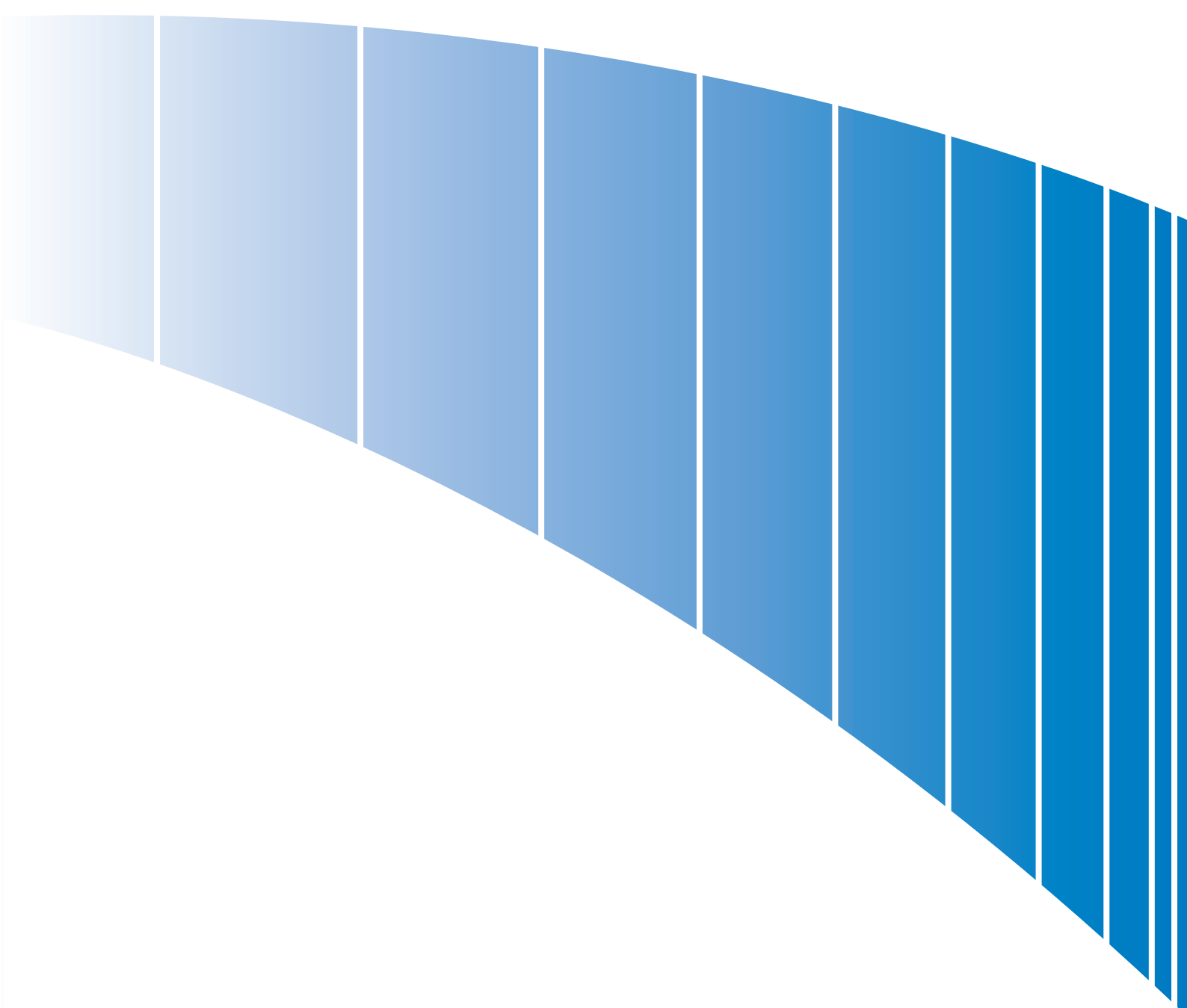


The NHS in England: the operating framework for 2007/08



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Foreword

from David Nicholson, NHS Chief Executive

The NHS in England: the operating framework for 2007/08

We have a clear vision for the NHS. It is to promote health, reduce health inequalities, and deliver the best possible care for the population with the resources available. The reform tools, implemented and delivered locally, are the means by which the NHS will achieve this vision, by improving the quality and responsiveness of services for patients and ensuring better value for tax payers.

In order to ensure focus and consistency of purpose, there are no new national priorities for the service to deliver on for this year. But the operating framework for 2007/08 does set out a number of changes in the way we expect the NHS to conduct its business that are significant. We are deliberately moving towards a much more rules based system which will bring some much needed rigour and transparency to the NHS.

But it is vital that the reforms do not get reduced to a set of contracts or transactions. Our ambition is to achieve transformational change for patients, and the behaviours of NHS organisations and individuals needs to reflect this. We expect primary care trusts (PCTs), practice based commissioners, providers and local government and other stakeholders to work in partnership for the benefit of tax payers and patients. We are publishing a set of principles for consultation alongside the NHS Contract, and these will help to bind together all members of the NHS family in a partnership for patients and the public.

The operating framework for 2007/08 provides consistency of purpose for the NHS, setting out the key targets that our staff need to focus on in order to improve patient experience, reduce health inequalities and achieve financial health.

Greater clarity and consistency of purpose means that we can increasingly devolve the way in which change is delivered at a local level. Tackling health inequalities is one of our key priorities, but we recognise that PCTs are in a better position to identify the issues that require most urgent attention locally and the operating framework requires them to agree local priorities with their local authorities. The operating framework sets out the importance of tackling all healthcare associated infections, and instead of setting a new national target requires PCTs to engage with clinicians and to agree local targets for reducing levels of

Clostridium difficile. Achieving 18 weeks is a national target, but we recognise that the degree of transformation required cannot be delivered from the centre, and that it is local clinicians and managers who need to drive this change.

We are devolving power from the centre to the service in many ways, not least in how we allocate money, such as the unbundling of central budgets. Some of the key enablers of service transformation, such as the delivery of Information Technology will also increasingly need to be driven and owned out in the service rather than from the centre, so that patients can get the full benefits as quickly as possible.

And we wish to go further still. 2007/08 represents the last year of the current Comprehensive Spending Review settlement and the due date for delivery of several key targets. Ultimately our ambition is to create an environment in which the health care reforms, local organisations and patients create an inbuilt dynamic for continual service improvement, no longer requiring (or indeed benefiting from) traditional top down performance management as we know it.

But we can only do this if we continue to deliver. By the end of this financial year (2006/07), we expect the NHS to return to net financial balance. This will be an important step towards us being able to consider reversing the impact of past resource accounting and budgeting (RAB) deductions, as recommended by the Audit Commission.

The operating framework for 2007/08 provides timely clarity for the service not just about what needs to be done but why we need to do it. This is a national framework designed to help local NHS staff shape services around the needs of their local communities. But the degree of transformation and change that our patients and citizens require can only be delivered by our greatest resource – the staff who work for NHS patients.

A handwritten signature in black ink, appearing to read 'D Nicholson', with a long horizontal flourish extending to the right.

David Nicholson CBE

NHS Chief Executive

11 December 2006

1. Introduction and context

- 1.1 The NHS Plan, published six years ago, set out a programme of investment and reform to transform services to make them more responsive to patients, and deliver the best possible care for the population within the resources available. The first phase focused on building workforce and physical capacity, and tackling issues of major concern to the public. Thanks to the efforts of NHS staff, progress has been significant. Waiting times have fallen to record lows; clinical outcomes for cancer and heart disease have improved; and many NHS facilities have been modernised. This phase of the programme has relied heavily on targets and top-down performance management to get the improvement needed in the short term.
- 1.2 2007/08 marks the second phase of reform. By 2008/09, we will have an NHS characterised by free choice across a wide range of providers, competing on quality, as money follows patients. Funding growth will be steadier after a sustained period of significant investment, which will have brought NHS funding in line with European comparators. This imposes new disciplines and responsibilities on all parties.
- 1.3 The proposals in *Our health, our care, our say*¹ set the strategic direction for delivering healthcare in the future. Reforming and improving community services will enable a greater focus on prevention, promoting well-being and delivering services in more local settings, which are flexible, integrated and responsive to people's needs and wishes. Health reform provides the means of improving service delivery. Health reform provides balanced incentives, transparency, plurality and patient choice, supported by better commissioning.
- 1.4 A great deal has already been done to embed the reforms in the system – patients are getting more choice, we have a wider range of providers and payment by results (PbR) is being rolled out. But we now need to see a further, decisive shift towards building a self-improving system in which change is led and driven by clinicians and other staff, and managers at a local level, responding to the needs of their patients and the public. Increasingly, the focus will be on the way the NHS responds to patients, and the outcomes it achieves by tackling variations in healthcare through improved productivity.

