

Operating framework 2007/8

In December 2006, the Department of Health issued its second 'operating framework', *The NHS in England: The operating framework for 2007/08* (Department of Health 2006f), which provides a set of rules and guidance for NHS organisations in England for the year ahead. Aimed primarily at managers and clinical staff, the operating framework for 2007/8 is the latest in a series of explanatory documents that aim to explain the purpose of NHS reforms and add detail on how those reforms should be carried out.

This briefing outlines the main points in the operating framework for 2007/8 and provides some analysis of the content. In addition, it discusses the implications of two of the accompanying documents recently issued by the Department of Health. The first of these documents focuses on the new model contracts (Department of Health 2007b), the second, on care and resource utilisation (Department of Health 2006b).

Priorities for 2007/8

The operating framework for 2007/8 sets out four key priorities for the NHS over the coming year: to achieve the 18-week target; to reduce rates of health care associated infections; to reduce health inequalities; and to achieve financial health.

The 18-week target

The aim of the 18-week target is for all patients to be treated within 18 weeks of referral by their GP. Although the target is not due to be met in full until the end of 2008, the operating framework states that by the end of the next financial year in March 2008, 85 per cent of patient pathways ending in admission to hospital should be completed within 18 weeks, as well as 90 per cent of pathways that do not involve an admission (such as fitting a hearing aid). This challenging milestone reflects a concern that meeting the overall target is not going to be straightforward for the NHS. The target for inpatient treatment will be particularly challenging. The latest data from a baseline exercise conducted by the Department of Health in October 2006 suggests that around 35 per cent of patients admitted for inpatient or day case treatment are treated within 18 weeks, compared with 'between 70 and 80 per cent' of patient pathways that do not involve an admission to hospital (Department of Health 2006a, 2007a).

The operating framework allows PCTs to impose penalties on hospital providers that underperform against the 18-week milestone. These penalties are intended to be embedded into contracts between the two parties and provide PCTs with a key piece of leverage to use in their relationships with providers.

Health care associated infections

The operating framework also allows PCTs to set local targets for reducing health care associated infections in their contracts with providers. These targets apply to both MRSA infection rates (which have fallen from a peak in 2003/4 but are still only slightly lower than in 2001, when surveillance became mandatory), and to *Clostridium difficile* rates (which increased by more than 17 per cent between 2004 and 2005). There are currently no national targets for *Clostridium difficile*, although the government has set a Public Service Agreement (PSA) target for hospital providers to reduce MRSA rates by 50 per cent by 2008, compared with the baseline rates of 2003/4. However, the latest progress report by the Health Protection Agency (2006) remarks that, overall, there is 'little movement towards the target'.

Health inequalities

Achieving the PSA targets on reducing health inequalities are also proving challenging for the NHS (Department of Health 2006a) and have become a priority in the operating framework. Specifically, the framework encourages PCTs to focus efforts on interventions that 'evidence shows can have the biggest impact on reducing health inequalities' and promises a national support team for the areas 'that are most challenged'.

Financial health

The operating framework reiterates the need for the NHS as a whole to return to 'net financial balance' but also says that the NHS should generate a surplus of £250 million. It recognises that a 'handful' of organisations will remain in deficit, but states that the size of the gross deficits should be significantly reduced. In particular, the framework looks at some of the issues surrounding 'resource accounting and budgeting' (RAB) for NHS trusts. However, it provides no immediate prospect of reversing the policy. This government-wide public accounting principle has been inconsistently applied across the NHS, but in some cases, has led to trusts in deficit being penalised twice. This is because, under RAB principles, they are required to make up their previous year's overspend with an income that has been reduced by an amount equivalent to the previous year's deficit. The operating framework concedes that RAB is problematic, not only because of the inconsistent way it has been applied, but also because it both conflicts with the principle of payment by results (whereby income should be linked to activity) and does not apply to foundation trusts. Although the framework does not accept the need for a reversal of RAB yet, it promises to review the issue again in the future.

The operating framework also announces the creation of a borrowing regime to replace the capital allocations scheme. This is to prevent the 'leakage of cash' from capital to revenue budgets, which was technically outlawed from 2004/5. In addition, cash 'brokerage' between trusts will be replaced by a more transparent system of loans. Generating strategic reserves by top-slicing PCTs should take place on a smaller scale than last year but will still be used, for example, to 'moderate the impact of RAB'.

