups are involved, or leading, in developing and signing off commissioning intentions;
- commissioners ensure that they understand from each provider what other providers could do to support their delivery and that where appropriate this is built into commissioning intentions;
• commissioners understand the position of providers and the impact of proposed QIPP initiatives on their cost base;

• providers are clear as to the overall commissioner position early in the planning process including the level of QIPP challenge to be delivered. The expectation is that where providers do not consider that the proposed QIPP plans can be delivered, they propose alternatives to commissioners, recognising that QIPP has to be delivered;

• commissioners ensure that any provider quality issues are specifically discussed as part of the planning process and trajectories for improvement are renewed and form part of the contract for 2012/13;

• commissioners ensure that the requirements of The Operating Framework for the NHS in England 2012/13 expressed in terms of local priorities or needs are clearly set out to providers at the beginning of the contract negotiation process.

2.15 Commissioning intentions are expected to have been developed with and agreed by Clinical Commissioning Groups prior to the submission deadline and to have been shared with providers before or around this date.

Improving health care

2.16 The specific local priorities for action to improve health care in NHS South of England set out in Appendix 1 include:

• long-term conditions;

• vascular disease and trauma services;

• urgent care;

• end of life care.
Section 3

Roles and responsibilities for delivering
The Operating Plan for NHS South of England 2012/13

This section sets out the roles and responsibilities of each organisation during the planning process to ensure a successful and robust Operating Plan is achieved for 2012/13.
3. Roles and responsibilities for delivering The Operating Plan for NHS South of England 2012/13

3.1 This section sets out the roles and responsibilities of the Strategic Health Authority, Primary Care Trust clusters, Clinical Commissioning Groups and providers including, NHS Trusts, NHS Foundation Trusts, Social Enterprises, independent and voluntary sector organisations in finalising a robust Operating Plan for NHS South of England 2012/13.

Strategic Health Authorities

3.2 NHS South of England will:

- ensure that health communities continue to deliver high quality health care for all, closer to home within an agreed financial framework;
- set out a clear framework within which the planning process will take place;
- ensure that Operating Plans for 2012/13 deliver against all priority areas within The Operating Framework for the NHS in England 2012/13 covering patient safety, quality, finance, reform and people issues;
- ensure capacity and capability is maintained and developed to enable successor organisations to sustain a high performing health system;
- ensure that Operating Plans for 2012/13 will achieve recurrent financial headroom as well as meeting service delivery standards and demonstrate taxpayer value.

3.3 NHS South of England will hold individual organisations to account for the development and achievement of their own Operating Plans for 2012/13 but success will require Primary Care Trust clusters, Clinical Commissioning Group leaders, providers and social care colleagues working together to ensure all:

- are fully involved in and supportive of the planning process;
- understand, and take ownership and responsibility for, delivery of their contribution to meeting the quality and financial challenges of the health system;
- are clear on which programmes they work as individual organisations to deliver improvement and on which programmes they need to work together to deliver transformational change;
- work to common activity, finance, capacity and workforce assumptions;
support clinical engagement and leadership across commissioning pathways particularly between primary and secondary care;

contribute to the effective management of agreed workstreams and initiatives.

3.4 The Chief Operating Officer of NHS South of England, with the Director of Finance, will lead the planning process to ensure the preparation of a plan that meets the challenges identified by NHS South of England and delivers the priorities set out in The Operating Framework for the NHS in England 2012/13.

**Primary Care Trust clusters**

3.5 Primary Care Trust clusters are the lead NHS organisations locally and are responsible for assessing need, planning, securing services and improving health. Each Primary Care Trust cluster, working with Clinical Commissioning Groups, will:

- develop an Operating Plan for 2012/13 which incorporates the following:
  - describes national and local priorities;
  - describes local indicators;
  - defines success;
  - details milestones;
  - details the progress made;
  - reduces variation;
  - delivers recurrent financial headroom;
  - delivers high quality care for all;

- ensure the preparation of an Operating Plan for 2012/13 for all provider organisations for which they have a lead commissioning responsibility;

- deliver the requirements of The Operating Framework for the NHS in England 2012/13;

- deliver current operational and financial performance requirements as the basis for sustainable local health systems for the future;

- demonstrate how QIPP will be delivered in 2012/13, 2013/14 and 2014/15;
update their transition plans to support the implementation of the reform programme and prepare for the new NHS architecture from 1 April 2013;

support all Clinical Commissioning Groups in making progress to full authorisation by the NHS Commissioning Board through delegation of available budgets and active involvement in the planning process.

3.6 Primary Care Trust clusters will need to have robust engagement mechanisms in place to ensure that they involve local communities as key stakeholders in decision-making and to provide for a mechanism to report back on progress and achievements. Primary Care Trusts will be expected to work closely with other Primary Care Trusts, NHS Trusts, NHS Foundation Trusts, Social Enterprises, independent sector and voluntary sector providers, Local Authorities, especially adult social services departments and other local partners to ensure that services are provided in support of patient need and across organisational boundaries.

Role of Clinical Commissioning Groups

3.7 The expectation of NHS South of England is that Clinical Commissioning Groups and Primary Care Trust clusters work together to develop and deliver the Operating Plan for 2012/13. This joint working will enable Clinical Commissioning Groups to build experience to move them forward towards authorisation by 1 April 2013 at the latest. It will also enable the health system to maximise the benefits of clinical leadership of QIPP.

3.8 The role of Clinical Commissioning Groups is to work with their Primary Care Trust cluster to:

- participate in the planning process for 2012/13, developing commissioning intentions to deliver national and local priorities; aligning these with other relevant Clinical Commissioning Groups in relation to individual providers and working with Primary Care Trust clusters to negotiate contracts for 2012/13 which deliver commissioning intentions;

- work with and agree a plan for their Primary Care Trust cluster for 2012/13 which sets out what each Clinical Commissioning Group will deliver in 2012/13. This will be submitted to NHS South of England on 16 March 2012;

- agree with their Primary Care Trust cluster the activity and finance budgets for which each Clinical Commissioning Group will take devolved responsibility from 1 April 2012. The current position nationally is that in 2011/12 over 50% of budgets are devolved and that this will significantly increase in 2012/13. NHS South of England expects that Clinical Commissioning Groups will work towards 100% of relevant budgets being devolved from 1 April 2012;
• agree with their Primary Care Trust cluster the areas for which the Clinical Commissioning Group will take on lead responsibility for QIPP delivery in 2012/13 and how delivery will be monitored as part of monitoring delivery against the overall plan and devolved budget;

• agree how the Clinical Commissioning Group will work with their constituent practices to review clinical variation by practice and understand how this can be reduced to support delivery of better patient care;

• agree with their Primary Care Trust cluster an accountability agreement for 2012/13 including performance management arrangements with the Primary Care Trust cluster and performance management arrangements with the constituent practices within the Clinical Commissioning Group;

• agree with their Primary Care Trust cluster the assignment of staff sufficient that the Clinical Commissioning Group can deliver the agreed responsibilities, and that in the future will enable the Clinical Commissioning Group to operate within £25 per head running costs;

• agree commissioning support arrangements for 2012/13, with a service level agreement in place with the shadow commissioning support unit from 1 April 2012;

• use the learning from their involvement in the planning process to update the Clinical Commissioning Group organisational development plans and prepare for the authorisation assurance process.

Providers of NHS services

3.9 The role of all providers of NHS Services including NHS Trusts, NHS Foundation Trusts, Social Enterprises, and independent and voluntary sectors in the planning process is to:

• maintain and improve on the standards of performance that have already been achieved, particularly in relation to quality of care and financial control;

• agree the national contract with all commissioners by the national and local deadlines;

• contribute to the Operating Plan for 2012/13 of their coordinating commissioner, which sets out how they will achieve the national and local requirements and priorities for which they are accountable;

• develop their own Operating Plans for 2012/13 which align to commissioner plans and deliver national and local priorities within the funding available to them;
contribute to the development of QIPP plans for the local health system and play an active role in supporting their delivery;

demonstrate in the Operating Plan for 2012/13 how they will reduce variation in clinical practice and outcomes through the use of benchmarking and best practice guidance.

Ambulance services

3.10 The role of ambulance NHS Trusts in the planning process is to:

- agree QIPP plans, delivery of national priorities and requirements and contracts with the four ambulance NHS Trusts working with the lead Primary Care Trust cluster for 2012/13. Lead clusters are expected to ensure appropriate focus on local priorities and requirements to support delivery of overall health community QIPP plans.

Specialised commissioning

3.11 Primary Care Trust clusters will continue to have financial and commissioning responsibility for the Specialised Commissioning Group budget in 2012/13. Specialised Commissioning Groups will be working within a national commissioning framework for 2012/13, but as the Strategic Health Authority cluster will continue to have responsibility for delivering performance improvement, the three Specialised Commissioning Groups will work to the same timescales as Primary Care Trust clusters for submission of plans and provide the same documentation.

3.12 The lead commissioners for the Specialised Commissioning Groups will oversee this process as in 2011/12 and it will be performance managed by the Director of Performance for each local area.

3.13 The Strategic Health Authority cluster will expect the three Specialised Commissioning Groups to produce initial commissioning intentions and financial plans by the January 2012 deadline and will expect to see an equivalent process agreed with Primary Care Trusts which enables realistic planning of budgets, deliverable QIPP plans and contract signature achieved by 31 March 2012.

3.14 It is anticipated that there will be convergence of Specialised Commissioning Group commissioning in 2012/13 to a minimum list of the Carter definition set. The impact of this has been shared with Primary Care Trust clusters and the expectation is that this is agreed between Primary Care Trust clusters and the three Specialised Commissioning Groups before 23 December 2011.

3.15 The expectation is that Primary Care Trust clusters will agree contracts with providers for 2012/13 for those services that are transferring into Specialised Commissioning Groups from 1 April 2012.
3.16 For services transferring into Specialised Commissioning Groups, Primary Care Trust clusters would include within these agreements the relevant QIPP plans for specialised services which will be agreed between Primary Care Trust clusters and each of the three Specialised Commissioning Groups. They would also include the national service specifications, quality dashboard and specialist services CQUIN which will be separate to the local CQUIN.

3.17 There will be a contract variation enacted shortly after 1 April 2012 to transfer relevant services from the Primary Care Trust cluster contract into the Specialised Commissioning Group contract. The contract variation would transfer any contract rules or requirements so that financial and performance stability is maintained into 2012/13.

3.18 It is essential however that whilst progressing the Specialised Commissioning Group reform agenda, the grip on day to day performance and financial management is not lost. To enable this, the three Specialised Commissioning Groups and Primary Care Trust clusters will need to work closely together and it is recommended that contract negotiations with providers are undertaken with the Primary Care Trust cluster, viewing the contract as a whole rather than separately.

3.19 Clinical Commissioning Groups will not in future have direct responsibility for Specialised Commissioning budgets but will have an important role to play in terms of ensuring that pathways across primary, secondary and tertiary care are integrated and that care is managed as close to home as is clinically effective. Primary Care Trust clusters are therefore expected to ensure that Clinical Commissioning Groups are briefed on the Specialised Commissioning Group operating plan process for 2012/13 and their views sought as appropriate.