¹ Department of Health. *Our health, our care, our say: a new direction for community services*. January 2006. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXlecj

1.5 It is important that everyone understands why these changes are so necessary. Significant progress has been made in transforming how care is delivered by individual organisations. We now need to focus our efforts on transforming the whole system of care delivery. The reforms are the means of achieving this. The changes we are implementing are not in response to some centrally driven agenda, but to real changes that we cannot afford to ignore:

- > **Rising expectations:** we are delivering shorter waiting times and better services, but we are still some way short of providing people with the control, choice and convenience they expect in other parts of their lives.
- > **Demographics:** an aging population, with increasing numbers of people with long-term conditions, requires the NHS, in partnership with local authorities and others, to focus more on promoting good health, well-being and independence. This has implications for how services are organised.
- > **Changes in medical technology:** these are transforming the ability of the NHS to prevent, cure and manage disease, but are also creating new costs and a need to change the way services are configured.
- > **Variations in quality, safety, access and value for money:** in a national health service, people are rightly concerned about ongoing variations in the care on offer in different parts of the country.

1.6 Our strategy is to address these challenges through:

- > more choice and voice for patients, giving patients real power, backed up by strong commissioning;
- > more diverse providers, with more freedom to innovate and improve services, and more competition on quality;
- > financial incentives to improve care and promote sound financial management and best value;
- > national standards and regulation to guarantee quality, safety and equity;
- > sustained focus on information management and technology to underpin the reforms and deliver better, safer care.

- 1.7 The purpose of this document is to set out the parameters within which local organisations will work in 2007/08, and which underpin the expectations for the local delivery plans (LDPs) to be agreed between strategic health authorities (SHAs) and the Department of Health (the timetable for this is set out in Annex A). It does this by clarifying:
- > **The health and service priorities for the year ahead:** we are not setting new priorities for next year. The emphasis is on continuity. 2007/08 marks the last year of the existing three-year planning cycle and we expect organisations to deliver existing planning commitments. Within this there will be issues that require particular attention because of the degree of challenge faced (notably, 18 week referral to treatment and healthcare associated infections).
 - > **The next steps in reform:** the aim is to embed reform so that local clinicians and managers can use the new reform tools and levers to transform services and therefore to improve and save more people's lives.
 - > **Financial objectives:** achieving financial health, including a net surplus of at least £250 million, will be a key priority for the NHS next year. This is critical to building public confidence in the ability of the NHS to manage tax payers' money, and to provide a solid basis for improving services as the NHS moves to steadier levels of growth from 2008/09. The surplus level balances the need for contingencies to manage risk in a future of PbR and choice, with a recognition of the existing challenges for organisations in financial recovery.
- 1.8 Strong accountability for performance will continue throughout the system. But the nature of accountability relationships and behaviours will evolve in 2007/08. We are giving local organisations, including primary care practices, more freedoms and placing ever-greater trust in them to deliver. In this context, the role of local boards, and their non-executive members, becomes increasingly critical. The *quid pro quo* of less central prescription and intervention is that local boards take greater ownership for continuous service improvement and acting in the public interest. We expect this to be an underlying principle of local approaches to performance management across the NHS.
- 1.9 Increasingly PCTs need to be outward-facing organisations, accounting to their local communities for the outcomes they achieve and reflecting local needs and feedback in the way they commission services for their communities. They will need to anticipate

and develop responses to future challenges, not be the passive recipients of the next set of instructions.

- 1.10** Contracts will be the key accountability mechanism between PCTs and an increasingly diverse range of providers. This has serious implications for PCTs in 2007/08. They need to ensure that expectations, planning assumptions, and the balance of risks and controls are all clearly defined in the contracts they put in place.
- 1.11** It is the very nature of the reforms that improvements must be owned and delivered by clinicians, managers and other front-line staff on the ground. It is vital, therefore, that everyone who works in the health service understands the new levers, powers and incentives we have introduced so that they can use them to deliver improved patient care and save more lives.
- 1.12** It is the responsibility of the NHS community leadership (in PCTs, practices, NHS trusts and foundation trusts² (FTs)) to engage fully with clinicians, staff, patients and the wider public to communicate and explain the need for change and the potential of the reforms locally to improve services and people's lives.
- 1.13** The NHS cannot deliver this agenda on its own. In particular, PCTs need to work with local authorities to improve health and well-being, reduce inequalities and achieve a shift towards prevention. We have brought the NHS planning timetable forward to facilitate effective joint working with local government. PCTs are expected to play their full part in the local area agreement process and to agree with local authorities those aspects of LDPs that require joint work.

² NHS foundation trusts can use their wider governance arrangements to engage with their membership base and trust governors.

2. Health and service priorities

- 2.1** The NHS is an increasingly complex system dealing with a wide range of healthcare needs and services. It is the responsibility of all NHS organisations to ensure the continuous improvement of all services they are responsible for, all the time. That is why we have introduced in recent years a standards framework, which is intended to give patients and the public confidence in the fact that all aspects of healthcare are quality assured. It is also designed to encourage organisational self-improvement.
- 2.2** NHS national priorities need to be seen in this context. Just because something is a priority does not mean that other things do not matter.
- 2.3** PCTs and other NHS organisations are already working to three-year LDPs for the period 2005/06 to 2007/08. The full list of commitments and due dates is in Annex B.
- 2.4** The NHS is making good progress in many of these areas. PCTs are expected to ensure that this progress is sustained and that national milestones for delivery in 2007/08 are achieved. PCTs also need to ensure that they continue to meet existing Government commitments. Progress against national commitments will continue to be monitored by the Department and will form part of the Healthcare Commission's annual performance assessment.

Development priorities for 2007/08

- 2.5** Four issues will require particular attention by all organisations in 2007/08 because of both the degree of challenge they pose and their importance to public confidence in the NHS. These are:
- > achieving a maximum wait of 18 weeks from GP referral to start of treatment of patients;
 - > reducing rates of MRSA and other healthcare associated infections;
 - > reducing health inequalities and promoting health and well-being;
 - > achieving financial health.

18 weeks maximum wait from GP referral to start of treatment

- 2.6** The NHS has delivered historic levels of improvement in waiting times in recent years. This progress is real and is not to be dismissed. But, at the same time, we all know this does not tell the full story from the patient's point of view. Existing waiting time targets do not focus on the patient's whole journey. Our ambition is to transform people's experience of the NHS by reducing the total time from GP referral to start of treatment to 18 weeks.
- 2.7** Delivering this objective will not be achieved only by doing more of the same. The experience of reducing cancer waiting times is relevant here. Progress on cancer has been achieved through the collaboration of clinicians and managers in primary and secondary care who have worked together to fundamentally alter the pathway of care in order to reduce delays. Genuine clinical engagement, the development of new alternatives to existing services and the effective use of information management and technology, will be the key to successfully delivering the 18 week objective and should be a priority for all NHS leaders. Commissioners are also expected to take advantage of the reforms being implemented to ensure delivery of this objective. We do not underestimate the scale of our ambition, nor the benefits for patients that success will deliver.
- 2.8** The key milestones to be achieved as a minimum by all PCTs and all providers by the end of March 2008 are:
- > 85% of pathways where patients are admitted for hospital treatment should be completed within 18 weeks; and
 - > 90% of pathways that do not end in an admission should be completed within 18 weeks.
- 2.9** These milestones will be explicit in the NHS contract.
- 2.10** There are risks to the delivery of this objective because of the potential for referrals that do not need to be made to consultants – such as referrals direct to audiology departments for simple hearing problems or direct to therapy – to be redirected via consultants in order to bring them into the scope of 18 weeks. PCTs should therefore commission sufficient direct access activity in these areas to substantially reduce waits – for audiology and hearing aid fitting in particular – and to ensure that referrals are not redirected to consultants. Further updated guidance on the 18 week programme can be found at www.18weeks.nhs.uk.

MRSA and other healthcare associated infections

- 2.11** It is a significant cause of distress to patients, their families and NHS staff that the actions we take to help people sometimes result in unintended harm. No healthcare system can ever be entirely risk free. But we must do more to reduce the rate of healthcare associated infections in order, ultimately, to reduce the number of avoidable deaths.
- 2.12** As part of their current three-year plans, PCTs and providers have signed up to local targets for year-on-year reductions in MRSA infections. The number of MRSA cases has decreased but faster progress in reducing them is needed to achieve the target and improve patient care.
- 2.13** When we set the MRSA target, we also made it clear that we would look further at other healthcare associated infections as data became available. The evidence shows that *Clostridium difficile* is a particular problem because, unlike other infections, patients become vulnerable to it through the antibiotics used to treat their underlying illness. Coupled with the fact that the number of cases reported is increasing, this suggests that further controls are required to limit the spread of infection. On this basis, we expect PCTs and providers to engage with clinicians and agree local targets for a significant reduction in *Clostridium difficile* infections, which is locally appropriate in order to tackle the avoidable suffering and deaths it can cause. These targets need to be reflected in contracts between PCTs and providers. Rigorous implementation of existing guidance is required to tackle this problem.