NHS reforms

As in last year's operating framework, the 2007/8 framework sets out the rationale behind current NHS reforms and explains how the four key elements of the reforms are designed to improve services. These include: demand-side reforms, such as more choice and voice for patients and improved commissioning; transactional reforms, such as payment by results; regulatory reforms, such as new contracts between PCTs and providers; and supply-side reforms, such as allowing greater diversity of provision.

Demand-side reforms

The operating framework contains no new developments in relation to patient choice other than establishing a milestone for April 2007, by which date 80 per cent of patients are expected to be able to recall being offered a choice of provider (compared with the current level of 35 per cent) (Department of Health 2006e). No milestone has been set for the use of the electronic booking system Choose and Book, which, according to the most recent government figures, is currently used for 28 per cent of referrals (Department of Health 2006d).

Detailed guidance on the commissioning of hospital services has already been published by the Department of Health but the operating framework reminds PCTs of the continuing need to develop community-based treatment alternatives and develop practice-based commissioning (PBC). In relation to the latter, the framework reminds PCTs that the emphasis must be on the 'practical implementation' of PBC – a reflection, perhaps, of the need to demonstrate that there is progress beyond the initial take-up by GPs of the first element of the incentive payment.

Regulatory reforms

The operating framework highlights the importance of the contracts between PCTs and providers as a central mechanism for delivering efficiency and quality improvements, stating that 'the relationships PCTs have with providers will increasingly be based on contracts'. The Department of Health has published long and detailed model contracts (2007c) alongside the operating framework – one updates the existing contract with foundation trusts, the other provides a new contract for acute services provided by all other NHS trusts and the independent sector.

From these it is clear that the new contracts enshrine the right of PCTs to set activity plans with providers and review them on a monthly basis. Deviation from the plan by providers can result in them incurring financial penalties, as can failure to deliver the 18-week targets. The contracts also give PCTs the right to use a variety of 'care and resource utilisation' techniques, which will enable PCTs to control the referral patterns of both GPs and hospitals and to review in detail the referral and utilisation patterns of hospital services, with a view to reforming them. It is clear that a good deal rests on the power of the contracts to deliver change. However, the framework also emphasises that it is important that the 'reforms do not get reduced to a set of contracts or transactions'.

Provider-side reforms

The operating framework has little that is new to say about provider-side reforms apart from reminding PCTs that they should consider commissioning from a wide variety of provider types, including social enterprises.

Transactional reforms: payment by results

The operating framework restates previous agreements with the NHS to increase the national tariff for payment by results by 2.5 per cent in 2007/8 and makes clear that only a few tariffs will be 'unbundled' (split up) to make non-hospital alternatives possible for sections of certain treatment pathways. The framework acknowledges an unwanted consequence of payment by results, whereby 'more accurate' coding by trusts can 'potentially lead to increased payment for no additional activity'. The framework also gives strategic health authorities the right to provide additional financial support for certain trusts on top of their tariff income. In particular, this is intended to help specialist hospitals, which have been encountering problems with the national tariff as a result of the higher costs of treating very complex cases.

Future plans

The operating framework indicates that PCTs are expected to start planning the delivery of some of the targets due in 2009, including the creation of more choice for users of maternity and end-of-life services. It also includes a more general aim for PCTs to continue to conduct needs assessments on behalf of their local populations and, in particular, to make sure that services are tailored to meet the

needs of the different groups identified in the recent equality legislation, which highlights disability, gender, sexual orientation and age in addition to existing obligations on race.

Discussion

As we have seen, the key vehicles for delivering the priorities of the operating framework are the new contracts between PCTs and providers, and care and resource utilisation techniques. More detailed guidance about each of these is presented in two of the documents that accompany the framework: *Guidance on the NHS Contract for Acute Hospital Services for 2007/08* (Department of Health 2007b) and *Care and Resource Utilisation: Ensuring appropriateness of care* (Department of Health 2006b) respectively.

New contracts

The new contracts between PCTs and providers will be particularly important to the delivery of two of the objectives in the operating framework: namely, achieving financial health and reaching the 18-week target. The new contracts are designed to help the NHS achieve financial health by empowering PCTs to keep a tight rein on the flow of money to hospital providers. Not only will this assist PCTs affected by deficits, but it will also provide an essential counterweight to the strong incentives generated by payment by results for providers to increase their activity. The new contract makes clear that PCTs should agree ‘activity plans’ with providers that include unit costs and are scrutinised on a monthly basis. The contract allows PCTs to use financial penalties and other ‘mechanisms’ to ‘mitigate the risk of providers conducting activity exceeding that agreed in the activity profile’ – in other words, to prevent them doing additional work without good reason.