3.20 For those provider contracts which are transferring to be the responsibility of other Strategic Health Authority clusters, the three Specialised Commissioning Groups will lead the process on behalf of Primary Care Trust clusters ensuring that this transfer is achieved safely and that financial and performance stability is managed effectively during the transition.

3.21 The three draft Specialised Commissioning Group Operating Plans for 2012/13 will be reviewed at a single meeting towards the end of January 2012, which includes Primary Care Trust cluster and national representation. Final plans will be signed off by the Strategic Health Authority cluster by 31 March 2012.
Section 4

The financial framework for
The Operating Plan for NHS South of England 2012/13

This section sets out the financial framework within which NHS South of England, Primary Care Trust clusters, NHS Trusts, NHS Foundation Trusts, Social Enterprises, independent and voluntary sector organisations and Clinical Commissioning Groups will be working when developing their plans for 2012/13.

4.1 The 2012/13 planning round will be undertaken as a refresh to the detailed, robust medium term plans that were developed for the 2011/12 to 2014/15 Spending Review period.

4.2 The financial framework is outlined below and includes:

- financial strategy;
- financial planning assumptions and process;
- financial plans 2011/12 to 2014/15.

Financial strategy

4.3 2012/13 will be a very challenging year for the NHS as it takes on the demands of continuing to improve health and healthcare within a revised economic scenario whilst building momentum and progressing the transition to the new system envisaged in the Health and Social Care Bill.

4.4 The over-arching goal for 2012/13 is to build a strong platform for the new system by maintaining and improving quality, keeping tight financial control and delivering on the quality and productivity challenge.

4.5 The financial strategy for NHS South of England for 2012/13 and beyond is built on the firm financial foundations laid in the previous five years of surplus delivery.

4.6 For 2012/13 the emphasis will be on ensuring Primary Care Trust clusters and Strategic Health Authority clusters are in the best position to implement the objectives of the Health and Social Care Bill by maintaining a strong financial position underpinned by demonstrable financial flexibility.

4.7 The key financial requirements of the strategy for 2012/13 in NHS South of England will centre on:

- delivering the NHS South of England share of the national net surplus made up of the three constituent statutory bodies agreed planned positions;
- delivering a surplus in the NHS Trust sector to cover any legacy deficit positions and/or further generation of surpluses to service working capital loan repayments and/or the need to strengthen financial positions as a precursor to NHS Foundation Trust authorisation;
- ensuring all NHS organisations operate in recurrent balance;
- ensuring every Primary Care Trust has resolved any outstanding legacy debt issues and is debt free by 31 March 2013;
planned investment in the key priorities outlined in The NHS South of England Workforce Development Investment Framework for 2012/13;

ensuring every Primary Care Trust has only recurrently committed a maximum of 98% of their revenue resource allocation and has planned for at least 2% of recurrent uncommitted headroom. The 2% headroom will be used non recurrently in year to create the financial flexibility and headroom to support change;

development of plans to identify a minimum recurrent Cash Releasing Efficiency Saving (CRES) of 4.0%;

complying with the developments outlined in the Commissioning for Quality and Innovation (CQUIN) payment framework for 2012/13;

observing the changes made to 2012/13 tariff structure and business rules that support the operation of Payment by Results in 2012/13;

planning for the implications of adopting International Accounting Financial Reporting Standards as required;

ensuring the full implementation of all guidelines from the National Institute for Health and Clinical Excellence;

investing further in an innovation and improvement fund, to support innovative practice, service redesign and new technologies.

4.8 In line with current policy, the aggregate surplus that will be delivered in 2011/12 by NHS South Central, NHS South East Coast and NHS South West will be carried forward into 2012/13.

4.9 In line with the financial strategy 2012, the NHS surplus in the Primary Care Trust sector will continue to be deployed in a planned and managed way. In 2012/13, the expected draw down of surplus in the Strategic Health Authority sector in NHS South of England is currently projected to be £37 million (a weighted capitation share of the expected £150 million national control total based on the Quarter 1 forecast surplus). The NHS South of England surplus for 2012/13 is yet to be agreed with the Department of Health and will flex dependent on the level of surplus achieved in 2011/12.

4.10 In 2010/11 the NHS financial strategy was refined to include a requirement to have a minimum of 2% recurrent uncommitted headroom available by the end of 2013/14 at a Primary Care Trust cluster level to mitigate financial risk.
4.11 For 2012/13 this requirement has been built upon and every Primary Care Trust cluster is required to ensure that a minimum of 2% of their recurrent allocation is only ever committed non-recurrently. This requirement is in addition to the delivery of the agreed Primary Care Trust surplus control total. The potential use of the 2% headroom will be considered as part of the Operating Plan meetings including the need for business cases to sign off spend.

4.12 To reinforce financial control in 2012/13, this 2% recurrent uncommitted headroom reserve will be transferred to and held by NHS South of England. In line with the policy attached as Appendix 3, Primary Care Trusts will be required to submit business cases to NHS South of England to access the headroom funding that robustly demonstrates:

- the non-recurrent nature of the expenditure proposed;
- the expenditure has been incurred to support the change programme required to deliver the Quality, Innovation, Productivity and Prevention agenda or the change programme associated with delivering the reform agenda.

4.13 Once NHS South of England is satisfied that these criteria are met the business cases will be signed off by the Chief Executive of NHS South of England and submitted to the Strategic Health Authority Directors of Finance Group.

4.14 As part of the Annual Operating Plan for 2012/13, NHS South of England will agree the process for the elimination of any residual legacy debt to comply with the requirement of The Operating Framework for the NHS in England 2012/13. Clinical Commissioning Groups will not be responsible for resolving legacy debt that arose prior to 2011/12. Any debt that is incurred in Primary Care Trusts from 2011/12 onwards however will be the responsibility of Clinical Commissioning Groups to resolve.

4.15 Each Primary Care Trust has prepared a four year financial plan that should include a detailed analysis of the recurring and non-recurring sources and applications of funds over the four years from 2011/12 to 2014/15. This provides assurance around a number of recurring and non-recurring issues including how the draw down of the surplus is being managed.

**Running costs**

4.16 By 2014/15 the overall running costs of the new NHS architecture, compared to the running costs of the Strategic Health Authorities and Primary Care Trusts must have reduced by one third. This reduction includes the 45% reduction in management costs detailed in Equity and Excellence: Liberating the NHS in relation to Strategic Health Authority and Primary Care Trust non provider management costs.
4.17 The running cost definition and detailed trajectory for releasing the running cost savings is yet to be finalised with the Department of Health and will be notified to Primary Care Trust clusters when available.

**NHS contract and payment system**

4.18 A high quality and productive NHS needs a payments system and national contract that offers the right incentives.

4.19 Good commissioning is absolutely essential to realising the vision of a more productive higher quality NHS. Commissioners have a legal duty to secure the best services, in terms of quality and productivity, for the population they serve. This requirement is delivered through the development of a clear set of commissioning intentions and a robust contract management process.

4.20 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. Commissioners must ensure that the standard terms of the contract are fully enforced.

**Penalties**

4.21 The standard national contract includes a number of mandatory fines that Primary Care Trusts are required to levy on providers for failure to achieve key performance measures. These fines must be enforced by commissioners during 2012/13 and any funds secured from the collection of levied fines will be deployed at the discretion of the Strategic Health Authority cluster (NHS South of England).

4.22 To ensure this process is managed appropriately, Primary Care Trusts are required to inform NHS South of England on a monthly basis of the value of the fines levied by organisations and will have their resource limit reduced by the agreed value.

4.23 In some circumstances it will be appropriate following the receipt of an agreed recovery plan that this resource is returned to the Primary Care Trusts to recover the performance issue. It should be noted however that the deployment of funds secured from the collection of levied fines is wholly at the discretion of the Strategic Health Authority. See Appendix 4 for details of this policy.

**Commissioning for Quality and Innovation (CQUIN)**

4.24 As in previous years it is expected that Commissioning for Quality and Innovation (CQUIN) payments will be used to support tangible improvements in quality.
4.25 Primary Care Trusts should ensure that CQUIN payments are not used to support the achievement of existing performance measures. Instead payments should be linked to national, regional and local outcomes and used to support stretching ambitions agreed between commissioners and providers.

4.26 Primary Care Trusts are encouraged to develop a CQUIN framework that is aligned to the delivery of the quality, innovation, productivity and prevention challenge.

4.27 In 2012/13 CQUIN will be developed for all standard contracts and the amount providers can earn will increase from 1.5% to 2.5% on top of the actual outturn value.

4.28 In line with national expectations up to 20% of the CQUIN payment (0.5%) will be made in line with the national goals on:

- venous thromboembolism risk assessment, including starting the patient on appropriate prophylaxis if at risk;
- responsiveness to personal needs of patients;
- improving diagnosis of dementia in hospitals;
- incentivisation of use of the NHS Safety Thermometer.

4.29 Further guidance on the details of these CQUINs is expected from the Department of Health. If this is not available, NHS South of England expectations will be set which standardize CQUIN requirements against each of these national goals.

4.30 Commissioners and providers must take into account the NHS Chief Executive’s Innovation Review, Innovation Health and Wealth, that was published in December 2011 when developing local CQUIN schemes for 2012/13. This will be used as a prequalification criteria for CQUIN in 2013/14 and commissioners and providers must prepare for this during 2012/13.

4.31 It is also considered appropriate for commissioners to confirm that eligibility for CQUIN payments will be determined by passage through the following three local gateways:

- satisfaction of national data collection requirements;
- delivery of all national performance measures with specific focus on:
  - accident and emergency four hour wait;
  - NHS Constitution requirements;
  - Cancer waiting time standards;
  - MRSA;
* Clostridium Difficile;

- delivery of the trajectory towards implementing the six high impact innovations (see below).

4.32 From 2013/14, implementation of the high impact innovations set out in Innovation Health and Wealth will be a gateway to accessing CQUIN. 2012/13 will be a transitional year towards this with the expectation that by the end of 2012/13 all relevant providers/commissioners will have the high impact changes published to date in place. Up to 0.5% of the CQUIN will be made available to relevant providers in 2012/13 relating to this. This could be used to provide non recurring funding to support the changes necessary to implement the high impact changes against an agreed trajectory. For those providers who have already implemented the high impact innovations it should be used for stretch targets to implement further innovation.

4.33 The high impact innovations are set out below:

- assistive technologies;
- oesophageal doppler monitoring;
- child in a chair in a day;
- international and commercial activity;
- digital by default;
- carers for people with dementia.

4.34 The expectation for NHS South of England is that the majority of the remaining CQUIN would be used to support the key priority of improving care for elderly and vulnerable patients. The exact CQUIN performance measure would be determined by local health systems in line with local QIPP plans; however delivery must be measurable and demonstrate sufficient stretch.

