The Government has published its revisions to the Operating Framework for the current financial year. They aim to support a health service that puts patients at the heart of decision making, focuses on quality and outcomes over processes and has more devolved responsibilities. Alongside changes to existing targets and priorities, the document outlines policies in areas such as reconfiguration, payment systems, management efficiencies and the future of community services. These reforms appear to be laying the foundations for “substantive systemic changes” to come in the Operating Framework for 2011/12.

This Briefing highlights the key points from the paper.

Overview

The revision to the Operating Framework sets out a number of changes that reflect the new Government’s desire to remove process targets, devolve responsibilities and focus on quality and outcomes. The document covers revisions to five areas including:

- vital signs
- reconfiguration
- transforming community services
- finance and efficiencies
- accelerating development of the payment system.

Although the document focuses on a small number of areas, it highlights further areas where change can be expected. These changes, which are signalled to be radical and far reaching, will be set out in the NHS Strategy, expected in July 2010.

Primary care trusts (PCTs) should continue to work towards their existing commitments in their operational plans.

They will be expected to collaborate more effectively with local authorities to drive improved patient outcomes and should make better use of Secondary Uses Services, placing a demand on providers to ensure their data is of an improved quality.

An evaluation will be undertaken to determine whether revisions to the NHS Constitution are required.

The Department of Health (DH) will stop performance managing the 18 week referral to treatment objective. However, commissioners are expected to “maintain their contractual position” for the remainder of the year and data will still be published.

While some process targets will be discarded, the Government emphasises that this move cannot be used as an excuse to allow longer waiting times to develop.
Reconfiguration

While the Government has announced a moratorium on “future and ongoing” reconfiguration schemes, the document confirms that plans for trauma care and paediatric cardiac surgery will proceed.

Reconfiguration proposals are expected to pass four tests in order to continue:

- endorsement from GP commissioners
- robust patient and public engagement
- clear clinical evidence
- remaining in tune with both current and prospective patient choice frameworks.

The Secretary of State may refer cases to the Independent Reconfiguration Panel if he feels that the four tests have been insufficiently applied.

Transforming community services

The separation of PCT commissioning from service provision “must be achieved by April 2011.” Therefore, PCTs are expected to proceed with the development of their plans, ensuring that the agreed structure complies with the aims of the NHS Strategy, which will be published shortly. Guidance on the approval process and timescales involved will be issued soon after this. A staff membership foundation trust model might be added to the list of potential solutions for PCTs to consider.

The Government is keen to alleviate barriers to entry for independent and voluntary sector providers of community services, with the objective of moving towards an Any Willing Provider model.

Management costs

Concern is expressed about the growth in management costs at strategic health authority (SHA) and PCT level (contained in the draft accounts for 2009/10), which have now reportedly reached around £1.85 billion. Therefore, “each SHA region must now go further and faster” to deliver management cost reductions. The ceiling for 2013/14 has been set at £1,006 billion (compared to £1,509 billion in 2008/09), with SHAs provided with a measure of autonomy for meeting this goal. Savings of at least £222 million in 2010/11 and at least £350 million by the end of 2011/12 are expected. It is anticipated that the delivery of such efficiencies will help to address the current variance in per capita management costs.

Freezes across Government have been implemented on new consultancy, marketing and ICT spending, civil service recruitment and central procurement for goods and services. A new Efficiency and Reform group will be responsible for overseeing this. NHS organisations are expected to “demonstrate similar discipline across these areas.”

The above efficiencies should be achieved in addition to the

Local prioritisation

Three areas are highlighted for greater prioritisation:

- care for military veterans
- delivery of the National Dementia Strategy (PCTs and partners are expected to report on the actions they are taking, although with no central requirements on the format)
- mixed-sex accommodation (capital scheme guidance to be revised in an effort to widen availability of single rooms).
The key question is whether any social care funding will be made available to meet this or whether there is an expectation that NHS funding will be used to meet social care requirements.

