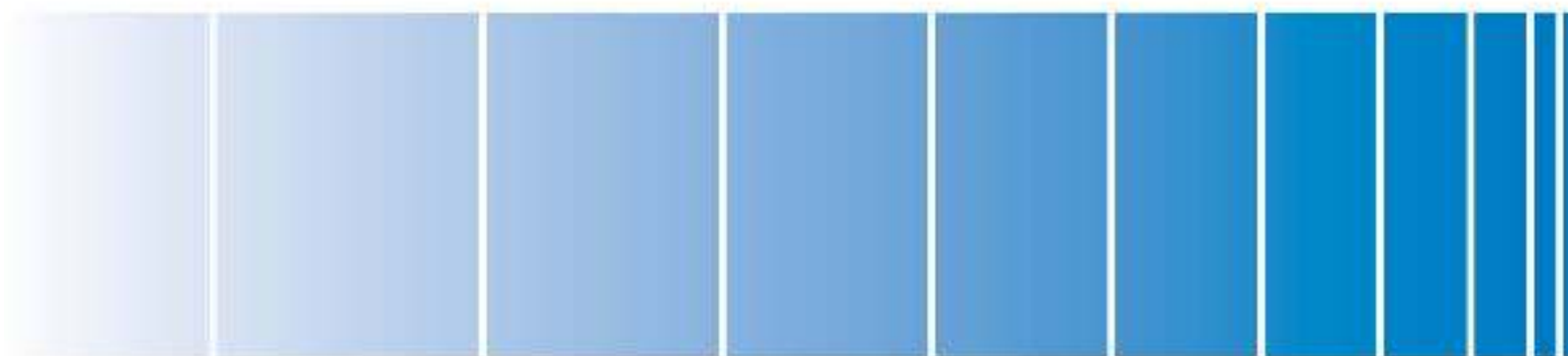


The NHS in England: the operating framework for 2006/7



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Foreword

from Sir Nigel Crisp

The NHS in England: the operating framework for 2006/7

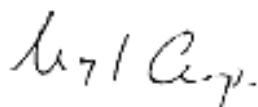
This document sets out the agenda for the NHS for 2006/7. It is designed to help you lead health services and health improvement locally by clearly setting out the framework of priorities, expectations and rules that we want you to operate in 2006/7. While this document is primarily addressed to NHS leaders, I know how crucial the partnership with local authorities will be to delivering improvement.

2006/7 is a critical year. The NHS must deliver improved services for patients; it must press forward with reform to deliver substantial and lasting improvements for the future; and it must return to robust financial health.

This document sets out the service priorities for the year. It describes how we want to see the reforms extended to include more choice, universal practice-based commissioning, new NHS Foundation Trusts and more Independent Sector Treatment Centres, as well as the extension of Payment by Results. It also provides information on the tariff and describes the financial expectations for the year.

I know that 2006 will be a year of considerable change for individuals and organisations as well as for systems. This document therefore aims to strike a fair balance between increasing the pace of improvement in the NHS, and the particular environment of 2006/7. In some cases, the document introduces interim arrangements that will evolve over the next two years as organisations become established and the reform programme continues to develop.

I know that the year ahead will be a challenging one for all of us. However, I believe that we have a real opportunity to build on the achievements of the past and to create real improvements for patients and the public.



Sir Nigel Crisp
Chief Executive, Department of Health and the NHS

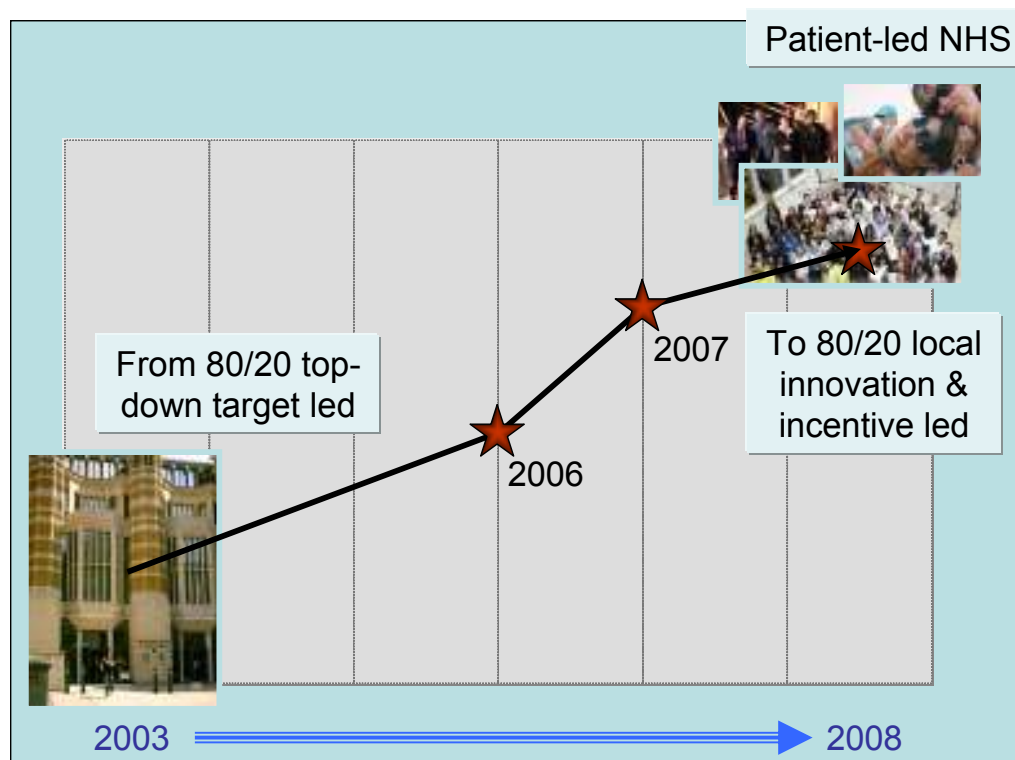
26 January 2006

1. Introduction and context

1.1 The NHS has a clear strategic vision. Within the funds available, over the next three years we are committed:

- > to transform the services that patients receive, in line with the commitments set out in the Planning and Priorities Framework for 2005/6 to 2007/8¹. Principal among these are substantially to reduce mortality rates from heart disease and stroke, to support people with long-term conditions, to reduce overall emergency bed days by 5% and to reduce the maximum waiting time for hospital treatment to 18 weeks; and
- > to reform the health system fundamentally, so that change is driven more by incentives to respond to patients than by top-down target setting. The vision for the reforms was restated in *Health reform in England: update and next steps*, published on 13 December 2005. It will be augmented in the forthcoming White Paper, which will set out plans to bring better services closer to home by strengthening prevention, primary and community services.

