

The NHS in England

THE OPERATING FRAMEWORK FOR 2006/7

The 2006/7 Operating Framework,¹ published at the end of January 2006, sets out the Department of Health's priorities for the NHS in England over the next financial year, a year which the document expects to be 'challenging'. It is aimed primarily at NHS managers and their counterparts in local government. It sets out priorities and guidance for the NHS but also contains some rules of engagement, which, it makes clear, are binding: 'no health community will be able to opt out or change the rules unilaterally'. This briefing describes the main points contained in the document and provides some commentary about what the document implies for the competing strands of NHS reform.

Context

This is the second document the Department of Health has published that attempts to pull together different strands of NHS policy and explain how they work together. The first, *Health Reform in England. Update and next steps*², published in December 2005, described a framework for reform of the NHS in England and explained how the individual reforms patient choice, a wider range of providers, more freedom for hospitals, stronger commissioning, new payment mechanisms and independent inspection of quality were intended to be mutually reinforcing. The Operating Framework adds more detail to this same theme, setting out the priorities for the coming year.

What are the key priorities for 2006/7?

The document reminds the NHS that there are targets to be hit in 2007/8 and that service improvements are the root of the reform programme. In particular, targets are: substantially to reduce mortality rates from heart disease and stroke, to support people with long-term conditions, to reduce overall emergency bed days by 5 per cent and to reduce the maximum waiting time for hospital treatment to 18 weeks. It also sets out an aim to reform the health system fundamentally, so that change is driven more by incentives to respond to patients than by top-down target setting. It recognises that this year, 2006/7, represents a 'particular environment' that requires a particular approach from the leadership of the NHS.

Financial health

The top priority is to improve the financial health of NHS organisations. The Operating Framework makes clear that for 2006/7 NHS organisations should achieve in-year financial balance *and* recover any deficits incurred over 2005/6, with only a few exceptions (for example, where a 'turnaround team' has been sent in). As a whole the NHS should be aiming to do more than achieve financial balance; financial surplus should become the norm in the NHS as a matter of good business practice but also because there will be more 'financial volatility as new incentives take effect' in the future.

In the short term, efficiency improvements should produce savings of 2.5 per cent (or £1.6 billion) across the NHS. Generating a surplus does not represent an immediate incentive (for local reinvestment) as surpluses generated by primary care trusts (PCTs) will be ‘lodged’ with strategic health authorities (SHAs), and redistributed elsewhere across the NHS. The details of how this will work for London have already been published: even those PCTs not planning to lose money are now having to set aside 1 per cent of their allocations for distribution elsewhere.³

Funding for PCTs will rise by 9.2 per cent or £5.4 billion in 2006/7. The Department calculates that after inflation, and factoring in the expected efficiency savings, £3 billion will be available to PCTs to address deficits and improve services over the year.

	<i>by March 2006</i>		<i>by March 2007</i>
Practice-based commissioning	20% of practices		100% of practices
Choice of hospital	4+		Extended
Payment by Results	£9 billion of services covered		£22 billion of services
Choose and Book	25%		90%
Foundation trusts	32 (acute) trusts		65 to 80, including between 5 and 10 mental health trusts
Primary care trusts	303		120 to 160
Independent sector treatment centres	18		24

Implementing reform

The Department of Health is committed to accelerating the pace of reform across the NHS. The Operating Framework outlines the progress it expects to be made by the end of the financial year.

In addition, strategic health authorities are also being slimmed down, from 28 to 9 or 10, but the timescale is not as tight as for the PCTs, which have to be restructured within 12 months.

Meeting service targets

The Operating Framework reiterates the importance of PCTs and NHS trusts working towards meeting the service targets that were set in their three-year local delivery plans (LDPs) in 2004/5.

Within the existing targets, particular emphasis over the next 12 months is to be given in six service areas.

- **Health inequalities** Progress towards reducing health inequalities by 10 per cent by 2010 with an initial focus on smoking cessation.
- **Cancer waiting times** To continue to deliver maximum waiting times of 62 days from urgent referral to treatment and 31 days from diagnosis to treatment for all cancers by March 2007.
- **Maximum waiting times** Work towards guaranteeing no patient will wait longer than 18 weeks from GP referral to hospital treatment by 2008.
- **MRSA** Deliver year-on-year reductions in MRSA infection rates.
- **Patient choice** Extend Choose and Book to account for 90 per cent of all GP referrals by March 2007 and to ensure all patients have a choice of at least four providers.
- **Sexual health** Enable all patients requiring access to a sexual health clinical to have an appointment within 48 hours of referral.

