

Health reform in England: update and next steps



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Contact Details	Bill McCarthy Director of Policy Department of Health Quarry House Quarry Hill Leeds LS2 7UE
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Foreword

The Secretary of State for Health

Patients are already seeing much shorter waiting times and better services from their National Health Service. This would not have happened without the dedication of staff, more money than ever before and matching the investment with radical reform of the way the system works.

But we are still some distance from meeting people's expectations and ensuring that the revolution in medicine helps improve everyone's health.

To achieve this we must continue to reform the NHS as well as invest in it.

The main aim of our reforms is to give people more choice and control over their health and care. To achieve this people need to be able to choose from a greater variety of convenient high-quality providers: including NHS trusts, NHS Foundation Trusts and the voluntary and private sector.

Doctors, nurses and other staff, in turn, need to have more freedom to meet patients' expectations. GPs and Primary Care Trusts (PCTs) will enable a stronger voice for patients, bringing more services out of hospital and into the community. And we are improving value for money by cracking down on waste and driving up efficiency.

That's what we mean by moving from a politician-led NHS to a patient-led NHS. With the first, we can use targets and performance management to drive up standards. But it can only ever take us some of the way. With the second,

improvements become continuous, driven by the NHS always responding to patients' needs and expectations. The imperative for reform is urgent and growing. People want more from their public services, to match the choice, customer service and personalisation they can get from their bank, supermarket or on-line shopping. The revolution in technology and pharmaceuticals means more opportunities, but also more costs. Globalisation means that 'health tourism' will increase, with people travelling the world or surfing the net to get information, drugs or treatment from emerging economies.

So the NHS must rise to these challenges if it is to thrive for the next generation. A patient-led NHS will be self-improving and sustainable over the long term. But it will only happen if we make reform a reality. Now is not the time to rest on our laurels; now is the time to step up the pace of reform.

All of this gives us a chance, for the first time, to make real our founding values: a universal service, with equal access free at the point of use, with treatment based on clinical need not ability to pay. This is what we mean by a patient-led NHS: free for all and personal to each.



Rt Hon Patricia Hewitt
Secretary of State for Health

Contents

Foreword	
Executive summary	2
1 Introduction	4
2 Rationale	6
3 The framework for the reforms	9
4 The benefits for patients	13
5 Taking stock and the next steps	15
Annexe A – Health reform in England: Framework	17
Annexe B – Health reform in England: Implementation timetable	18
Annexe C – Health reform in England: Forthcoming guidance timetable	21
Annexe D – Commissioning for a patient-led NHS	25

Executive summary

This document describes a framework for reform of the NHS in England and

- > explains how the reforms are intended to be mutually reinforcing;
- > re-states the rationale for reform;
- > summarises the initiatives already announced;
- > lays out a programme of further policy development for 2006.

Rationale

Many of the initiatives are well known: patient choice, a wider range of providers, more freedom for hospitals, stronger commissioning, new payment mechanisms and independent inspection of quality.

Much has been achieved during the last five years of investment and reform, but we need to go further. The aim is to achieve an NHS that is 'self-improving': to provide the highest possible quality of care, delivered in the most efficient way, led by the needs and wishes of patients and supported by staff. Such an in-built dynamic for continuous improvement is essential to enable the NHS to keep pace with fast-changing technology, to tackle inequalities and to raise standards of care.

The reforms will give doctors, nurses, managers and other NHS professionals incentives to help drive improvements in health and healthcare, and to increase responsiveness to patients.

That said, the reforms are a means to improvement rather than a blueprint for how services should be delivered. They will support the development of high-quality services by embedding the right balance of incentives, transparency, plurality of providers and patient choice into the system. Better commissioning of healthcare services will be critical.

These reforms are rooted in the core values of the NHS: providing equal access to care that is available at the point of need regardless of ability to pay, personal to the individual patient and achieved within a taxpayer-funded system that must demonstrate value for money.

Patients will notice the difference. The reform programme, when fully implemented, will offer significant benefits. Patients will no longer have to make do if their local service is underperforming; they will have a choice and information to back that choice. Shorter waits, one-stop clinics and increased provision of healthcare at home will be just some of the features of the new system. Social and healthcare service boundaries will appear less obvious to patients as co-operation between health and social care improves. Staying healthy will become easier as GP practices put increasing effort into supporting people to manage and protect their own health and well-being.

The framework and next steps

The reforms are inter-related and mutually reinforcing. There are four connected streams of work:

- > more choice and a much stronger voice for patients (demand-side reforms);
- > more diverse providers, with more freedom to innovate and improve services (supply-side reforms);
- > money following the patients, rewarding the best and most efficient, giving others the incentive to improve (transactional reforms);
- > system management and decision making to support quality, safety, fairness, equity and value for money (system management reforms).

Between now and 2008 we will continue to develop and implement the new incentives and a revised management and regulatory framework. We will build the momentum of reform over this period. To ensure we do so without endangering financial or service delivery, we will produce annual rules for the NHS until the full range of reforms are in place in 2008. The rules for 2006/7, including information on the tariff, will be available in January 2006.

Early in the new year, we will publish a White Paper that will describe how this programme of reforms will be applied to primary and community care.

Further work is now required to complete the policy design in a number of areas. During 2006, the Department of Health, working in close collaboration with people from across the NHS and health related organisations, will produce a series of policy framework documents including:

- > Commissioning, practice based commissioning and contracting
- > The next steps on patient choice
- > The future of NHS workforce development
- > The future of provider reform
- > A review of information requirements
- > Payment by results in 2007 and beyond
- > Management and regulation of the healthcare system
- > Quality and safety of clinical care in the reformed healthcare system.

These reforms are challenging. They offer a real opportunity to provide a better service to patients and the public, enabling the people working in the NHS to make the most of their skills and commitment.

1. Introduction

1.1 This document:

- > describes the reforms we are introducing to the healthcare system;
- > explains how they are intended to work together;
- > supports NHS managers and healthcare professionals as they contribute to, lead and implement elements of the reform programme, including patient choice, the extension of payment by results (PbR) and practice based commissioning (PBC); and
- > provides the necessary context to the development of NHS Foundation Trusts and to the Strategic Health Authority (SHA) and Primary Care Trust (PCT) organisational changes.

1.2 This is the first in a series of publications building on the commitment in *Creating a Patient-led NHS*¹ to explain how the whole reform programme fits together. Many of the policies and initiatives described below are already underway and well known; this document is important because it explains how the reforms are intended to be mutually reinforcing and sets out a programme of further work for 2006. Inevitably, it reflects the fact that most work to date on the reform programme has addressed the acute and hospital care sector. Looking to the future, the introduction of new incentives to enable

healthcare professionals and NHS managers to better respond to the needs and preferences of their patients will continue to hold good for other parts of the healthcare system.