2006/7 will be a critical year for increasing the rate of progress:



¹ *National Standards, Local Action*, Department of Health, July 2004

- 1.2 There is no doubt that 2006/7 will also be a challenging year:
- > As Payment by Results (PbR) and the NHS Foundation Trust financial regime are extended, long-standing financial problems and weaknesses will become more transparent. They will no longer be passed on to commissioners through more expensive services or to patients through poorer access. They will need to be tackled head-on in the organisations with performance problems.
 - > Progress towards the 18-week referral-to-treatment target will require locally-driven service re-design; old methods of top-down performance management will not be sufficient to deliver this.
 - > Organisational change, while essential, will carry an inevitable risk for leadership focus during 2006/7.
 - > Some of the reform levers, such as those moving activity from secondary to primary care, are still being developed. These will not therefore be as effective in 2006/7 as they will be by 2008/9.
- 1.3 This guidance is intended to strike a fair balance between increasing the pace of improvement in the NHS and reflecting the particular environment in 2006/7. It does this by:
- > setting clear priorities for the year ahead;
 - > describing expectations around choice and commissioning in 2006/7 (including practice-based commissioning);
 - > setting out some key objectives for the provision of NHS services;
 - > summarising the PbR rules for 2006/7; and
 - > setting out roles and levers for system management and regulation in 2006/7.
- 1.4 Since 2006/7 is a year of transition and development, parts of this guidance describe interim arrangements that will evolve over the next two years as new organisations become established and the reform programme continues to develop.
- 1.5 Any guidance of this sort can only set the parameters within which local organisations will work. Leadership across the NHS, and particularly in the new Primary Care Trusts (PCTs), remains the key to delivering improved services to patients. There will be a great responsibility on new Strategic Health Authorities (SHAs) to ensure that guidance is implemented locally, that the new system and organisations are developed rapidly and effectively, and that problems are successfully managed locally. The role of boards, with their non-executive members,

will be critical in providing high-quality support, challenge and governance.

- 1.6 Monitor has successfully implemented a rules-based regime of assessing compliance by NHS Foundation Trusts in respect of their authorisations and of intervening in the event of a breach. The rules and systems in this document are not intended to cut across Monitor's compliance regime. It will be important that SHAs work closely with Monitor under circumstances in which the application of this document could have an impact on NHS Foundation Trusts.
- 1.7 Any comments or queries should be addressed through SHAs. SHAs, in turn, have a direct link to the Department of Health via the Recovery and Support Unit (RSU). More general comments about health reform in England may be addressed to DH at nhs.reform@dh.gsi.gov.uk.

2. Priorities for 2006/7

- 2.1 The NHS is, and will remain, committed to delivering the plans set out in *National Standards, Local Action*, published in July 2004, covering the three years 2005/6 to 2007/8. Nationally, we shall be putting a particular focus in 2006/7 on:
- > achieving robust **financial health**;
 - > pushing forward the implementation of **reform**; and
 - > achieving **six specific service priorities** derived from the Planning and Priorities Framework.

Achieving financial health

- 2.2 No organisation can develop effective service plans for the future, make strategic investment in quality of facilities, or guard against normal fluctuations in income without planning to achieve financial surplus. This should become the norm for the NHS. Monitor has already required NHS Foundation Trusts to adopt an appropriately rigorous approach to financial discipline. These arrangements will continue without material amendment in 2006/7 and beyond, therefore paragraphs 2.5 and 2.6 below are not relevant to NHS FTs.
- 2.3 The further implementation of practice-based commissioning, PbR and patient choice makes planning for financial surplus even more important and urgent. There will be greater transparency and financial volatility as the new incentives take effect, and as money flows to reflect patient experience and provider quality and responsiveness. Excellence in financial management is a pre-requisite for high-quality, sustainable services.
- 2.4 Cutting waste, reducing costs and improving productivity are essential for financial health. These measures ensure that the extra resources invested in the NHS produce a reasonable return for the taxpayer through more and better care for patients. In aggregate we shall be expecting a 2.5% improvement in efficiency across all parts of the NHS next year. The Integrated Service Improvement Programmes (see www.ISIP.nhs.uk) provide the practical toolkits for change and will be used as benchmarks for assessing organisational progress. The Department will produce a table of key productivity and efficiency indicators at trust and PCT level.
- 2.5 As a first step along this path, next year, for the system as a whole, we expect to recover any overspend from 2005/6, and we are planning for a surplus. The size and distribution of this surplus will be agreed between

the Department and the SHAs, and between the SHAs and local organisations.

- 2.6 Within this overall total, the planning presumption is that organisations should both achieve in-year balance and recover 2005/6 deficits. In exceptional circumstances organisations may be allowed more time to recover the 2005/6 deficit, but they should still plan for in-year balance. Such exceptions will only be made where:
- > this is affordable within the control totals agreed between the DH and the relevant SHA; and
 - > both the DH and the relevant SHA are satisfied that there is the management capability to deliver turnaround and recover the deficit over the agreed period; and
 - > all reasonable action has been taken both to achieve balance and to recover the deficit; and
 - > the organisation is formally included within the DH 'turnaround programme' and is subject to the monitoring and control that this will imply.
- 2.7 To support this process and to deliver the overall financial position, PCTs will be expected to lodge reserves with their SHAs. The amounts and terms will be for local agreement, but will be within a framework agreed by the DH.
- 2.8 SHAs will be responsible for ensuring that commissioners can afford their plans. Responsibility for ensuring financial viability of providers rests with SHAs for NHS trusts and with Monitor for NHS FTs.
- 2.9 The overall requirement is challenging, but is both achievable and necessary. In 2006/7 PCT allocations will grow by 9.2%, or £5.4 billion. Without any efficiency saving, underlying pay, price and other cost pressures will account for up to £3.8 billion. However, investment made to date means that this year should not be about further significant increases in capacity, but rather about improving the efficiency of the existing capacity, so that we deliver efficiency improvements of 2.5%, or £1.6 billion. Across the system as a whole this suggests that we should be able to realise £3 billion to deal with legacy issues and to deliver service improvements. Annex A summarises the financial management regime for 2006/7, drawing from this and subsequent chapters.

Implementing reform

- 2.10 2006/7 will see the pace of reform being stepped up. All organisations will be affected and will need plans in place to implement changes and to deliver benefits. The sections that follow give further details; the table below summarises the main objectives.

Implementing reform: expectations of change by March 2007

	by March 2006	by March 2007
Practice-based commissioning	20% of practices	Universal coverage
Number of PCTs	303	120 to 160+ depending on consultation
Choice of hospital	4+	Extended
Choose and Book	25%	90%
NHS Foundation Trusts	32 (acute)	65 to 80 including 5 to 10 mental health
Independent Sector Treatment Centre (ISTC) capacity	18	24
Payment by Results	£9 billion of services covered	£22 billion of services covered
More service delivered in the community	The forthcoming White Paper will create new levers and incentives for shifting care	

Service priorities

- 2.11 Further to the publication of *National Standards, Local Action* in July 2004, PCTs and other NHS organisations are now working towards the delivery of their three-year Local Delivery Plans (LDPs) covering the national targets.
- 2.12 PCTs are expected to ensure the delivery of all their agreed LDP commitments. Targets already achieved must be maintained. Progress against plans will continue to be monitored by the Department and will form part of the annual performance assessment by the Healthcare Commission. In addition, we expect all healthcare organisations to play their part in delivering Local Area Agreements, reflecting the importance of joint working with local government and other agencies to reduce health inequalities.
- 2.13 In addressing all aspects of LDPs, NHS organisations are expected to place a strong emphasis on the quality and safety of care, ensuring that local clinical governance arrangements are strong, that systems are geared to reducing the risks of care and enhancing patient safety, and that the patient's experience is central to the day-to-day running of services. The standards-based approach to delivery is very important. It is intended to give patients and the public confidence in the fact that NHS services are quality assured. It is also designed to drive improvements in the quality of services over time.

