Forward

**Focus on Quality**
changes to payment system, e.g. ‘best practice’ tariffs

**Risk Management**
marginal rates to encourage better demand management
all organisations to register with CQC

**New System**
more services closer to home, less activity in acute sector
organise service differently, deliver care in new ways

**Integration**
Integration of services; Integration of organisations
Reduce overheads and management costs

1. Chapter 1 – Overall Context

Five-year vision for the NHS set out in ‘NHS 2010-2015: from good to great’ of which the 09-10 Operating Framework represents first year of this vision.

- PCT Allocation uplift in 2010-11 = 5.5%
- £15 - £20 billion of savings required by 2013-14
- 2010-11 growth to be used to invest in radical changes
- 18-week healthcheck & treatment and 2-week cancer wait delivered by 1 April 2010
- CQC registration for all organisations in 2010-11
- Push for all secondary and tertiary care to be delivered by FT remains (where does NEAS sit?)
- Proposed National Care Service – develop arrangements with Las
- Equality Bill in early 2010 – ‘age equality in health and social care’
- New cross-border and patient mobility guidance – early 2010

2. Chapter 2 – Priorities

- Still a focus on improving performance in failing organisations

**National Priorities**

- Five national priorities:
  - Improving cleanliness & reducing HCAIs
  - Improving access (18-week treatment referral pledge; OOH access to GPs)
  - Keeping adults & children well, improving health & reducing inequalities
  - Improving patient experience, satisfaction and engagement
  - Emergency preparedness

- **Improving Cleanliness:**
  - Continued emphasis on reducing MRSA and *clostridium difficile* infection rates
  - New ‘cd’ standard to be implemented from April 2011. *Nb: No mention of ambulance vehicle hygiene or any new standard for vehicle cleaning – need to be aware of what Commissioners will expect.*

- **Access:**
  - 18-week waiting times
- Re-iterate that achievement of 18-week standards are expected for all specialties
- Removed 3 month target for ‘revascularisation’ – now within 18-week target
  o **Primary Care Access**
- PCTs to progress ensuring GP practices extend hours to evenings/ weekends
- Where GP services are not provided PCTs can commission other services – possibly outside local boundaries (new framework agreement being drafted). *Nb: Impact on Urgent care transport and PTS patient flows (cross-boundary referrals increases) – needs to be modelled. Opportunity – home care / OOH urgent care service development?*

**Keeping adults & children well, improving health, reducing inequalities**
- Aim to reduce demand for acute service and health inequality
- Particular emphasis on heart disease, cancer, children & maternity
  o **Stroke**
    - Require health economies to ensure more patients receive scans within 1 hour of admission. *Nb: Expect more FAST campaigns with consequent increases in A&E demand?*
  o **Cancer**
    - Commissioners to ensure capacity exists to meet requirements for screening services and 31-day radiotherapy standards. *Nb: Is there likely to be any impact on our PTS demand patterns? Who manages PCT screening lists – can we offer a service?*

**Experience, satisfaction and engagement**
- Patient views will be required in Quality Accounts
- Payments within CQUIN will have a ‘patient experience’ element
- Staff health and well-being improvements - ‘The Boorman Review, 2009’ – to save NHS £555m nationally *Nb: HR need to identify improvements that can be fed into our long-term CIP. Opportunity – income stream additional services to local NHS by Occ Health*
- Need to set targets for reduction of sickness absence over 2010-11 and improve sickness information input to ESR
- Need ‘health and well-being’ and ‘organisational health’ strategies

**Emergency preparedness**
- Focus on CBRN, terrorism, fuel/ supplies disruption, flooding, public health
- Ensure pandemic plans are reviewed, tested and updated
- PCTs to have plans for ‘vaccination clinics’ – *Stores resilience?*

3. **Chapter 3 – System Levers And Enablers**

Aim to provide a health care system with the following characteristics:
- More care closer to home
- Fewer acute beds
- Reduced unit costs
- Reduced variations
- More standardisation of care pathways
- Early intervention
  - People taking more ownership of their health

- Five key levers and enablers identified:
  - Financial framework
  - Incentives and business rules
  - Workforce
  - Commissioning and system reforms
  - Informatics
- **The Financial Framework**
- **Management of NHS revenue surplus**
  - Aggregate surplus of SHAs and PCTs for 2009-10 c/f to 2010-11
  - Planned £1 billion surplus in 2009-10 (1% of NHS budget)
  - At least 2% of 2010-11 regional funding will be available to be deployed non-recurrently in year on service transformation developments
  - Expect any 2010-11 surplus will be c/f for spending in next CSR period (2011-12 to 2013-14) – but at a rate determined by SHAs.
  - A requirement throughout the next CSR period for PCTs to set aside 2% of their resources for use on the non-recurring costs of service transformation. *Nb: NEAS to consider setting aside a similar ‘non-recurring service transformation’ budget from 2010-11?*

- **Revenue and capital allocations**
  - PCT allocation growth in 2010-11 to be 5.5%
  - ‘Flat real revenue allocations’ for 2011-12 and 2012-13
  - Capital – no changes planned to PCT or Trust schemes but expect a reduction in funding over next CSR period from 2011-12 (‘capital constraint’).