Reducing health inequalities and promoting health and well-being

- 2.14** It is important that patients receive high quality healthcare, no matter where they live in the country, and that where inequalities exist, they are dealt with. For 2007/08, PCTs need to focus on the interventions that evidence shows can have the biggest impact on reducing health inequalities. This builds on the recommendations in a review of the life expectancy target. The introduction of local data on all age all cause mortality, introduced in both LDPs and local area agreements, provides the incentives for effective partnership working with local authorities and the other partners that need to deliver the life expectancy aspect of the health inequalities target. It will also give flexibility for organisations to focus on the interventions that are most important to their local population. The health inequalities national support team is currently being developed to provide intensive support to those areas that are most challenged.

- 2.15** While progress has been made to improve access to sexual health services, more needs to be done, in particular to deliver 48-hour access to genito-urinary medicine (GUM) clinics. Quick access to services means fast diagnosis and treatment for individuals who have a sexually transmitted infection (STI). It reduces the risk of STIs being passed to others. The Sexual Health National Support Team is providing intensive support to the areas that are most challenged.

Financial health

- 2.16** By the end of this financial year we expect the NHS to return to net financial balance. 2007/08 will be a further year of financial recovery and we will require the NHS to make a net surplus of at least £250 million across NHS trusts, PCTs and SHAs. Monitor requires NHS FTs to be financially viable. We are also planning on the basis of a 2.5% efficiency improvement across the NHS. This is important not just as a matter of public confidence in the ability of the NHS to manage resources effectively – it is fundamental as a basis for improving services to patients.
- 2.17** Organisations simply cannot develop credible service plans, make long-term investments in facilities, or manage fluctuations in income or expenditure without achieving a surplus. As the pace of reform takes hold and new incentives through PbR and patient choice take effect, the need for a more transparent financial regime and more effective financial planning will be vital. Commissioners will need to shift the balance of investment to reflect the choice dynamic, requiring more flexibility in service and cost structures.
- 2.18** The arrangements for 2007/08 are therefore changing to help organisations deliver high-quality services that can be sustained in this new environment while recognising that the NHS has been in financial recovery. These changes are described in more detail in Section 4.

Recovery action to improve mental health services

- 2.19** The NHS has already gone a long way towards modernising mental health services. However, sustained action has been required in 2006/07 in some areas where progress has slipped. Specifically, there is a national expectation that 500 community development workers are recruited to help improve the mental health of people from black and minority ethnic backgrounds. This was not delivered by the target date of December 2006, so progress needs to be made on revised plans to achieve this by December 2007. Similarly, further progress against recovery plans is needed in

commissioning services for the estimated 7,500 new cases each year of people needing early intervention. Recovery action on these issues will need to continue into 2007/08, so that patients receive the levels of care promised and we can be confident that comprehensive mental health services are in place in all areas.

Local action in preparation for 2008/09

2.20 PCTs need to begin laying the foundations in 2007/08 to plan for future improvements in a number of areas. The reasons for this are:

- > to prepare the ground for future implementation of government commitments, including the strategy set out in *Our health, our care, our say*;
- > to address issues of public concern. This includes concerns about standards and statutory obligations, identified by bodies such as the Healthcare Commission. These may be specific to an organisation or for all organisations in a locality;
- > to reinforce the need for PCTs to own and drive continuous improvements locally in outcomes and productivity.

2.21 Specifically this means PCTs should:

- > undertake preparatory work with providers to implement the *Our health, our care, our say* commitment that by 2009 all women will have access, choice and continuity of maternity care ante-natally, in labour and delivery, and post-natally. A DH survey found that most women are pleased with the care they receive when they have a baby but would prefer more choice about the type of care and where to have their baby. Progress against the commitment is an important step towards providing the more individualised maternity services that people have asked for. In particular, PCTs should use 2007/08 to assess current services, identify gaps and the barriers to service development, and set out their local strategy for meeting the maternity commitment in 2009. This should include an assessment by PCTs of workforce capacity. A national delivery plan will be published in early 2007;
- > be prepared to undertake a local end of life service baseline review during 2007/08. DH is developing an end of life care strategy in response to the manifesto commitment to increase choice at the end of life, which will be published in late 2007. It is likely that PCTs will need to undertake a baseline review in preparation for the strategy. More detail on what this review should cover will be available early in 2007;

- > continue to use needs assessment systematically to identify and address the specific needs of different groups in the population. In particular, PCTs should review how commissioning should be tailored to meet the needs of disabled people, people with learning disabilities, people from black and minority ethnic communities, and people from different gender, sexual orientation and age groups. Both the Commission for Racial Equality and the Healthcare Commission have highlighted concerns about DH and NHS compliance with equality legislation. It is the responsibility of all NHS boards to ensure compliance with statutory obligations such as the Race Relations Act (as amended) and the Disability Discrimination Act (as amended). We are producing guidance to clarify for boards their responsibilities under equality and human rights legislation;
- > work with partners at a local level, and in particular with schools, to significantly improve the level of information reported on weighing and measuring children, to inform PCTs and their partners on action needed locally to tackle obesity. The current year's (2006/07) weighing and measuring exercise therefore needs to deliver 80% coverage in 2007/08. PCTs should refer to the refreshed LDP technical note and revised guidance on conducting this exercise;
- > ensure local implementation of the commitment to reduce mixed sex accommodation, and maximise privacy and dignity in situations where the need to treat and admit takes precedence over complete segregation;
- > proactively seek to improve safety and drive quality and productivity improvements through a more systematic use of information and analysis to benchmark performance, and to assess the quality, efficiency and equity of resource use. These are not new performance targets. The Better Care, Better Value Indicators³ and programme budgeting information⁴ already published by the DH can help PCTs and providers in this task. PCTs are expected to use this information to demonstrate in their prospectus how they are spending money on behalf of the local population.

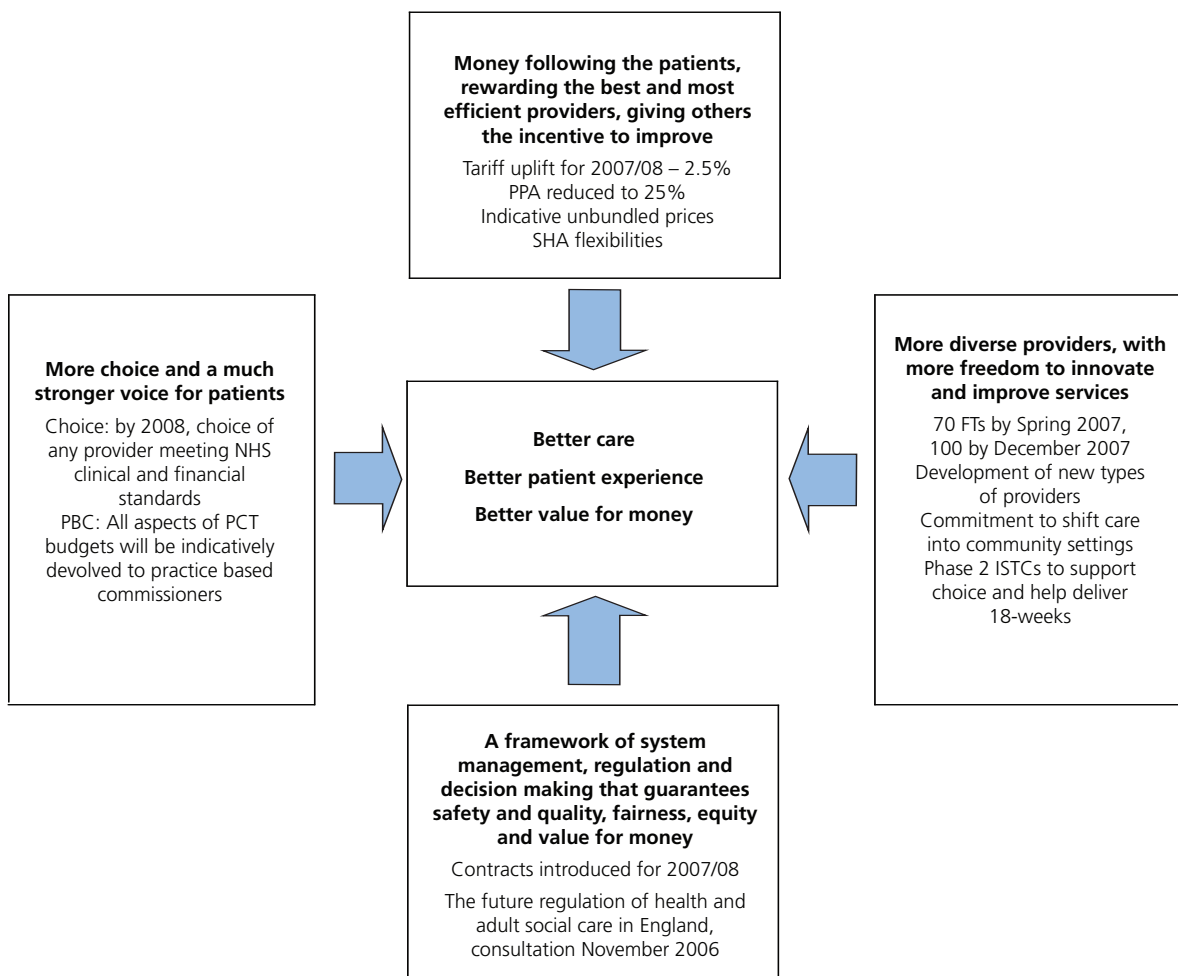
3 Better Care Better Value Indicators. September 2006. www.connectingforhealth.nhs.uk/dhproductivity