1.3 In early 2006, we will publish a White Paper following the *Your Health, Your Care, Your Say* consultation. It will set out both a strategic vision for health and healthcare services in the community and a description of how new incentives and flexibilities will be used to support better quality and more responsive and patient-focused services in primary and community settings. It will also take forward the outcomes of the consultation on the Green Paper on social care, *Independence, Well-being and Choice*.²

1.4 Between now and 2008, we will continue progressively to develop and implement the new set of incentives and a revised management and regulatory framework. The proposals set out in the White Paper will also start to make a significant impact over this period. To help ensure stability within the system during this time of transition, we will agree and publish 'system rules' for 2006/7 and 2007/8. These will reflect progress made in implementing the reforms, set the pace of change required and identify the operational parameters and expectations

¹ *Creating a Patient-led NHS: Delivering the NHS Improvement Plan*, March 2005, page 35

² *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England: Social Care Green Paper*, March 2005

for the healthcare system as a whole.

This gradual introduction of incentives and flexibilities within a context of 'system rules' will build the momentum needed to deliver more benefits for patients and taxpayers, while at the same time ensuring financial stability and building organisational capability.

- 1.5 This document identifies those areas where more work is needed to develop policy. The continuing involvement of clinicians from all professions, of managers and of the wider healthcare community will be essential in this next phase. There are many opportunities to become involved, locally as well as nationally. A timetable for the further policy work is included in the annexes, along with a proposed set of major publications for 2006. We will invite and encourage a high level of NHS involvement in this work.
- 1.6 The reforms will provide many opportunities, yet they will not automatically bring about the changes in culture and practice that we all seek for the NHS. Leadership at every level will be fundamentally important both to explain the reforms and to implement them productively in local health communities. In maintaining the direction and momentum of reform, we will also ensure that there are strong processes for identifying any unintended consequences, feeding back lessons learned and, in turn, for adapting the reforms over time.

2. Rationale

- 2.1 We are now halfway through a ten-year programme of reform which began with the NHS Plan³ and the Wanless Report.⁴ These identified the need for a programme of sustained investment in and reform of the NHS to ensure that it could deliver its core aim: providing high-quality care for every patient, responding to need, not ability to pay. Both reports also highlighted the importance of value for money: the need to achieve consistently the best use of resources in a taxpayer-funded service.
- 2.2 The reports also made clear that, for the reforms to be successful, patients would need to be fully engaged in decisions and choices about their own health and healthcare. The NHS, for its part, would need to give greater focus to the prevention of illness, by tackling inequality of access and by empowering people to make choices that improve and protect their own health.
- 2.3 Until recently, the healthcare system has not adequately rewarded hospitals and other providers for responding to patients and improving clinical services and productivity. A combination of, on the one hand, payments based on historical budgets and, on the other, patients not having a choice meant that funding could be taken for granted rather than being linked to patients' experience or to the health outcomes achieved. As a result, while financial risk in the system was low, so too was the challenge to hospitals that performed poorly. And high-quality, well-run services lacked the incentive or support to develop further. Even today, there continue to be some unacceptable variations in quality and accessibility across the country. Patients, lacking information and choice, have been unable to use their muscle to exert pressure for improvement. We need to give patients and the public more control over their health and their health services and to enable NHS professionals to further develop the quality of services.
- 2.4 Much has been achieved during the last five years of investment and reform to tackle this agenda. For example, the significant investment in NHS staff, along with more flexible working across traditional boundaries, is enabling healthcare professionals to take advantage of the freedom and opportunities that reform will bring. Nurses, midwives, doctors and other NHS staff, working flexibly and using improved technology and clinical service redesign, are better able to respond to patients' needs and changing expectations and are achieving improvements in quality and productivity across the system. By 2008 investment in the NHS as a whole will have risen from

³ *The NHS Plan, July 2000*

⁴ *Securing Our Future Health: Taking a Long-Term View, Final Report, Derek Wanless, April 2002*

£43.9bn per year in 2000, when the NHS Plan was launched, to £92.6bn. Numbers of early deaths from cancer, coronary heart disease and suicide continue to fall as services improve; over 98% of patients at Accident and Emergency (A&E) Departments are seen within 4 hours; and hospital waiting lists are lower than ever, with half a million fewer patients waiting since lists were at their peak.⁵

- 2.5 Improvements have been made through a combination of centrally driven targets and a huge amount of hard work on the part of NHS staff. Local innovation and changed ways of working have also been fundamental. Supported by the Modernisation Agency, about 100,000 people have learned the techniques of service redesign and are now using ideas such as those in *10 High Impact Changes*,⁶ along with workforce flexibilities, to improve both productivity and care for patients.
- 2.6 All of this has made a big difference to patients, but we need to go further: to provide consistently the highest possible quality of care, delivered in the most efficient way, led by the needs and wishes of patients and supported by staff. In an environment as complex and changing as that of healthcare, for the NHS to improve

and innovate on a sustainable basis, the system as a whole has to better support the motivation and aspiration of staff to provide good-quality services. Targets alone, especially targets driven from the centre, cannot achieve this.

- 2.7 We are aiming therefore for an NHS that is 'self-improving', led by patients and the public in partnership with staff. As was made clear in *Creating a Patient-led NHS*, to achieve an in-built dynamic for continuous innovation and improvement will mean both a change of culture and a change of systems so the right incentives are in place. *Commissioning a Patient-led NHS*,⁷ which described how SHAs and PCTs would need to change, supports this intention. Good progress has been made in assessing the options for boundary changes, and consultation exercises will be a key feature of the first part of 2006.
- 2.8 The reforms are not designed as a blueprint for *how* services should be delivered; they are a means to improvement and not an end in themselves. The reform programme seeks to embed the right balance of incentives, patient choice, plurality and transparency in the system. It will make the patient's voice and choice heard. It is also intended to give clinicians and managers the tools

⁵ *Chief Executive's Report to the NHS, December 2005*

⁶ *10 High Impact Changes*, September 2004, available online at www.modern.nhs.uk/highimpactchanges or by calling 08701 555 455 and quoting the reference MAHICRES