- **SHA bundle and central allocations**
  - Small growth (0.8%) in central initiative budgets held by SHAs for local implementation

- **Improvements in financial management**
  - 2010-11 financial plans must be compliant with IFRS
  - All organisations must achieve minimum ALE requirements

- **Efficiency management**
  - Re-iterates the Operational Efficiency Programme (OEP) requirements that all NHS organisations should
    - ‘rigorously consider’ how to reduce back-office costs (CIP scheme identified)
    - Required to publish benchmarking data using UK Audit Agency ‘value for money indicators’ for back-office functions (DH to issue guidance)
    - Explore more collaborative procurements arrangements (50% of procurement spend through such methods by the end of (2010-11)
    - Develop plans to reduce estate costs and emissions. (New tool available April 2010 – the ‘NHS Premises Assurance Model’)

- **Incentives and business rules**
  - **Tariff structure 2010-11**
    - Design to incentivise providers, maximise efficiency and improve quality of care
    - Encourage providers and commissioners to share responsibility for care pathways
    - Shift care from hospital to community settings
    - Best practice tariffs introduced in 10-11 for two elective & two emergency services
    - Mental Health PbR currency for local use launched in 10-11
    - CQUIN income for 2010-11 represents up to 1.5% of contract income
    - From 2011-12 PCTs will be able to withhold up to 10% of contract payments if providers fail to meet patient satisfaction goals
    - Uplift for 2010-11:
      - 0% uplift in national tariff prices
      - Includes an efficiency requirement of 3.5% to ‘offset’ the inflationary impacts of pay and prices. *Nb: Assumption, therefore that income uplift is 3.5% - 3.5% efficiency = 0% net*
    - Uplift for 2011-12 to 2013-14 = maximum of 0%
    - Expected efficiency target will rise from 11-12 to 13-14 (rates not explicitly identified)

- **Marginal rates for activity variations**
- Income to be earned from activity levels above contract to be capped at 30% \( Nb: \) Refers to 30% of the ‘relevant emergency tariff’ so confirmation is required from Commissioners on whether they will seek to apply this margin to non-tariff over-activity (e.g. on services such as A&E transport)

- Activity baseline to be used is 2008-09 emergency activity outturn \( Nb: \) Again not explicit if this would impact on non-tariff services. If it did, NEAS would receive less in contract for 10-11 for both its 08-09 over-activity and 09-10 predicted over-activity – Commissioner intentions to be sought; financial impact to be modelled

- PCT expenditure saved through applying this marginal rule to be used for risk management and service transformation investment
  
  o Other tariff issues
  
  - From 2011-12, national tariff = maximum price rather than mandated price

- **Workforce**
  - **Pay**
    
    - 2010-11 – final year of current pay agreement stands at 2.25% \( Nb: \) No information on likely awards beyond 2010-11, but pre-Budget report specifically identified maximum public sector pay uplifts of 1% from 2011-12. No information on increments – assumption that they will continue as per Agenda for Change

  o **Workforce flexibility**

    - To avoid redundancies organisations must enable easier transfers between employers in both health and social care economies, improve collaborative arrangements and use the NHS Staff Passport toolkit (HR to investigate whether applicable)

  o **Management and agency costs**

    - Seek to reduce the proportion of NHS resource expended in these areas
    - SHA – target 30% reduction in management and agency costs by 2013-14 \( Nb: \) Expect NEAS to be included in this target – but need clarity in terms of definitions and level of saving contribution expected over the next four years to 2013-14
    - Use of ESR must be consistent to allow comparisons with other organisations
    - Final Accounts must include details of management costs, consultancy costs and spend on agency costs

  o **Education, training and professional regulation**

    - Review training plans and align with local clinical ‘visions’
    - Review/ reduce the number of pre-registration commission for allied health professionals \( Nb: \) Do we need to bring in students paramedic training contracts immediately?
    - Invest in better re-deployment of staff where necessary
    - Review of MPET – improved metrics; introducing a ‘tariff for education’ \( Nb: \) Phased in from 2011-12, until then SHA will continue to fund MPET on a discretionary basis
    - PCTs to seek assurance of an appropriately regulated clinical workforce (patient safety)

  o **Commissioning and system reform**

    - PCT commissioning plans to be assessed through WCC assurance
    - Strengthening joint PCT commissioning with local government and other public partners (police, housing, education) to stimulate efficiency, innovation and better services
    - Revised standard NHS contracts to be published for 2010-11 covering:
      
      - Hospital services
      - Community services
      - Mental health services
• Ambulance services
- Care homes standard contract to be published July 2010
- New service-delivery models, greater co-operation between providers within the NHS and across sectors enabled by:
  ▪ Simplifying merger, acquisition and joint venture processes
  ▪ Expect all remaining MH and acute trusts to be FTs by end of 2013-14
  ▪ Social enterprises – to improve pump-priming of new services through the Social Enterprise Investment Fund (Are there opportunities here?)

  o Transforming Community Service
- PCT commissioning plans to be assessed through WCC assurance
- Opportunity for vertical and horizontal integration to transform community service provision – not just Community FTs
- PCTs must provide SHA with proposals for future organisational structure of current PCT-provided community services by March 2010
- Any provider change will provide more integrated primary, community and secondary care

4. Chapter 4 – Planning
- DH initial collection of SHA 2010-11 plan due 29 January 2010
- DH will review the full submission of SHA plans by 26th March 2010.
- All NHS providers must ensure compliance with levels of quality and safety detailed by the CQC.
- Performance monitoring – driven by existing frameworks such as
  ▪ CQC’s periodic review
  ▪ Monitor’s compliance framework
  ▪ NHS performance framework
  ▪ WCC
- CQC review – assess performance against national priorities set out in the 10-11 NHS Operating framework and measured against existing commitments & ‘Vital Signs 1 and 2’
- Should be an ambition to identified by CQC as a high performer
- Ongoing registration with the CQC required
- Expect links with ‘Total Place’ pilots – aimed at a cross-sector approach to local collaboration to improve productivity/ efficiency and service quality

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