4 Programme Budgeting Information. July 2006. www.nchod.nhs.uk

3. Reforms

3.1 The reform tools, implemented and delivered locally, are the means by which the NHS will drive up quality and improve services for patients and provide better value for tax payers. Therefore, there will be no let up in the pace of implementation. The challenge now is to engage clinicians and managers locally so that they use the reform tools to ensure their communities gain the maximum benefits of investment and reform as quickly as possible. We are looking to the newly established PCTs, working with practice-based commissioners, to take a leadership role in this respect.

3.2 The key issues for 2007/08 are summarised below:



Patient choice and voice

Patient choice

3.3 Patient choice, together with PbR, provides a powerful incentive for providers to respond to patients' preferences, driving up quality and improving access to services.

- 3.4** The NHS will reinforce patient choice in 2007/08 through the following:
- > from April 2007, maintaining the standard of 80% of eligible patients referred for planned elective care recalling being offered clinically appropriate choices from a menu of four or more providers commissioned by their PCT or from the national choice menu;
 - > extended choice to be rolled out further during 2007/08, as new NHS FTs, independent sector treatment centres (ISTCs) and independent sector providers are added to the national menu. By 2008, all patients needing planned elective care will be able to choose to be treated by any provider that meets NHS clinical and financial standards;
 - > further development of the *Choosing your hospital* booklet to make good information available to inform patient choice;
 - > exploiting local investment in Choose and Book and its integration with local information management and technology (IM&T) systems.

Patient and public engagement

- 3.5** As well as becoming more responsive to the patients who use it, the NHS needs to be more accountable to the citizens who fund it. There are a number of requirements aimed at ensuring a greater connection between PCTs and their communities, and that, as well as choice, citizens have more 'voice' in the healthcare system, particularly where this is not often heard, for example in public health/prevention.
- 3.6** PCTs are expected to produce the first version of their prospectus during 2007/08. The PCT prospectus will signal the strategic direction for local services and highlight commissioning priorities, needs and opportunities to service providers.
- 3.7** A proposed formal approach to petitions was consulted on through *Health reform in England: update and commissioning framework*.⁵ Work will continue with the NHS and other stakeholders to fully develop the mechanisms in early 2007, to be published for implementation during 2007/08.

⁵ Department of Health. Health reform in England: update and commissioning framework. July 2006. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4137226&chk=D2YSig

- 3.8** In addition to this, we expect PCTs as the custodian of tax payers' money to continue to innovate and explore how they might better understand and respond to the needs of their communities.

Service reviews

- 3.9** In *Our health, our care, our say* we set out an expectation that PCTs should undertake regular systematic reviews of the services they commission (including those they directly provide). PCTs should initiate a service review programme during 2007/08 in agreement with their SHA.
- 3.10** This is not about compulsory tendering of services. The reviews should be risk-based, and respond to the views of patients, users and overview and scrutiny committees (OSCs), as well as to information from benchmarking and best practice studies. They should drive continuous improvement in services, ensuring they deliver effective outcomes, are responsive to patient needs, provide value for money, and are developed through engagement with local government and other partners. It is important that NHS organisations involve and consult patients and the public, staff and unions, and OSCs on decisions affecting the operation of services. This includes having good strategies in place to deal with the workforce implications of any changes in the way services are delivered.

Care closer to home

- 3.11** PCTs also need to reach early decisions about the best way to take forward the shift of care into community settings and the other priorities set out in *Our health, our care, Our say*, including how they will:
- > promote health and emotional well-being, with stronger local services and support to reduce the prevalence of physical and mental illness;
 - > develop services to support people in maintaining independent lives in their own homes, reducing avoidable emergency hospital admissions;
 - > provide for timely hospital discharge with support from appropriate community services;
 - > increase community capacity to support the shift of appropriate services from acute hospitals to convenient and safe local facilities.
- 3.12** PCTs may therefore want to consider taking forward reviews of community-based services in 2007/08. New community hospitals and facilities, developed by partnerships

within the NHS, with local government and with independent or voluntary sector providers, can support this shift. *Our health, our care, our community: Investing in the future of community hospitals and services*,⁶ published in July, announced a £750 million fund to launch a new generation of community hospitals, and a new way of delivering services using community ventures.

Commissioning

3.13 A greater focus on joint commissioning between healthcare and social care and better integration between healthcare, social care and other local government services will bring benefits for patients and service users. We are looking to PCTs, working in partnership with practice based commissioners and local authorities, to ensure that commissioning makes an increasing contribution towards supporting the needs of patients and giving them more control over their care. Strong contracting arrangements will be key to driving these changes.

Practice based commissioning

- 3.14** Practice based commissioning (PBC) is not just about devolving budgets and commissioning decisions to practices. PBC is essentially a partnership between patients and their primary care practices to get the best quality service out of the NHS.
- 3.15** PBC places GPs and primary care clinicians at the heart of decision-making, giving them the tools to innovate and influence local service development for the benefit of patients.
- 3.16** Efforts in 2006/07 have focused on putting in place the building blocks for PBC to support practices. Good progress has been made. In 2007/08, the emphasis must be on practical implementation so that it makes a real difference to people's lives. To make this happen, *Practice based commissioning: practical implementation*⁷, (November 2006) states that:
- > practices will receive clear budgets and information flows;
 - > all aspects of PCT budgets will be indicatively devolved to practice based commissioners, with the elements that need to be returned to the PCT clearly

⁶ Department of Health. *Our health, our care, our community: Investing in the future of community hospitals and services*. July 2006. http://195.33.102.76/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4136930&chk=4fllx1

⁷ Department of Health. *Practice based commissioning: practical implementation*. November 2006. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4140709&chk=lcmUWc

identified (eg centrally managed services). This will enable them to redesign services and, where appropriate, release resources, which can be used to address specific national or local priorities as determined by agreement between the practice and the PCT;

- > all practices will receive regular referral and financial information, including benchmarking data, to make informed decisions;
- > a locally agreed incentive scheme will be developed and offered to all practices;
- > a small set of indicators to help SHAs and PCTs understand the effectiveness of PBC implementation will be in place;
- > the Improvement Foundation support programme will continue.

3.17 It is the responsibility of PCTs to ensure that PBC works successfully. They need to work in partnership with practices to engage clinicians, strengthen relationships and create the environment for PBC to flourish so that it transforms care for patients.

National NHS contracts

3.18 The relationships PCTs have with providers will be increasingly based on contracts. 2007/08 will be a year of transition to the introduction of a more rules-based system and the introduction of the new NHS contract, which we will consult on fully early in 2007, for implementation in 2008/09. As commissioners and providers prepare for this, we are introducing two interim contract models:

- > for NHS trusts, a version of the new NHS contract, which is expected to be agreed with broadly the same rigour as for NHS FTs;
- > for NHS FTs, a number of essential amendments have been made to strengthen the existing NHS FT model contract. New and existing NHS FTs, whose contracts expire by the end of 2006/07, are expected to adopt the revised version of the contract. NHS FTs whose contracts extend beyond 2006/07 may choose to adopt the contract or retain their existing contracts.

3.19 These models are based on common underlying principles and, as such, will bring greater consistency in key areas for 2007/08 in commissioners' agreements with NHS FTs, NHS trusts and new independent sector providers. This includes signing up to:

- > an agreed statement of NHS principles based on the statement of principles in the NHS Plan, binding together all members of the NHS family in a partnership for

patients and the public. A draft of the principles we are consulting on are in Annex C;

- > four core schedules covering patient booking and choice; national and locally-agreed quality standards; the activity plan and plan to deliver the 18 week target and manage demand; and information requirements;
- > specific dispute resolution arrangements;
- > key policies such as the payment by results assurance framework.

