

Civica Health & Social Care

An Insider's Guide to the new PCT Clusters Reporting Needs



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01.

Allocating resources under the PCT Clusters Operating Model

Whatever the fine detail of the NHS reforms after the Future Forum consultations and the legislation's passage onto the statute book, it was apparent at an early stage that the 51 new PCT Clusters would rapidly have to determine the allocation of resources to reconcile their strategic objectives of enhancing health care outcomes, delivering the aims of the QIPP, and contributing towards the NHS' target of £20 billion in operational savings.

The Department of Health (DH)'s Operating Model for PCT Clusters¹ and guidance on the NHS Commissioning Board (NHSCB)'s hosting of commissioning support has further focused minds on the management capacity and resourcing and data quality issues. The operating model guidance is essential for clusters to work out key priorities: how they will guide and share resources with clinical commissioning groups (CCGs) while continuing to deliver the different reporting criteria required by the NHSCB, Strategic Health Authorities, SUS, and Monitor, from March 2012.

The cluster's operating model's key organising principles include:

- > integrated finance
- > operations and delivery
- > commissioning development
- > ensuring quality (effectiveness, experience and safety)
- > emergency planning and resilience
- > the commissioning elements of provider development and communications and engagement

It is clear that the PCTs' management teams will rapidly need to establish operating frameworks and assign appropriate departmental resources to key areas such as the commissioning, costing and monitoring of services.

In particular, the NHSCB's demand for commissioning support services to be delivered at scale within a national framework and the PCT Clusters' operating model call for the rapid establishment of standardised operations to support national and local health care outcomes. However this standardisation will take place across what are, in effect, new bodies – for example, clusters building on the merger of individual trusts, each with their own legacy business processes and technology infrastructures. The new regional PCT clusters' management teams recognise the need for economies of scale and robust processes that will help deliver quality of care and patient choice. The new bodies' executives will be under no illusion that these internal systems will have to accommodate greater and larger

scale co-operation with other care providers and public and third sector organisations in the future. This is of growing importance in the future because of the Government's stated aim of encouraging advanced co-operations with local government in future health care delivery.

To fulfill their designated roles – quality-driven health care, effective co-operation with NHS partners and cost efficiencies while managing reporting to a plethora of audiences – PCT clusters will require highly scalable commissioning and monitoring models. They will be reliant on effective and faster information exchange, shorter financial reporting cycles and automation of manual processes to maintain tight control of funding allocations and ensure transparency and accountability for an entirely new structure.

Clusters and CCGs' shared management information systems will, therefore, need to be resilient and scalable from the off, to deal with ever-increasing transaction levels, complex new partnership arrangements, and ensure flexibility to support national outcomes while meeting changing local health care priorities. The smooth transition to the new PCT Clusters – or their replacements, in whatever form – will depend to an increasing extent on their Directors of Commissioning and Finance as well as Chief Executives' ability to harness their management information (MI) systems. These MI tools have to be based on very flexible and scalable analytical and financial reporting tools – whether existing or new ones.

¹ DH, Operating Model for PCT Clusters, July 2011.

02.

Trends in commissioning and operational challenges

The transition to the NHSCB and PCT Clusters Operating Model strongly advocates standardisation of each group's operations while continuing to address specific local health care needs around guiding operational principles of:

- > standardisation and automation of clusters' operations and processes
- > streamlined allocation of resources
- > intelligent commissioning
- > effective financial control and monitoring
- > effective longer term planning of outcomes.

While convergence of each cluster's operations towards these core areas aims to help a reformed NHS achieve its strategic objectives, such wide-ranging adjustments will immediately pose searching questions of management decision-making. This is because the new clusters will be sharing objectives and workloads with partner commissioning groups.

This step change to larger groupings while meeting local needs will require senior executives to review their provision of management information ahead of their March 2012 starting point. Senior personnel know they will have to determine if they are able to adequately support effective decision-making and new funding arrangements. This is essential given the prospect of more data-heavy service delivery and expanded reporting across collaborative service models. Additionally, there will be greater analysis and scrutiny of new service lines.

Standardisation

To balance the national and local health care and reporting agenda, the Clusters Operating Model guidance demanded operational consistency from the new bodies. Existing health trusts brought into the new clusters will need to evaluate, adapt and automate

their management of data and reporting systems as this transition occurs. Given the differences between clusters (and the overlap of different functions in some existing trusts) that the published document has already noted, the call for standardisation nevertheless represents something of a *fait accompli* that Trusts' Finance Directors and designated Commissioning Directors are already having to actively plan for.

Given variations in trusts' internal reporting (an inevitable consequence of previous market reforms) in-house reporting models may struggle to meet managements' expectations for two reasons. Firstly, the information required from NHS trusts' finance and IT departments will change to meet the needs of larger, merged organisations, particularly the future NHSCB, PCT Clusters and CCG pathfinders. Secondly, the new clusters will need to share information regularly with the new CCGs as a priority. It is inevitable that information delivery protocols and standards – and the staff resources and business intelligence products needed to deliver them – are subject to a further period of review and likely change.