2.14 Many of the service targets and related standards are to be met in 2007 and 2008. But it is clear from discussions during the planning round that some LDP issues will require particular attention in 2006/7 in order to ensure delivery of national targets by 2008 and beyond. Therefore priorities for action in 2006/7 as part of the existing three-year plans are:

- > **Health inequalities:** to deliver the LDP trajectories that make the most progress in reducing health inequalities by 10% by 2010, focusing on life expectancy at birth. The initial focus will be on smoking cessation. We will establish systems for implementation and to track progress for 2007/8 on this and other key interventions, particularly in the spearhead PCTs.
- > **Cancer 31-day and 62-day waits:** to ensure the sustained delivery throughout 2006/7 of a maximum waiting time of two months from urgent referral to treatment, and of one month from diagnosis to treatment, for all cancers.
- > **18-week maximum wait:** to ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.
- > **MRSA:** to achieve year-on-year reductions in MRSA levels, as set out in the agreed LDPs for 2006/7.
- > **Patient choice and booking:** to ensure that every hospital appointment will be booked for the convenience of the patient (by implementing the Choose and Book system) and that every patient is offered a choice of at least four providers.
- > **Sexual health and access to Genito-Urinary Medicine (GUM) clinics:** to deliver the 2006/7 LDP trajectories so that by 2008 everyone referred to a GUM clinic should be able to have an appointment within 48 hours.

2.15 Annex B reproduces the current planning lines for each of the areas included as part of the LDP. While we have identified six for particular national focus, all lines remain part of the Healthcare Commission annual health check.

3. Choice and commissioning in 2006/7

- 3.1 *Health reform in England: update and next steps*² set out the basic framework for commissioning, which will be developed into full guidance in the summer. Its key components are:
- > the move towards free choice for patients;
 - > universal coverage of practice-based commissioning (PBC);
 - > standard template contracts for use across the service, with clear national standards and scope for local conditions; and
 - > the essential role of PCTs in reflecting local patient needs in contracts and in ensuring the effective operation of PBC to deliver service improvements.

The following section sets out the interim arrangements for 2006/7.

Choice

- 3.2 Currently patients are offered a choice of at least four hospitals. 2006/7 will see a big step forward by extending this choice to include any NHS Foundation Trust, any nationally procured Independent Sector Treatment Centre, and any other subsequently centrally accredited independent-sector providers. The intention is both to give patients more options and to increase competition between providers. Extended choice will be rolled out during 2006/7 for specified procedures. Guidance setting out the procedures and the mechanics will be issued in March 2006.

Practice-based commissioning

- 3.3 The aim of PBC is to give practices the freedom, support and incentives they need to improve care and services for their patients, within a governance framework that ensures value for money and fairness. The detailed rules for practice-based commissioning next year will be published at the same time as this guidance; see www.dh.gov.uk/practicebasedcommissioning. Our priority is the recruitment and development of practices, so that the NHS can achieve universal coverage by December 2006. The main features of the guidance are that:

² See Annex D of *Health reform in England: update and next steps*, Department of Health, December 2005

- > by December 2006 practices will be working with benchmarking information about their patients' use of services, as well as indicative budgets covering (as a minimum) prescribing and the services covered by PbR. Practices will have access to a Directed Enhanced Service (DES) payment recognising preparation for PBC. They will receive support and advice from PCTs to enable them to improve services and to stay within budget;
 - > all practices will be guaranteed a minimum indicative budget equivalent to their actual historic use of resources, uprated to 2006/7 prices, enabling the purchase, on behalf of their patients, of a range of services agreed with their PCTs;
 - > PCTs will put financial risk-pooling and management arrangements in place with practices; and
 - > PCTs will operate a governance and accountability framework, including approving the re-investment of practice surpluses.
- 3.4 Implementation of PBC will be supported and monitored by SHAs as part of next year's performance framework.

Contracting

- 3.5 There will be no new national template contract for 2006/7 – this is planned for 2007/8. Existing model contracts, for example those for use with NHS Foundation Trusts, will continue to be available.
- 3.6 For 2006/7 agreements will not be permitted to set activity limits: this would go against the reform principles of choice and payment for work done. However, all agreements and contracts must include planned activity levels, profiled across the year. All partners to contracts and to other agreements with PCTs and practices must work towards these plans to ensure that choice is available for patients, that further progress is made on waiting times, that there is scope to shift services into the community, and, critically, that the local financial targets are delivered.
- 3.7 The expectation is that the aggregated increase in elective activity levels across the country as a whole should not exceed 3%, and that all areas will make progress towards achieving the objective of reducing emergency bed days. Both PCTs and providers should monitor activity plans and contracts closely. Where activity plans are being breached, there is a joint responsibility on the PCT and the provider to take action to safeguard access to services and to ensure affordability within the resource and cash limits in place locally.
- 3.8 Agreements and contracts will also need to:
- > meet required performance standards and deliver Public Service Agreement (PSA) targets;

- > reflect the plans of practice-based commissioners to improve and develop local services; and
 - > include locally-agreed strategies to manage demand (for example target conversion ratios for some procedures and agreement on a sustainable and affordable profile for reducing overall waiting-list size), and to enhance productivity, drawing on local Integrated Service Improvement Programme (ISIP) plans. Annex C summarises the overall approach to managing demand next year.
- 3.9 SHAs will oversee this process so that agreements and contracts between PCTs and providers are in place by 31 March 2006. They will ensure that PCTs have signed all legally binding contracts with NHS Foundation Trusts by this date. They will arbitrate any disputes between PCTs and NHS Trusts. Contracts with NHS Foundation Trusts must set out dispute resolution arrangements.

Development programmes

- 3.10 All PCTs will take part in a development programme, similar to that undertaken for NHS Foundation Trust status. This will involve an independent assessment of the PCT's fitness for purpose, the use of a diagnostic tool that enables benchmarking against best commissioning practice, and a development plan. The assessment and diagnostic tools will be piloted during the spring, ahead of national roll-out during the summer.
- 3.11 Practice-based commissioners will also benefit from a dedicated development programme being run by the National Primary Care Development Team. This programme has already begun, giving support and assessing the readiness of PCTs and practices.
- 3.12 In addition, effective commissioning will be supported by the evidence and best practice set out in the ISIP programme. Delivering quality and value in patient services using the enablers of clinical service redesign, workforce reform and information technology will be a critical challenge for commissioners.

4. Providing NHS services in 2006/7

- 4.1 Next year we shall be pressing ahead with creating a greater variety of providers of NHS services, to underpin choice and to create competitive incentives for quality and value for money.