3.20 Specifically, this means:

- > service providers will benefit from the incentives of patient choice and PbR, and will be paid at tariff for the referrals they attract;
- > PCTs have a right to use a range of agreed care and resource utilisation techniques (eg utilisation review and prior approval). Guidance⁸ will be made available to help commissioners in primary care to understand what techniques are available to maximise resources available to them, to ensure that patients get the right high quality treatment, from the right professional, in the right place at the right time, within the context of PBC;
- > commissioners and providers are required to review the activity plan and assumptions on a monthly basis. Where additional activity is undertaken and puts financial balance at risk, and is the result of provider decisions that go beyond the ranges of agreed activity and underlying assumptions, the contract will enable appropriate action to be taken. Financial adjustments will also be available for repeated breaches of prior approval requirements and for underachievement of the 18 week milestone. Adjustment may be waived by the commissioner when they agree that all reasonable actions have been taken to avoid breaches.

3.21 We are issuing the schedules on patient booking and choice, national and locally-agreed standards, and information and IT requirements for consultation. Views on these schedules should be submitted to nhs.reform@dh.gsi.gov.uk.

3.22 Further details can be found in the NHS contract guidance published alongside this document. A summary of the requirements for contract implementation, in the context of overall roles and responsibilities, are set out in Annex D.

⁸ Department of Health. Care and resource utilisation. December 2006. www.dh.gov.uk

- 3.23** The new NHS Contract specifically covers acute hospital services. PCTs will have contracts with a range of providers, including NHS Trusts and NHS FTs, for a range of other services, including ambulance services, mental health and learning disability services. We expect that commissioners will incorporate the same timetable and the key principles of the NHS Contract into these agreements, especially the core principles, the national and local quality schedule and the local IT and information requirements.
- 3.24** It is vital that the reforms do not get reduced to a set of contracts or transactions. Our ambition is to achieve transformational change for patients, and it is therefore vital that the behaviours of NHS organisations and individuals reflect this. The principles we are publishing for consultation are a touchstone in this respect.

Commissioning primary medical services

- 3.25** While it is important to drive up the quality of care in secondary care, we should not lose sight of the fact that the majority of patient interactions take place in primary care, where we need to continue to improve access to and the convenience of services. In commissioning primary medical services, PCTs should plan on the basis that investment in 2007/08 will increase by around 1% net over 2006/07 expenditure, given that resources will be released from non recurrent elements of the 2006/07 contract. This is a planning assumption that is the subject of negotiations between NHS Employers and GP national representatives. This net increase is in addition to any other local investment planned by PCTs to support the shift of services from secondary care to primary care, including planned investment to improve the premises from which primary medical services are provided. The shift in services should be targeted at securing the key priorities identified in this document. In contracting for primary medical services, PCTs should:
- > demonstrate to their SHA that the services provided, including those provided directly by PCTs, deliver value for money as well as maintain the quality of provision of care to patients;
 - > ensure that they conduct open and transparent procurement processes in contracting for new or replacement primary medical care services (ie the provision of essential and additional services to patients);
 - > make more use of their new contracting freedoms to engage new providers (including social enterprises) to address local gaps in service capacity or responsiveness (for example to offer patients more flexible opening hours).

Commissioning arrangements for specialised services

- 3.26** PCTs are expected to implement the recommendations contained in the *Review of Commissioning Arrangements for Specialised Services*⁹, published in May 2006, and set out in the *Health reform in England: update and commissioning framework*.
- 3.27** SHAs are expected to ensure that effective collaborative commissioning arrangements for specialised services are in place in good time and that business continuity is maintained. Ten Specialised Commissioning Groups (SCGs) will be in place and the National Specialised Services Commissioning Group (NSSCG) will be established to take forward the priorities for 2007/08.
- 3.28** Key milestones for 2007/08 are:
- > the establishment of the National Commissioning Group (NCG) on the transfer of the National Specialist Commissioning Advisory Group from DH to the NHS;
 - > SCGs to collectively commission a minimum of 10 specialised services; by 2008/09 SCGs to collectively commission most specialised services for their populations.

Commissioning services for military personnel

- 3.29** PCTs are reminded that when dealing with the provision of services to military personnel, and in certain circumstances their dependants, it is important that full account is taken of the special provisions that apply in these instances, to ensure that comprehensive access to NHS services is available for service personnel, dependants and veterans. Guidance is available in the following documents, which are available on the DH website:
- > *Establishing the responsible commissioner;*
 - > *Health service guidance covering arrangements between the Ministry of Defence and the NHS;*
 - > *Delivering our Armed Forces' healthcare needs: A concordat between the UK Department of Health and the Ministry of Defence.*

⁹ Department of Health. Review of Commissioning Arrangement for Specialised Services. May 2006. www.dh.gov.uk/PolicyandGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/CommissioningSpecialisedArticle/fs/en?CONTENT_ID=4135174&chk=H2g0oV

Strengthening PCTs

- 3.30** The reconfiguration of PCTs in 2006/07 was the first stage in strengthening the commissioning function of PCTs. The next stage focuses on ensuring that PCTs are fit for purpose and have the opportunity to develop the right capabilities to carry out their roles in a system of choice, PBC, and commissioning in partnership from a plurality of providers.
- 3.31** All PCTs, by March 2007, will have undertaken a 'Fitness for purpose review' focusing on developing commissioning capacity, which will inform the production of a customised development plan. This is crucial in ensuring that PCTs are fit for purpose within 18 months. A development planning model has been produced in partnership with the NHS Institute to support this process – full details, including the manual and capability gaps analysis tool to support this process, can be found at www.institute.nhs.uk/ServiceTransformation/PCT+Fitness+for+Purpose.htm.
- 3.32** The manual and capability gaps analysis tool act as a guide to the four steps of the development plan process:
- > prioritisation of diagnostic elements;
 - > identification of underlying capability gaps;
 - > generation of big solutions and tactical actions;
 - > implementation planning.
- 3.33** In preparing a PCT development programme, PCTs have a number of options available to them to address their needs, which they should consider in consultation with their SHA who will ensure any plans are properly evaluated. The current commissioning services framework procurement will offer a range of services to PCTs who wish to obtain support in the management of their commissioning functions. It is important to stress that in this context PCTs are, and will remain, public bodies. Thus, regardless of which option they choose, PCTs will continue to be accountable for commissioning for their populations. Board level accountability cannot and will not be contracted out.

Strengthening providers

3.34 Provider-side reforms build on the core principles and values of a national health service that is free at the point of delivery and provides world class services. These reforms will continue in 2007/08 with a focus on:

- > strengthening NHS providers through the NHS FT programme;
- > increasing the plurality of provision through the ISTC and Extended Choice Network programmes, and new ways of delivering care, including community services, in line with what the local population wants.

Strengthening NHS providers

3.35 We are committed to the FT programme and to developing all NHS trusts, through the Whole Health Community Diagnostic, to become NHS FTs at the earliest available opportunity, giving more providers devolved decision-making responsibilities and enabling them to become more responsive to the needs of the local population. Each trust now has an action plan for the areas it needs to address and SHAs will be responsible for ensuring that plans are followed through in order to meet the national expectation of up to 70 NHS FTs by spring and 100 by December 2007.

Plurality of provision

3.36 The FT programme is complemented by a continuing drive for a greater plurality of providers to extend patient choice, increase quality and foster innovation. This includes:

- > the successful implementation of the ISTC programme for elective care and diagnostic services, enabling greater participation by a broader range of providers, including social enterprises and other not-for-profit organisations;
- > highlighting the range of different provider models that commissioners can consider for community care, including:
 - continuing PCT directly managed provision (with appropriate governance arrangements in place);
 - general practice;
 - third sector providers;
 - social enterprise;
 - independent sector providers;
 - partnerships with local government;
 - care trusts;

- acute and mental health NHS FTs;
- ambulance trusts;
- > developing further potential governance models, such as:
 - **community NHS FTs:** we have been working with Monitor and a group of interested PCTs to explore the feasibility of NHS FT status as one of the options for providers of community services. We are looking at how this might work in a small number of areas. Like other NHS FTs, Community NHS FTs would be publicly-owned organisations that would be part of the NHS. They would have greater operational freedoms to respond to the needs of commissioners and patients. Further discussions will be carried out with stakeholders around these options, and we will involve staff and their unions, as well as patients and the public, in considering how this work might be taken forward;
 - **social enterprises:** these bring new opportunities for PCTs to enhance the quality of health and social care provision and to better fit services to the needs of particular client groups. PCTs should be open to the possibilities both of contracting with existing social enterprises, and supporting the development of new ones. More information about the support available from April 2007, including start-up funds, is at www.dh.gov.uk/socialenterprise.