Paragraph 31 takes this even further. We had assumed that hospitals would remain financially responsible for readmissions for the same reason as the original admission within 30 days. However, the revision to the Operating Framework states that hospitals will be responsible for patients for 30 days after discharge…“making hospitals responsible for a patient's ongoing care after discharge will create more joined-up working…” This appears to make the hospital responsible for readmission for causes over which it may have no control. The unintended effect could be to delay discharge and to confuse whether the GP or the hospital consultant is accountable for the ongoing care of the patient: discharge means handing responsibility back to the GP, not the consultant maintaining ongoing responsibility. This is to be left to local discretion but if it is to work beyond the relatively simple area of surgery there needs to be clarity about who is managing the patient and a redesign of the tariff.

The previous announced requirement that SHAs and PCTs should deliver a £1 billion aggregate surplus in the current financial year.

**Payment system**

The Government envisions that its reforms to the payment system will ensure that it will become “an increasingly vital means of supporting quality and efficiency.” Tariff guidance for 2011/12 will be published later this year, including a range of pathway (or year of care) tariffs. The emphasis will be placed firmly upon outcomes, with payments aggregated across patient pathways and across service sectors.

A specific tariff reform discussed in the document is centred on re-ablement and post-discharge care. This is perceived as enabling acute providers to work effectively with GPs and local authorities to deliver coordinated care and ensure patients are discharged appropriately. The DH would be grateful for submissions from interested organisations to help with the formulation of best practice in this area before April 2011.

**Discharged patients**

Providers and commissioners are both expected to apply the guidance regarding hospital responsibility for discharged patients1 from 1 December 2010 if they have not already done so. The way in which non-payment for additional treatment should be managed is to be determined by local health economies in consultation with GPs and local authorities. Initial analysis suggests that the full effect of these changes could create an additional 1.7 per cent cost pressure on acute trusts.

**Confederation viewpoint**

While there are not many surprises in the revision to the Operating Framework, it signals an important change of direction and has significant implications for NHS organisations.

The removal of some targets will allow for more imaginative solutions to improving performance but does carry some risks that performance will drift. It will be important to hold onto the performance improvements that have been made for patients and to avoid the typical cycle of *laissez-faire*, followed by rigorous performance management.

The additional management cost requirement, while widely flagged, does raise a question about how much resource might be available to support GP commissioning groups and about the ability of the system to hold the line on finance and performance over the next couple of years with a significantly depleted management resource.

Perhaps the most surprising elements of the new framework come in paragraphs 29 and 31. In paragraph 29 on re-ablement there is a strong implication that the tariff will include social care.

**“The revision to the Operating Framework signals an important change of direction and has significant implications for NHS organisations”**

Paragraph 31 takes this even further. We had assumed that hospitals would remain financially responsible for readmissions for the same reason as the original admission within 30 days. However, the revision to the Operating Framework states that hospitals will be responsible for patients for 30 days after discharge…”making hospitals responsible for a patient’s ongoing care after discharges will create more joined-up working…” This appears to make the hospital responsible for readmission for causes over which it may have no control. The unintended effect could be to delay discharge and to confuse whether the GP or the hospital consultant is accountable for the ongoing care of the patient: discharge means handing responsibility back to the GP, not the consultant maintaining ongoing responsibility. This is to be left to local discretion but if it is to work beyond the relatively simple area of surgery there needs to be clarity about who is managing the patient and a redesign of the tariff.
that recognises that some readmission is unavoidable and the consequence of sensible clinical risk management.

The document overall brings together a number of previously announced or trailed policy initiatives and some exacting additional management cost and reconfiguration requirements. The context for many of the requirements set out in the Operating Framework lies in the new NHS Strategy white paper expected in early July. The strategy, its accompanying documents to be published over the next two to three months, and the comprehensive spending review expected in the autumn, will provide a framework for extensive changes to the way in which healthcare is commissioned and provided in the NHS in England.

For more information on the issues covered in this Briefing, contact nigel.edwards@nhsconfed.org

References
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_110107