NHS Foundation Trust programme

- 4.2 The Government is committed to giving all NHS providers the opportunity to become NHS Foundation Trusts (FTs). Wave 2 applicants that meet the criteria and successfully complete Monitor's authorisation process will achieve NHS FT status early in 2006/7. A third wave of applicants is likely to be authorised later in the year.
- 4.3 A diagnostic programme, led jointly by DH, Monitor and the SHAs, is underway to help all other acute trusts determine what action they need to take to be able to apply for NHS FT status by 2008. Towards the end of the diagnostic programme, the Department of Health will ask each SHA for a trajectory to show when each trust will be in a position to apply for NHS FT status and to confirm that action plans are in place. These trajectories will then be performance-managed in the usual way.

Independent Sector Treatment Centres (ISTCs)

- 4.4 Waves 1 and 2 of the ISTC programme will deliver more capacity and choice for NHS patients. The first scheme opened in 2003, and all of the wave 2 centres are expected to be operational by 2008. The programme is expected to include elective surgery, and ophthalmic, orthopaedic and general surgery, in addition to significant levels of diagnostic testing. From 2006/7 we anticipate that about two million diagnostic procedures will be delivered annually around England, from a range of providers and via a range of delivery methods. All 31 ISTCs from wave 1 will be operational by 2008, delivering 105,000 procedures in 2006/7 and approximately 170,000 procedures a year over the lifetime of the schemes.
- 4.5 Wave 2 is expected to deliver 250,000 episodes of care at a cost of £500 million p.a. for five years. The procurement has commenced with Invitations to Negotiate (ITNs) being issued for six of the proposed schemes and a further batch of ITNs expected to be issued shortly. Wave 2 contracts are expected to be operational by 2008. All nationally procured ISTCs will become options for patients under the extended choice initiative.

PCT provider role

- 4.6 Following the publication of the forthcoming White Paper, from 2007 each PCT will be expected to review formally and systematically whether local services are delivering high-quality, effective and efficient care, and whether they are tackling health inequalities. This applies both to directly-provided and contracted services, and will be a central part of each PCT's role as a commissioner. Good management of community services is essential for good patient and carer experience. There is no requirement for PCTs to divest themselves of provision, and nor will there be in the future, but PCTs will also be free to make different arrangements where they believe these will continue to improve services, especially in relation to health inequalities. Where PCTs do continue to provide services, they will need to put in place clear governance procedures that ensure that there is no undue influence from the provider side on commissioning decisions. Further details will be available in the forthcoming White Paper on provision in primary and community settings.

General practice

- 4.7 Most NHS primary care is provided through contracts with independent general practices and their teams. Working with the General Practice Committee of the British Medical Association (BMA), the Government agreed new contractual arrangements, which have improved quality and access, for example through the Quality and Outcomes Framework (QOF). The forthcoming White Paper will make further proposals to support improvement, particularly in localities of greatest need. These proposals will include greater choice and more diversity of provision.

Reconfiguring services

- 4.8 PCTs and trusts will have plans for reconfiguring services, arising from a number of factors:
- > safety and sustainability of services;
 - > quality;
 - > appropriateness of facilities;
 - > response to patient choice;
 - > a need to tackle health inequalities; and
 - > value for money, productivity and maintaining sound finances.

The forthcoming White Paper will set out a vision for the shift of services to primary and community settings, and will provide a further trigger for reviewing existing configurations as the year progresses.

- 4.9 The process of change is important in any service reconfiguration. It is essential to engage patients and users at a very early stage in considering the challenges, opportunities and options for strengthening services through reconfiguration. This process needs to be made visible to the public, for example through a citizens' jury or panel, so that they can be involved in developing the options for consultation. This is not intended to block or even slow down change; by involving local people early, it is more likely that the best decisions will be made and that the right changes will be made quickly, smoothly and effectively.

Proposals to merge organisations

- 4.10 Any proposal for an organisational merger, arising for example from the foundation trust diagnostic process, carries a requirement for early public involvement and consultation with key stakeholders.
- 4.11 In addition, such proposals may have an impact on the ability of patients to choose from a range of local providers, and they could reduce the incentive to providers to be flexible and responsive.
- 4.12 By April 2006 the Department of Health and Monitor will establish a set of principles to test any proposals for provider mergers. These are likely to include:
- > a fully worked-up and financially viable service integration plan that takes priority over organisational convenience;
 - > explicit action to address the consequences of a more primary-care-focused health service and of services closer to home;
 - > the need to reduce health inequalities;
 - > demonstrable clinical support for service integration; and
 - > choice and plurality.
- 4.13 SHAs, taking account of local views including those of commissioners, will consider the strategic fit of any proposal that involves only NHS trusts, and will make recommendations to the Department of Health. Proposals involving NHS FTs will be scrutinised and dealt with by Monitor.

Private Finance Initiative (PFI) and capital developments

- 4.14 Working with their SHAs, PCTs and trusts are required to reconfirm their investment plans. Hospitals procuring or planning a major capital development, including PFI schemes, will be expected to take account of the current reforms to the NHS, specifically choice, a movement of services into primary and community settings, and the current and new financial regime. Business cases should be assessed in the light of the reform programme.
- 4.15 The Department will therefore shortly be writing to all SHAs with practical guidance on applying the experience of previous procurements, both in the NHS and in wider government. The guidance will take the form of a range of questions which will provide firm indications as to the likelihood of the scheme being viable, and which will assist boards in discharging their governance obligations. In light of these indicators, trusts will need to consider whether their investment plans are likely to be financially robust, affordable and sustainable or not. Guidance will cover levels of affordability in relation to size of capital investment against income, assumptions on efficiency gains and income growth, liquidity, activity shift and reference cost. As part of this process, trusts will also need to consider longer-term affordability carefully. The need to ensure that a project is affordable before going to market is set out in HM Treasury's *Value for Money Guidance* and in specific Department of Health guidance. Trusts must follow this best practice. It should be clear that any trust with significant deficits will not be allowed to proceed to market with large capital investment schemes without agreed plans to deal with those deficits before financial close.
- 4.16 SHAs will need to have conclusions ratified by the Department before proceeding. This exercise will be prioritised to ensure that resources are applied to the more developed schemes and the Department will provide support to the NHS if it requires it. In addition, in future, trusts will be required to seek formal approval, under the usual delegated authorities, before they can appoint a preferred bidder. This process will help to ensure that plans are robust and viable in the context of the reformed NHS, and deliverable once they are put to the market. Initial indications on the impact of the more developed schemes are expected by the end of February, with final details being confirmed thereafter.
- 4.17 This process reaffirms our commitment to the Government's investment programme for health. PFI will remain the major vehicle for delivering capital investment in acute services in the NHS. Even after completion of this reappraisal, we expect that the NHS will remain the largest single user of PFI in government, with a programme valued at an estimated £7–9 billion. Furthermore, the investment programme will be on a more sustainable footing and the delivery of that programme will continue at renewed pace.

- 4.18 With regard to NHS FTs, if, as part of a PFI contract, they require a DH 'deed of safeguard', then they will be included in the process described above on a basis to be agreed between DH and Monitor.