Payment by results

3.37 The PbR scheme is a vital part of the infrastructure supporting the reforms. Money follows the choices that patients make and trusts are paid for the activity that they do. Providing a transparent, rules-based system for paying trusts, it rewards efficiency, supports patient choice and diversity and encourages activity for sustainable waiting time reductions.

3.38 Feedback from the road test of the national tariff confirms that it works as intended so it has now been confirmed as final for 2007/08. Full details of PbR in 2007/08 can be found at www.dh.gov.uk/pbr and will be reflected in the updated implementation support guidance, which will follow shortly with clarification of any outstanding issues.

Scope

3.39 The scope and structure of PbR is fundamentally the same, with a few changes that aim to strike a balance between maintaining some stability in what is a developing system, and broadening the opportunities that PbR offers through unbundling in other areas. In summary, we have:

- > increased the overall value of the tariff by 2.5% (ie 5% net of 2.5% efficiency);
- > set the threshold for the reduced (50%) emergency tariff at the 2005/06 out-turn;
- > reduced PCTs' purchaser parity adjustment from 50% to 25%. It will be 0% in 2008/09.

3.40 A national tariff complements, but does not remove, the need for good local commissioning. The existence of a national tariff should not be an impediment to changing care pathways. It is not the intention nationally to unbundle every tariff. Instead, a few national exemplar unbundled prices have been developed for 2007/08, and we would encourage organisations to adopt these locally where it makes sense to do so. Indicative unbundled prices published include:

- > a few healthcare resource groups – for stroke, elective hip replacement, fractured neck of femur and pneumonia – to help PCTs identify the funding that can potentially be transferred if they redesign the pathway of care and support the implementation of care closer to home;
- > diagnostic imaging, removing the disincentive for GPs to conduct investigations themselves.

Assurance

3.41 Organisations are reminded that they are expected to co-operate with the new data quality assurance programme, which is focused on improving the quality of patient-level data that underpins effective PbR.

3.42 From 1 April 2007, the Audit Commission will roll out a national programme of external audit of clinical coding. This will help to establish the current level of accuracy of coding and will expose any financial implications of poor coding. More accurate coding is welcomed but, where improvements in coding could potentially lead to increased payment for no additional activity, organisations need to handle these in line with the

provisions of the Code of Conduct. DH is committed to reviewing the risk of activity inflation associated with improved coding and counting.

SHA flexibilities

3.43 There are specific instances in which an SHA may exercise its discretion to provide support to NHS organisations in addition to any tariff income. These are:

- > specialist hospitals;
- > providers whose PbR gains are capped.

Information management and technology

3.44 IM&T is central to the delivery of health reform, supporting patients in their choices and helping to deliver better, safer care. That is why we remain committed to the vision of a modern IT-enabled NHS set out in *Delivering 21st century IT support for the NHS*¹⁰ and to a national programme for IT (NPfIT). The vision will be achieved by improving NHS IM&T and service transformation capability, placing ownership of the NPfIT and its commitments with the NHS under the NPfIT Local Ownership Programme, and by the NHS making sustained local investment. Progress towards the vision will be assured through performance management, and national IM&T standards will be established in discussion with regulators. We will support the NHS by providing tools and services to assess and develop local IM&T capability.

3.45 2007/08 marks a shift in expectations and responsibilities for the NHS, in which an NHS organisation's capability to deliver this agenda will come into sharper focus. This means:

- > for all NHS providers, having a comprehensive forward-looking IM&T plan which is core to their business, exploits fully the NPfIT opportunity and thereby demonstrates migration to the NHS Care Record Service;
- > for PCTs as commissioners, both having their own comprehensive IM&T plan, and working with all providers in their local health communities to align IM&T plans and enable patient-centred service transformation;
- > for SHAs, now accountable for implementation and realisation of the benefits from the NPfIT, assuring that the local NHS has the capability and resources to deliver their plans.

¹⁰ Department of Health. *Delivering 21st century IT support for the NHS*. June 2002. www.dh.gov.uk/assetRoot/04/06/71/12/04067112.pdf

3.46 For 2007/8, plans should demonstrate how, in addition to local objectives, the following national priorities will be delivered:

- > sound information governance in light of the Care Record Guarantee;
- > achieving national data quality standards;
- > preparing for the roll-out of the national summary record;
- > implementation of GP Systems of Choice;
- > deployment and benefits realisation for Patient Administration Systems (PAS) and Order Communications and Results functionality, in line with existing commitments and targets set by each SHA in the context of existing commercial arrangements;
- > completing implementation and benefits realisation for Picture Archiving and Communications Systems (PACS) in line with existing plans, ie all deployments completed no later than December 2007;
- > fulfilling all other current deployment commitments;
- > further exploitation of electronic booking;
- > implementation and benefits realisation for the Electronic Prescriptions Service.

3.47 More detailed guidance to support organisations in preparing their plans will be issued shortly.

4. Moving to a modern financial regime

4.1 The principles underlying our approach to managing finances in 2007/08 will be:

- > **transparency:** ensuring that the financial performance of each and every NHS organisation is clear, with all organisations understanding their cumulative, in-year and recurrent financial performance;
- > **consistency:** ensuring a consistent approach to the management and reporting of financial performance across the NHS, allowing like-for-like comparisons across all the country;
- > **independence:** ensuring that all organisations and their Boards take responsibility for their own financial performance preparing the way for NHS trusts to move towards FT status and for PCTs and GP practices to earn greater autonomy;
- > **fairness:** ensuring that all organisations carry the financial consequences and enjoy the financial benefits of the management decisions they make.

4.2 2006/07 will see the NHS return to net financial balance recovering at a national level the over-spend from 2005/06. For 2007/08 we need to build on this foundation to create a sustainable financial position for the future. This requires:

- > delivery of a net surplus across the NHS of at least £250 million as organisations generate surpluses to recover historic overspending;
- > a significant reduction in the value of gross deficits;
- > all but a small handful of organisations operating in recurrent balance throughout the year.

4.3 Achieving these goals will leave the NHS well placed to continue delivering service improvement into the next allocation period as levels of growth inevitably become steadier.

4.4 Delivery of these goals will be supported by:

- > changes in the financial regime that continue the process of improving the transparency of performance and providing better alignment of incentives;
- > an increasing focus on the delivery of efficiency improvements;
- > early notification of financial planning assumptions.

Financial regime

4.5 Over the past 18 months, we have been working on changes to the financial regime to ensure that it is fit for purpose for the future. This work has been supported by the Audit Commission *Review of NHS Financial Management and Accounting*¹¹, published in July. The changes we plan to make, which are described below, will aid financial management but will not in themselves provide a solution for organisations with financial problems.

Application of resource accounting and budgeting to NHS trusts

4.6 The RAB system helps to ensure that public sector organisations manage and account for their use of resources in a way that requires a focus not only on short term cash flow but also managing commitments. As a cross-government system, RAB will continue to apply to the Department of Health and, as confirmed by the Audit Commission, it remains appropriate for PCTs.

4.7 The way in which RAB is applied to NHS trusts, although providing a strong disincentive to overspend will become increasingly unsustainable as we move forward with the programme of reform. There are three reasons for this:

- > the system is applied inconsistently across SHAs with some taking the deduction down to individual trusts and others absorbing it at SHA level;
- > income deductions are inconsistent with the principles underlying PbR.
- > the system cannot be applied to FTs.

4.8 For these reasons, we recognise the rationale behind the Audit Commission's recommendation to reverse the impact of past RAB deductions made to NHS trust income and to create a central buffer to absorb the impact. However, at this stage we cannot commit to implementation of this recommendation for two reasons:

- > the resource buffer needs to be created from within the resources available to the NHS. As we have made clear in the past no additional resources will be provided by the Government for this purpose;

11 Audit Commission. Review of NHS Financial Management and Accounting. July 2006. <http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=F27AD3E2-7FF4-4cdd-BB92-DF5C4BDD18FF&SectionID=toc>

- > we need to demonstrate that NHS trusts have the financial discipline to operate outside the RAB regime and that it can respond appropriately to the incentives and disincentives created by cash control similar to that applied to FTs.

4.9 In this context, we will look again at the case for reversing the impact of past RAB deductions on delivery of financial balance in 2006/07.

Replacement of cash brokerage with loans

4.10 Any change in the application of RAB to NHS trusts cannot lead to any write-off of 'historic debt'. NHS trusts will have financed deficits through short term cash brokerage or reducing their working capital and they will be expected to recover their cash position.

4.11 To ensure that this happens, we are introducing tighter control of cash through the conversion of cash brokerage into a formal system of loans in advance of any potential decision on the application of RAB. In order to finance the repayment and servicing of loans NHS trusts will be required to generate surpluses, thus ensuring that the system as a whole balances. The loans system will be introduced in the final quarter of 2006/07.