4.35 CQUIN performance measures should link to the improvements required through the NHS Outcomes Framework 2012/13.

4.36 The expectation is that CQUIN would be set on a whole community basis, to incentivise community working. An example of this would be where acute, mental health and community trusts works together to develop a scheme with an expected outcome of a 10% reduction in hospital deaths over 2010/11 outturn as a result of responding to the preferences of individuals. If through working as a system this outcome was achieved, all providers would receive the payment for this element of CQUIN. If the outcome was not achieved no part of the system would be rewarded.

4.37 This approach recognises the integrated nature of working required to deliver such outcomes and that it is not possible to attribute success or failure for delivery to a particular NHS organisation.
4.38 Further examples of CQUIN performance measures could include:

- 10% reduction in 0-1 day emergency admissions below the lower of 2009/10 and 2010/11 baseline as improved front door processes in hospitals and strengthened primary care and community care input avoid unnecessary admissions;

- 10% reduction in length of stay excluding 0-1 days as community, primary care and secondary care staff work together to ensure that patients are discharged out of hospital as soon as they are clinically fit and there are no unnecessary delays;

- 10% reduction in hospital deaths, moving towards the performance measure that patients can choose where to be at the end their life;

- increasing by whole health community working, the numbers of patients discharged on a Saturday and Sunday, to levels for the rest of the week in order to support improved care for patients.

4.39 In 2012/13 it will be necessary for CQUIN agreements to be submitted to NHS South of England for ratification and final sign off.

4.40 NHS South of England will expect commissioners to plan for the whole of CQUIN payment to be made to providers based on agreed contract values excluding pass through charges. Actual payments will be made on the basis of delivery.

4.41 It is expected that all local systems will work closely together to submit metrics and CQUIN schemes that are signed off by the key stakeholders which reflect the need to tackle variation in each local health system.

4.42 Primary Care Trusts will be required to report progress against CQUIN performance measures to NHS South of England on a quarterly basis.

**Social care funding**

4.43 In line with the national commitment, a further allocation will be made to Primary Care Trusts in 2012/13 to transfer to social care services to benefit health. This financial investment will continue in 2013/14 and 2014/15.

4.44 Primary Care Trust clusters and Local Authorities will need to work together to jointly agree a plan which sets out local priorities and outcomes for use of the investment allocated for reablement including metrics by which delivery will be jointly measured.

4.45 Once the joint plan has been agreed, the Primary Care Trust cluster will be required to transfer the social care funding to Local Authorities via a Section 256 agreement under the NHS Act 2006. There is an expectation that joint plans will be agreed and finalised by 31 March 2012.
4.46 The funding for social care needs to be seen as a continuing catalyst for change, supporting sustainable unscheduled care services. Primary Care Trust clusters must be able to demonstrate the improvements gained in health following the investment of the additional resources in social care services.

4.47 A continued focus on reducing the number of days of delay in discharge from hospital should be one area of focus. There is also an expectation that the plan will focus on reducing inappropriate admissions and lengths of wait, increasing reablement and preventing readmissions.

4.48 An appropriate use of this funding would be investment in services such as:

- additional short-term residential care places or respite and intermediate care;
- more capacity for home care support, investment in equipment, adaptations and telecare;
- investment in crisis response teams and other preventative services to avoid unnecessary admission to hospital;
- further investment in reablement services to help people regain their independence and reduce the need for ongoing care.

4.49 NHS South of England will adopt a whole system approach to assessing the use of the funding and will roll out a single set of data appropriate to both health and social care to monitor delivery. This will include monitoring hospital admissions, length of stay and readmissions and a set of metrics on which to assess the performance of community services.

Financial planning assumptions and process

4.50 Primary Care Trusts remain the statutory body and plans for finance, activity and workforce data must be submitted on this basis.

4.51 As the plans being refreshed will outlive the lifespan of Strategic Health Authorities and Primary Care Trusts, it is essential that Clinical Commissioning Groups are involved in shaping the development of Primary Care Trust plans, as it is these plans that Clinical Commissioning Groups will inherit when they are authorised.

4.52 Local financial planning processes in NHS South of England have been developed over a number of years and are underpinned by Medium Term Financial Strategies. The process adopted has ensured that robust financial plans have been developed successfully for each of the last five years and facilitated the delivery of the regional control total over this period.
4.53 For the 2012/13 planning round each constituent Strategic Health Authority will establish a financial planning group with a remit to:

- consider best practice in financial planning and determine how best practice could be utilised to improve financial planning;
- review, consider and recommend a consistent set of financial planning assumptions to which all Primary Care Trusts could adhere;
- share financial planning issues, concerns, solutions and approaches within the group. This approach facilitates shared learning and ensure consistency across the region;
- advise on the financial planning collection processes in respect of the time and format of the plan.

4.54 Details of the financial planning assumptions used for this plan reflect The Operating Framework for the NHS in England 2012/13. Primary Care Trusts are to submit plans in January 2012 that are consistent with these planning assumptions. Table 1 outlines the key tariff and price assumptions. For completeness the full list of financial planning assumptions is also attached in Appendix 2. These will be updated following the publication by the Department of Health of allocations in mid December 2011.

Table 1: Tariff and price assumptions

<table>
<thead>
<tr>
<th>Item</th>
<th>Payment by Results tariff assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011/12 %</td>
</tr>
<tr>
<td>Tariff uplift</td>
<td>2.5</td>
</tr>
<tr>
<td>Efficiency</td>
<td>(4.0)</td>
</tr>
<tr>
<td><strong>Net change in tariff prices</strong></td>
<td>(1.5)</td>
</tr>
<tr>
<td>Primary Care Contractors (net uplift)</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Financial plans 2011/12 to 2014/15

4.55 Primary Care Trust allocations were published in mid December 2011 and following this point it is expected that the NHS South of England cluster surplus for 2012/13 will also be agreed. This will enable NHS South of England cluster to share the summary financial plan for 2011/12 to 2014/15 detailing expected allocation, surplus and uncommitted headroom by Primary Care Trust cluster.
A summary of the financial plans for the period 2011/12 to 2014/15 is set out in Table 2 and will be updated now that the allocations have been published.

**Table 2: Summary of financial plans 2011/12 to 2014/15**

<table>
<thead>
<tr>
<th>NHS Organisation</th>
<th>2011/12 £’000</th>
<th>2012/13 £’000</th>
<th>2013/14 £’000</th>
<th>2014/15 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS South East Coast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline allocation</td>
<td>6,798,474</td>
<td>6,965,716</td>
<td>7,147,522</td>
<td>7,341,219</td>
</tr>
<tr>
<td>Headroom</td>
<td>135,969</td>
<td>139,314</td>
<td>142,950</td>
<td>146,824</td>
</tr>
<tr>
<td>Surplus</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td><strong>NHS South Central</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline allocation</td>
<td>5,853,418</td>
<td>5,997,412</td>
<td>6,153,944</td>
<td>6,320,716</td>
</tr>
<tr>
<td>Headroom</td>
<td>117,068</td>
<td>119,948</td>
<td>123,079</td>
<td>126,414</td>
</tr>
<tr>
<td>Surplus</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td><strong>NHS South West</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline allocation</td>
<td>8,135,160</td>
<td>8,337,173</td>
<td>8,556,332</td>
<td>8,788,208</td>
</tr>
<tr>
<td>Headroom</td>
<td>162,703</td>
<td>166,743</td>
<td>171,127</td>
<td>175,764</td>
</tr>
<tr>
<td>Surplus</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
</tr>
</tbody>
</table>

**Capital plans**

There will be no automatic capital allocations for Primary Care Trusts in 2012/13. The primary source of capital funding for NHS Trusts will continue to be internally generated with additional finance provided through interest bearing loans where affordable.

It should be noted that access to exceptional public dividend capital will be highly unlikely and no NHS Trust should assume access to public dividend capital in their plan without prior approval from NHS South of England.

The 2012/13 Primary Care Trust and NHS Trust capital plans submitted by NHS South of England are expected to be consistent with the previously submitted three year capital programme covering 2010/11 to 2012/13.
4.60 In 2012/13 any capital for community services will follow the regime applicable to the NHS organisation into which the asset transfers.

4.61 The capital plans will be reviewed to ensure that no new capital schemes are being planned in 2012/13. To gain assurance that this is the case all capital plans will be analysed over the following headings:

- backlog maintenance/Health and Safety;
- Information Management and Technology costs;
- capital grants;
- approved schemes.

**Alignment of financial, activity, capacity and workforce plans**

4.62 NHS South of England has in place a reconciliation process to test that the finance, activity, capacity and workforce plans produced by health communities are fully aligned. Planning templates are designed to highlight explicitly the alignment between finance, activity, capacity and workforce plans. Reasonableness tests are then performed in order to ensure that:

- financial planning assumptions are consistent where appropriate, for example, tariff inflation and efficiency and the impact of new policies such as reablement and the cancer drugs fund;
- likely changes in activity and cost over the spending review period are based on local trends in acute sector demand and primary care prescribing;
- the size of the financial challenge to be met by quality and productivity schemes is quantified;
- quality and productivity schemes are clearly analysed by:
  * workstream;
  * provider and commissioner, to clarify to which organisation the benefit accrues;
  * recurring and non recurring savings;
- savings required are split between those that will be delivered through improved efficiency and those that need to be delivered as cashable savings;
- cashable savings are split between pay and non pay within an acceptable range;
• cashable savings at provider level meet the minimum cashable savings that will be required by providers to manage both the reduction in contract values and the cost of inflation;

• the planned reduction in whole time equivalents will deliver the cashable pay savings required for each provider;

• assumptions about activity changes within financial plans are aligned to the changes within activity plans and key performance indicators developed to monitor delivery of plans;

• activity, productivity and workforce plans are changing in a proportionate way over the planning period to provide one element of the assurance that changes should not affect the quality and safety of services.

4.63 To ensure financial plans are consistent with other key operational issues for example, patient experience, choice and cancer reform, Primary Care Trusts in NHS South of England will submit a checklist with their mid February 2012 submission (to be available by 10 January 2012) confirming progress made.
Section 5

The requirements and timetable for The Operating Plan for NHS South of England 2012/13

This section sets out the requirements and timetable for preparation of The Operating Plan for NHS South of England 2012/13 including details of the required content of the submitted plans.
5. The requirements and timetable for The Operating Plan for NHS South of England 2012/13

5.1 This section summarises the requirements of Operating Plans for 2012/13 and the timetable for their preparation.

5.2 The roles and responsibilities of the key organisations involved in producing Operating Plans for 2012/13 are set out in Section 3 including:

- Primary Care Trust clusters;
- Clinical Commissioning Groups;
- NHS Trusts;
- other providers of NHS services including NHS Foundation Trusts, Social Enterprises and the independent and voluntary sector.

5.3 This section sets out:

- overall requirements of Operating Plans for 2012/13;
- requirements for Primary Care Trust clusters;
- requirements for Clinical Commissioning Groups;
- requirements for NHS Trusts;
- plans for improved quality and productivity;
- workforce plans;
- the timetable for the preparation of Operating Plans for 2012/13.

