From the Office of Sir Ian Carruthers OBE
Acting NHS Chief Executive

Richmond House
79 Whitehall
London
SW1A 2NL

Tel: 020 7210 5692
Fax: 020 7210 5409
Ian.Carruthers@dh.gsi.gov.uk

10 May 2006

Gateway reference number: 6509

To: PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Special HA CEs, Directors of Finance, Communications Leads

Dear Colleague

THE OPERATING FRAMEWORK FOR 2006/07

1. In the Operating Framework published at the end of January 2006 the Department set out priorities and management arrangements for the NHS in 2006/07. This letter emphasises that we will continue to drive and wherever possible accelerate the programme of reform as set out in the Operating Framework and *Health Reform in England.*

   (i) more choice and a much stronger voice for patients (demand-side reforms);

   (ii) money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (transactional reforms);

   (iii) more diverse providers, with more freedom to innovate and improve services (supply-side reforms);

   (iv) a framework of system management, regulation and decision-making which guarantees safety and quality, fairness, equity and value for money;

   all leading to better care, better patient experience and better value-for-money. The letter also gives further advice where this was promised in the operating framework.

2. I have discussed this with the SHA Transition Leads, the NHS Confederation, the NHS Foundation Trust Network and Monitor and I am grateful to them for

their help. It now puts the NHS in a position to focus on achieving excellent care within a balanced budget.

Further advice on the Operating Framework

3. Published on 28 January 2006, the Framework identified a number of areas where further advice would follow after discussion with stakeholders. My letter of 17 March issued the corrected tariff for 2006/07 and confirmed the way Purchaser Parity Adjustments would work. The key parts of the PbR operational guidance are also on the website at: http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/NHSFinancialReformsArticle/fs/en?CONTENT_ID=4127039&chk=bypVXH

4. I am now setting out our approach to:

- the framework for SHAs holding reserves (paragraph 2.7 of the Operating Framework);

- joint responsibility for taking action to stay on plan (paragraph 3.7 of the Operating Framework);

- the framework for 'special circumstances' (paragraph 6.9 of the Operating Framework);

- service reconfiguration process (paragraph 4.9 of the Operating Framework);

- joint DH and Monitor merger principles (paragraph 4.12 of the Operating Framework);

- confirmation of PFI plans (paragraph 4.14). Annex A summarises the process in place.

5. The Operating Framework established the case for PCTs being required to lodge reserves with SHAs. The purpose is to recover any deficit carried forward by the PCT and to provide cash and resource cover for the NHS in aggregate next year. There will not be a contingency reserve to cover against failure to manage to plan. The amounts and terms of reserves will be for local agreement between SHAs and PCTs but within the following framework to ensure fairness and consistency:

- SHAs must maintain the integrity of the allocations system. PCTs will be entitled to repayment of contributions to the reserve over a reasonable period not usually exceeding the three year allocation cycle; there may be exceptional circumstances where the overall financial environment in the SHA determines a longer pay-back period that does not damage the donating PCT. Organisations lodging reserves with the SHA will receive interest on the funding, as long as they lodge cash as well as resources;

- SHAs will have full regard to the financial and service position of each organisation in determining how reserves are generated and applied. In particular, SHAs will take into account the impact of the change to PPA and local PCTs;

- there will be transparency in both the creation and use of reserves, with donors having oversight and regular reports from the SHA. While reserves may be used to ensure a fair and reasonable starting point, they will not be used to bail out organisations which fail to deliver their financial plans during the year. The impact of poor financial performance may affect the scale and timing of pay-back;

- decisions will be made and reserves held at the level of transition SHAs.

6. The Operating Framework emphasised the importance of contracts between PCTs and providers setting out agreed service requirements and shared activity plans. These are essential for good financial and service planning and will be the vehicle through which PCTs and SHAs can ensure consistency and

affordability within a health community. There cannot, under PbR, be caps. But there is an expectation that all parties will aim to deliver on plan. There is a joint responsibility to identify and rectify emerging problems. In practice we expect this joint responsibility to be discharged in a number of ways:

- shared plans must be based on good analysis and understanding of need, demand and affordability. Unrealistically low or high plans are equally unsustainable;

- shared plans will be at a sufficiently detailed level to be financially meaningful. This should be at HRG level; at the least, we shall expect shared plans for high cost and volatile HRGs. Plans will have monthly profiles;