Capital finance

4.12 In order to impose greater discipline over capital investment decisions and to prevent the leakage of cash from capital to revenue we will also replace the current capital allocation system with a new borrowing regime. From 2007/08, access to capital funding will be determined solely by the affordability of proposed investments with investment financed by a system of loans and borrowing subject to a prudential borrowing regime similar to that operated for FTs. There are no changes to the PCT capital allocations and financing arrangements. The 2007/08 PCT capital allocations will be announced shortly.

Strategic reserves

4.13 As a consequence of the return of the NHS to financial balance, SHAs will not generally require the scale of contribution to strategic reserves seen in 2006/07. They should largely only be used to moderate over a reasonable timescale the impact of RAB deductions to PCTs or support locally agreed revenue investment linked to service change. Where continuing contributions are required, they must be subject to

transparent rules clearly covering the purpose of the reserves and the timescale over which each organisation will recover its contribution.

Efficiency improvements

4.14 We are planning for 2007/08 on the basis of a 2.5% efficiency improvement across the NHS. We expect the plans of individual organisations to show how this improvement will be delivered at a local level. At a national level, we will extend the publication of productivity metrics and benchmarking tools to support this.

Central budgets

4.15 The total near cash envelope for Central Budgets in 2007/08 is £14,445.62 million, an increase of 5.3% on 2006/07. There are two key components for how these funds are used:

- > budgets held and managed centrally by the Department;
- > budgets which will go to the NHS as an SHA Bundle.

4.16 The total value of Central Budgets held and managed by the Department is £7,499.75 million. This funding is split between those budgets over which the Department has no direct control, and others.

4.17 Budgets held by the Department with no direct control include budgets such as PSS Grants, European Economic Area Medical Costs, and Ophthalmology, and total £3,471.05 million in 2007/08. The total for other budgets is £4,028.70 million.

4.18 Support for PCT-led primary dental services is £1,874 million for 2007/08, net of patient charge income. Details of the allocation will be issued separately to the NHS.

SHA bundle

4.19 It has been agreed that there will be another SHA Bundle of Central Budgets for 2007/08 and the proposed value is £6,945.8 million.

4.20 A small number of additional budgets have been included in the Bundle: the most significant ones are Student Bursaries and National Specialist Commissioning (NSCAG).

4.21 The 2007/08 Bundle will be supplemented by a Service Level Agreement between DH and SHAs. This agreement will include details of the services to be provided from the Bundle, and governance and accountability arrangements.

4.22 Details of the SHA Bundle will be issued separately to SHAs.

Early notification of financial planning assumptions

4.23 We are publishing alongside this document the key financial information that will impact on NHS trust and PCT income and expenditure in 2007/08:

- > the final road-tested PbR tariff;
- > the purchaser parity adjustment;
- > the central budgets that will be devolved to the SHAs for management;
- > the central budgets retained by the Department.

4.24 This early notification will allow the production of robust plans in advance of the start of the new financial year.

4.25 Early confirmation of the financial arrangements and the parameters within which organisations will work in 2007/08 in relation to service priorities and reform implementation in the operating framework for 2007/08, provides timely clarity for the service, not just about what needs to be done but why we need to do it.

Annex A: Timetable

The timetable below sets out the main stages and decision-making points for commissioners to be aware of during planning discussions.

December 2006

- > This operating framework sets out the specific business and financial arrangements for 2007/08, supported by accompanying guidance needed to aid planning locally.
- > Confirmation of the tariff uplift for 2007/08.
- > PCTs should continue to work with their local authority partners on meeting the goals set out in existing local area agreements (LAAs) and ensuring that next year's LAAs reflect local priorities.
- > DH/SHA discussions on Referral to Treatment plans for 18 week target.
- > IM&T planning requirements for NHS confirmed.
- > Consultation begins on proposed principles for the NHS.

January 2007

- > LAA six-month reviews.
- > SHAs to submit refreshed Phase III LDP trajectories and preliminary workforce and financial risk assessment by end of January.
- > PCTs to begin to develop plans for engagement activities with the local community.

February 2007

- > Consultation on the future of PbR (to include PbR communications strategy).
- > SHAs conduct detailed assurance of PCT plans, including reconciliation with provider assumptions.
- > SHAs and DH discuss key risks and mitigation strategies.
- > PCT agree contracts with providers subject to SHA sign-off of PCT plans.

March 2007

- > SHAs submit final LDP, workforce and financial plans to DH by 2nd March.
- > PCT contracts with providers signed-off by end of March.
- > NHS organisations to submit IM&T plans.
- > PBC directed enhanced services incentive ends, local incentives start in April.
- > Round 3 LAA sign-off.

Annex B: National targets and local delivery plan requirements

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

<u>Priority</u>	<u>Delivery date</u> ¹²
<p>Priority I: Improving the health of the population</p> <p>By 2010 increase life expectancy at birth in England to 78.6 years for men and 82.5 years for women.</p>	December 2010
<p>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.</p> <p>PSA01a: Cardiovascular disease mortality PSA01b: Practice-based Registers PSA01c: Blood Pressure PSA01d: Cholesterol Levels</p>	December 2010
<p>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.</p> <p>PSA03a: Cancer mortality rates PSA03b: Cancer – Implementation of NICE Improving Outcomes Guidance (IOGs) PSA03c: Bowel cancer screening (returning plans to DH is deferred)</p>	December 2010
<p>Mental health: substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%.</p> <p>PSA05a: Suicide rates PSA05b: CPA 7-day follow-up</p>	December 2010

12 For targets based on ONS data, the target year is the average of the three years 2009, 2010, 2011.

<u>Priority</u>	<u>Delivery date</u>
<p>Inequalities: reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.</p> <p>PSA06a: Infant mortality: Smoking during pregnancy</p> <p>PSA06b: Infant mortality: Breastfeeding initiation rates</p> <p>PSA07a: Life Expectancy: All Age All Cause Mortality rates</p>	December 2010
<p>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.</p> <p>PSA08a: Smoking quitters at 4 weeks attending NHS Stop Smoking services</p> <p>PSA08b: Smoking status amongst the population aged 15 to 75 years</p>	December 2010
<p>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.</p> <p>PSA10a: Childhood obesity</p> <p>PSA10b: Broader strategy on obesity: Obesity status amongst the GP registered population aged 16 and over</p>	December 2010
<p>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.</p> <p>PSA11a: Teenage conception rates</p> <p>PSA11b: Broader strategy to improve sexual health: Access to GUM clinics</p> <p>PSA11c: Broader strategy to improve sexual health: Decrease in rates of new diagnoses of gonorrhoea</p> <p>PSA11d: Broader strategy to improve sexual health: Percentage of people aged 15 to 24 accepting Chlamydia screening</p>	December 2010

<u>Priority</u>	<u>Delivery date</u>
Priority II: Supporting people with long-term conditions	
<p>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.</p> <p>PSA12a: Emergency bed days PSA12b (Part1): Number of community matrons PSA12b (Part 2): Number of additional case managers PSA12c: Number of Very High Intensity Users (VHIUs) under the case management of a Community Matron or Additional Case Manager</p>	<p>March 2008</p>
Priority III: Access to services	
<p>Access: to ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.</p> <p>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 PSA13g: Referral to Treatment (RTT)</p>	<p>December 2008</p>
<p>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.</p> <p>PSA14a: Number of drugs misusers in treatment PSA15a: Drugs misusers sustained in treatment</p>	<p>March 2008</p>

<u>Priority</u>	<u>Delivery date</u>
<p>Priority IV: Patient/User Experience</p> <p>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.</p> <p>PSA16a: Annual national improvements in patient surveys/ ensuring individuals are involved, offering choice. SHAs are not required to submit plan data to DH</p>	<p>March 2008</p>
<p>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.</p> <p>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</p>	<p>March 2008</p>
<p>MRSA: Achieve year-on-year reductions in MRSA levels.</p> <p>PSA20a: Number of MRSA infections</p>	<p>March 2008</p>

Annex C: Principles for the NHS

The NHS Plan in 2000 was underpinned by a set of core principles, which key stakeholders supported. Some restated founding principles of the NHS, others reflected issues that were important at the time.

The NHS Plan set out a process of investment and reform, designed to create a modernised health service. As reform has proceeded – for instance, with the creation of NHS FTs and the introduction of new providers – some people have expressed fears that the NHS could become fragmented, or public service values weakened.

We are therefore proposing that everyone providing care to NHS patients should commit themselves to a set of core principles as part of their contract with the NHS. The principles will also guide commissioners. We have largely followed the statement of principles in the NHS Plan, updating them where necessary to reflect new issues that have emerged or to be applicable to all providers. We will consult widely before they are finalised. These principles will help to bind together all members of the NHS family in a partnership for patients and the public.