Resource allocation

The national agenda, including the demands for operating commissioning services at scale and 'more with less', will continue to strongly influence CCGs' thinking. As a result, the new operating model requires the streamlining of organisations' resources used for producing management information as well as optimising local health care outcomes from those resources. While this is a logical (if challenging) demand in the timeframes, it has several far-reaching implications for trust boards and the commissioning and finance teams that support their strategic role.

This planned streamlining of resources effectively requires new clusters' constituent trusts to review the resources they allocate to reporting (i.e. the internal finance, development and ICT teams working on gathering and analysing and reporting on data) executives will need to satisfy themselves that their processes, business intelligence engines and reporting capabilities are up to the task. Clusters will also require standardised and scalable reporting systems that enable greater automation of any existing manual analysis and reporting tasks. This in turn will force clusters to assess their reporting capabilities and seek ways to optimise the performance of ICT infrastructures, particularly data warehouses, that underpin these operations.

Simplified commission models

The call for simplification of the commissioning-service relationship towards what the Cluster Operating guidance terms 'affordable and viable' models is again a logical part of a reformed NHS structure. However, it may be a challenging requirement in an area which is known to lead to tensions over the accuracy of data surrounding services, episodes and other treatments and the claims validation process that supports it. To operate a national-level commissioning, many organisations such as a CCG drawing on 10 or more GP practices, will need to streamline manually-based processes to deliver the necessary affordability and viability to balance national and local priorities effectively.


The reorganisation of commissioning under a national board with sensitivity to local needs will clearly demand national-level standardisation (or commonality) of information delivery and underlying

processes. However, experts in the supply of NHS management information tools believe that this setting up of new, scaled-up organisations that need consistent information and more effective claims validation processes could present an opportunity for more constructive dialogue and smoother interactions between the commissioning body and service providers. Some observers even believe that advances in software-based reporting opens up the possibility of more providers operating their own commissioning models which have already been successfully progressed as individual pilots so far.

The PCT cluster model's call for business systems that foster intelligent commissioning will no doubt cause Directors of Commissioning to devote time and resources to establishing new or updating existing commissioning processes in this area. This approach could lead to the wider adoption of smarter commissioning support (i.e. optimised resource spent on gathering and analysing data). Although this may require investment in resource and technologies, this re-engineering and refinement process could free up staff time previously spent on resolution of claims in favour of added value analysis that supports efficient processes and ultimately service innovations.

Financial controls

Another key area is the delivery of financial controls for effective allocation of funds to service providers. The reorganisation of trusts into clusters will require streamlining, re-engineered and automation of legacy manual reporting processes to maintain the accuracy of financial data while reducing the overall internal resources the clusters will need. The published model's emphasis on clusters developing reporting that enables the development of autonomous operations/budgets for CCGs places further responsibility



Directors of commissioning or finance that harness the latest business intelligence systems to optimise existing reporting engines could help clusters and CCGs achieve more targeted funding for long term health care planning.

on PCTs to deliver resilient and flexible financial reporting systems whose data will be shared with their peers. It will also help simplify reporting for external scrutiny by the NHS Commissioning Board.

While this change is part of the transition to larger scale reporting arrangements, experts in NHS financial reporting and analytics see potential for innovation here as well. They believe there is an opportunity for the new PCT clusters to develop reporting systems that simplify the management of today's separate systems governing SUS for Payment by Results (PbR), Local PbR and block funding streams, which it is generally accepted, absorb considerable finance department resource among commissioning bodies and service providers alike.

Quality

While PCT clusters will be committed to meeting the aims of QIPP, the new model restates the need for quality-driven health care based on full accountability of the clustering model to the NHS Commissioning Board, SHAs, CCGs, and Monitor (and ultimately the general public) as it receives funding in the new financial year.

The published PCT Clusters model's demand for alignment with QIPP will further cause clusters' senior management to review operational performance more regularly. Directors will review their information systems as they move to these more quality-focused measures. This demand could help clusters' management teams determine where and how data quality can be made more consistent, contract monitoring improved, and required administrative resources reduced.

These different operating, reporting and compliance demands will place added burdens on senior management. Senior executives are aware that they will need standardised and repeatable data management processes.

However, informed observers believe there is scope for innovation in this challenging situation. Software providers are now marketing specialist reporting tools that meet expanded reporting needs of the PCT Clusters Operating Model and contribute to re-engineering and enhancing PCTs' core functions. These advances are possible because the latest products:

- > Streamline the allocation of resources for producing management information
- > Deliver optimal performance from ICT resources such as data warehouses as well as greater scalability for trusts' reporting and analytical needs
- > Help NHS organisations achieve improved financial reporting based on automated and scalable analytics capabilities
- > Develop better, more efficient, and smoother commissioning data, with simpler service monitoring and claims validation based on more consistent information
- > Achieve more sophisticated and faster analysis of lines of service and operating cost efficiencies
- > Helps PCT Clusters develop common financial and reporting systems that support shared services and collaborations.