⁷ *Commissioning a Patient-led NHS*, July 2005

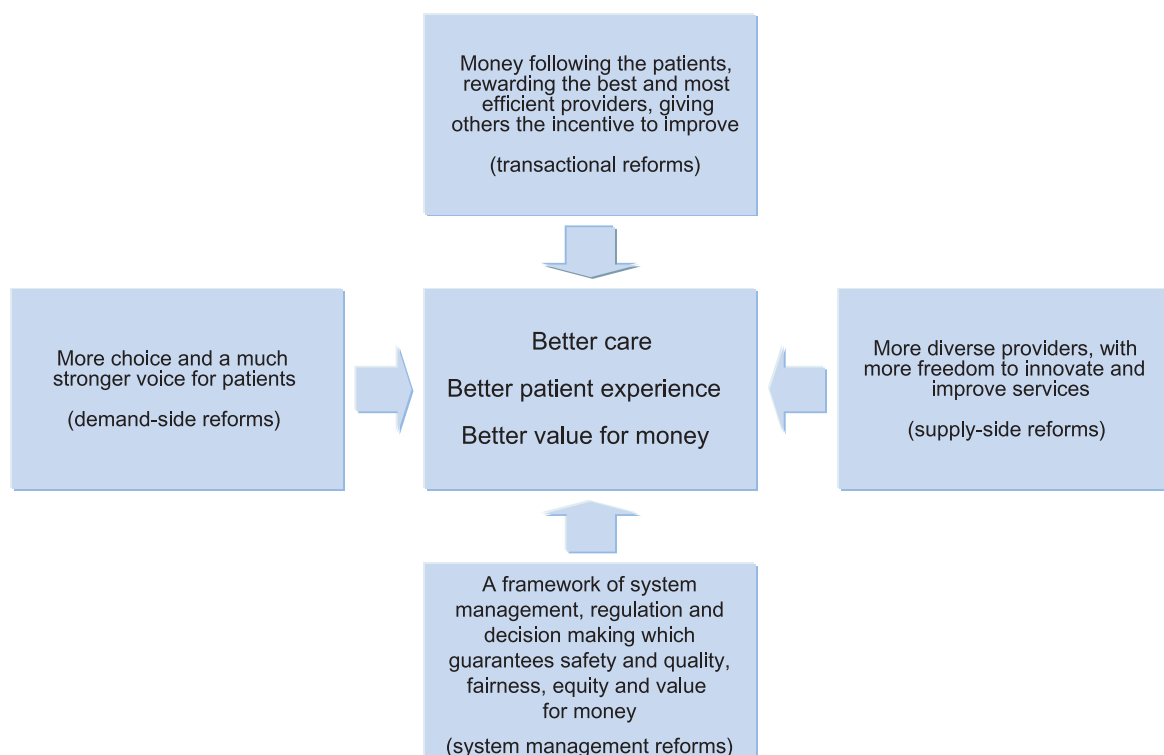
they need to make good use of resources, to respond flexibly to the changing needs of their patients and populations.

- 2.9 Above all, the reform programme continues to be founded on and reinforces the core values and principles of the NHS: equal access to care available at the point of need, regardless of ability to pay; care that is personal to each individual patient, and all achieved within a tax funded system which must achieve value for contributors' money.

3. The framework for the reforms

- 3.1 The aim is to create a service devoted to identifying and meeting the needs and preferences of patients and the public and to shaping service delivery accordingly.
- 3.2 The system reform programme represents a coherent and mutually supporting set of reforms, which together provide systems and incentives to drive improvements in health and health services, increase responsiveness to patients and help to achieve reductions in health inequalities.
- 3.3 While the impact of the programme will depend upon its coherence as a whole, it is most easily described as four related streams of work, as set out in the diagram below.
- > **More choice and a much stronger voice for patients** (demand-side reforms):
 - **Patient choice.** Providing more choice and control over treatment and services is a key feature of a system that is self-improving and within which services are designed around patients.
 - **Better information for the public about health and health services.** High-quality information that is accessible and can be tailored to individual needs will ensure that choice is meaningful (based on factors that will improve patients’ experience and drive better health outcomes) and will help

Framework for the reforms



patients, especially those living with long-term conditions, to manage their own health.

– **A new system of commissioning.**

Practice based commissioning will give GPs and primary care professionals, working closely with and supported by stronger PCTs, the tools to innovate and influence local service development for the benefit of patients, and on behalf of local populations and the taxpayer. It will also help to strengthen commissioning with local partners, especially social care commissioners. This is discussed in more detail in annexe D.

> **More diverse providers, with more freedom to innovate and improve services** (supply-side reforms):

– **NHS Foundation Trust status.**

The continuing programme to create NHS providers with more freedom from central performance management and greater accountability to local people is a key element of reform. The freedom and flexibilities of foundation trust status give front-line healthcare professionals and local managers the incentive to improve services and innovate in response to the needs of their patients and local populations.

– **A wider range of providers.**

Introducing more providers from the private and voluntary sectors, including new NHS social enterprises, will bring more capacity, more innovation and new ways of working. The development of a wider range of primary and community services, including those provided by PCTs, will also provide new and innovative models of care. Both of these developments will offer real alternatives for patients.

– **Workforce reform.** Workforce modernisation is key to ensuring we have flexible, productive working practices that will support a patient-focused NHS. There has been significant investment in new contracts for almost all NHS staff, and a move away from traditional occupational roles towards defined competencies is supporting greater flexibility. Education, training, pay, workforce planning and regulation are all being designed to support staff competencies and to ensure that staff are enabled to deliver the changes in practice and culture that will underpin the reforms set out in this document.

- > **Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve** (transactional reforms):
 - **Payment by results (PbR).**
Combined with patient choice and better information for patients, PbR will bring greater financial transparency to the system. It will benefit respected and productive services and whole hospitals, and provide incentives to improve for those providers struggling on quality or cost control. PbR also provides incentives for the development of alternative primary and community services where these are more clinically effective and cost effective than hospitalisation.
 - **Access to information** (including the National Programme for IT (NPfIT) programmes). As well as information to support patient choice, more and better clinical and management information, including robust mechanisms for hearing the views and experiences of patients and the public, will enable providers to understand and respond to patients' needs. Practices and PCTs will use such information to drive commissioning decisions to align services with population needs. Better information will also help practices, PCTs and regulators to track quality and performance.
- > **A framework of system management, regulation and decision making which guarantees safety and quality, fairness, equity and value for money** (system management reforms). The framework will need to address:
 - **governance:** a comprehensive description of roles and responsibilities of organisations which, respectively, performance manage or regulate the system as a whole;
 - **standards:** setting standards and monitoring compliance with the required standards among both the NHS and independent sector providers of NHS services;
 - **licensing providers:** ensuring that providers meet the required quality standards, and potentially using a licensing or accreditation system;
 - **competition policy:** setting the rules for an appropriate degree of competition and challenge within a public service framework that protects essential services and promotes co-operation where needed;
 - **performance regime:** a system to identify problems early on, to provide help and support and to address serious clinical and/or financial failure; and
 - **setting prices:** advising on and determining the level of NHS tariff so as to create incentives for improving services and health outcomes and increasing productivity.

