The NHS Operating Framework and update on clinical commissioning groups

Date: 05 December 2011

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Overview

The Operating Framework sets out the Department of Health’s planning, performance and financial requirements for the NHS in the coming year. It has four key themes:

- Quality – putting patients at the centre of decision making in healthcare, preparing for an outcomes approach to service delivery, meeting standards and improving dignity.
- Reform – completing the transition to new NHS systems, building the capacity of clinical commissioning groups and supporting the establishment of health and wellbeing boards so they become ‘key drivers of change’ and ‘local system leaders’ across health social care and public health.
- QIPP – increasing the pace on the quality, innovation, productivity and prevention challenge. This has focused on central actions such a reducing administration costs, but in future will need to build on this with clinical service redesign.
- Service and financial performance – the framework identifies a ‘limited’ number of key performance measures that will be subject to national assessment and sets out financial rules and efficiency requirements for the coming year.

The Operating Framework repeats existing measures identified in previous frameworks such as requirements relating to cancer, mental health, and reducing mixed-sex hospital accommodation. It also contains technical requirements on performance and finance. Rather than covering these issues, the main body of this briefing will focus on selected issues that are of relevance to local authorities, and issues that are proving problematic in some areas, such as the development of clinical commissioning groups (CCGs).

There are some welcome elements in the framework for local authorities, such as the focus on dementia and carers, suggestions that PCTs could be using reablement funding for social care services, and the importance of health and wellbeing boards.
Some of the measures relating to CCGs and payment by results demonstrate the complexities and nuances of NHS reform.

**Briefing in full**

**Measures of particular interest to local authorities**

The Operating Framework highlights a number of areas ‘requiring particular attention’ from commissioners and providers. Those of particular interest to local authorities are dementia/care of older people and carers.

In relation to dementia, the requirement to produce plans with local authorities continues this year. There should also be efforts to ensure providers are compliant with NICE quality standards, GP practices should make improvements so that people only access hospital if it will provide the best clinical outcome, and there should be initiatives to reduce a two-thirds overall reduction in the prescription of anti-psychotic drugs.

On the subject of carers, the framework indicates that following a joint assessment of local needs, PCT clusters need to work with councils to agree and publish plans and budgets in line with the carers strategy. Plans to support carers must:

- be explicitly signed off by councils and PCT clusters
- identify the financial contribution of both organisations and ensure that any transfer of funds from the NHS to local authorities is through a section 256 agreement
- identify how much of the total expenditure is spent on carers’ breaks
- identify an indicative number of breaks that should be available within the funding
- be published on the PCT website by 30 September 2012.

Some health commentators had speculated that the system in which commissioners need not reimburse hospitals for readmission within 30 days of discharge following elective surgery (highly unpopular with providers) may be relaxed. The operating framework has not done this. Savings from this non payment should continue to be invested in initiatives such as reablement and post discharge support, and NHS commissioners should work with local providers, GPs and councils on this. The DH will seek confirmation of how the savings are used.

On safeguarding, PCT clusters should ensure a ‘sustained focus’ on robust arrangement, working in partnership with local safeguarding boards and working with CCGs to support them in preparing for their safeguarding responsibilities.

On the transfer of public health, the framework indicates that PCT clusters should maintain ‘appropriate investment’ in public health services throughout transition, e.g.
screening and immunisation programmes as well as maintaining progress on obesity and alcohol related harm. Progress on the following areas will be monitored nationally – number of four week smoking quitters and NHS healthchecks. PCT clusters must ensure that the public health transition elements of their plans for 2012-13 are supported by local authorities, to ensure that they have a good understanding of the basis on which they will take on responsibilities from the following year.