Advertising and marketing

- 4.19 It is important that patients and the public have access to reliable information about the services available to them, so that they can exercise informed choice. Providers of healthcare also need to be able to inform patients and GPs of the potential advantages of being treated by a particular provider.
- 4.20 Marketing activity by providers must, however, follow statutory guidelines such as the Advertising Standards Authority Code, and must also reflect the values and brand policy of the NHS. No activity should be undertaken which undermines the reputation of the NHS or of any individual provider(s). The cost of TV and cinema advertising is very unlikely to be justifiable. Providers will not want to spend excessively on marketing, and are likely to welcome clear guidance on what is acceptable. Advertising should present accurate and fair information about services. Any claims must be independently verifiable.
- 4.21 We prefer an approach that, while protecting patients and the public, is largely self-regulating. To this end, we will now begin to consult interested parties on how this might best be done, and we will announce the next steps later this year.

5. Payment by Results in 2006/7

5.1 Payment by Results (PbR) rewards quality and efficiency of both commissioning and providing. Full details of the scheme, including the new tariff for 2006/7, are given at www.dh.gov.uk/paymentbyresults. We have used 2005/6 to review the scope and structure of the tariff in the light of experience here and abroad. The development of PbR for 2006/7 has been supported by expert groups with a wide range of stakeholders, including:

- > NHS trusts;
- > NHS Foundation Trusts;
- > Primary Care Trusts;
- > Strategic Health Authorities;
- > clinical/commissioning networks;
- > professional bodies;
- > the independent sector;
- > Monitor;
- > the Audit Commission; and
- > the Healthcare Commission.

There will continue to be extensive discussion and consultation as the system develops.

Tariff increase

5.2 In summary, the tariff uplift for 2006/7 has three components:

- > a pay, prices and reform uplift of 6.5%;
- > an efficiency requirement of 2.5%; and
- > adjustments for new cost and activity data, and issues identified in the 2006/7 PbR baseline exercise, which reduce the tariff by 2.5%.

Taken together, the overall weighted increase across the full tariff in 2006/7 is therefore 1.5%. This comprises 5% for electives, around -0.5% for non-electives, 1.5% for outpatients and almost 3% for A&E.

For services not covered by the tariff, the pay, prices and reform uplift along with the efficiency requirement, will be the benchmark.

Changes to the scope of the tariff in 2006/7

5.3 The key points on scope are:

- > PbR scope is being extended in 2006/7 to cover electives, non-electives, A&E and outpatients in all hospitals;
- > PbR will **not** cover critical care; instead, adult critical care will operate in shadow form; this reflects expert advice on the robustness of the data;
- > PbR for mental health will be piloted next year; and
- > PbR will cover £22 billion worth of services in 2006/7, compared to £9 billion in 2005/6.

Changes to the structure of the tariff in 2006/7

5.4 The principles used in deciding changes to the tariff structure were:

- > stability;
- > simplicity balanced by fairness;
- > that changes should be based around services, not organisations; and
- > that the advice from clinicians and managers should form the basis of changes.

5.5 Changes of note for next year are as follows:

- > There will be a combined tariff for minor A&E and minor injuries unit attendances.
- > For emergency care there will be a differential tariff, with any changes above or below a nationally-set threshold priced at 50% of average cost. The threshold will be 2004/5 outturn plus 3.2%.
- > The short-stay tariff for emergencies will only apply to medical Healthcare Resource Groups (HRGs), will not apply to children, and will be based on HRG-specific average lengths of stay.

- > A new tariff will be payable for nine identified procedures undertaken in outpatient clinics.
- > Specialised service tariffs have been re-calibrated.
- > We will publish shadow tariffs for certain diagnostic procedures to assist towards the ‘unbundling’ of prices for elements of the care pathway.

Transitional protection for providers and commissioners

- 5.6 Transitional adjustments for providers have been calculated on the following transition paths:

Organisation type	Activity type	2005/6	2006/7	2007/8	2008/9
Wave 1 FT gainer	Elective	50% x gain	75% x gain	100%	100%
	Non-elective A&E, outpatient				
Wave 1 FT loser	Elective	25% x loss capped at 2% change p.a.	50% x loss capped at 2% change p.a.	75% x loss capped at 2% change p.a.	100%
	Non-elective A&E, outpatient				
NHS Trusts and other FTs	Elective	25% x loss/gain capped at 2% change p.a.	50% x loss/gain capped at 2% change p.a.	75% x loss/gain capped at 2% change p.a.	100%
	From 2006/7: non-elective A&E, outpatient				

Transition paths for 2006/7 have been calculated using data submitted as part of the 2006/7 PbR baseline exercise.

- 5.7 We are planning to phase out purchaser parity adjustment (PPA) for PCTs by 2008/9. We shall assess the potential benefits for increasing transparency and fairness. Details of PPA in 2006/7 will be published shortly.

Code of conduct and assurance regime

- 5.8 As well as publishing the tariff and core technical guidance, we are putting in place a PbR code of conduct and assurance framework – see www.dh.gov.uk/paymentbyresults. These emphasise the importance of:

- > transparency and rigour in coding and costing systems;
- > excellent monitoring, making use of shared data; and
- > the need for mature relationships between commissioners and providers, to achieve the maximum benefits for patients.

- 5.9 The Audit Commission will manage the implementation of the assurance framework in 2006/7, and will establish an implementation group to support them in this work. The framework will include national analysis of provider data to identify anomalies which could signal potential data quality issues. It will also include strengthened local arrangements for data quality and monitoring payments and a programme of random and targeted external audits of clinical coding and data quality. A pilot will be undertaken in one or two health economies in order to test the approach. Based on the findings from the pilot data, an audit programme will be initiated in the second half of 2006/7.
- 5.10 The audits are expected to inform payment reconciliation and data quality improvements locally as well as policy refinement at the national level. In the longer term, the Department will consider and consult on the use of additional penalties for poor quality. Arrangements will be reviewed in light of the first year's experience, with a view to establishing long-term arrangements from 2007/8 onwards.
- 5.11 Any deliberate fraudulent activity will be referred to and dealt with by the appropriate authorities.

6. System management and regulation

- 6.1 2006/7 will be a transition year for a number of organisations within the healthcare system, but particularly for SHAs and PCTs. This section sets out the interim arrangements for next year, placing the setting up of new PCTs and SHAs in the context of the continuing development of the reform programme.
- 6.2 Our starting point is that the recruitment and development process arising from *Commissioning a Patient-led NHS*, combined with the NHS FT licensing and diagnostic processes, will ensure that the most senior roles across the NHS are occupied by exceptional leaders. In this context, the job of DH increasingly is to set the framework, rules and priorities for a national system, and then to give these leaders the headroom to work together locally to deliver the services that patients want and need.

Role of SHAs in system management in 2006/7

- 6.3 New SHAs will have a pivotal role next year and beyond, holding the confidence of both DH and the local NHS. Annex D summarises their interim role next year.
- 6.4 Subject to consultation, from July 2006 Chief Executives of the new SHAs will be in place and will be appointing their management teams. In the meantime, to support individual SHAs in the next six months, on 20 January 2006 Sir Nigel Crisp announced transitional arrangements. The following people have agreed to take on transition leadership roles for SHA clusters:
- > John Bacon, London
 - > Mike Farrar, Yorkshire
 - > David Flory, North East
 - > Neil Goodwin, North West
 - > Terry Hanafin, Eastern
 - > Thelma Holland, South West (SW Peninsula and Dorset / Somerset)
 - > Trevor Jones, South West (Avon, Gloucestershire and Wiltshire)
 - > Candy Morris, South East (Kent & Medway, Surrey and Sussex)

- > David Nicholson, West Midlands
 - > Nick Relph, South East (Thames Valley/Hampshire and Isle of Wight)
 - > David Sissling, East Midlands
- 6.5 The transition clusters will help to ensure continuity and accountability at a time of organisational change. The cluster-based transition tasks will include involvement in:
- > business continuity;
 - > 2006/7 planning;
 - > managing the change (*Commissioning a Patient-led NHS* and trust development);
 - > motivation and engagement; and
 - > communication.