- 3.4 The forthcoming White Paper will build on these strands of work, setting out proposals for improving patients' choice of health and care services in the community and strengthening their influence over available services. The elements of the health system reform programme described in this document will be key drivers to deliver the vision for the future of community services.
- 3.5 Annexe A provides on a single page a brief summary of the four strands of the reform agenda. While it is useful to categorise the reforms into these four strands, in practice the benefits of higher quality and more responsive care for patients, and better value for money for the taxpayer, will be realised through the interactions between all four elements.
- 3.6 Better and more responsive services will be driven by the combined effect of more information on quality, patients exercising choice on the basis of such information and advice, and money following the patient. The combination of PbR and better commissioning by practices and PCTs will make it easier to invest in local services. A clear rules-based system will provide confidence for patients, and will encourage innovation as providers understand the rewards and risks. Moreover, it will be for local health communities to use the incentives and opportunities offered by the reforms to achieve improvements locally.

4. The benefits for patients

- 4.1 This section looks at the reforms from the perspective of patients. When any one of us or our loved ones is ill, we expect safe and high-quality treatment. We also expect to be cared for as individuals, with dignity and respect. All of the reforms are designed, in different ways, to introduce more incentives for hospitals and commissioners to fulfil patients' expectations and, crucially, more incentives for those who are not meeting patients' expectations to improve.
- 4.2 **Quality.** National standards and independent inspection will continue to assure patients that all NHS-funded services are safe and of a high quality. Good clinical governance will remain a high priority. At the same time, patients will have much more information about individual services and their performance, enabling them to choose the services that best meet their needs. Choices made by patients combined with PbR will provide powerful incentives for providers to improve service quality. In future when patients choose to go to their local hospital, it will not be because it is the only option but because it is the best option for them. Patients will no longer have to make do if their local service is underperforming.
- 4.3 **Personalised, responsive services.** Staff will have the incentives and levers to make the changes patients need and want. This will help to ensure that services are easier to access and more responsive. As patients express their preferences, and general practices use their influence to develop new services to meet local needs better, services should become increasingly responsive to patients' wishes. Shorter waits, one-stop clinics for diagnostics, and increased provision of healthcare in patients' homes are just some examples of services that are likely to develop in response to new incentives.
- 4.4 **Access.** Patients will be able to gain access to healthcare in new ways that are more flexible and fit around the rest of their lives. For example, PBC will enable general practices to shape services in line with what they know is important to their patients. This is likely to mean more services delivered in local communities, such as urgent, preventative and rehabilitative care, so helping to avoid unnecessary admissions to hospital. It is also likely to mean more services provided in places other than hospitals, close to where people live and work and available at times that are convenient. Strengthened PCTs working with practice-based commissioners will be critical to these changes. Better information will help patients understand and make best use of the options available.
- 4.5 **Joined-up services.** Patients should not have to negotiate their way around the system or give the same details time and again. The reforms will support services to become more integrated. Improved information systems will be key here, enabling clinical information to be more

easily exchanged between clinicians according to protocols and where appropriate. General practices, PCTs and local authority commissioners, working together, will look at the whole patient 'journey' of care and how it can be made smoother, using and developing clinical networks. There will therefore be a greater focus on joint commissioning between healthcare and social care and better integration between healthcare, social care and other local government services.

4.6 **Having a say.** Choice and flexible access will give patients much more of a say about how and where they use healthcare. GPs refer over nine million patients to hospital every year for a first outpatient appointment. The choices patients make will provide powerful insights into the things patients believe are important and the services they want. There will be more opportunity for local people to influence the way hospitals are run: NHS Foundation Trusts (NHSFTs) have local people, including patients and staff, as the majority on their boards of governors. On the commissioning side, increasingly, there will be opportunities for patients to have a voice and to influence the pattern of services within their locality.

4.7 **A health service as well as a sickness service.** Increasingly, the healthcare system will become more proactive in working with patients to enable them to manage and protect their own health in the long term. Local practices will have incentives to provide locally based health improvement and health protection services. They will be able to use their budgets to invest in such services, which could be provided by the local PCT or by private or voluntary sector providers, or by a combination of these. Patients, for their part, empowered by more and better information and able to choose from a range of services, will be in a stronger position to manage their own health and well-being. Tackling inequalities in health will become more important, as it will ensure that more people can benefit from good health.

4.8 The forthcoming White Paper will describe how the reform principles can be used to bring benefits to patients cared for in primary and community settings; it will also set out expectations of how services need to work together locally to improve the health and well-being of local populations.

5. Taking stock and the next steps

- 5.1 This document has described a three-year programme of development and implementation of reform. The objective is to embed within the healthcare system incentives for continuous improvement in quality, health and health outcomes, and value for money. The next three years will be a period of transition during which implementation and organisational change will have to be achieved at the same time as financial balance is held and performance is maintained and improved.
- 5.2 This is a *reform programme* rather than a single event. Annexe B sets out the key implementation milestones for aspects of the reform programme already announced. Clearly, there are a number of areas where significant additional development is required. This is to be expected given the scale of the reform. Annexe C lists guidance which will be published in 2006. The Department of Health will lead the process to develop this guidance, with the close involvement of the National Leadership Network (NLN),⁸ SHAs, clinicians and managers from across the NHS and other stakeholders to inform options and develop recommendations. We will also want to ensure that the perspectives of taxpayers and of patients are fully reflected in all aspects of reform.
- 5.3 As mentioned earlier, strong commissioners will be crucial to the development of a patient-led NHS. During 2006, following consultation, there are likely to be changes to SHAs and to a number of PCTs. The roles of both types of organisation will also develop and change. Annexe D looks in more detail at the vision for commissioning in the new system. These descriptions will inform the development process for the reconfigured organisations. A fuller policy document on all aspects of commissioning will be published in 2006.
- 5.4 An understanding of the context and direction of health reform is important to the management and delivery of services over the next three years. At the same time, a crucial role for the Department of Health will be to set clear expectations of the requirements on the NHS in these transition years. Maintaining financial balance in the system will be critical as we introduce such a complex set of transformational reforms. It will also be essential for the NHS to meet existing and already announced targets, especially that of an 18-week maximum wait from referral to the start of treatment. There will be specific risks associated with different stages of the transition, particularly in 2006/7, as aspects of the reforms, such as PbR, are implemented and SHA and

⁸ The NLN brings together over 170 leaders from across healthcare and social care, including from the voluntary sector. Its members will not only assist in developing the reform agenda, but also provide feedback as the different elements are implemented.