Health and wellbeing boards (HWBs) are identified as central to the new system, providing local system-wide leadership across health, social care and public health. They will operate in shadow form from April 2012 and will be statutorily operational from April 2013 (subject to the Health and Social Care Bill). SHA and PCT clusters should encourage CCGs to play an active part in their formation, including participation in the programme of accelerated learning sets. HWBs will contribute to the CCG authorisation process and will ‘play a part in supporting the NHS Commissioning Board in holding CCGs to account’. NHS organisations need to be active leaders in work on joint strategic needs assessments (JSNA) and joint health and wellbeing strategies (JHWS). Emerging CCGs must explicitly support the PCT cluster plan for 2012-13 and build on this for their planning from 2013-14. Plans should reflect the outcomes of JSNA and JHWS and support integration of delivery.

PCT revenue allocations will be announced in December 2011 and will include the funding to be transferred to local authorities for social care services of benefit to health. Transfers will need to be made via agreement under section 256 of the NHS Act 2006. Shadow allocations for CCGs and shadow grants for local authorities’ new health responsibilities will be published after the PCT allocations.

PCT clusters will need to work together with local authorities to agree joint priorities, plans and outcomes for the investment of money allocated to PCTs for reablement in 2012-13. This could include extending current services such as telecare, community-directed prevention (e.g. falls prevention), community equipment and adaptations and crisis response services. (In the framework’s section on quality it advises PCTs and councils to consider investment in telecare and telehealth in light of emerging positive findings from the whole system demonstrator programme.) Investment could also be in new services such as funding the social care aspect of the national dementia strategy, impacting on delayed discharge though developing post discharge care and support services which are the responsibility of social services.

Access and finance

In recent weeks a number of concerns about access to healthcare have been discussed in the media. For instance, if the 18 weeks referral to treatment target is missed for a patient there is no incentive to make sure the person is seen as quickly as possible, so in some hospitals people have been put on lengthy ‘planned waiting lists’ sometimes called ‘hidden’ lists. An analysis published in the Health Service
Journal (HSJ) showed that around 20,000 people had been on elective lists for more than a year, with just six hospitals accounting for around half of these.

The framework indicates that this is not acceptable and that all organisations must review their planned waiting lists for all specialities and diagnostic services by December 2011; also patients should only be added to such lists if there are clinical or personal reasons why they cannot have a procedure until a certain time.

Another issue causing concern has been blanket bans by some PCTs on particular treatments and requiring minimum waiting times from providers. The framework makes it clear that patients should be seen on the basis of individual clinical need and that blanket bans on treatment and minimum waiting times are not justified.

The framework discusses the rules for payment by results (PbR) – a set tariff for types of NHS activity e.g. hip replacement. There had been an expectation that rules would be relaxed to allow, for instance, block contracting, to drive down costs and limit activity. The NHS Future Forum had also called for flexibilities. However, the framework stresses that current national rules for PbR are mandatory. Local variations can only be made where commissioners find that the rules prevent them from doing the best for patients. In response to concerns about providers cherry-picking types of patients, the framework indicates that commissioners are required to adjust the tariff price if the provider is incurring lower costs than the average of the tariff category.

Health Service Journal reports that John Appleby chief economist of the Kings Fund indicates that this was ‘in effect, going back to a maximum price’ leading to price negotiation. The DH has denied that it is introducing price competition, saying that price can only vary in relation to quality. However, it does seem that messages are not exactly clear and are likely to lead to interesting local contract discussions.

Development of CCGs

Configuration

The framework says that ‘as far as possible CCGs should be coterminous with a single health and wellbeing board’ (3.11). However, it is still possible for there to be more than one CCG within a council’s borders and some may cross boundaries. HSJ reports an interview with NHS Chief Executive & NHS Commissioning Board Chief Executive designate Sir David Nicholson saying that around 85 percent of CCG boundaries will match councils, and for the remaining 15 percent this will be a ‘matter for local determination’. HSJ also reports that a letter from Health Minister Earl Howe to peers examining the Health and Social Care Bill indicates that ‘CCGs should not normally cross the boundaries of unitary or upper tier local authorities … this is not intended to preclude the possibility of a single CCG covering an area greater than one local authority area’ – in which case each CCG would have to be a member of any HWB that covers part of its border. The letter also indicates that the government expects CCGs to be made up of neighbouring GP practices, not disparate practices from different areas or spread across the country (as a few CCGs are proposing).
The framework indicates that running cost allowances for CCGs are expected to be £25 per head of population per annum before any entitlement to a quality premium. The size of this allowance is linked with the viable size of a CCG. Recent speculation has been that there could be a minimum size of 200,000 people per CCG. The latest view, informed by DH supported work by the Clinical Commissioning Alliance, is that the minimum could be 100,000. The framework indicates that SHA clusters should be supporting practices and emerging CCGs to resolve configuration issues. SHA clusters should ‘be confident’ by the end of January that any outstanding issues can be resolved by the end of March 2012.