- contract monitoring will be regular, timely and detailed with monthly reports shared with Boards. We expect activity and finance reporting to include year to date against profiles as well as forecasts. Contracts and SLAs should reflect these information needs. Contracts must be signed. Unresolved issues from 2005/6 do not provide a reason to fail to sign contracts for 2006/7 in the next few weeks. Contracts must require compliance with the PbR Code of Conduct;

- where monthly monitoring meetings identify significant variances, both parties to the contract will undertake a joint exercise to identify the reason for variation and to agree appropriate remedial action. Where there is higher than planned demand, commissioners will need to employ target and demand management strategies or identify other services where they can agree compensating changes. Where demand is within expectations but providers accelerate activity beyond plan, there will need to be agreement about reasonable rates of waiting list and time reductions (as flagged in paragraph 3.8 of the Operating Framework). Responses need to be rapid, fair across all providers, and jointly owned. Boards must be fully engaged in the process.

7. Where remedial actions are ineffective or fail to be agreed; where the variance from plan persists; and where the impact is material to the financial health of the local community, the transition SHA lead may apply for 'special circumstances' designation for the area concerned. I expect such applications to be rare and be targeted on specific local systems rather than the whole SHA area. This will be a serious measure and will constitute an admission of failure on behalf of the commissioners, the providers and the SHA. In no case will PbR or other reforms be allowed to be suspended.

8. Applications for 'special circumstance' status must be made to DH through the RSU. As set out in the Operating Framework, before submitting any application that has a material impact on an NHS Foundation Trust, the SHA must work together with Monitor to reach agreement about an appropriate approach that is consistent with Monitor's compliance regime.

9. An application must include the proposed actions the SHA wishes to take. These will fall in three areas:

   i. management intervention; SHAs will need to set out how they will ensure progress at a level of detail. They will agree with RSU accountability arrangements to DH;

   ii. additional local rules for the operation of PbR, for example capped payments for specified HRGs. In no case will PbR or other reforms be allowed to be suspended;

   iii. the proposed period for special circumstances. In all cases this must be time-limited and must be less than 12 months.

10. The main drivers of service re-configuration proposals are patient safety and service improvement. Alongside these, the need for financial recovery and sustainability is likely to lead to an increase in the volume of proposals. Effective management and communication of these is a core responsibility of SHAs, PCTs and trusts. It is essential that there is strong involvement of

patients, public and clinicians in putting together viable proposals. We shall issue best practice guidelines on process by June 2006; the principles are set out in *Strengthening Accountability – Involving Patients and the Public* and *Overview and Scrutiny of Health*. SHAs are responsible for co-ordinating and quality-assuring proposals in their areas and ensuring the RSU is informed of progress.

11. Proposals should bear in mind the strategic context for the development of community services set out in the White Paper, *Our health, our care, our say*, especially the expectation of a shift to services provided in the community, and to greater partnership working between health and social care. Proposals for community hospitals should be consistent with the Department's letter of 16 February.

12. Service or organisational reconfiguration in the NHS has too often in the past failed to deliver the required quality and cost improvements. Proposals must have rigorous business cases with integration and benefits plans and clear accountability so that quality and financial improvements are realised.

13. All organisational merger proposals (including proposed acquisitions) will be assessed against the following principles:

- has the process of consultation been adequate (including an assessment of stakeholder, particularly practice-based commissioner, PCT and SHA views);

- will safety and quality of services be sustained or improved;

- will financial balance and surplus be accelerated and long-term financial viability improved through improved efficiency and cost-control;

- will access, choice and competition post-merger be adequate. Applicant NHS trusts and NHS foundation trusts should consult with their PCTs and

SHAs and reach agreement on the expected effects before making a formal application;

- are rigorous, robust and credible post-merger integration and benefits realisation plans available and owned by the leadership teams involved.

DH and Monitor will continue work on the detailed processes and metrics to underpin these principles.

14. The processes will differ depending on the status of the organisations involved:

- proposals involving only NHS trusts will be decided on by Secretary of State with advice from SHAs;

- decisions on mergers proposals involving the authorisation of a new NHS foundation trust are made by Monitor in line with its statutory responsibilities, following due consultation. Where an existing NHS trust is involved, the Secretary of State decides whether or not to allow the application to proceed for Monitor's decision.

15. The Operating Framework set out a requirement for Trusts to reconfirm any plans they had for a PFI scheme. The aim of this process is to ensure the sustainability of the PFI programme, and to deliver schemes that are locally affordable and take account of the direction of travel signalled in the recent White Paper. Annex A provides more detail.