PCT reconfigurations are put in place. We will therefore produce clear rules to cover each stage of the transition, rules which take full account of the state of reform implementation and the capacity and capability of the NHS as a whole to manage each phase of change.

- 5.5 The first of these sets of rules, those for 2006/7, will be published in January 2006. This will be a comprehensive document covering all aspects of the system specific to 2006/7, including:
- > financial requirements;
 - > information on commissioning;
 - > the approach to contracts;
 - > rules for PBC;
 - > supply-side issues, including rules on mergers, integration and reconfigurations;
 - > plans for and update on PbR;
 - > performance management in 2006/7 (ie what is to be measured, how and when); and
 - > governance and accountability as we move to new SHAs and PCTs.

Conclusion

- 5.6 This document has described a single framework for reform of the NHS in England and explained how the elements of reform are expected to interact. The intended outcomes are better-quality patient services and improved value for taxpayers' money. The document has also provided a framework, up to 2008, for taking forward the implementation and further development of this work. This next stage will now be co-ordinated and led by the Department of Health's Policy Directorate, with significant contributions from the NHS and wider health community, to ensure that the reforms are well designed and that experience of implementation is fed back into policy development.
- 5.7 If you would like to comment on any aspect of this document or the attached annexes, please email Bill McCarthy, Director of Policy, at nhs.reform@dh.gsi.gov.uk.

Annexe A

Health reform in England: Framework

<p>More choice and a much stronger voice for patients (demand-side reforms)</p>	<p>More diverse providers, with more freedom to innovate and improve services (supply-side reforms)</p>	<p>Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (transaction reforms)</p>	<p>System management, regulation and decision making to support safety and quality, fairness, equity and value for money (system management reforms)</p>
<p>Aim: to create more knowledgeable, assertive and influential users of services</p>	<p>Aim: to create more flexible, responsive and innovative service providers</p>	<p>Aim: to ensure that the impact of patients' choice is understood, and that good provider response is rewarded</p>	<p>Aim: to ensure safety and to safeguard core standards in all services and to provide a transparent, rules-based framework for key management and decision-making functions in a more dynamic system</p>
<p>Policies:</p> <ul style="list-style-type: none"> > patient choice > the commissioning framework including PBC > <i>Commissioning a Patient-led NHS</i> > information for patients > public and patient involvement 	<p>Policies:</p> <ul style="list-style-type: none"> > NHS Foundation Trust status > a wider range of providers, including the independent (private and voluntary) sector > workforce reform 	<p>Policies:</p> <ul style="list-style-type: none"> > PbR > management information 	<p>Policies:</p> <ul style="list-style-type: none"> > definition of new performance management and regulatory functions > processes for ensuring quality, licensing providers and price setting, the competition policy and the performance and support regime > wider review of regulation

Annexe B

Health reform in England: implementation timetable

The vision

Our vision is one where the founding principles underlying the NHS are given modern meaning and relevance in the context of people's increasing ambitions and expectations of their public services. An NHS which is fair to all of us and personal to each of us by offering everyone the same access to, and the power to choose from, a wide range of services of high quality, based on clinical need, not ability to pay.

The Prime Minister, *The NHS Improvement Plan*

The tables below provide an overview of the commitments already in place or promised, as part of the transition to a reformed healthcare system.

Stronger voice for patients (demand-side reforms): to create more knowledgeable, assertive and influential users of services

Date	Commitment
Jan 2006	DH to develop NHS.UK website, extended to include information to support choice at point of referral (access, location, waiting times and quality)
Jan 2006	Choice: DH to produce choice information leaflet for patients (customised by PCTs)
Jan 2006	Choice: all eligible NHS patients offered a choice of at least four providers on GP referral for a first consultant outpatient appointment
Jan 2006	<i>Commissioning a Patient-led NHS</i> : launch of local consultations on changes to PCT and SHA boundaries
Mar 2006	<i>Commissioning a Patient-led NHS</i> : local consultations end
From Jul 2006	<i>Commissioning a Patient-led NHS</i> : new SHAs and PCTs will be established
Dec 2006	Arrangements in place for universal coverage of PBC in full
During 2006	Choice: 'Choose and Book' will be rolled out
2006 and 2007	Choice: extended choice network – choice options to include NHSFTs, nationally procured independent sector treatment centres and independent sector providers
2008	Choice: all NHS patients offered a free choice on referral of any provider that meets NHS standards and price

Greater variety of services (supply-side reforms): to create more flexible, responsive and innovative service providers

Date	Commitment
From Nov 2005	Two-star acute, specialist and mental health trusts can submit applications to become NHS Foundation Trusts
Dec 2005	Improved access to elective surgery through opening of 46 NHS treatment centres by the end of 2005
From Dec 2005	DH to issue further invitations to negotiate to the independent sector for elective and diagnostic services
Jan 2006	Launch of NHS Foundation Trust preparation project
Jan to Jul 2006	Transition to NHS Foundation Trust status: Monitor to lead diagnostic process on local NHS trusts; SHAs to lead implementation plans
From Jul 2006	Reconfiguration of ambulance trusts (see also below)
Oct 2006	First independent sector diagnostics service open
During 2006 and 2007	DH procurement of additional elective capacity from the independent sector through the first wave of the treatment centre programme
2008	Patients' treatment will commence within a maximum of 18 weeks from referral by their GP
2008	All NHS trusts have the opportunity to apply to become NHS Foundation Trusts
From June 2005 to 2008/9	Implementation of the ambulance review, <i>Taking Healthcare to the Patient</i> , ⁹ including new ways of working to deliver patient-centred care, eg emergency care practitioners (ECPs)

Transactions and incentives: to ensure that the impact of patients' choice is understood, and that good provider response is rewarded

Date	Commitment
Implemented from Apr 2006	New General Medical Services contractual arrangements for GP practices (subject to agreement by all parties)
Apr 2006	The national tariff (PbR) for acute services will cover A&E, elective and non-elective admissions and outpatient care in hospitals
Apr 2008	The new system of PbR will be fully operational
Apr 2008	Improved and more clinically meaningful Health Resource Groups (version 4) in support of PbR

⁹ *Taking Healthcare to the Patient: Transforming NHS Ambulance Services*, June 2005

System management, regulation and decision making: to support quality, safety, fairness, equity and value for money

Date	Commitment
Jan 2006	System management: operational 'rules' for 2006/7
Apr 2006	Code of conduct for PbR in place
Apr 2006	Core assurance framework for PbR introduced
2006 and 2007	Changes to SHAs and PCTs implemented; new roles and responsibilities introduced

Annexe C

Health reform in England: forthcoming guidance timetable

The tables below describe the major publications and guidance planned for 2006, the next phase of the reform programme.