Overall requirements of Operating Plans for 2012/13

5.4 The key priorities to be delivered through Operating Plans for 2012/13 are set out in Section 2 including:

- improving quality through better health outcomes;
- developing innovation through accelerating the adoption and diffusion of best practice in the NHS;
- delivering against the reform agenda;
- developing a robust financial framework;
- meeting local priorities in NHS South of England.
5.5 The plans for delivering against the reform agenda include the preparation of updated transition plans for:

- developing the new commissioning landscape, including the NHS Commissioning Board, Clinical Commissioning Groups, Health and Wellbeing Boards and clinical networks and senates;
- supporting the development and authorisation of Clinical Commissioning Groups through:
  * devolved relevant commissioning budgets from 1 April 2012;
  * provision of commissioning support;
  * active involvement in the planning round, taking ownership of those parts of a Primary Care Trust cluster plan which it will inherit;
- developing the new public health landscape, including establishment of Public Health England in shadow form in 2012/13 and delivering a successful public health transition through close working with local authorities;
- developing the new provider landscape, including progress on the NHS Foundation Trust pipeline through delivery of agreed Tripartite Formal Agreement milestones;
- empowering patients, including choice over how, where and when they receive treatment, choice of Any Qualified Provider in at least three services and improving the transparency of information and outcomes;
- developing the workforce including the establishment of Health Education England and supporting staff through the transition;
- preparation for the transfer of functions from Primary Care Trust clusters and Strategic Health Authorities to the organisations in the new architecture by 1 April 2013.

5.6 The reform agenda will lead to the creation of new organisations that will be responsible for the NHS from 1 April 2013 including:

- the NHS Commissioning Board;
- Clinical Commissioning Groups;
- Public Health England;
• Health Education England;
• the NHS Trust Development Authority.

5.7 Local Authorities will take responsibility for certain public health functions and for Health and Wellbeing Boards.

5.8 Each Operating Plan will be expected to set out how Primary Care Trust clusters, NHS Trusts and Specialised Commissioning Groups will deliver the requirements of The Operating Framework for the NHS in England 2012/13 as set out in detail in Section 2 of this report.

5.9 The Strategic Health Authority cluster will expect that each Primary Care Trust cluster and NHS Trust ensures that plans are consistent in terms of written plans, activity, finance, workforce, QIPP and transition plans.

Requirements for Primary Care Trust clusters

5.10 In order to maintain consistency with the existing timetables in each local area, Primary Care Trust clusters in NHS South of England will submit initial Operating Plans for 2012/13 as set out in Table 3. Activity and finance templates have already been sent out by each of the three Strategic Health Authorities which will be used for these reforms.

Table 3: Submission of Operating Plans for 2012/13

<table>
<thead>
<tr>
<th>Area</th>
<th>First submission</th>
<th>Second submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>6 January 2012</td>
<td>17 February 2012</td>
</tr>
<tr>
<td>East</td>
<td>6 January 2012</td>
<td>17 February 2012</td>
</tr>
<tr>
<td>West</td>
<td>13 January 2012</td>
<td>17 February 2012</td>
</tr>
</tbody>
</table>

5.11 Primary Care Trust clusters and Specialised Commissioning Groups are required to submit the following to NHS South of England in the first submission:

• commissioning intentions for the following services;
  * acute;
  * mental health/learning disability;
  * community;
  * primary care;
  * social care;
  * CQUIN;
  * ambulance;
• summary commissioning intentions for each Clinical Commissioning Group confirming that where they relate to the same provider they are aligned;

• activity plans: general practitioner referrals; other referrals; first outpatients; elective day cases; elective inpatients; total elective; non elective:
  * 2011/12 plan;
  * 2011/12 forecast outturn;
  * 2012/13, 2013/14, 2014/15 plan;

• finance return:
  * income and expenditure;
  * QIPP savings;
  * major contract values; 2011 plan, 2011/12 outturn, 2012/13 plan;

• planned QIPP milestones for 2012/13, 2013/14 and 2014/15. These should relate to the key five to seven transformational programmes through robust milestones toward an overall goal. The aggregate savings from these key programmes should be no less than 50% of total QIPP savings over the period. For each scheme include: the aim of the scheme; a brief summary of how this will be delivered; the changes in activity and finance as a result of the scheme; the key milestones;

• milestones for reform in 2012/13 and 2013/14. Outcomes to be achieved are expected be set out in the Department of Health planning guidance due to be published in December 2011. They are expected to cover Clinical Commissioning Group development, commissioning support and direct commissioning functions;

• summary of headline or supporting performance measures not being achieved in 2011/12 and plans and trajectories to achieve in 2012/13;

• workforce return using the Department of Health 2 December 2011 template detailing workforce plans for all major providers including NHS Foundation Trusts and Social Enterprises;

• risks, opportunities and mitigating actions for all elements of the above.
5.12 All Primary Care Trust clusters and Specialised Commissioning Groups are required to submit the following to NHS South of England in the second submission by 17 February 2012:

- a draft Operating Plan including the requirements set out in Section 2 and Appendix 1;
- a revised financial return (if required);
- a checklist of requirements (template to be sent out no later than 10 January 2012);
- updated transition plans to include:
  * developing the new commissioning landscape, including the NHS Commissioning Board, Clinical Commissioning Groups, Health and Wellbeing Boards and clinical networks and senates;
  * supporting the development and authorisation of Clinical Commissioning Groups through:
    - devolved relevant commissioning budgets from 1 April 2012;
    - provision of commissioning support;
    - active involvement in the planning round, taking ownership of those parts of a Primary Care Trust cluster plan which it will inherit;
  * developing the new public health landscape, including establishment of Public Health England in shadow form in 2012/13 and delivering a successful public health transition through close working with local authorities;
  * developing the new provider landscape, including progress on the NHS Foundation Trust pipeline through delivery of agreed Tripartite Formal Agreement milestones;
  * empowering patients, including choice over how, where and when they receive treatment, choice of Any Qualified Provider in at least three services and improving the transparency of information and outcomes;
developing the workforce including the establishment of Health Education England and supporting staff through the transition;

preparation for the transfer of functions from Primary Care Trust clusters and Strategic Health Authorities to the organisations in the new architecture by 1 April 2013.

5.13 For the 17 February 2012 and 16 March 2012 final returns, Primary Care Trust clusters should submit Operating Plans plus finance, activity and workforce information. The templates for these returns will be confirmed once the Department of Health technical guidance has been published in mid December 2011; these will be standardised across NHS South of England.

Requirements for Clinical Commissioning Groups plans

5.14 Every Clinical Commissioning Group will be expected to produce a plan for 2012/13 which will be agreed with their Primary Care Trust cluster. The final version of the plan will be sent to the Strategic Health Authority cluster by 16 March 2012. The information requirements which must be provided within the plan are set out below. The Strategic Health Authority cluster will test at the January review meeting progress with Clinical Commissioning Group plans. Primary Care Trust clusters and Clinical Commissioning Groups have shared responsibility for delivering plans which have:

- delegated activity and finance budgets from 1 April 2012 and arrangements for discharging devolved powers;

- details of QIPP or other priority areas for which the Clinical Commissioning Group will take responsibility for delivery, including an explanation of the reasons for this choice;

- details of the Clinical Commissioning Group approach to managing the remainder of activity and finance budgets not directly covered by QIPP above, recognising that the responsibility is for overall budget management, not elements of it;

- details of how the Clinical Commissioning Group will take on commissioning responsibility for 2012/13 such as contracting and negotiation with providers, in-year performance management, leadership of service reconfiguration;

- summary of the organisational priorities and plan;

- commissioning support arrangements for 2012/13 (including Primary Care Trust cluster assigned staff) and plans for developing full specification of commissioning support requirements for 2013/14 onwards within the £25 per head running costs funding envelope available;
accountability agreement setting out governance arrangements for the Clinical Commissioning Group, including the parameters and ‘rules’ around how they will manage their delegated authority from the Primary Care Trust cluster;

performance management arrangements within the Clinical Commissioning Group particularly in relation to their system leadership role in holding others to account;

performance management arrangements between the Clinical Commissioning Group and the Primary Care Trust cluster in relation to how the Clinical Commissioning Group will be held to account as a sub-committee of the Primary Care Trust cluster Board.

Requirements for NHS Trusts

5.15 NHS Trusts are required to submit to NHS South of England their first submission by the date in paragraph 5.10 as follows:

- income and expenditure 2012/13 and 2013/14;
- CRES plans 2012/13 and 2013/14;
- anticipated contract values with major commissioners;
- confirmation that activity/finance monitoring will be provided at practice level for all areas of activity from 1 April 2012;
- risks, opportunities and mitigating actions for all elements of the above;
- plans to achieve any headline or supporting milestones which are not going to be delivered by 31 March 2012 with trajectories and milestones;
- commissioning intentions which they would wish to negotiate with their commissioner or would wish their commissioner to negotiate with other providers to support delivery of their provider QIPP plans;
- workforce plans for 2012/13 using the Department of Health template issued on 2 December 2011.

5.16 NHS Trusts are required to submit the following to NHS South of England in the second submission by 17 February 2012:

- a draft Operating Plan including the requirements set out in Section 2 and Appendix 1;
- a revised financial return (if required);
- a checklist of requirements (template to be sent out no later than 10 January 2012).
5.17 For the 17 February 2012 and 16 March 2012 final returns, NHS Trusts should submit Operating Plans plus finance, activity and workforce information. The templates for these returns will be confirmed once the Department of Health technical guidance has been published in mid December 2011; these will be standardised across NHS South of England.

**Plans for improved quality and productivity**

5.18 For each QIPP workstream and initiative, the impact on activity should be clearly shown for example in terms of reduced activity or activity diverted to another service. The consequent impact on the current workforce should be described, for example, workforce redesign, transfer or reduction. Primary Care Trust clusters, Clinical Commissioning Groups and providers will also need to be able to demonstrate that in each case the quality of the service has been maintained or improved via an impact assessment. This identifies the change in cost of the service and a net saving. This needs to identify real cash out of the system. Each workstream and initiative should be ‘triangulated’ in this way.

5.19 The implications for capacity in the health system in relation to what capacity is affected and where it is located can then be derived for the plan as a whole. The impact on capacity needs to be described in terms of reducing the number of beds or increasing capacity in a lower cost environment.

**Workforce plans**

5.20 The Director of Workforce Development will be preparing a Workforce Investment Plan for the commissioning of education and training throughout NHS South of England.

5.21 Staff continue to be the most vital resource for the NHS and the expectations set out in The Operating Framework for the NHS in England 2012/13 will require changes to the NHS workforce. For 2012/13 Primary Care Trust clusters are expected to lead workforce planning for their health communities while the new infrastructure is established. They will also monitor performance around workforce. In particular this will include delivery of action plans to:

- improve staff survey performance;
- achieve workforce numbers against plan;
- decrease agency staff usage and costs;
- review skill mix changes;
- improve sickness absence rates;
- improve workforce productivity.
5.22 Providers should plan and manage workforce in a way which is consistent with commissioning requirements and internal savings plans as well as taking the required steps to improve staff health and wellbeing set out in The Operating Framework for the NHS in England 2012/13.

5.23 NHS South of England will expect Operating Plans for 2012/13 from Primary Care Trust clusters, Specialised Commissioning Groups and NHS Trusts to include plans to deliver the above requirements. All NHS Trusts should also be able to demonstrate that their plans, including profiling for finance, activity and workforce, are consistent with both commissioning agreements and savings plans.