High-Level Financial Plans and LDPs

16. During May, the Department will meeting SHA Transition Leads and new SHA Chief Executives to review high-level financial plans and LDPs.

17. The Operating Framework committed us to publish productivity and efficiency indicators at trust and PCT level (paragraph 2.4). SHA leaders have

agreed a list of indicators for PCTs and for acute NHS trusts that will be published quarterly by the NHS Institute of Innovation and Improvement. These are set out in Annex B, and will help managers and clinical staff identify areas for improvement. The NHS Institute and ISIP will provide support to local health communities to ensure that the benefits for patient care and financial delivery are realised. Further detail on the proposed metrics will be issued shortly, and additional metrics including indicators for ambulance and mental health trusts, will be developed.

Conclusion

18. Our shared task is to get on with delivering continued improvements to care within the increased resources available. We are accountable to taxpayers for the effective stewardship of public money; and to patients for ensuring excellent services are available promptly. These imperatives cannot be traded off against each other. This ambitious agenda presents us with complex management challenges in the coming year and will require high quality leadership across the service, and excellent communications. It is essential that together we grip and overcome the problems we currently face and ensure that the reform programme is embedded so that the benefits are realised in each local health community.

Yours faithfully

SIR IAN CARRUTHERS OBE
ACTING NHS CHIEF EXECUTIVE

Annex A

PFI

- We announced in "The NHS in England: the operating framework for 2006/7" that all Trusts would need to reconfirm any plans they had for PFI or any other major investment. The aim of this process will be to confirm the sustainability of the PFI programme and that they take account of the direction of travel signalled in the recent White Paper and patient needs.

- The process will be iterative. The Department will work particularly closely with SHAs, and there will be wider collaboration with Monitor, PCTs, and trusts. Initial focus will be on those schemes that have already engaged with the market and will concentrate on:

  - affordability;

  - financial position of the Trust concerned;

  - financial suitability of the scheme;

  - project need (including capacity analysis of capacity assumptions).

- An experienced PFI scheme director from the NHS will lead the process. He will be responsible for working with trusts, to ensure they reach workable solutions. Working alongside him will be representatives from the ISTC programme and from DH's Capacity Planning Team.

- For those schemes that have not yet engaged with the market, the process will be less stringent, reflecting the fact that for most of these schemes trust plans are not detailed enough to merit in-depth scrutiny. Instead we aim to agree an affordability envelope based on the experience of trusts with fully operational PFI projects. This will take into account viability of the project within this

envelope. For trusts in this category, priority will be given to those who wish to issue OJEUs in the second half of 2006.

- The numbers on which the affordability envelope will be based to allow for what is included (soft and hard FM, MES, etc), and what additional income the trust will receive because of, for example, low reference costs, and the scope of their project.

- The entire process will take no longer than 4-5 months and the objective will be to reaffirm the size, scope and timing of the NHS's PFI programme. It is intended that the agreed scale and scope of each scheme, together with the timing of its entry into the market, will be made publicly available.

Annex B

Initial List of Productivity and Efficiency Indicators

Acute Trusts

1. ***Clinical Productivity***: data from Hospital Episode Statistics
   - Reduced variation in length of stay (potential bed days saved)
   - Day case rate for Audit Commission basket of procedures
   - Reduction in wasted pre-operative bed days

2. ***Finance***: data from the Financial Information Management System new return
   - Income and expenditure
   - Cash
   - In Year monthly run-rate

3. ***Workforce***: data from the new workforce return linked to the Financial Information Management System
   - Staff turnover
   - Sickness absence
   - Agency costs
   - FCEs per consultant

4. ***Prescribing and Procurement***: data from organisational returns to Purchasing and Supplies Agency
   - Uptake of nationally negotiated contracts

Primary Care Trusts

1. ***Clinical Productivity***: data from Hospital Episode Statistics
   - Admission rates for selected procedures where unnecessary surgery is a recognised issue
   - Reduction of avoidable emergency admissions against specific recognised diagnoses
   - Referral rates to first outpatient appointment standardised

2. ***Finance***: data from the Financial Information Management System return
   - Income and expenditure
   - Cash
   - In-year monthly run-rate

3. ***Workforce***: data from the new workforce return linked to Financial Information Management System
   - Staff turnover
   - Sickness absence
   - Agency costs

4. ***Prescribing and Procurement***:
   - Uptake of nationally negotiated contracts: data from organisational returns to the Purchasing and Supplies Agency

- Adoption of national guidance for primary care prescribing for specific drugs such as statins: data from Prescription Pricing Authority