Vision and direction

Publication date	Guidance	Description
Dec 2005	1. Health reform in England: update and next steps	(The present publication).
Jan 2006	2. Rules for 2006/7	This will be a comprehensive document covering all aspects of the system specific to 2006/7, including: financial requirements; information on commissioning; the approach to contracts; rules for PBC; supply-side issues; plans for and update on PbR (see document 9 below); performance management in 2006/7; and governance and accountability during the transition to new SHAs and PCTs.
Early 2006	3. White Paper on primary and community health and care	The White Paper will set out a strategic vision for health and healthcare services in the community; it will explain how the reform programme's incentives and flexibilities (thus far focused on hospitals) will be available in primary and community care settings.
Dec 2006	4. Updated framework and rules for 2007/8	At the end of the year, this paper will provide an update and will describe rules for 2007/8, taking account of progress, feedback and lessons from implementation during 2006 as well as developments in organisational capacity.

Stronger voice for patients (demand-side reforms): to create more knowledgeable, assertive and influential users of services

Publication date	Guidance	Description
Summer 2006	5. Framework for commissioning, practice-based commissioning and national contract template for 2007/8	<p>This will be a detailed framework for commissioning, bringing together in one place policy and implementation guidance on commissioning and PBC and expectations of how PCTs, GPs and health and social care commissioners will work together. The document will include:</p> <ul style="list-style-type: none"> > further advice on roles and responsibilities; > the approach to specialised commissioning in the reformed health system; > a legally robust framework for local contractual negotiations, which is likely to include: <ul style="list-style-type: none"> – national requirements setting out minimum standards expected of all providers for NHS patients (ie the route for delivering key national priorities); and – a component to be agreed locally allowing for PCT priorities. It will explain the transitional issues and set out the contracting processes and tools for implementation for 2007/8; > details of proposed back-office functions, including a national settlement system to support commissioning.
Autumn 2006	6. Framework for next steps on patient choice: implementation (to 2008) and options on future policy	<p>This will set out the framework for policy and practice on choice, looking forward to 2008 and beyond. It will include elements for discussion and consultation, particularly on the themes of how best to maximise and broaden choice in the context of a publicly funded service and of the range and type of information (particularly clinical information) to support informed choice.</p>

Greater variety of services (supply-side reforms): to create more flexible, responsive and innovative service providers

Publication date	Guidance	Description
Summer 2006	7. Framework for future of provider reform	Bringing together in a single document a comprehensive view of the provider side of the healthcare system, including next steps on NHSFTs; the medium-term future of independent sector providers; guidance on future models of provision for primary and community services (building on proposals in the White Paper); policy on 'social enterprise'; and accreditation of providers.
Summer 2006	8. Framework for future workforce development	An overview of the workforce strategy for the NHS and an assessment of policy developments needed to support the next phase of reform of the healthcare system. This paper will include issues relating to education and training.

Transactions and incentives: to ensure that the impact of patients' choice is understood, and that good provider response is rewarded

Jan 2006	9. PbR 2006/7 – tariff and scope	Publication of tariff, and update on code of conduct and assurance framework.
Spring 2006	10. Review of information requirements	An updated assessment of the information requirements to support reform of the healthcare system, to be carried out in conjunction with the NHS Connecting for Health business needs refresh.
Autumn 2006	11. Framework for future of PbR 2007/8 and beyond	To address wider policy issues into the future and how PbR could and will be used as a tool to achieve overall policy objectives. The document will also include a policy update on extension of PbR to cover critical care, mental health, ambulance services and long-term conditions.

System management, regulation and decision making: to support quality, safety, fairness, equity and value for money

Spring 2006	12. Wider review of regulation	Conclusions of the wider review.
Summer 2006	13. Framework for management and regulation of the healthcare system	This will address whole system governance for 2008 and beyond. It will cover extent of competition; competition policy within a public service framework; how the system as a whole will be managed and regulated; consequential detail on roles and responsibilities of DH, SHAs and PCTs; the future of regulation and regulators; performance management; the support and action regime for organisations in difficulty; and franchising and joint ventures.
Autumn 2006	14. Ensuring quality and safety of clinical care in the reformed healthcare system	In one document, this will be a description for clinical and NHS management leaders of how the reforms should support safety and quality and a prospective assessment of areas for particular focus. This document will also examine the continuing contribution of clinical networks and clinical collaboration in securing good-quality care.

Other important documents and initiatives that are relevant to the reform programme will become available in 2006, including a financial strategy for the medium/long term and a new national health research strategy. There will also be organisational development programmes: the Department of Health is preparing a development process for reformed PCTs, and there will be programmes of support for new SHAs and for aspirant NHS Foundation Trusts. All of this work – the guidance and development programmes – will be informed by the work currently underway on the values of the NHS.

Annexe D

Commissioning for a patient-led NHS

Introduction

1. This year the NHS will spend £76.4bn on health and healthcare. This represents 17% of public expenditure. This annexe sets out the best current description of commissioning and offers more detail on how it could work in practice. This provides an operational framework to take forward the development of commissioning in 2006. A fuller policy document, building on this analysis and further consultation, will be published in the summer of 2006.
2. 'Commissioning' is the process which determines how the health and healthcare budget is used. The process must result in a good deal both for taxpayers and for patients. The NHS has obligations as:
 - > **the advocate for patients.** This brings with it a requirement to secure a range of high-quality health and healthcare services for people in need. Patients must have good access to primary, community, mental health, local hospital and specialised services; standards must be constantly improving; and reliable and relevant information must be freely available to patients;
 - > **the custodian of taxpayers' money.** This brings with it a requirement to secure best value in the use of resources. Budgets must not be over-spent; value for money must be optimised; and resources must be used where they will generate the greatest benefit. The allocation and control of resources is important not only to ensure that the NHS lives within its budget, but also to secure the greatest possible benefit for the greatest possible number of people. Challenging how the NHS spends its money and ensuring that the best outcomes are achieved are at the core of the commissioning role.
3. The way commissioning is carried out must fit with the core values of the NHS:
 - > available to all at the point of need, regardless of ability to pay
 - > fair to all, regardless of income, age or background;
 - > personal to each.
4. Commissioning will not be the responsibility of a single organisation in a patient-led NHS. Rather it will be a partnership between PCTs, general practice and local government. General practice is closest to individual patients and best placed to advise them on their choices. Under payment by results (PbR) in 2006/7, patient choices for elective care, and where patients are treated in emergencies, will determine how around 30% of NHS funds are spent. Through practice based commissioning (PBC),

practices will have more freedom to determine the services that are made available to the local population. PCTs will bring a wider view of the overall needs of people living in their communities and can identify inequalities. PCTs will work with practices to facilitate local services that address inequalities and fit with wider service plans (for example the local delivery plan (LDP)). PCTs will also act as the agent of their practices, securing and holding contracts on behalf of practices. Local authorities are responsible for services, including social services and economic regeneration; effective partnership working between the NHS and local authorities is essential to provide local people with effective public health, prevention and support for those who are vulnerable. PCT commissioning, PBC and joint commissioning are not alternatives. They are each essential components of an effective commissioning process.