Proposed principles

As providers of care to NHS patients we commit ourselves to the following 10 principles:

- 1. The NHS will provide a universal and comprehensive service with equal access for all, free at the point of use, based on clinical need, not ability to pay.**

Healthcare is a basic human right. Unlike private systems, the NHS will not exclude anyone because of their health status or ability to pay. Access to the NHS will continue to depend upon clinical need, not ability to pay. Unless a charge has been specifically sanctioned by the NHS (eg for prescriptions or dental treatment), we will not charge a fee or require a co-payment from any NHS patient. We will provide appropriate care for all those referred to us, within our clinical competence.

- 2. We will help keep people healthy and work to reduce health inequalities.**

We will continually seek opportunities to promote health, as well as to treat illness. Recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition, we will work with other services as appropriate to prevent ill health and reduce health inequalities.

3. We will work continuously to improve quality and safety.

We will ensure that services are driven by a cycle of continuous quality improvement. Quality will not just be restricted to the clinical aspects of care, but include the entire patient experience. We will work with our staff, our patients and the public, those commissioning care and the regulators to make the care we provide ever safer and support a culture where we can learn from and effectively reduce mistakes. We will provide information about the outcomes of the treatment we provide, complying with national inspections and regulation.

4. We will strive for the most effective and sustainable use of resources.

We will continuously seek to improve our efficiency, productivity and performance in order to provide the best value for tax payers' money, recognising that best care and best value go together. We are committed to the sustainable use of resources and will aim to reduce our use of energy and other natural resources, minimise production of waste and contribute to the sustainable development of the wider community.

5. We will treat every patient with dignity and respect.

We will treat every patient, service user and carer as a valued individual, with respect for their dignity and privacy. Our aim is to give each patient the care and service we would want for ourselves and our families.

6. We will shape our services around the needs and preferences of individual patients, their families and their carers.

As far as possible, we will design our services around the needs of our users and their carers, rather than expecting them to fit around our convenience. Wherever possible, we will offer patients and the public more choice and a greater say in their treatment, and will seek to engage them, individually and jointly, in designing and improving services.

7. We are committed to equality and non-discrimination.

We are committed to equality for patients and service users no matter what their age, gender, disability, sexual orientation, race, language, religion or national, ethnic or social origin. We will seek to provide services that are culturally appropriate to the needs of different communities.

8. We will support and value our staff.

The strength of our organisation lies in our staff, whose skills, expertise and dedication underpin all that we do. They have the right to be treated with respect and dignity. We will continue to support, recognise, reward and invest in individuals, providing opportunities for staff to progress in their careers and encouraging education, training and personal development. Professionals and organisations will have opportunities and responsibilities to exercise their judgement within the context of nationally agreed policies and standards.

9. We will work in partnership with others to ensure a seamless service for patients.

We will work in partnership and co-operation with others providing and commissioning NHS and social care services, including in the public, voluntary and private sectors, to ensure a seamlessly co-ordinated, patient-centred service. We will share clinical information with other providers of care to ensure that patients receive a seamless service, wherever they are.

10. We will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

We will respect the confidentiality of patients and service users throughout the process of care, including access to their information. Wherever possible, we will provide high quality information and support to patients and the public about services and treatments that are available, and their performance, to improve transparency and accountability. Where technology can improve patient safety, we will use it. We will publish information about our clinical and operational performance to allow the NHS to assure quality and enable patients to make informed choices.

Annex D: Roles, responsibilities and business processes (including special circumstances) for 2007/08

Delivery of the goals set out in this document require more effective business processes throughout the system, particularly:

- > more explicit and reliable activity plans at PCT, SHA and DH level;
- > 'fit for purpose' planning, monitoring and reporting, and delivery;
- > strong local ownership and accountability;
- > robust arrangements to discharge 'co-ordinating PCT' or equivalent roles;
- > greater focus on forward looking risk assessment.

To achieve these objectives, the following arrangements will apply in 2007/08:

Contract Implementation

PCTs and providers are expected to agree the central elements of contracts for 2007/08 by end February 2007. As well as signing up to an agreed statement of NHS principles and inclusion of the four schedules, referred to earlier, it is also expected that:

- > commissioners agree a realistic and affordable activity plan with clear assumptions and plans for resource utilisation, which ensure that patients receive the most appropriate care in the most appropriate setting. This will be fundamental to making the required progress to achieve the 18 week target;
- > any disputes on the agreement of contracts are to be resolved locally. SHAs will help commissioners and providers to resolve any disputes for which a local solution cannot be found, working with Monitor where NHS FTs are involved.

Roles and responsibilities

Lead responsibility in the Department for implementing the operating framework rests with Duncan Selbie, Director General of Commissioning.

A framework to track local progress in reaching agreement will be established by DH and SHAs, to provide assurance around financial, activity and service plans for 2007/08. We will also

provide a set of unambiguous definitions for plans to enable greater consistency in approach and clarity about what plans are demonstrating.

NHS trusts will:

- > sign off contracts with commissioners;
- > show how required efficiency gains are being generated;
- > sign off fully worked up cost improvement programmes, risk rated and profiled on a month by month basis;
- > have board approval of budgets and operational plans (including workforce numbers) that incorporate cost improvements and cost pressures. These are to be monitored at the board on a monthly basis;
- > profile and monitor their workforce numbers and the payroll on a month by month basis.

PCTs will:

- > sign off costed LDPs which show income and expenditure balance, and clearly state assumptions about activity levels with 'best case' 'worst case' and 'likely' scenarios;
- > agree contracts with providers which reconcile with the LDP, and manage contracts in ways which are consistent and compatible with the national contract;
- > profile and monitor income and expenditure on a month by month basis;
- > show how growth monies, and those generated through improved efficiency, will be deployed;
- > agree contingency actions to respond to the 'worst case' scenario;
- > profile and monitor workforce numbers and the payroll on a month by month basis;
- > have reporting and monitoring of the LDP and contracts sign-off, at each board meeting.

SHAs will:

- > assess PCT plans with a more risk based approach, looking at 'best', 'worst' and 'likely' scenarios for the year particularly around hospital activity and care and resource utilisation. There needs to be clear, quantifiable contingency measures identified before the commencement of the year to deal with 'worst' case scenarios;

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- > reconcile plans across health communities so that different expectations on money and activity between commissioners and providers are known to all parties and unrealistic expectations are moderated;
- > be able to describe the regional position on expenditure, staffing, service improvement and health improvement in the same way the DH does nationally;
- > profile expenditure, workforce and cost reduction programmes on a month by month basis and report it through their boards;
- > performance manage PCTs and NHS trusts on behalf of DH.

The Department will apply key assurance tests to plans to ensure they:

- > provide evidence that at least 50% cost improvement will be delivered in the first 6 months of 2007/08;
- > are based on robust demand and activity assumptions that support delivery of the 18 weeks target; and
- > give assurances to delivery of national commitments and reconcile across the three elements of finance, workforce and activity.

The rules and systems in this document are not intended to cut across the compliance regime that Monitor have in respect of NHS FTs.

SHAs are expected to play a supporting role, providing visible leadership to local leaders in developing approaches to responding to patients and reforming services while enabling local creativity and innovation. SHAs will only intervene where it is necessary in the interests of patients or the tax payer. When SHAs do intervene, they will act quickly and decisively. It is important that SHAs work closely with Monitor where the application of this document could have an impact on NHS FTs.

System management

Other responsibilities for managing the system locally that are particularly important in the context of managing performance are described below.

Reconfiguration

Decisions about how to configure and reconfigure services are for local bodies, and it is for PCTs, NHS trusts and NHS FTs to decide the way forward. This needs to be done in consultation with clinicians and other staff, the public and local stakeholders. Local overview and scrutiny committees need to be engaged where significant changes are proposed. In the case of FTs, this means effectively engaging the existing wider governance mechanism of members and board of governors. SHAs will oversee merger proposals between NHS trusts, including safeguarding choice for patients.

Special circumstances

As in 2006/07, the rules set out in this document are binding. 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 FT is affected, additional measures will only be implemented after seeking to agree them with Monitor.

The future regulation of health and adult social care in England

On 27 November, we published *The future regulation of health and adult social care in England*. The publication confirms the commitment to merge the three organisations responsible for regulating healthcare, adult social care and the operation of the Mental Health Act in 2008. It focuses on the development of a regulatory framework for health and adult social care in England to be used by the Regulator, and outlines their likely roles and functions. Consultation questions consider operational aspects of the regulatory framework.

Code of practice for promotion of NHS services

We have previously signalled our preference for a largely self-regulating approach to promotion of NHS services and provision of information to patients by providers, and have published proposals on a code of practice to support this approach, which sets out the principles that providers must follow. The final code will be published in spring 2007 following a three month consultation. Sign up to the code of practice and self-regulatory system will be included in the NHS Contract for NHS trusts and the amended NHS FT model contract, and will be required once the final Code is published.



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