5.24 Workforce submission requirements are set out in the timetable and action plan below. Primary Care Trust clusters will be required to assure that returns in January and March 2012 are aligned with cluster-wide commissioning intentions. The workforce template to be used was published by the Department of Health on 2 December 2011.

5.25 It is anticipated that a return analogous with the Financial Information Management System (FIMS) return, and including both paybill and whole time equivalent information, will be a mandatory requirement for all providers of NHS services (including NHS Foundation Trusts and Social Enterprise providers. This is currently pending national approval). In the meantime Primary Care Trust clusters are required to agree with NHS Foundation Trusts and Social Enterprises that they will provide this information.

5.26 Strategic Health Authority workforce leads will continue to work with individual organisations to support effective workforce planning and use of best practice tools.

Timetable for the preparation of Operating Plans for 2012/13

5.27 The key milestones for the development of Operating Plans for 2012/13 are set out in Table 4.
Table 4: Key Milestones for the Development of Operating Plans for 2012/13

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 November 2011</td>
<td>Publication of The Operating Framework for the NHS in England 2012/13</td>
</tr>
<tr>
<td>Mid December 2011</td>
<td>NHS contract 2012/13 available</td>
</tr>
<tr>
<td>Mid December 2011</td>
<td>Department of Health technical guidance and allocations published</td>
</tr>
<tr>
<td>Early January 2012</td>
<td>Strategic Health Authority to send out upper decile benchmarking information to all commissioners and providers</td>
</tr>
<tr>
<td>Early January 2012</td>
<td>Department of Health financial planning guidance published</td>
</tr>
</tbody>
</table>
| 6 January 2012 for South Central and South East Coast/ 13 January 2012 for South West to maintain consistency with existing timetable | Primary Care Trust clusters and Specialised Commissioning Group, (SCG) submit draft Operating Plans for 2012/13 as set out in paragraph 5.10  
NHS Trusts to submit draft Operating Plans for 2012/13 as set out in paragraph 5.15. |
| Mid January 2012              | • Strategic Health Authority review of Primary Care Trust cluster Operating Plans for 2012/13;  
• Strategic Health Authority review of NHS Trust Operating Plans for 2012/13;  
• Strategic Health Authority review of three Specialised Commissioning Group Operating Plans for 2012/13. |
| 20 January 2012 (to be confirmed following publication of Department of Health technical guidance) | Primary Care Trust clusters and NHS Trusts submit to Unify/FIMS/workforce:  
• activity plans and trajectories for relevant performance measures set out in the Annex to The Operating Framework for the NHS in England 2012/13;  
• workforce plans using Department of Health template;  
• trajectories for financial indicators set out in the Annex to The Operating Framework for the NHS in England 2012/13 using FIMS template. |
<table>
<thead>
<tr>
<th>Deadline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 January 2012</td>
<td>Strategic Health Authority cluster submits to the Department of Health:</td>
</tr>
<tr>
<td></td>
<td>• data trajectories for all Primary Care Trusts for the relevant indicators set out in the Annex to The Operating Framework for the NHS in England 2012/13;</td>
</tr>
<tr>
<td></td>
<td>• milestones for each Primary Care Trust cluster (drawn from their integrated plan), covering transformational change elements of QIPP and reform;</td>
</tr>
<tr>
<td></td>
<td>• milestones for each Strategic Health Authority cluster about the transition of the functions within the Strategic Health Authority to new bodies;</td>
</tr>
<tr>
<td></td>
<td>• short narrative outlining the Strategic Health Authority cluster assurance process and the Strategic Health Authority cluster assessment of key risks and mitigating action within the region (both geographical and programme based).</td>
</tr>
<tr>
<td>17 February 2012</td>
<td>Primary Care Trust clusters and Specialised Commissioning Groups to submit revised Operating Plans for 2012/13 to Strategic Health Authority as set out in paragraph 5.12. and NHS Trusts as set out in paragraph 5.16.</td>
</tr>
<tr>
<td>28 February 2012</td>
<td>All heads of terms to be signed and forwarded to Strategic Health Authority.</td>
</tr>
<tr>
<td>End February and March</td>
<td>NHS South of England Executive Team meetings with all Primary Care Trust clusters to review Operating Plan for 2012/13 submissions. Strategic Health Authority performance teams to review NHS Trust Operating Plan for 2012/13 submissions including meetings if required.</td>
</tr>
<tr>
<td>Deadline</td>
<td>Action</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16 March 2012</td>
<td>Primary Care Trust clusters and Trusts submit to Strategic Health Authority /Unify/FIMS/workforce:</td>
</tr>
<tr>
<td></td>
<td>• final Operating Plan for 2012/13;</td>
</tr>
<tr>
<td></td>
<td>• activity and trajectories for the relevant performance measures set out in the Annex to The Operating Framework for the NHS in England 2012/13;</td>
</tr>
<tr>
<td></td>
<td>• workforce indicators using Department of Health template;</td>
</tr>
<tr>
<td></td>
<td>• trajectories for financial indicators set out in the Annex to The Operating Framework for the NHS in England 2012/13 using FIMS template;</td>
</tr>
<tr>
<td></td>
<td>• checklist of requirements (to be sent out no later than 10 January 2012).</td>
</tr>
<tr>
<td></td>
<td>Clinical Commissioning Groups to submit:</td>
</tr>
<tr>
<td></td>
<td>• final plan 2012/13.</td>
</tr>
<tr>
<td>31 March 2012</td>
<td>• All contracts to be signed including agreement with local authorities for use of social care funding;</td>
</tr>
<tr>
<td></td>
<td>• Clinical Commissioning Groups to have signed Service Level Agreements/contracts with Commissioning Support Units;</td>
</tr>
<tr>
<td></td>
<td>• Clinical Commissioning Groups to have 100% of relevant budgets devolved and budgets agreed with Primary Care Trust clusters;</td>
</tr>
<tr>
<td></td>
<td>• Clinical Commissioning Group accountability agreements with Primary Care Trust clusters to be in place by 1 April 2012.</td>
</tr>
</tbody>
</table>
## Deadline vs. Action

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 April 2012</td>
<td>Strategic Health Authority cluster to submit to Department of Health:</td>
</tr>
<tr>
<td></td>
<td>- data trajectories for all Primary Care Trusts for the relevant indicators set out in the Annex to The Operating Framework for the NHS in England for 2012/13;</td>
</tr>
<tr>
<td></td>
<td>- milestones for each Primary Care Trust cluster (drawn from their integrated plan), covering transformational change elements of QIPP and reform;</td>
</tr>
<tr>
<td></td>
<td>- milestones for each Strategic Health Authority cluster about the transition of the functions within the Strategic Health Authority to new bodies;</td>
</tr>
<tr>
<td></td>
<td>- short narrative outlining the Strategic Health Authority cluster assurance process and the Strategic Health Authority cluster assessment of key risks and mitigating action within the region (both geographical and programme based).</td>
</tr>
</tbody>
</table>

## Risk management

### 5.28 Risk management:

- all Operating Plans will outline actions planned for all significant recovery and risk areas;

- Operating Plans should cover the key enablers to delivery (such as informatics, service improvement, contract levers) and the metrics for measuring progress and success.

### 5.29 The risks will be minimised and the opportunities maximised by the planning process, particularly through testing the following:

- triangulation of activity, financial and workforce plans to ensure that these are consistent for individual organisations and across organisations;

- assurance that savings plans will support delivery of quality of services, not detract from it;

- early planning to ensure that financial savings are identified early and that heads of terms and contracts are signed on time;
• system-wide incentives and penalties are in place to support quality, innovation, productivity and prevention delivery including the potential use of community-wide commissioning for quality and innovation schemes;

• consistency of opportunities being taken across areas such as primary care, community care;

• review of investment plans to ensure that there are clear benefits identified and that agreement is in place as to how these will be monitored;

• use of NHS South of England benchmarking to test deliverability of plans and that opportunities for efficiency have been built into plans.

Queries

5.30 If you should have any queries or require clarification on any aspect of the preparation of The Operating Plan for NHS South of England 2012/13, please contact the Director of Performance for your local area:

• Central Jane Dale
  jane.dale@southcentral.nhs.uk

• East Guy Boersma
  guy.boersma@southeastcoast.nhs.uk

• West Lisa Manson
  lisa.manson@southwest.nhs.uk

5.31 A more detailed contacts table for each Strategic Health Authority, covering the different areas of the plan, will be circulated shortly but any queries in the meantime should be addressed to the relevant Director of Performance as above.
Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>Appendix 1</td>
<td>NHS South of England Local Priorities</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Financial assumptions for the Operating Plan for NHS South of England for 2012/13</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Process for accessing non-recurring headroom in 2012/13 for Primary Care Trust clusters</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Mandatory penalties tracker</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>National Performance Measures</td>
</tr>
</tbody>
</table>
Appendix 1

NHS South of England Local Priorities

This appendix sets out the local priorities which NHS South of England requires organisations to plan to deliver in 2012/13.
NHS South of England Local Priorities

Commissioning intentions

1.1 The commissioning intentions below are expected to be used by all commissioners across NHS South of England to support delivery of the requirements of the NHS Operating Framework and of QIPP.

1.2 Commissioning intentions should include a requirement for compliance with all aspects of the NHS Operating Framework 2012, in particular the local plans to deliver improvements in the following areas:

- medical revalidation;
- staff recommending their hospital to patients as part of the staff survey;
- comply with the Equality Act 2010 and its associated public sector Equality Duty;
- promotion and conduct of research to address future challenges;
- care for patients with dementia and care for older people;
- support for carers using direct payments or personal budgets;
- military and veterans health;
- an increase in the number of Health Visitors and Family Nurse Partnerships;
- introduction of the NHS Outcomes Framework;
- summary care records;
- mortality rate through use of HSMR and SHMI;
- delivering NHS Constitution patient rights;
- staff health and wellbeing;
- the implementation of Any Qualified Provider;
- the development of the NHS 111 service,

1.3 More detailed guidance may be sent out by Strategic Health Authority leads or the Department of Health in these areas over the next few weeks in terms of expectations.
Referral to Treatment waiting times

1.4 The Operating Framework for the NHS in England for 2012/13 sets out further expectations in addition to the NHS Constitution requirements for ensuring that patients have appropriate access to care. In line with this, commissioners will, in 2012/13, agree with providers plans to deliver NHS Constitution requirements for 90% admitted and 95% non admitted at performance speciality level, and to achieve the 92% requirement for patients on an incomplete pathway.

1.5 Commissioning intentions for all providers should include a requirement to comply with the Best Practice Guidance around 18 weeks which will mean that providers and commissioners report on the reasons for every 18 week Referral to Treatment breach from 1 April 2012 onwards in their Board papers, giving reasons for each breach classified as choice, complexity and capacity. Commissioners and providers are expected to work together to ensure that breaches for reasons of capacity are minimal and to agree recovery plans where appropriate.

