Royal College of Nursing

RCN Policy Unit

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

ABSTRACT
This briefing details the final stages of the NHS reforms for 2006/7 and 2007/8 with particular focus in 2006/7 on achieving robust financial health; pushing forward the implementation of reform; and achieving six specific service priorities derived from the Planning and Priorities Framework.

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Introduction

According to the opening paragraph, the NHS is committed to delivering the plans set out in National Standards, Local Action, published in July 2004. This publication is the first of many designed to detail the 'rules of the game' for the final, most ambitious stages of the reform over the years 2006/7 and 2007/8. There are further publications of this nature in March, July and September of this year. This publication puts a particular focus in 2006/7 on:

- achieving robust financial health;
- pushing forward the implementation of reform; and
- achieving six specific service priorities derived from the Planning and Priorities Framework.

Context

This paper should be read in conjunction with the numerous other papers published by the DH over the last few months. In particular, '*Health Reform in England: Update and Next Steps*' and the reform agenda revealed in the DH guidance '*Delivering Quality and Value: A briefing for NHS Chairs and Non-Executive Directors*' (and its associated products – the 'Efficiency Map' and Productive Time initiatives).

The Department's national Productive Time Programme focuses on a single approach to "…encourage the integration of people, process and technology reforms to support the provision of excellent patient care, within financial balance." In essence the approach detailed above lays outs 3 assumptions underpinning the reforms program for 2006/7

- The current system of NHS service delivery still has excess to be trimmed, in particular how staff *spend* their time;
- Further reform and outsourcing is the solution for cost savings in procurement and back office functions. Aside from some small gains in procurement, this is *barely* supported by evidence; and
- Greater use of IM&T will produce system efficiencies.

'Achieving financial health'

During 2005/6 the emphasis (at least in the last 6 months of the year) was on planning to achieve financial break even. For 2006/7 this has been upgraded to a requirement to achieve a financial surplus. The document makes it quite clear that this should become the "norm for the NHS".

Within this overall total, the planning presumption is that organisations should both achieve in-year balance and recover 2005/6 deficits. In exceptional circumstances organisations may be allowed more time to recover the 2005/6 deficit, but they are required to plan for in-year balance. There are exceptions to this rule but only where (for example) this is affordable within the control totals agreed between the DH and the relevant SHA and all reasonable action has been taken both to achieve balance and to recover the deficit. This would also mean that the organisation in question will be subject to the monitoring and control from the SHA/DH e.g. via turnaround teams.

As has been mentioned in previous briefings, the common response to our work exposing deficits across the NHS is that the problems were always there, just not monitored as closely as they have been. For 2006/7, there will be greater transparency and financial volatility as the new incentives take effect, and as money flows change to reflect patient choice and provider responses, we can expect to see more reactionary reconfigurations. Later in the document, mention is made of the SHA role in monitoring reconfiguration in the light of the further roll out of PbR – it is clear that the DH expect FT applications, PbR and financial instability to explicitly drive service redesign.

In terms of additional money to the NHS, it is true to say that there has been significant investment. However we must also highlight the substantial organisational cost of reforms in comparison to the relatively small sums of money being provided.

Whilst the headline uplift for the PbR Tariff (and thus in turn for acute trusts) is 6.5%, the DH are expecting a 2.5% improvement in efficiency returns across all parts of the NHS next year as well as adjusting tariff prices down by 2.5% to compensate for data and baseline issues identified last year. In other words, acute Trusts can expect to receive only 1.5% uplift on income, whilst PCTs will receive 9% uplift (minus the 2.5% efficiency returns and without additional funds for implementing PBC or choice). For services not covered by the tariff, the pay, prices and reform uplift along with the efficiency requirement, will be the benchmark.

Implementing reform

The DH has made it publicly known that there is no intention of slowing down the pace of reform this year. The table below summarises the main policy objectives for this year (*see also RCN Policy Briefing 05/2005 'NHS Reform; Update and Next Steps' for further information on the timetable for reform beyond 2006/7*).

Implementing reform: expectations of change by March 2007

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

Planning and priorities framework

Whilst many of the service targets identified don't need to be met until 2007 and 2008 the publication makes it clear that some will require particular attention this year in order to reach target levels of activity/quality. Areas for particular targeting include

- *Health inequalities*: The initial focus will be on smoking cessation
- *Cancer 31-day and 62-day waits*: a maximum waiting time of two months from urgent referral to treatment, and of one month from diagnosis to treatment
- *18-week maximum wait*: to ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.
- *MRSA*: to achieve year-on-year reductions in MRSA levels, as set out in the agreed LDPs for 2006/7.
- *Patient choice and booking*: to ensure that every hospital appointment will be booked for the convenience of the patient
- *Sexual health*: enhanced access to clinics and an appt in 48hrs

Whilst there is nothing new here, the commitment is clearly to ramp up the pace of achievement in 2006/7.

Choice and commissioning

This section of the guidance deals in the main with the challenges for PCTs. There is a substantial organisational change agenda detailed including developing PBC, Contracting arrangements, and practice development.

The main challenge for PCTs will be engaging a suspicious GP community in the now mandatory development of PBC and in particular, new forms of budget planning and risk pooling. This is likely to severely challenge a number of PCTs who will have had only 3-6months to recover from the CPLNHS reviews before tackling this project.

Providing services

This section turns its attention to managing the future configuration and behaviour of the various providers but stops short of discussing in detail who will be involved in any attempt to increase provider plurality.

For PCTs there is a familiar restatement of the DH position on reprovision of PCT provider services but also a requirement for PCTs review "…formally and systematically whether local services are delivering high-quality, effective and efficient care, and whether they are tackling health inequalities."

This clearly means that 2005/6 will contain a significant challenge for RCN activists and members in responding to a large number of whole service reviews in primary care which will inform the future of provider services. This should be a key consideration in planning activist briefing and support for the 2nd and 3rd quarter of 2006/7.

For SHA's, they are charged with providing a distinct regulatory function as opposed to their normal strategic planning function. There is no mention in the guidance about the workforce planning role of SHA's. Coupled with the absence of any consideration of this in CPLNHS, this should be a target for concerted lobbying and debate this year.

The FT diagnostic process is seen as a possible catalyst for merger and reconfiguration this year. Given that a number of Trusts applying for FT status have more than one hospital site, consideration should be given for scoping out the possibility of further merger and reconfiguration proposals in the coming year, particularly for those Trusts whose FT application was deferred at this stage.

Conclusions

Financial instability and rapid reforms are the chosen catalysts for change in the NHS. This casts some doubt on the notion of the next year or so being patient-led.

FT applications as well as financial instability will also act as a catalyst for further reconfiguration and possibly, whole site closures over the coming year.

The pace of reform shows no sign of slowing meaning service reconfiguration consultation is likely to be a regular feature of the coming months and will be run very tightly against strict timescales for delivery – RCN may need to consider current methods of briefing activists and staff regarding the impact of the changes.

RCN should continue to lobby for a slowing of pace; protection for vulnerable services; and a public debate on the use of competition to determine service distribution. We should continue to raise the question – where is the patient is this new apparently patient led NHS?