The tasks, which will be undertaken in partnership with individual SHAs, are described more fully in Annex E.

The role of DH in system management in 2006/7

- 6.6 The Recovery and Support Unit (RSU) will remain the key conduit for delivery and performance management conversations between SHAs and DH. During 2006/7 the RSU will engage with SHAs primarily on performance at SHA level, but it will also discuss with SHAs the performance of specific NHS Trusts and PCTs that require attention. The aim is that by 2007/8 the RSU will be working with SHAs to focus on performance through the new PCTs; it will continue to track individual PCT performance but will not engage with PCTs directly except with explicit agreement from the SHA.
- 6.7 The basis of the planning and performance regimes in 2006/7 will be the same as in previous years: SHAs will work with the local NHS to maintain the strong record of delivery. However, there is a need to change the role of the SHA in the planning framework to join up service, finance and system reform and to reflect the new organisational arrangements. The Director of Performance will shortly write to SHAs with planning requirements for 2006/7.
- 6.8 Although the performance management regime for 2006/7 will remain similar to that currently in place, DH will work through the SHAs so as to be involved in ensuring the turnaround of NHS trusts and PCTs. Only in exceptional circumstances will there be a more intensive performance

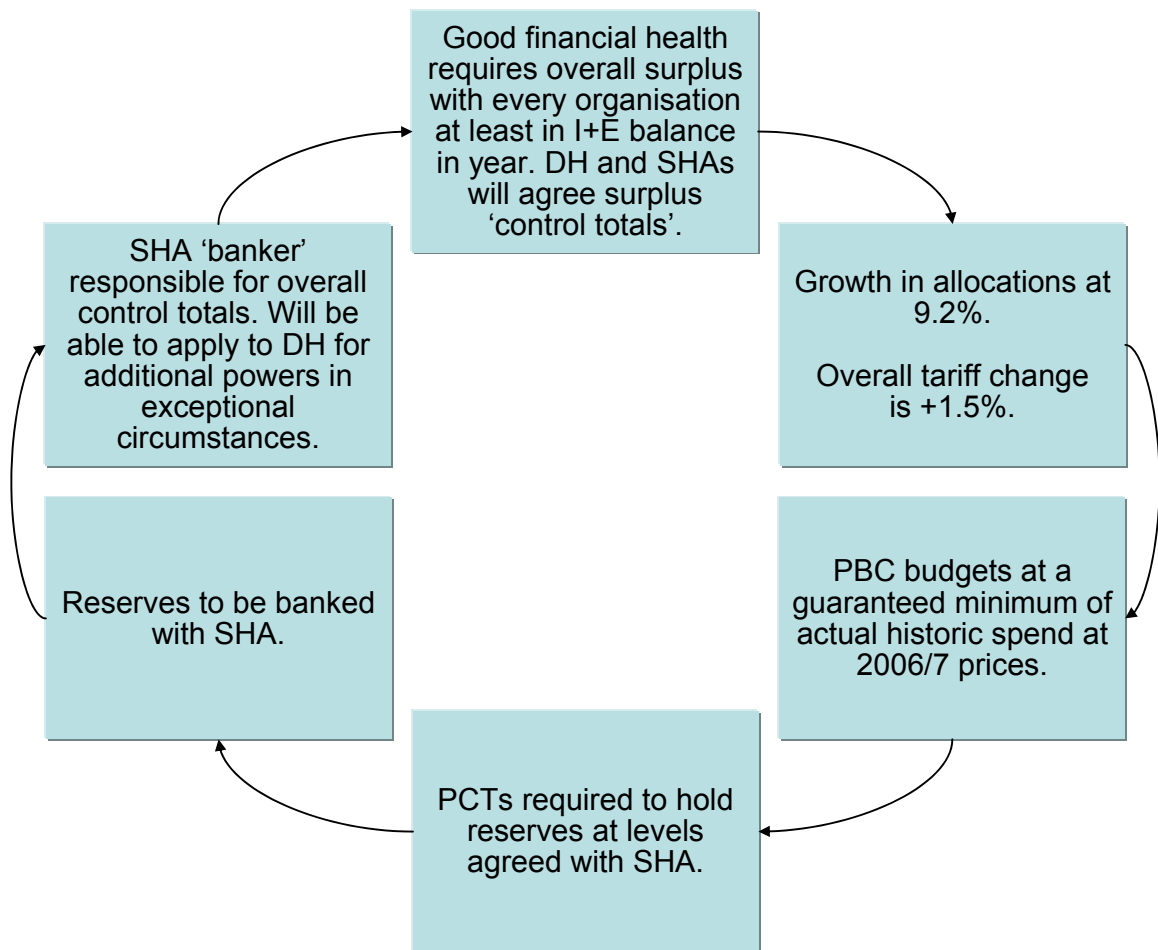
regime between DH and SHAs for specific health communities. These exceptional circumstances will be agreed between DH and the SHA, and will include any area whose performance differs significantly from the agreed plan on any of the key national deliverables.

Special circumstances

- 6.9 The rules set out in this document are binding. No health community will be able to opt out or to change the rules unilaterally. In exceptional circumstances, an SHA may request permission from DH to introduce additional measures to dampen financial volatility in a particularly challenged community. This will be a last resort, will be for a time-limited period and will trigger very close attention from the RSU. Where an NHS Foundation Trust is affected, additional measures will only be implemented with the prior agreement of Monitor, as well as DH. DH and Monitor will issue guidance at the end of March on the circumstances under which this might be acceptable, and on the additional measures that might be considered. Reform measures will in no case be suspended – they are critical to sustainable recovery. For a temporary period, the intention of any additional measures will be to implement reform, with additional safeguards reflecting local capability.

Annex A

Financial management in 2006/7



Annex B

National targets and Local Delivery Plan (LDP) measures

These targets and measures are as described in *National Standards, Local Action* (July 2004).

Priority I: Improving the health of the population

By 2010 increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.

Cardiovascular disease mortality and inequalities: substantially reduce mortality rates by 2010 from heart disease, stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

PSA01a: Cardiovascular disease mortality

PSA01b: Practice-based Registers

PSA01c: Blood Pressure

PSA01d: Cholesterol Levels

Cancer mortality and inequalities: substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

PSA03a: Cancer mortality rates

PSA03b: Cancer – Implementation of NICE Improving Outcomes Guidance (IOGs)

PSA03c: Bowel cancer screening (returning plans to DH is deferred)

Mental health: substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%.