The new contract also allows PCTs to penalise trusts that underperform against the 18-week target. This suggests that the bolstered power of PCTs is designed to act as one of the main levers for the successful delivery of the target. However, as mentioned earlier, the scale of the 18-week challenge only recently became obvious when the baseline data was published for the first time in December 2006 (Department of Health 2007a). From this it was clear that there are still some very long waiting times. Trauma and orthopaedics, for example, is one of the most ‘challenged’ specialties, with only one in five patient journeys currently being completed within the target time (Department of Health 2007a).

Work is still going on across NHS trusts to devise new pathways and other techniques for achieving the reductions in waiting times, but an *increase* in activity is a likely component of any solution. The guidance on the new contract concedes that there might, therefore, be a ‘tension’ between the activity needed to meet the target and the levels previously agreed with PCTs in ‘activity’ plans. To deal with this issue, the Department of Health recommends that PCTs and providers undertake ‘regular review[s]’, and if necessary, amend their activity plans. It will be interesting to see to what extent this ‘tension’ does indeed emerge during the course of the year and whether the drive to achieve financial balance competes with the 18-week target.

Care and resource utilisation techniques

As we have seen, the contract makes reference to various mechanisms that PCTs can use to prevent providers from carrying out higher levels of activity than agreed. These ‘mechanisms’ include Prior Approval schemes and Utilisation Management schemes. Prior Approval schemes enable commissioners to scrutinise clinical decisions, and Utilisation Management schemes allow commissioners to monitor patient flows closely and require providers ‘to participate and cooperate’ with this.

Detailed guidance on these mechanisms is set out in the care and resource utilisation document (Department of Health 2006b). However, there is uncertainty surrounding the workability and impact of some of them – particularly Prior Approval schemes, which will now have contractual force behind them. There is much to be welcomed in the suggested focus of these mechanisms – namely, the drive

to restrict those activities whose clinical effectiveness is questionable (for example, tonsillectomies) and to reduce potentially unnecessary work (such as post-surgery outpatient appointments and abnormally high consultant-to-consultant referrals).

Nevertheless, Prior Approval schemes in particular have the potential to delay treatment, reduce choice, disempower good GPs and add a layer of bureaucracy. It is worth noting that when similar techniques were introduced in US health maintenance organisations (HMOs), they ultimately proved unpopular. This was partly because clinical decisions were often overridden by the HMO payer, partly because of the bureaucracy and cost involved, partly because of delays in treatment while decisions were pending and – pertinently for the NHS – partly because of the infringement on patient choice. In fact, the techniques were so unpopular that there was significant provider and consumer ‘pushback’ involving legal challenges to outlaw some of these practices. Ultimately, this resulted in a significant reduction in gate-keeping within HMOs across the United States from the mid-1990s.

Public accountability

The example of US HMOs raises a further question, as yet unresolved in the operating framework: how will PCTs, beefed up by contracts and new powers to enforce the ‘redesign’ of care pathways, ensure that they are accountable to the public? Already there are many PCTs embroiled in bruising confrontations with local communities over the reconfiguration of services (an issue that is absent from the framework document). The operating framework acknowledges that PCTs have a critical role to play in engaging with the public, encouraging ‘local boards [to] take greater ownership for (sic) continuous service improvement and acting in the public interest’. The framework encourages PCTs to be ‘outward facing’, but offers no new mechanisms to ensure accountability beyond the statutory powers of overview and scrutiny committees. Although there are new proposals for reforming the old Patient and Public Involvement (PPI) structures (Department of Health 2006c), the new bodies are arguably more about facilitating better and more meaningful consultation rather than ensuring better accountability. Given the already obvious imbalance between PCTs and the elaborate local governance structures of foundation trusts (an imbalance that will become more visible as the number of foundation trusts increases), the question of how the PCTs should account for their actions to local communities will certainly need revisiting.

In summary

The operating framework reinforces a picture of reform that will now hinge on effective local commissioning, underpinned by potentially punitive contractual relationships but nevertheless relying on NHS professional staff to ‘own’ reform and, above all, to co-operate and collaborate across organisational boundaries to improve services. It is not clear how the mix of competition, contract and cooperation will work in practice. And, as with the 2006/7 operating framework, nor is it clear how prominent a role patient choice will play in driving reform. Rather the emphasis seems to remain on top-down ‘activity’ planning, with choice positioned as a risk to be managed rather than as a lynchpin of reform.

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