The current position is that many CCGs are not coterminous with councils and 63 of the 257 pathfinders have populations of less than 100,000. Some are already planning to merge or federate – for instance nine of the twelve possible CCGs in Birmingham are planning this. Many cities have negotiated down to one or two consortia.

Support

The framework indicates that PCT clusters must assist CCGs to full authorisation by the NHS Commissioning Board. They should also explore and develop commissioning support for CCGs from a range of suppliers which might include the independent sector, voluntary organisations and local authorities. They must demonstrate that they are allocating commensurate running costs and staff to support emerging CCGs.

The issue of support to CCGs is proving controversial with a whole range of conflicting drivers, all of which ultimately impact on PCT staff. In the summer PCTs were instructed to assign four managers in specified roles to CCGs and the operating framework reinforces the need to assign staff. If staff are transferred, it is likely that TUPE (protected employment) rules will apply.

PCT clusters are also setting up commissioning support units to provide support to CCGs. The aim is that ultimately these will run as independent enterprises. Draft guidance circulated in the NHS, suggests that support units could be hosted at arms length by the NHS Commissioning Board until no later than 2016. The DH will set up a business development unit intended to help the switch to stand alone units as soon as possible with a view to prospective support units developing business plans.

HSJ has covered different views about this topic, and developing versions of DH guidance. Organisations supporting the independence of CCGs, such as the Clinical Commissioning Coalition, are calling for them to be able to choose their support (e.g. from the independent sector or different PCT clusters) as soon as possible. While stressing the importance of choice, it seems that DH is keen to maintain PCT commissioning expertise – to retain capability and continuity, but also possibly to avoid redundancy bills if CCGs choose support from elsewhere. Some PCT boards also appear reluctant to transfer staff because although they would be transferred under TUPE arrangements, ultimately if this could lead to them being made redundant, if the CCG chooses independent support.
POLICY BRIEFING

The latest version of the guidance highlights the potential for joint working between commissioning support suppliers – for example joint ventures – and emphasises the role of local authorities.

Comment

It is well known in the NHS that anything not mentioned in the operating framework goes to the bottom of the priority list, and that the more prominent the coverage, the more likely an issue will be addressed. Therefore it is helpful to see dementia and carers as particular areas requiring attention. It is particularly welcome that the DH has listened to longstanding concerns from carers’ organisations about the need for PCTs to account for the expenditure on carers’ breaks.

It is also helpful to see mention of PCTs maintaining the level of their public health budgets and some national monitoring of activity. The ultimate budget and allocations are of course crucial. Early information from a freedom of information request by HSJ suggests that it will not be lavish (see health, social care and public health round up October and November). It would seem advisable that local authorities and joint DsPH should maintain local awareness of PCT budgets and activity (also, JDsPH will no doubt wish to be aware of local authority budgets for functions which impact on health).

The configuration of CCGs is clearly a pressing, and in some areas difficult, issue which local authorities will be seeking to influence – as far as is possible. There need to be good reasons for any CCGs seeking to cross council boundaries and councils, with health and wellbeing boards which will be formally involved in authorisation, will wish to assure themselves that this would benefit communities and citizens rather than organisational convenience. A useful discussion of the issues involved appears in the Clinical Commissioning Coalition paper.

The framework indicates that the NHS at the end of 2012-13 will ‘look and feel’ very different from how it does today. It can only be hoped that it will no longer reflect the complexity and uncertainty of this transition time.

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