Choice and commissioning

The Operating Framework outlines the interim arrangements for extending patient choice and practice-based commissioning over the next 12 months.

Choice

In 2006/7, the choice of hospitals offered to patients will be extended to include any NHS foundation trust, any independent sector treatment centre 'and any other subsequently centrally accredited independent sector providers'.

Practice-based commissioning

To achieve universal coverage of practice-based commissioning, additional funding will be made available to GP practices. This is designed to offset the financial risks that may arise from moving to practice-based commissioning.

PCT commissioning

The framework makes it clear that PCTs cannot enter into new contracts with service providers that prescribe 'activity limits', since these undermine the principle of patient choice and payment for work done. However, limits are being built into the system. New contracts must include planned activity 'levels'. The increase in these levels for elective surgery should not, on aggregate, exceed 3 per cent, while emergency bed days should be reduced. If planned activity levels are being breached, there is a joint responsibility on the PCT and the provider to take action to safeguard access to services and to ensure affordability within the resource and cash limits in place locally.

Furthermore, PCTs are also expected to manage demand through locally agreed strategies, including setting thresholds for referrals.

Provision and contestability

Foundation trusts

Over the next 12 months all NHS trusts will be assessed by the Department and Monitor to determine their current suitability for foundation trust status. The steps individual NHS trusts need to take to be able to apply for foundation status by 2008 will be subsequently identified and acted upon.

Independent sector treatment centres

The role and capacity of independent sector treatment centres (ISTCs) will continue grow. The government anticipates that 105,000 procedures will be delivered by the existing 'Wave 1' facilities in 2006/7. The second wave of ISTCs is expected to cost £500 million each year for five years and deliver 250,000 episodes of care (the 3 per cent limits to growth in elective care do not, apparently, apply to the ISTC sector).

Primary and community services

The document reiterates that PCTs will not be required to stop providing services themselves, now or in the future, but emphasises that they will also be free to make 'different arrangements' with other providers where necessary.

Any changes to local service provision (such as mergers) will require public consultation and should also be tested against a set of principles, to be issued by Monitor and the Department of Health in April 2006. The Operating Framework recognises that decisions to change or merge services will now have to be evaluated carefully so that they do not conflict with other reform objectives, such as increased patient choice or more care closer to home.

Private finance initiatives

PCTs and NHS trusts are required to reconfirm their capital investment plans with the Department and local SHAs. All new hospital development programmes, including private finance initiative (PFI) schemes, are to be reappraised to verify that they support the Department's new strategy for shifting the balance of services into primary and community settings. Additionally, PCTs and NHS trusts must reconsider the long-term financial viability of their proposals. Demonstrating sustainability is a prerequisite for confirmation.

Trusts running significant financial deficits are not to be permitted to take forward their proposed capital investment programmes without agreeing plans to address their shortfalls with their SHA and the Department.

Advertising

The Department highlights the need for guidance on the advertising and marketing activities NHS service providers can engage in to inform patients and GPs of the advantages of commissioning their services. This issue reflects the increasing level of competition that is being introduced into the NHS and the importance of patients having access to information about the services they can choose. While stating that advertising should stay within the ASA code, the Department insists that it favours a 'self-regulating' approach. Nevertheless, TV and cinema advertising is stated as 'unlikely to be justifiable' on cost grounds and no activity that would undermine providers' reputations should be allowed. The Department says it intends to consult further on this matter.

Incentives and drivers

Payment by Results (PBR) is identified as the principal tool for driving forward reform, and the scheme's tariff structures and prices are to be modified to promote desired commissioning outcomes.

The price for the work hospitals carry out will increase over the whole tariff by only 1.5 per cent in 2006/7. This is substantially below the inflation rate for NHS costs. Moreover, this uplift is not equally distributed across the range of tariffs. Non-elective activity will in fact experience a 0.5 per cent reduction, reducing the money hospitals will receive for providing these services. These decisions are designed to provide incentives to shift the balance of services into primary and community settings and check hospital admissions.

PbR will be extended to cover all elective, non-elective, A&E and outpatient activity in hospitals by April 2006. This will result in an increase of 133 per cent in the number of services funded via PbR compared to last year.