PSA05a: Suicide rates

PSA05b: CPA 7-day follow-up

Inequalities: reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

PSA06a: Infant mortality: Smoking during pregnancy

PSA06b: Infant mortality: Breastfeeding initiation rates

Smoking: tackle the underlying determinants of health and health inequalities by reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.

PSA08a: Smoking quitters at 4 weeks attending NHS Stop Smoking services

PSA08b: Smoking status amongst the population aged 15 to 75 years

Obesity: tackle the underlying determinants of health and health inequalities by halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.

PSA10a: Childhood obesity (returning plans to DH is deferred)

PSA10b: Broader strategy on obesity: Obesity status amongst the GP registered population aged 15 to 75 years

Sexual health: tackle the underlying determinants of health and health inequalities by reducing the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health.

PSA11a: Teenage conception rates

PSA11b: Broader strategy to improve sexual health: Access to GUM clinics

PSA11c: Broader strategy to improve sexual health: Decrease in rates of new diagnoses of gonorrhoea

PSA11d: Broader strategy to improve sexual health: Percentage of people aged 15 to 24 accepting Chlamydia screening (returning plans to DH is deferred)

Priority II: Supporting people with long-term conditions

To improve health outcomes for people with long-term conditions by offering a personalised care plan for the most at risk vulnerable people; and to reduce overall emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

PSA12a: Emergency bed days

PSA12b: Number of community matrons

PSA12c: Number of Very High Intensity Users (VHIUs) under the case management of a Community Matron

Priority III: Access to services

Access: to ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.

PSA13a: Number of outpatients waiting longer than the standard

- PSA13b Number of patients waiting longer than the standard for MRI or CT scans
- PSA13c Number of patients waiting longer than the standard for other diagnostic tests and procedures
- PSA13d: Number of inpatients waiting longer than the standard
- PSA13e Number of outpatients waiting longer than the standard in Trauma and Orthopaedics
- PSA13f: Number of inpatients waiting longer than the standard in Trauma and Orthopaedics

Drugs: increase the participation of problem drug users in drug treatment programmes by 100% by 2008, and increase year-on-year the proportion of users successfully sustaining or completing treatment programmes.

- PSA14a: Number of drugs misusers in treatment
- PSA15a: Drugs misusers sustained in treatment

Priority IV: Patient / User Experience

Patient experience: secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently-validated surveys, and ensure that individuals are fully involved in decisions about their healthcare, including choice of provider, as measured by independently-validated surveys.

- PSA16a: Annual national improvements in patient surveys/ ensuring individuals are involved, offering choice. SHAs are not required to submit plan data to DH

Older people: improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008 and increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

- PSA18a: Increase the proportion of older people being supported to live in their own home, and increase the proportion of those supported intensively to live at home. SHAs are not required to submit plan data to DH

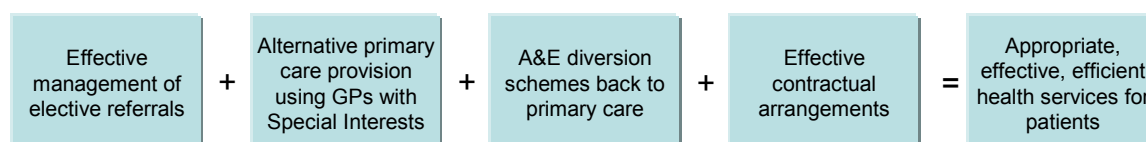
MRSA: Achieve year-on-year reductions in MRSA levels.

- PSA20a: Number of MRSA infections

Annex C

Demand management in 2006/7

- C.1 All PCTs will need to have effective demand management strategies in place for next year. They should cover three areas:
- > Implementation of **practice-based commissioning**. This will ensure that all practices have the incentive to control referrals and other use of services. Freed-up resource will be able to be re-invested in better services for patients.
 - > Provisions in **contracts**. PCTs will not be able to apply activity caps in contracts. But they should consider other indicators, for example outpatient-to-inpatient conversion ratios, which they would expect to remain stable. They might also look at expected clearance times for existing waiting lists, to ensure affordability.
 - > **Activity plans** in contracts. This should include monitoring arrangements and a joint responsibility for agreeing measures to deal with significant variance from plan. This will include joint actions to free up resources for re-deployment where activity is reflecting patient choice and/or a genuine, unexpected increase in demand for a service.
- C.2 In addition, with the approval of DH (and Monitor where appropriate), SHAs will be able to put in place additional measures in exceptional circumstances.
- C.3 A national health service will always need to operate within the resources available. It is in no one's interest locally to 'break the bank'. Strong relationships, excellent monitoring and joint commitment to remedial action will ensure that funding translates into the maximum benefit for patients. These are the behaviours that DH and Monitor expect to see locally.
- C.4 In summary



C.5 Some examples of current good practice are set out below.

- > Some PCTs have implemented schemes to **more effectively manage patients within primary care** reducing the need for referrals to secondary care.
 - A PCT in the North West has developed a tier 2 diagnostic centre covering orthopaedics, ophthalmology, gynaecology and dermatology. For orthopaedics and ophthalmology, referrals to hospital have been reduced by 30%. In dermatology, 70% of patients have been referred on to a community-based GP with special interests (GPwSI) service, avoiding long hospital waits.
 - A PCT in Yorkshire has developed a primary-care-facing diagnostic centre with an independent-sector partner. It provides a one-stop service, allowing patients a definitive diagnosis on the day they attend, and has delivered reductions in waiting times through protocol-driven referrals direct to day surgery lists in the local hospital.
- > PCTs have also worked with local NHS Trusts to **locate GPs alongside A&E facilities** to help manage demand for emergency services.
 - A PCT in Yorkshire has co-located its out-of-hours service with the local hospital A&E. Close joint working across the two services to triage patients has allowed 3% of all A&E attendances to be streamed into primary care.
- > PCTs have used their **contracts with NHS Trusts** to manage demand within the secondary care element of the care pathway.
 - PCTs across one SHA have developed agreements with their acute trusts to require referrals for a limited range of specialised services to be referred back to the PCT as the commissioner. Referrals are then judged against key criteria agreed by the whole PCT community.

Annex D

Interim SHA system management role in 2006/7

This summary covers the role of SHAs in relation to system management; they will, of course, have other responsibilities next year. The description applies to all SHAs from April 2006. It should be noted that SHAs have no direct intervention or management powers with NHS Foundation Trusts.

Banker for PCT reserves

SHAs will hold reserves on behalf of PCTs. They will have responsibility for meeting overall surplus 'control totals' in their areas.

Performance management

SHAs will continue to manage performance on behalf of the Department of Health.

Organisational and system development

SHAs will have responsibility for the development of PCTs and NHS trusts in their areas, making use of the development programmes. They will also have overall responsibility for ensuring the full implementation of system reforms.

Arbitration

SHAs will minimise intervention with individual organisations. But they will have authority to arbitrate between NHS trusts and PCTs.

Reconfiguration

SHAs will ensure effective processes of engagement and consultation with patients, users and local people. They will oversee any merger proposals between NHS Trusts, including safeguarding choice for patients.

Special circumstances

SHAs may, in wholly exceptional circumstances, request that DH allows additional rules to apply in areas with particular challenges. These will be temporary.