1.6 Commissioners should also require providers to analyse on a monthly basis the position with all those patients reported as waiting over 35 weeks and identify whether they are being incorrectly reported as waiting or whether a care plan needs to be put together to enable them to be dated, or whether there are genuine reasons for their long wait which relate to either complexity or choice.

1.7 Commissioners should require providers to report on a monthly basis the numbers of patients waiting on a planned list by time band and speciality and provide further evidence that all patients waiting on this list are appropriate if required.

1.8 In order to build sustainable headroom to secure sustainability of Referral to Treatment, NHS South of England would encourage commissioners to commission stretch performance measures for Referral to Treatment. These could include reducing the median wait and 95th percentile time for surgical outpatient appointments to, for example, 3.5 weeks and/or reducing maximum diagnostics waits from six weeks to four weeks. The waiting times position will vary by provider and health community and will therefore require different approaches to ensure the NHS Constitution is delivered in a robust and sustainable way.

Provider efficiency

1.9 Commissioners and providers should agree through the 2012/13 planning process a trajectory to move to upper decile performance for a range of benchmarked indicators at an agreed pace that is both affordable and deliverable. Information on current performance on these indicators for NHS South of England will be sent out in early January 2012 including the upper quartile and upper decile levels for the NHS South of England. A minimum expectation for 2012/13 should be achievement of upper quartile performance.
1.10 Agreed trajectories should be reflected in the contracts agreed between commissioners and providers and used to develop the activity assumptions required within the contract. Performance in year will be managed against these expectations.

**Tertiary providers**

1.11 In the same way that general practitioners and other referrers to secondary care are peer reviewing their referrals to ensure that they are of a high quality and that patients are treated nearer to home where appropriate, the expectation is that secondary care providers will put in place measures to ensure the same review.

1.12 This will enable commissioners to review referrals into tertiary care and identify if there are any care pathways which can be managed closer to home or if there is clinical variation in referrals which needs to be addressed by the host provider.

1.13 Specifically NHS South of England would expect commissioners to agree with secondary care providers the process which the secondary care provider will manage within its organisation to ensure that referrals onward are clinically appropriate, offer patients a choice of tertiary centres where appropriate and that the patient’s care continues to be supported by the secondary care hospital so that the patient can be returned to local care at an appropriate time.

**Information to support clinical commissioning group commissioning**

1.14 NHS South of England expects all commissioners to agree with providers that information around healthcare is provided on a patient basis for all areas of activity from 1 April 2012 to support monitoring of activity and finance at a clinical commissioning group level. This includes non Payment by Results activity and community/mental health activity.

1.15 Where this cannot be achieved in full by 1 April 2012, the expectation is that commissioners will agree with providers’ deadlines by which this information will be provided and backdated to 1 April 2012. This must be at the latest by 1 October 2012 to support the process around clinical commissioning group planning for 2013/14.

**Community care**

1.16 NHS South of England is expecting to support a particular focus on evaluating the performance of community providers in supporting QIPP delivery in 2012/13. A review of current community metrics is currently underway and will be shared with commissioners in late December 2011 to inform contract discussions for 2012/13.
1.17 NHS South of England expects all commissioners to agree with their community providers that they will submit the Community Information Dataset from 1 April 2012. NHS South of England also expects commissioners to agree with providers that they will provide appropriate benchmarking information on performance during 2012/13; this could be for example by membership of the NHS Benchmarking Network or similar.

**Primary care**

1.18 NHS South of England is expecting to support a particular focus on evaluating the performance of primary care providers in supporting QIPP delivery in 2012/13. A review of current primary care metrics and benchmarking is currently underway and will be shared with commissioners in early January 2012.

1.19 Primary Care Trust clusters will be expected to continue with plans to deliver primary care QIPP in 2012/13, 2013/14 and 2014/15 with a particular focus on the following:

- review arrangements for cleaning primary care registered patient lists;
- primary care estates review;
- PMS review;
- consistency and appropriateness of discretionary payments;
- approach to contracts and payment management;
- enhanced services review;
- dental contract review;
- optometry contract review;
- primary care prescribing.

**Improving health care**

1.20 Operating Plans should include the clinical work streams and constituent initiatives where it is clear that there are significant productivity gains to be realised. Strategic Health Authority leads for these work streams are working closely with Primary Care Trust clusters to ensure these opportunities are taken. A summary of the key initiatives expected to be reflected in Operating Plans for 2012/13 is given below.
Long-term conditions

- There are two key aspects to the priorities for improving the care of people with long-term conditions. Firstly, the implementation of the national COPD and asthma outcomes strategy, in particular earlier identification and improved diagnosis, oxygen use, medicines management, access to pulmonary rehabilitation and more effective acute care response. Secondly the QIPP programme to embed the three key drivers of population risk stratification, integrated care delivery teams and supported self-management / shared decision making, to reduce unscheduled hospital admissions, reduce length of stay and improve the patient experience.

Vascular disease and trauma services

- Vascular, stroke and trauma: plans should include updates and milestones for reconfiguration of services to meet national guidance. Where there are expected changes in activity flows these should be reflected in commissioning plans.

- Vascular surgery: where vascular surgery reviews have already taken place, Primary Care Trust cluster operating plans should detail any remaining engagement and consultation which is necessary and outline a plan of what changes will be commissioned, when and how quality will be assured throughout. Where a vascular surgery review has not yet taken place, commissioners are to decide whether this is necessary. In the event that commissioners do not consider that a review is deemed necessary, commissioners are to provide assurance to the Strategic Health Authority regarding the quality and sustainability of vascular services;

- Major trauma: Primary Care Trust cluster operating plans should set out how the revised activity flows following implementation of major trauma systems from 1 April 2012 are reflected in commissioning plans. Appropriate commissioning arrangements need to be agreed with providers to ensure that changes in flows are effected to improve patient care within a fixed financial envelope for major trauma;

- Stroke: Primary Care Trust cluster and NHS Trust operating plans should provide details of any service changes required in order to ensure quality is improved throughout the patient pathway and that services are sustainable;

Urgent care

- NHS 111/urgent care. Primary Care Trust cluster operating plans should ensure that Primary Care Trusts can mobilise the 111 contract in their area during 2012/13 and meet the national launch date for the service by April 2013. In particular, commissioners should ensure that:
the Capacity Management System Directory of Service is completed and updated in all relevant provider contracts;

* there are technical links in place between NHS 111 providers and all relevant organisations to ensure calls and data can be transferred in line with the technical specification;

* there is robust clinical engagement in the development and implementation of the NHS 111 service;

* there are robust clinical governance arrangements in place for NHS 111, including entire patient pathway and interfaces – specifically, Out of Hours;

* operating plans are expected to include, where not already exploited, opportunities for ambulance services to reduce conveyances and increase the use of 'Hear and Treat' where appropriate;

* Primary Care Trusts are expected to detail plans for adoption of the urgent care dashboard where this has not already been implemented (pioneer sites).

**End of life care**

- Primary Care Trust clusters will want to continue to implement the quality gains identified within their QIPP plans for end of life care, these are as follows:
  
  * identifying people in the last year of life;
  
  * ensuring these people are on a locality wide end of life care register or electronic palliative care co-ordination system;
  
  * ensuring that advance care planning is in place for all on the register and/or at high risk of unscheduled admission;
  
  * ensuring adherence to a unified DNACPR policy;
  
  * providing access to enhanced community care services to enable people to remain at home which will include meeting the end of life care requirements within contracts which reflect the NICE standards;
  
  * ensuring that training and education plans are in place across health and social care to meet these priorities.
This appendix sets out the financial assumptions to be used for the 6 January and 13 January 2012 submission. They may be updated for later submissions once Primary Care Trust allocations, national tariff 2012/13 and the Department of Health Technical Guidance 2012/13 is published.
# Financial Assumptions for the Operating Plan for NHS South of England 2012/13

<table>
<thead>
<tr>
<th><strong>Issue</strong></th>
<th><strong>Proposed assumption</strong></th>
<th><strong>Status of assumption and any other comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overarching issues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The 2011/12 plan established a four year plan and this planning process is a refresh of the existing plan</td>
<td></td>
<td>In line with Department of Health planning feedback.</td>
</tr>
<tr>
<td>How many years should the medium term financial plan cover?</td>
<td>Five years with 2010/11 final outturn, 2011/12 forecast outturn and plan for 2012/13 to 2014/15.</td>
<td>Assumption in line with four year spending review timescales.</td>
</tr>
<tr>
<td>Primary Care Trust surplus for 2012/13</td>
<td>All Primary Care Trust clusters aim to achieve 1% surplus in 2012/13</td>
<td>To be clarified when overall NHS South of England target is set</td>
</tr>
<tr>
<td><strong>Resource limit assumptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central budget assumptions</td>
<td>Primary Care Trusts and NHS Trusts to assume central budget values from 2012/13 to 2014/15 are the same as 2011/12 subject to any previously notified reductions e.g. Private Finance Initiative tapering support. All NHS Trusts to assume top-slice from 2012/13 onwards.</td>
<td>The Strategic Health Authority top slice is part of the 2012/13 position. The Operating Framework for the NHS in England 2012/13 confirms that the central budget bundle is the same value as it was in 2011/12. Assume these resources continue beyond 2012/13.</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Impairments and accelerated depreciation</td>
<td>All NHS organisations to assume the current arrangements continue Primary Care Trust sector – impairments and accelerated depreciation funded if in the FIMS plan. NHS Trust sector – impairments not counted in the control total i.e. below the line and accelerated depreciation from within own resources.</td>
<td>Status quo, no better information but some risk that national approach could change.</td>
</tr>
<tr>
<td>Revenue support for on balance sheet IFRIC12 schemes</td>
<td>Continued funding for the revenue costs of IFRIC12 coming on balance sheet for both Primary Care Trusts and NHS Trusts if included in FIMS plans.</td>
<td>Status quo, no better information but some risk that national approach could change.</td>
</tr>
<tr>
<td>Pace of change to move Primary Care Trusts closer to target</td>
<td>Pace of change for 2011/12 as per notified allocations. For 2012/13 onwards all NHS South West Primary Care Trusts to assume national average growth of 2.8%.</td>
<td>Planning assumption for 2012/13 onwards. Subject to change as more details become available in December 2011.</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Re-ablement funding</td>
<td>Assume in 2012/13 cost of re-ablement services equal to the value of non-payment for emergency readmissions. The details of commitments against the resources released from the non-payment for emergency readmissions will be collected in a memorandum table with the financial plans.</td>
<td>Paragraph 5.35 of The Operating Framework for the NHS in England 2011/12 describes how Primary Care Trusts will have reablement funding included in their allocations (see next issue below) plus savings from non payment for emergency readmissions which need to be reinvested in re-ablement. See Paragraph 2.25 and 4.21 of The Operating Framework for the NHS in England 2012/13.</td>
</tr>
</tbody>
</table>
| Resource to support social services | Combining information in the Spending Review 2010, Primary Care Trust allocations and the Operating Framework the planning assumptions are as follows:  
  - 2011/12 spend in social services as per AWP (2011/12) PCT03 plus weighted capitation share of £150 million to be spent in the NHS and to be found from Primary Care Trust allocations;  
  - in 2012/13 spend in social care as per AWP (2011/12) PCT03 plus weighted capitation share of £300 million to be spent in the NHS and to be found from Primary Care Trust allocations; | As per Allocation Working Paper (2011/12) PCT03 plus The Operating Framework for the NHS in England 2012/13 Paragraph 4.11 plus Spending Review 2010 and also note – Chapter 7 of ‘A vision for Adult Social Care: Capable Communities and Active Citizens’. |
• for 2013/14 and 2014/15 assume that the spend in the NHS remains at £300 million with the social care national spend being £800 million in 2013/14 and £700 million in 2014/15. The total 2013/14 and 2014/15 figures are taken from table 2.3 in the Spending Review 2010.