Tariff structures are also to be modified, partly to reflect policy priorities. This includes a change to the emergency tariff. The full tariff will be paid on extra cases, but only up to a threshold, which represents an increase of 3.2 per cent on the numbers of emergency cases from 2003/4. Any emergency cases treated on top of this will attract only 50 per cent of the tariff payment. The objective is to reduce the relentless growth of emergency admissions. In addition, tariffs for certain procedures will be 'unbundled' to specify costs for individual activities of a procedure, but in shadow form only at this stage. This will allow commissioners to start calculating how different providers might be used for different elements of a patient's care pathway (for instance, using diagnostic procedures outside hospital).

Management and regulation

The role of strategic health authorities (SHAs) remains undecided until the reorganisation of PCTs is complete. Transitional arrangements are, however, put in place over to specify the functions of SHAs over the next 12 months.

SHAs will play a supporting role:

- performance managing on behalf of the Department of Health;
- controlling overall spending;
- monitoring and managing organisation change; and
- arbitrating, where necessary, between PCTs and NHS trusts.

What can be drawn from the Operating Framework

The Operating Framework provides an interesting insight into the Department of Health's current thinking and outlook for the year ahead. The document notes that the general direction of travel is away from an NHS that is dominated by centrally driven top-down targets to one in that is primarily 'locally led and incentive led' by 2008.

What is noteworthy is that the NHS's financial crisis has risen to the top of the agenda and appears, in the short term, to have circumscribed the desirability of the 'incentives' to act in the way they were originally designed.

In theory, the incentives contained within the PbR system were designed to encourage not only efficiency but also increased activity on the part of hospital providers. The existing financial discomfort of many NHS organisations and the anticipation of further financial volatility appears to have led the Department of Health to damp down any expectations of increased competition between providers for extra activity in this document (at least within the NHS; the private sector is still on an upward curve).

The document clearly states that 'a national health service will always need to operate within the resources available. It is in no one's interest locally to break the bank'. Limits to aggregate growth in elective activity and talk of 'activity plans' suggest that the brakes are being applied to the expectations of providers, yet it is not clear what effect this will have on hospital finances, faced with a much-reduced tariff uplift for 2006/7 of 1.5 per cent. Changes to the tariff underlying PbR are also being used to manage demand, by reducing any incentives to admit more emergency cases. For this to work, hospital trusts will have to get some control over their emergencies, which requires co-operative working with commissioners, both PCTs and GPs. It is not clear how widespread co-operative relations are between PCTs and trusts at the moment.

Questions remain about how effective PCTs will be at 'managing demand' in this context. Efforts to set referral thresholds for orthopaedic surgery at a PCT in Suffolk last year were met with hostility from the national press.⁴ The document concedes that many of the levers to move care out of hospital into the community require further development. The 'universal' nature of practice-based commissioning will be judged, in the short term, by process-driven measures, such as practices receiving activity data or taking up an incentive payment. It will not be clear by the end of 2006/7 how many practices have 'redesigned' what proportion of their services and to what effect, or how many are engaged in meaningful practice-based commissioning.

The document also reveals how the pursuit of financial balance might lead NHS institutions into taking decisions that conflict with other policy objectives. The 'redesigning' of local services by PCTs or trusts such as merging or closing services could easily increase inequalities in access to care or reduce patient choice. But much of the regulatory detail is still awaited, not only for mergers but also for how trusts conduct themselves in a competitive environment.

The key tension identified in this document is apparently between the need for co-operation, generated by tight finances, and the force for competition (and even gaming), generated by the incentives contained within the reforms. Organisational reforms to PCTs and SHAs are a further complicating factor. The Operating Framework calls for 'mature relationships' between commissioners and providers 'in the interests of the patient'. The fact that it has to make the point at all is perhaps

testimony to how unclear the reformers are about short-term effects of the reforms on the behaviour of those delivering services with the NHS in England.

¹ Department of Health (2006). The NHS in England: The operating framework for 2006/7. London: The Stationery Office.

Available online at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127117&chk=BgslVK (accessed on 26 April 2006).

² Department of Health (2005). Health reform in England: Update and next steps. London: The Stationery Office. Available online at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4124723&chk=y2qlXE (accessed on 26 April 2006).

³ <http://patch.nwondon.nhs.uk/shared/cms/data/documentLibrary/273.pdf>

⁴ <http://news.scotsman.com/opinion.cfm?id=2311002005>;

http://comment.independent.co.uk/leading_articles/article328935.ece; “Row as docs ban ops for tubbies to save cash” The Sun November 23rd 2005; <http://www.guardian.co.uk/frontpage/story/0,,1648760,00.html>