The expectation is that SHAs will be supportive, providing good leadership for local leaders to respond to patients, to reform services and to be creative and innovative in their new rules. It will only intervene where this is necessary in the interests of patients or the taxpayer. When the SHA does intervene, it will have the influence and levers to act quickly, firmly and effectively.

Annex E

Transition arrangements: January to July 2006

Transition arrangements for SHA clusters

- E.1 This Annex sets out the arrangements for managing business in the period before new SHAs come into place following public consultation and subject to Ministerial decision. The arrangements have been discussed with SHA Chairs and Chief Executives to ensure that they fully address business continuity issues and that accountability for work done on a cluster-wide basis is clear.
- E.2 The way in which these arrangements will operate will differ around the country. Hence SHAs will shortly be agreeing with their local health communities how they will operate in practice.

Ongoing accountability for delivery

- E.3 All SHAs have a vital role to perform in this period to ensure:
- > delivery to – and through – the year end;
 - > that the local NHS has comprehensive plans for 2006/7 to ensure delivery of the national requirements on finance, national targets and system reform, as well as meeting local priorities;
 - > continued overseeing of their local health system; and
 - > ongoing support to NHS Trusts and PCTs.
- E.4 Each SHA Board will remain accountable to the Department of Health for its part of the NHS until ministers determine whether, following public consultation, to establish new SHAs.
- E.5 However, in the meantime, there are a set of transitional tasks that are best managed on a cluster basis, in anticipation of the proposed new SHAs. These transitional tasks are set out below, having been agreed with SHAs.
- E.6 A Transition Lead for each cluster was announced on 20 January 2006 to ensure that local arrangements will be in place to cover these tasks.

Local transition arrangements

- E.7 The way in which the transition tasks will be tackled will be determined locally within the SHA clusters in discussion with key stakeholders. It is expected that different arrangements will be agreed in different parts of the country, with flexibility to do what best fits local circumstances. The Department of Health will adapt its working model to fit these arrangements once they are agreed.
- E.8 Two things will be essential over this period:
- > that the governance arrangements for all work done on a cluster basis are clearly defined and agreed by all the SHA Boards involved; and
 - > that the transition programme is fully supported by the SHA Boards and that the nominated Transition Lead has the delegated authority and resources to act on behalf of the cluster.

Transition tasks

- E.9 The cluster-based transition tasks which build on the work of existing SHAs are as follows, with the job of the Transition Lead being to ensure arrangements are in place to ensure that they are carried out to suit the local context:
- > **Business continuity** - existing SHAs are responsible for delivery of the 2005/6 year-end agreed position on the national deliverables and are responsible for ensuring that there is no let-up in delivery in Quarter 1 of 2006/7. This includes delivery of turnaround in individual trusts and PCTs. The transition tasks to support this are:
 - maintaining momentum on partnership arrangements with local government; and
 - determining which issues could be managed in line with new organisational arrangements.
 - > **2006/7 planning** - existing SHAs are responsible for ensuring that the local NHS has comprehensive plans to ensure delivery of the national requirements on finance, national targets and system reform as well as to meet local priorities. These plans need to build on existing LDP trajectories and this guidance on system rules for 2006/7. The transition tasks to support this are:
 - ensuring a consistent basis for 2006/7 plans;
 - ensuring a consistent financial plan that addresses the underlying financial position;
 - building a benefits realisation plan from new commissioning arrangements;
 - implementing system reforms;
 - building links with ISIP; and
 - updating local tracking systems for delivery of PSA targets.

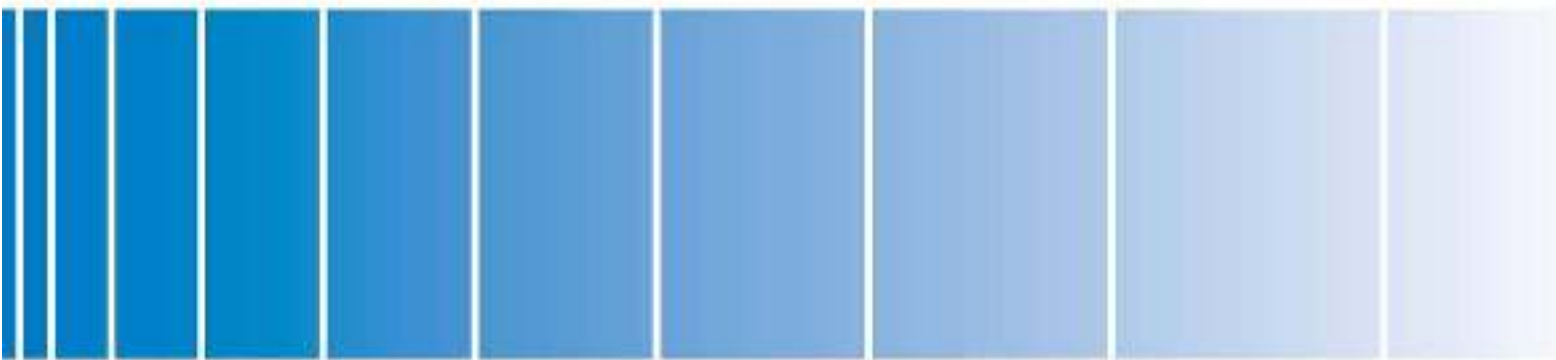
- > **Managing the change** (implementing *Commissioning a Patient-led NHS*) - existing SHAs are responsible for managing the *Commissioning a Patient-led NHS* consultation process. The transitional tasks to prepare for the future are:
 - ensuring consistent management of the outcome of the consultation process across the cluster;
 - overseeing the process for establishing the new SHA;
 - confirming the process for determining SHA, PCT and Ambulance Trust organisational structures;
 - reviewing the SHA, PCT and Ambulance Trust capabilities by role and staff training needs analysis;
 - establishing an HR framework including transition arrangements for staff;
 - confirming the process for PCT appointments;
 - confirming arrangements for handling 2006/7 accounts;
 - handling accommodation issues;
 - developing practice-based commissioning;
 - achieving PCT fitness for purpose;
 - confirming arrangements for supporting regional and national commissioning; and
 - developing NHS trusts for NHS FT status.

- > **Motivation and engagement** - existing SHAs are responsible for keeping the clinical and managerial community focused on and motivated about the task in hand. The transition task to support this is:
 - engaging clinicians and other health professionals on the system reform and White Paper agenda.

- > **Communication** - existing SHAs are responsible for ensuring arrangements are in place for the robust protection of the reputation of the NHS, both regionally and locally. The transition tasks to support this are:
 - outlining a strategic approach for stakeholder management regionally; and
 - developing a communication strategy which explains how patients, staff and the public will benefit from the new arrangements taking shape in the area.

Transition support

- E.10 In consultation with DH and SHA colleagues, the Transition Lead will determine how these transition tasks are dealt with. Priority needs to be given to finance (including turnaround where necessary), public health and clinical leadership, HR, and communications, to reflect the importance of these functions to a successful transition process.
- E.11 Transition Leads will also ensure that social care and other local government partners are actively contributing to the transition agenda.



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273048/*The NHS in England: the operating framework for 2006/7* is available to view or download from www.dh.gov.uk/publications