<p>| RAB carry forward | Primary Care Trusts to assume RAB carry forward of surpluses as per current process. Note that the planning assumption for 2012/13 is that the surplus draw down will be in the Strategic Health Authority sector and so Primary Care Trusts should plan for surpluses no lower than 2011/12 and in some Primary Care Trusts they will need to restore the surplus back to the expected level in 2011/12. From 2013/14 onwards the assumption is that the draw down of the surplus will be in the Primary Care Trust sector. | In line with Department of Health commitment. Para 4.7 of The Operating Framework for the NHS in England 2012/13 states that the final year-end aggregate surplus generated by Strategic Health Authorities and Primary Care Trusts in 2012/13 will be carried forward to the NHS Commissioning Board in 2013/14, with an expectation that Primary Care Trust originated surpluses will be made available to the relevant local health systems in future years. |
| Financially Challenged Trust payments | Commitments in line with previously agreed plans – final year 2012/13. | Agreements already in place. |</p>
<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed assumption</th>
<th>Status of assumption and any other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Drugs Fund</td>
<td>Assume each Primary Care Trusts weighted capitation share of £140 million set aside on a recurring basis for drugs in 2011/12 plus weighted capitation share of a further £60 million from 2012/13 onwards. National policy is no growth in £200 million for four years of the Spending Review 2010.</td>
<td>Risks to the value of treatment costs that are part of Primary Care Trust contracts with providers and cannot be charged to the cancer drugs fund. See Department of Health ‘The Cancer Drugs Fund: Guidance to support operation of the Cancer Drugs Fund in 2011-12’.</td>
</tr>
<tr>
<td>Additional voluntary contribution to the SIF</td>
<td>For those Primary Care Trusts and health communities affected profile of contributions to be agreed with the Strategic Health Authority.</td>
<td>Subject to local agreement – will need to be reviewed on an individual basis.</td>
</tr>
<tr>
<td>Move to MPET tariff</td>
<td>Any changes to the MPET tariff are not now expected until 2013/14.</td>
<td>Need to undertake a local impact assessment to understand the likely impact in 2012/13.</td>
</tr>
<tr>
<td><strong>Expenditure assumptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurring starting point</td>
<td>As per local information. Need to understand any significant recurring deficits and any significant movements from the expected recurring position in the four year plan.</td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>-----------------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Tariff uplift</td>
<td>As per The Operating Framework for the NHS in England 2012/13, requires 4% efficiency savings and a tariff deflator 1.8% (tbc) with final details confirmed in the Payment by Results guidance. The tariff price deflator is 1.8% will also be applied to non tariff services. The Chancellor announced pay increases of 1% for 2013/14 and 2014/15 so tariff inflation has been assumed at 3.2% with efficiency assumed at 4% (but CQUIN increasing over the period). Note: Non-Payment by Results pay and prices uplift of 3.2% and efficiency requirement of 4% in 2011/12 as per Para 4.26 of The Operating Framework for the NHS in England 2012/13. Assume Non-Payment by Results uplifts and efficiencies to be as per tariff assumption for all four years of plan.</td>
<td>Draft view, further validation will be available for 2012/13 in the Operating Framework. Key issue from 2013/14 onwards is pay award compared to expected GDP and inflation.</td>
</tr>
<tr>
<td>CQUIN</td>
<td>CQUIN will be developed so that, for all standard contracts, the amount that providers can earn will be increased to 2.5 per cent on top of actual outturn value. This is 1% higher than the maximum value payable in 2011/12. Primary Care Trusts should plan to put aside all of the 2.5% CQUIN on a recurring basis to be spent on a non recurring basis subject to any exceptions</td>
<td>See CQUIN section of guidance</td>
</tr>
<tr>
<td>Area</td>
<td>Description</td>
<td>Notes</td>
</tr>
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</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>Local circumstances to apply. Growth in items dispensed has been running at around 4% - 5% for some time and no PPRS savings after 2010/11 as part of five year deal. 2010/11 is year two of five. Each Primary Care Trust to determine local net and gross prescribing uplift. In previous plans the gross uplift of approximately 9%, less 4% efficiency = 5% net.</td>
<td>Local knowledge from prescribing teams and finance leads.</td>
</tr>
<tr>
<td>Primary Care Contractors uplift</td>
<td>Assume in 2012/13 gross uplifts of 4.5% for all primary care contractors offset by efficiency savings of 4% i.e. a net uplift 0.5%. This assumption is based on the agreements reached with GPs and dentists for 2011/12. For 2013/14 and 2014/15 assume a pay increase that will not be offset by efficiency. For 2013/14 and 2014/15 assume a gross uplift of 5.5% offset by 4% efficiency, a net uplift of 1.5%.</td>
<td>Considerable uncertainty in respect of primary care contract negotiations.</td>
</tr>
<tr>
<td>Volume change in acute sector</td>
<td>Percentage uplift down to local circumstances. Need to ensure activity, workforce and finance can be triangulated.</td>
<td>All local assumptions.</td>
</tr>
<tr>
<td>Drugs and devices excluded from the tariff</td>
<td>Assume 10% growth per annum in drugs and devices excluded from tariff in excess of tariff uplift.</td>
<td>Risk that estimate is understated.</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Specialist Commissioning</td>
<td>Assume in line with planning assumption as per Specialised Commissioning Group (SGG) for 2011/12 of flat cash i.e. increase in demand contained within tariff deflator and SCG QIPP. Starting point for 2012/13 plan is 2011/12 outturn.</td>
<td></td>
</tr>
<tr>
<td>Running costs</td>
<td>Each Primary Care Trust to assume they need to achieve, on a cumulative basis, the commissioner management cost target reductions by the end of 2012/13. The management cost reduction to be against the running cost total. Note that allowance has been made for the £2 per head non recurring commitment to Clinical Commissioning Groups in the running cost assessment for 2011/12 and assume this will continue for 2012/13 only.</td>
<td></td>
</tr>
<tr>
<td>Continuing healthcare</td>
<td>Demand growth for adults to be informed by local circumstances. Need to consider impact of children’s continuing healthcare implementation – each Primary Care Trust to assess impact locally.</td>
<td>All local assessments as each Primary Care Trust starts from a different baseline. Need to consider benchmarked position.</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cost shifting from other departments</td>
<td>National assumption of £500 million. Primary Care Trusts to assume weighted capitation share spread evenly over four years For 2011/12, if Primary Care Trusts had clearly assessed the risks from cost shifting and included these in their budget setting then this value can be removed. Please leave in for all later years.</td>
<td>Planning assumption.</td>
</tr>
<tr>
<td>National figure of additional 4,200 health visitors</td>
<td>Assume weighted capitation share of additional health visitors spread evenly over four years. WTE health visitor numbers by Primary Care Trust by year have been included in the final Primary Care Trust planning form distribution.</td>
<td></td>
</tr>
<tr>
<td>Aortic aneurysm screening</td>
<td>Weighted capitation share of £26 million from 2011/12.</td>
<td></td>
</tr>
<tr>
<td>Marginal rate for emergency admissions</td>
<td>Assume current rules continue around 30% marginal rate based on 2008/09 baseline, see Paragraph 4.21 of The Operating Framework for the NHS in England 2012/13.</td>
<td></td>
</tr>
<tr>
<td>Carers funding</td>
<td>Each Primary Care Trust Plan to plan for a weighted capitation share of £400 million by 2014/15 spread evenly over the four years. Primary Care Trusts were able to consider the likely timing of spend on carers in 2011/12 and allow for any unavoidable slippage. However, the recurring commitment each year needs to remain the same with any slippage shown as a non recurring deduction in 2011/12. This will ensure the NHS South West share of the £400 million commitment by 2014/15.</td>
<td>Recognised, valued and supported: next steps for Carers Strategy document. The Operating Framework for the NHS in England 2012/13 Paragraph 2.11 includes details of the expected local processes to agree with stakeholders and publish details of the changes made in carers services.</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hazardous Area Response Teams (HART)</td>
<td>Funding for HART in NHS Ambulance Trusts now in Primary Care Trust baselines. All Primary Care Trusts to include in operating plan with Primary Care Trusts to assume that they will need to pick up costs. Estimated values, Great Western Ambulance Service NHS Trust £3.2 million and South Western Ambulance Service NHS Foundation Trust £2.6 million.</td>
<td>See Paragraph 2.45 of The Operating Framework for the NHS in England 2012/13.</td>
</tr>
<tr>
<td>Public Health transfer</td>
<td>Primary Care Trusts to assume that the public health transfer will be 4% of the recurrent baseline in 2013/14 and the commitments that transfer will be the net spend as per the latest public health return.</td>
<td>Planning assumption, to be confirmed after Primary Care Trust allocations are announced. Additional memo table will be included in the financial plans to understand the funding sources for the public health return ie recurring resource limit / DAT / other NR resource limits.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Primary Care Trusts to plan for their weighted capitation share of £400 million over four years at the rate of £100 million per annum from 2011/12 to 2014/15. Primary Care Trusts to consider the unavoidable slippage in the plans for 2011/12 and show this as a non recurring reduction in spend in 2011/12. A part of this resource will fund the IAPT roll out and the impact of the dementia strategy.</td>
<td>No health without mental health: a cross-government mental health outcomes strategy for people of all ages document. See Paragraph 2.23 of The Operating Framework for the NHS in England 2012/13.</td>
</tr>
<tr>
<td>Issue</td>
<td>Proposed assumption</td>
<td>Status of assumption and any other comments</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rollout of 111 as an alternative to NHS Direct</td>
<td>As per business case – from 2012/13 assume NHS Direct funding not available to support changing service model.</td>
<td>Local prudent planning assumption – further guidance expected.</td>
</tr>
<tr>
<td>Olympics costs 2012/13 only</td>
<td>Affected Primary Care Trusts to assume that any resources required but not funded by Department of Health will be picked up by the Primary Care Trusts as non recurring costs in 2012/13.</td>
<td>Final Department of Health contribution to costs to the confirmed.</td>
</tr>
<tr>
<td>NHS Trust exceptional PDC</td>
<td>All former financially challenged NHS Trusts to assume no exceptional PDC will be available from 2012/13 onwards.</td>
<td>Assume that process in 2011/12 will continue in 2012/13.</td>
</tr>
<tr>
<td>NICE guidance</td>
<td>Note that the status of NICE guidance may be amended. Currently, Technology Appraisals are mandatory after three months but other guidance is not. Compliance with Interventional procedure guidance is taken into account by Care Quality Commission and NHS Litigation Authority.</td>
<td>Currently unclear about details</td>
</tr>
<tr>
<td>Former AGW ISTC contract</td>
<td>From 2012/13 Primary Care Trusts must fund all of the guaranteed fixed contract value. The final split between Primary Care Trusts is in the process of being agreed.</td>
<td>Local process underway to determine the final split of the contract values for the affected Primary Care Trusts.</td>
</tr>
</tbody>
</table>
Appendix 3

Process for accessing non-recurring headroom in 2012/13 for Primary Care Trust clusters

This appendix sets out the process for accessing non-recurring headroom in 2012/13 for Primary Care Trust clusters
1. **Introduction**

1.1 This paper will outline the background to the establishment of the recurring headroom in Primary Care Trusts and the process via which the NHS South of England will review applications for the release of non-recurring funds in 2012/13.