5. However, partnership working does not mean a reduction in accountability. The Department of Health will hold new PCTs ultimately accountable for the effective use of taxpayers' money in the interest of their local communities.
6. Good commissioning in a patient-led NHS will be easily recognisable:
 - > 100% of practices will be engaged with PBC.
 - > The PCT will be running a small financial surplus.

- > Overall health status will be improving and inequalities in health status across the PCT area will be narrowing over time.
- > Patient experience feedback will be regular and comprehensive; overall satisfaction will be improving; and the results of patient feedback and clinical outcome indicators will be the currency of contract discussions with all local providers.
- > Local people will:
 - be knowledgeable about the health and healthcare choices available to them;
 - understand the links between lifestyle and health and how to get support for changing their lifestyles when they need it;
 - be registered with a general practice offering a wide range of advice, support and treatment (directly or as part of a network) when they get ill;
 - have the choice of prompt care from a range of providers should they need to go to hospital;
 - have immediate access to quality-assured services in an emergency.
- > Services will be integrated around the patient. People with long-term or complex needs will have a single care plan that they have discussed and agreed with a designated lead professional. Their needs will be identified, and care packages will be designed to meet these needs.

Commissioning and practice based commissioning

7. The relationships between practices, PCTs, local government and local people will be critical to the success of commissioning in a patient-focused system. All will play a role across the key commissioning functions. Effective relationships and partnership will be needed if commissioning is to ensure the maximum benefit for the health and well-being of local populations.
8. Practices are closest to individual patients and, with patients, make the individual decisions that lead to the commitment of health resources. Practices will have the opportunity to shape services and clinical pathways to best meet patients' needs. They will have the freedom to innovate to deliver new services and models of care.
9. To help them make the most impact, practices will need the support of their PCTs. Practices will be entitled to an indicative budget and the opportunity to re-invest in alternative care wherever they can eliminate wasteful practice, or where they can more effectively and efficiently meet patient needs. Practices will be entitled to clinical and management information to help them make decisions about shaping services and decisions about the most appropriate care for individual patients. Practices will also receive information on the overall needs of the local population to help frame the decisions they make. Practices will provide real clinical leadership to the development of healthcare.
10. Not all of the opportunities on offer will be appropriate for individual practices to pursue alone. Practices will be able to choose to work together with other practices, whether in the same locality or not, to develop services. These associations will take many different organisational forms. Many practices will choose to combine in different ways to meet different challenges.
11. PCTs will collaborate with practices to ensure that taxpayers' money is used to best effect on behalf of patients. PCTs will carry out the analysis to support assessment of local needs and to provide the clinical and management information that will be needed by their practices. They will work with local government on behalf of practices to develop responses to the health and well-being of local people and to ensure the best use of the combined efforts of the NHS and local government. PCTs will also hold contracts on behalf of practices. To be successful in this role the PCT will need to be able to represent the requirements of its practices and patients to existing and potential providers of healthcare.
12. PCTs will continue to be accountable for the local use of NHS resources. This means that as well as supporting practices to innovate and take responsibility for improving services, PCTs will need to provide effective governance for practices.

PCTs will be responsible for ensuring that practices do act as the advocate of the patient and that services are of high quality and equitable. PCTs will also have a responsibility for ensuring that responsibilities to the taxpayer to provide value for money, and effective financial control, are met. Where there are problems in delivering responsibilities to either patients or the taxpayer PCTs will be expected to step in to resolve the problem.

Commissioning services usually provided in hospitals

13. The forthcoming White Paper will set out expectations for primary and community, public health and social care. The rest of this annexe looks in more detail at the commissioning process for those services usually provided in hospitals – effectively services covered by PbR in 2006/7.
14. Choice and PbR mean that money for the services covered (around 30% of NHS spending for 2006/7) will follow patient flows. Every clinical decision in general practice to treat a patient or refer a patient on will spend an identifiable sum of money; every time a patient visits an A&E department money will be spent; and every emergency admission to hospital will spend money.
15. In the past, these services were largely paid for through block (fixed-cost) contracts between purchasers and providers of care. This gave few incentives to purchasers and providers to understand and respond to the needs and preferences of patients. The patient-led NHS allows huge potential for more responsive services and puts a premium on strong and effective commissioning with clear functions and new skills.
16. Effective commissioning will depend greatly on the quality of the relationship between PCTs and their general practices. Where they work well together, practices will drive improvements in quality, efficiency and responsiveness within the financial and strategic framework set by PCTs, marrying closeness to patients with a population perspective. Together they can have a high impact on local services by using the influence that practices will have on patient choice to lever change at the PCT level in order to benefit patients' experience.
17. The following table sets out the functions of commissioning hospital services. Many of these functions and principles will also apply to commissioning other services.

Function	Comment
Assess the existing and future needs of local populations	Practices have always taken responsibility for assessing individual needs. PCTs will support practices with analysis of the overall population needs to set decisions on service development or even on individual patient care in their proper context and ensure equity and improve the health of the population. PCTs will work with local government on behalf of practices to most effectively meet the need to improve health and well-being.
Assess the availability of services and identify any gaps	Practices will look to identify gaps in existing services and pathways that need improvement. PCTs will use the aggregated intelligence of their practices and their local needs assessment to identify broader requirements for service change or development. PCTs will signal the future service needs to providers and engage with clinical networks to ensure effective delivery of complex care pathways.
Stimulate and incentivise providers to fill gaps and offer cost-effective alternatives	<p>Practices, PCTs and the Department of Health will all contribute to the delivery of this function.</p> <ul style="list-style-type: none"> > GP practices, working individually or often as groups, will invest in new services in the community through use of practice budgets. Patient choice will provide practices with real information on the services patients want. > PCTs will give strategic support to providers' proposals for service reconfiguration or expansion. They will be clear about the services and service specifications they and their practices and patients want to see developed. > National procurement by the DH will introduce new independent sector providers.
Assess and report on patients' experience	PCTs will be responsible for measuring and reporting on patients' experience. Practices will also want to monitor patients' satisfaction. Robust mechanisms for collecting and understanding patients' views will be required.
Provide information for patients on available services	Practices will provide patients with information and advice about services. PCTs will support practices in ensuring that appropriate information is available. National data sets are being developed to support patient choice and ensure that all patients have access to a standard set of information that can be supplemented locally.