Directors of commissioning and finance that harness the latest business intelligence systems to optimise their existing reporting engines could help clusters and CCGs achieve more targeted funding for long term health care planning. They could, at the same time, develop co-operation strategies with NHS and other public sector partners. These advances will also help reduce operating costs as required by the Coalition.

03.

Enhanced management information: New options for commissioning and finance directors

NHS professionals and clinicians alike are working hard to support the Government's rapid drive to rethink and reform the entire NHS organisational structure. To support the transition to new arrangements, the NHS Operating Framework 2011-12, supplemented by the PCT Clusters Operating Model and anticipating the establishment of the NHSCB from 2013, has laid down key reform milestones leading to the 51 new clusters beginning shared operations with CCGs in 2012.

While no stakeholders actively question the principle of commissioning, there needs to be a clear understanding of the direction of travel. As a crucial NHS management discipline, commissioning needs to be underpinned by the right type of management information. Irrespective of reform timelines, and because the Health & Social Care legislation's structural reforms will inevitably take time to have their full effect, there are key organisational principles that have by far the greatest implications for PCT clusters and their establishment of systems to manage their resources effectively.

Achieving four critical steps will enable organisations to develop the management systems that will ensure accurate allocation of resources, financial controls and system accountability as they work in collaboration with CCGs:

1. As time progresses, PCT clusters have had to increase the proportion of their budgets being delegated to CCG pathfinders.
 2. All CCG pathfinders had to complete a self-diagnostic model, or recognised equivalent, ensuring that they have effective oversight of their care services and operations.
 3. All PCT clusters will establish direct commissioning functions in line with an agreed shared operating model with commissioning groups.
 4. Since the NHSCB model anticipates that commissioning support services need to be delivered at a national and viable scale to deliver the necessary expertise with reduced costs, PCTs and CCGs alike will need to automate a range of processes to ensure health care outcomes and efficiencies at the local level.
- For the shared cluster-CCG model to begin operating in line with the reforms' ambitious scope, DoCs/DoFs will need robust reporting processes. Suitable systems will free management capacity (i.e. staff resources) to effectively handle a growing analytical and reporting workload as they assume a greater proportion of NHS annual budgets. These processes will be built on different management information tools that will be established in a number of ways, including:

- > Enhancements of existing management information systems that were developed in-house
- > Systems that are scaled up to new organisations' requirements
- > Information systems that are optimised to deliver enhanced reporting with reduce workloads
- > New innovations, such as managed services for system reporting, performance analysis and data management.

To obtain better information while retaining effective operational control of merged operations, directors of commissioning and directors of finance will need to evaluate their reporting processes and the data gathering and evaluation systems that support them. In many cases, clusters' senior executives will need to look beyond proprietary business intelligence (BI) systems that will be unable to address the scope and scale of the new NHS operating, commissioning and reporting environments. They will also have to look for alternatives for 'point' BI products that were never designed to manage multiple or shared organisations' transaction levels and associated reporting needs. Clusters' senior management will need tools that optimise existing systems or enable them to be re-engineered and expanded.

Conclusion. Planning ahead for control of resources

The reform of the NHS structure is intended to enable the new clusters to guide and support CCGs in delivering enhanced health care that is targeted at the changing requirements of their local populations.

The NHSCB model anticipating a national framework for commissioning support services to harness expertise, achieve economies of scale and balance national and local health care outcomes, PCT clusters will need to build close partnerships with CCGs that are based on improved information flows and communications between CCGs and service providers. This exchange of critical information is essential. Through it, clinicians will better allocate their resources to target local communities needs and ultimately, deliver greater choice for the individual citizen.

To bring about successful relationships, and to ensure longer term financial autonomy for CCGs, PCTs' directors of commissioning will need to provide trusts and commissioning groups' boards alike with data and insights that draw on information

from many different organisations and activities. However, the data must be consistent and reliable; good enough for boards to drill down to the individual patient or service line level. To achieve this near-unprecedented understanding of NHS operations, commissioning directors will need to work with trusted management information providers that will help them improve the production and evaluation of information, supporting better commissioner-provider models.

With the Government demanding relentless cost efficiencies in tandem with the DH's structural reforms, it is inevitable that directors will be asked to rationalise, merge or reduce the level of management/ICT resources that they devote to financial management and ensuring accountability. In such fast-changing working environments, it is very likely that directors of finance will need to protect – but ultimately transform – the capabilities of their existing finance and system development teams.

And to achieve that, they will need to rethink, streamline and automate many of their core processes. They will be forced to optimise the performance of both their previous investments in both the ICT infrastructures and development teams that use them.

New tools that ensure financial controls based on effective commissioning and costing processes, are essential for the PCT Clusters to achieve transition to the new operating framework while also guiding CCGs' own operations and move to autonomy. On these foundations rest the future of longer-term local health care planning based on patient-focused health care organisations and wider collaborations between public organisations.



Directors of commissioning will need robust reporting processes to free management capacity and effectively handle a growing analytical and reporting workload as they assume a greater proportion of NHS annual budgets.

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