2. **Background**

2.1 The NHS surplus strategy adopted over recent years has been replaced with a requirement to have 2% recurrent uncommitted headroom available by the end of 2013/14. It is the expectation that all Primary Care Trusts plan for at least 2% of recurrent uncommitted headroom in 2012/13.

2.2 This strategy ensures that Primary Care Trusts have the financial flexibility to manage risk and where necessary pump-prime and/or put transitional arrangements in place to support the transformational change programme requirements.

2.3 NHS South of England will manage this recurrent uncommitted headroom as a notionally held budget. Where approved by the Strategic Health Authority, this resource will be available for deployment non-recurrently in year to support service transformation and the local quality, innovation, productivity and prevention agenda.

2.4 Examples of the type of non-recurring spend that would be an appropriate use of headroom resources include:

- non-recurring investment that will generate a recurring saving in the next financial year e.g. pump priming QIPP schemes;
- non-recurring costs of change eg redundancies/transitional arrangements to cover fixed costs in the short term;
- other non-recurring costs that will have a financial benefit in later years.

3. **Treatment of 2% headroom for January operating plan submission**

3.1 In the 6/13 January submission each Primary Care Trust is required to demonstrate that it can deliver a balanced plan with no use of the 2% headroom.
3.2 The submission forms on this date ask for an initial indication as to potential uses of the 2% headroom non recurring in 2012/13 to support delivery of the plan. Submission will not mean that this expenditure is approved but will form a key part of the discussions around the robustness of the first submission at the operating plan review meetings in January 2012.

3.3 Use of the 2% headroom can be agreed by the SHA either during the operating plan process or in-year using the process outlined here. The 2% headroom belongs to the relevant PCT. If it is not spent at the end of 2012/13 it can be carried forward and/or will be returned to the PCT the following year through the appropriate mechanism.

3.4 No assumption should be made of any other access to headroom or to SHA funds.

4. Primary Care Trust Application and Review Process in 2012/13

4.1 Each time a Primary Care Trust wishes to access recurring headroom resources they will need to submit an application. There will be a prescribed summary format for applications, however, it is expected that Primary Care Trusts will have more detailed internal business cases which can be appended to the summary pro-forma.

4.2 The following is a description of the summary information that will be required in the pro-forma. The list of issues below should also be covered in each detailed business case:

- details of how and when resources will be committed, including a recurring and non recurring analysis over at least two years. If the resources are being used to pump prime schemes with recurring costs the application will need to clearly demonstrate how and when the schemes become at least cost neutral or produce a surplus;

- details showing how the application represents value for money;

- identification, quantification and mitigation of risks to the delivery of the plan including an exit strategy if the plan does not deliver the expected benefits;

- clear linkage of the application to each Primary Care Trusts QIPP plan showing which prescription and initiative the application will support the delivery of;

- description of the impact of the application on the quality of service being delivered;

- if the application involves changes to other partner organisations service model, volumes or finances then evidence of agreement to the plan by other affected partner organisations.
4.3 Each application must be made in writing by the Primary Care Trust Director of Finance to the appropriate Director of Finance West, Central or East.

5. **Strategic Health Authority Review Process in 2012/13**

5.1 On receipt of each application the NHS South of England will assess the paperwork to ensure it complies with the above requirements and if not will send an additional information request to the Primary Care Trust.

5.2 Once all the required information is available the NHS South of England will review the application and provide feedback to the Primary Care Trust. The feedback will usually be whether the application is approved or not but for more complex applications it may consist of further issues that need to be explored.

5.3 If the application is approved the Primary Care Trust can commit the resources on a non recurring basis and should amend their monthly finance monitoring returns accordingly.

6. **Conclusion**

6.1 This process will ensure that Primary Care Trusts and NHS South of England share an understanding of the non recurring use of recurring headroom which will be a critical factor in managing the changes required through the QIPP process.
Appendix 4

Mandatory penalties tracker

This appendix sets out the arrangements to be used in NHS South of England for monitoring penalties.
Guidance for the Submission of 2012/13 NHS Standard Contracts Mandatory Penalties Template

1. **Background**

1.1 The Operating Framework for the NHS in England 2012/13 sets a clear requirement for stronger contracting, including making effective use of the standard NHS contract and implementing penalties and sanctions where appropriate.

1.2 The new NHS Standard Contract in 2012/13 supports and reflects The Operating Framework for the NHS in England 2012/13 and should be read in conjunction with the Principles and Rules for Co-operation and Competition and the Primary Care Trust Procurement Guide.

1.3 The NHS Standard Contract covers agreements between Primary Care Trusts and all providers delivering NHS funded services. The contract will apply to new agreements from April 2012 for:

- NHS Trusts, NHS Foundation Trusts;
- Independent Sector Providers;
- charitable and voluntary sectors;
- Social Enterprises.

1.4 The NHS Standard Contract includes a number of quality requirements and nationally specified events where breaches should result in a mandatory financial penalty. National events with expected penalties are detailed in Schedule 3 Part 4 of the national contract, and a summary will be circulated by 10 January 2012.

1.5 It is expected that NHS South of England Primary Care Trusts will use the Standard NHS Contract and activate penalties where appropriate.

1.6 As a means of assessing Primary Care Trust performance in terms of contract management, and fulfilment of obligations under the Standard NHS Contract, as well as confirming any monthly changes in resource limit to be applied, NHS South of England is requesting that Primary Care Trusts complete and submit a monthly Mandatory Penalties Template.

2. **Mandatory Penalties Reporting**

2.1 NHS South of England will set up routine reporting of the monthly position in terms of breaches and penalties applied from April 2012 through to March 2013.

2.2 All Primary Care Trusts will report monthly performance in terms of breach numbers and related financial penalties for all events as applicable, and for each provider contract as applicable, using a Mandatory Penalties Tracker.
2.3 The Mandatory Penalties Tracker to be circulated by 10 January 2012 and should be submitted to a central returns mailbox in each geographical patch of NHS South of England on a monthly basis as appropriate.

2.4 The information in the Mandatory Penalties Tracker will be used to inform anticipated reductions in Primary Care Trust revenue and Cash Resource Limits which will be actioned in the following month subject to national reporting arrangements. For example, the fines reported on the July Tracker should be reported as an anticipated resource and cash limit adjustment in the Month 3 FIMS report and will be transacted as an Inter Authority Transfers in the Month 4 FIMS.

2.5 The timetable in Table 1 below will apply for the 2012/13 reporting year.

<table>
<thead>
<tr>
<th>Submission Date</th>
<th>Breach Data for submission</th>
<th>FIMS return</th>
</tr>
</thead>
<tbody>
<tr>
<td>tbc</td>
<td>tbc</td>
<td>tbc</td>
</tr>
</tbody>
</table>

2.6 NHS South of England will run monthly internal validation checks using standard information sources, such as Unify2, Open Exeter, and Health Protection Agency databases. The Performance Management team will discuss and resolve any significant discrepancies or queries with the Primary Care Trust leads on a quarterly basis.
3. **Performance Improvement**

3.1 Mandatory fines will be levied in areas where performance falls short of acceptable minimum standards. It is not appropriate for resources recouped from providers to be spent on other priorities, rather these resources need to be committed to new actions that will resolve the performance issue.

3.2 In order to access any of the mandatory fines that have been levied Primary Care Trusts will need to provide an action plan to NHS South of England that demonstrates how resources would be used in a non-recurring way to resolve the performance issue giving clear timescale and details of spending plans.

3.3 The action plans will be reviewed by NHS South of England after any queries have been resolved, the resources will be transferred back to the Primary Care Trust to spend in line with the agreed actions.

3.4 It should be noted that in some cases the solution to a performance issue may require actions in another part of the health system or the plans submitted may not be approved. In these instances NHS South of England will retain the resources.
Appendix 5

National Performance Measures

This appendix sets out the national performance measures as detailed in The Operating Framework for the NHS in England for 2012/13.
# Annex – National performance measures

## Quality

<table>
<thead>
<tr>
<th>1</th>
<th>Preventing people from dying prematurely</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Ambulance quality (Category A response times)</td>
</tr>
<tr>
<td>-</td>
<td>Cancer 31 day, 62 day waits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Enhancing quality of life for people with long term conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)</td>
</tr>
<tr>
<td>-</td>
<td>Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>Helping people to recover from episodes of ill health or following injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Ensuring that people have a positive experience of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Patient experience of hospital care</td>
</tr>
<tr>
<td>-</td>
<td>Referral to Treatment and diagnostic waits (incl. incomplete pathways)</td>
</tr>
<tr>
<td>-</td>
<td>A&amp;E total time</td>
</tr>
<tr>
<td>-</td>
<td>Cancer 2 week waits</td>
</tr>
<tr>
<td>-</td>
<td>Mixed-sex accommodation breaches</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>Treating and caring for people in a safe environment and protecting them from avoidable harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Incidence of MRSA</td>
</tr>
<tr>
<td>-</td>
<td>Incidence of <em>C. difficile</em></td>
</tr>
<tr>
<td>-</td>
<td>Risk assessment of hospital-related venous thromboembolism (VTE)</td>
</tr>
</tbody>
</table>

## Resources

- Financial forecast outturn & performance against plan
- Financial performance score for NHS trusts
- Delivery of running cost targets
- Progress on financial aspects of QIPP
- Acute bed capacity
- Activity (eg Elective and non-elective consultant episodes; Outpatients; Referrals)
- Numbers waiting on an incomplete Referral to Treatment pathway
- Health visitor numbers
- Workforce productivity
- Total pay costs
- Workforce numbers (clinical staff and non-clinical)

## Reform

- **Commissioning Development**
  - % delegated budgets
  - Measure of £ per head devoted running costs
  - % authorisation of clinical commissioning groups
  - % of General Practice lists reviewed and "cleaned"

- **Public Health**
  - Completed transfers of public health functions to local authorities

- **FT pipeline**
  - Progress against TFA milestones

- **Choice**
  - Bookings to services where named consultant led team was available (even if not selected)
  - Proportion of GP referrals to first outpatient appointments booked using Choose and Book
  - Trend in value/volume of patients being treated at non-NHS hospitals

- **Information to Patients**
  - % of patients with electronic access to their medical records