Function	Comment
Establish contracts with common national standards	DH will develop a single national template. The contract will incorporate national standards (quality, safety and service level), the national tariff and penalty schedules and will enable local modifications to reflect the local analysis of population need, service gaps and patients' preferences.
Agree and sign contracts with local providers	<p>For most services, PCTs will agree and sign contracts with local providers. They will use patient experience feedback, feedback from GP practices and clinical quality indicators to identify areas for negotiating local conditions with local providers.</p> <p>There are some services that best clinical practice suggests are better delivered at a national or regional level. Contracting structures should support this best practice. For a few very specialised services contracts will be held at national level. For other specialised services PCTs will group together to set contracts. A number of these specialised services will be outside PbR. A review of specialised commissioning that is due to report next spring will give full guidance on new arrangements.</p>
Assess needs of individual patients	Practices will be responsible for assessing the needs of their patients. They will work with social services and other agencies where appropriate. PCTs will provide analysis of population needs to set the context for practices' decisions and enable practices to drive health improvement and tackle inequity. In this way, access to care really will be based on need.
Advise patients on choices	In recognition of the fundamental importance of the doctor/patient relationship and the value many patients have always placed on their doctor's advice, it will be important to facilitate the opportunity for patients to make their choice with the benefit of good advice from their GP.

Function	Comment
Getting the best for patients from the available resources	<p>All practices will be allocated an 'indicative' budget for the hospital services their patients use. Over time this will move from an historical to a 'fair shares' basis. Some practices may choose to group together to share budgets. Practices which understand how they use resources, engage with patients, engage in redesigning pathways, and choose to take part in a formal scheme will have freedom to re-invest savings. PCTs will provide full information and support to practices, including direct intervention where there are problems.</p> <p>PCTs will establish demand management strategies. The aim will be to enhance quality and efficiency and to ensure that budgets are not breached. The tools of demand management are likely to include:</p> <ul style="list-style-type: none"> > benchmarking information for all GP practices; > clinical pathways and protocols that are developed by local clinicians, covering areas vulnerable to volatile demand or supplier-induced demand; > clinical advice and support for struggling GP practices; > facilitating clinical groups to agree training and development, and clinical protocols reflecting agreed clinical priorities locally. These will be included in local elements of contracts for admissions from A&E and for conversion rates from outpatient to inpatient/day case lists; > appropriate use of preventative intervention strategies to improve health and efficiency.
Monitor contracts	<p>PCTs will develop systems to allow practices to monitor the services their patients receive through accurate, relevant and timely data. These systems will need to include quality and patient experience feedback as well as financial data. Effective sampling techniques will be important if the necessary richness of the information is to be collected at an appropriate cost.</p>
Pay bills	<p>This will be a PCT responsibility.</p>
Balance the books	<p>Practices will be responsible for maximising the benefits from the resources available to them. PCTs will be responsible for the aggregated financial position and for ensuring financial balance overall.</p>

18. As mentioned in paragraph 1 of this annexe, a comprehensive and detailed framework for commissioning – bringing together in one place policy and implementation guidance on commissioning and PBC and expectations of how PCTs, GPs and health and social care commissioners will work together – will be developed for summer 2006. Further details can be found in annexe C of this document.

Practice based commissioning

19. As set out in the table above the new approach to commissioning will only work if practices have clear entitlements and freedoms. Equally, as they are ultimately accountable, PCTs must have sufficient direct influence to safeguard budgets overall and to ensure that care for patients is being enhanced. The PBC scheme, with its rules and governance framework, is the vehicle to make this possible. Further guidance on PBC will be available in January 2006 as part of the system-wide roles for 2006/7. In particular it will cover:
- > budget setting arrangements;
 - > minimum information flows to support PBC;
 - > the approach to surpluses and incentives;
 - > the opportunities for practices to choose to work together; and
 - > the governance framework for PBC.

Information, transactions and bureaucracy

20. Effective commissioning in this new model will have extensive information requirements:
- > for patients to inform choice;
 - > for GPs to support clinical decisions (use of protocols) and manage their budgets;
 - > for PCTs to manage the contracts they hold with the hospitals (including, for example, checking legitimacy in contracting) and to monitor practice-based commissioning;
 - > for existing and potential providers to understand their own performance and to be able to assess 'market opportunities'.
21. Choice and PbR also means that instead of paying against large block contracts, individual transactions will each attract a payment. To avoid any escalation of transaction costs we are specifically designing the system to reduce costs:
- > GP practices will not negotiate or hold individual contracts;
 - > we are assessing the options to simplify and streamline contractual arrangements.

22. Further work is needed on the practical steps we can take to ensure that commissioning is an efficient and effective process. The Department of Health is considering:
- > how the NHS might make better use of the independent sector in commissioning, particularly but not exclusively in the delivery of administration functions, for example data harvesting and analysis;
 - > the feasibility of a national bill settlement system (similar to the banking clearing system), which would significantly reduce NHS transaction costs and aid the speedy and robust flow of funds within the new system.

Support for PCTs and for practices in their commissioning roles

23. PCTs and practices will be taking on new roles that are both complex and important. New skills and behaviours will be needed – in particular, a blend of very good analytical skills and excellent relationship building and influencing. The Department of Health will be launching a flagship organisational support and development programme for PCTs and one for GP practices. The programmes will run in parallel with the recruitment and development of new PCTs and PBC.

Performance management of commissioning

24. Commissioning is critical to the success of the health reforms. SHAs will have responsibility for supporting and performance managing the implementation and operation of the new commissioning arrangements. In the short term the 'rules' of 2006/7 will set a very strong framework for this performance management to ensure that both 'custodian' and 'advocate' roles are effective in a transition year.
25. As we move forward the framework will become more transparent and rules based. It will include a 'performance regime' that puts a premium and incentive on PCTs and their local providers to identify problems early and to resolve them locally, avoiding reaching a crisis point that would, given that the NHS must live within its means, have a financial cost to commissioners and providers. The further work to complete the policy on management and regulation of the system as a whole, is identified as one of the workstreams in annexe C.
26. This annexe has set out a description of commissioning and PBC and provided a further level of clarity as to how these functions will be undertaken in the reformed health system. As mentioned earlier, a comprehensive policy document on all aspects of commissioning and contracting, addressing issues identified in this annexe, will be published in summer 2006.



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