DH Action Plan for responding to independent report

	How we will do this:
We will learn from experience	We shall increase the size of the PbR team and alter its composition. We are publishing our plans for the tariff in 2007/08 in mid July to ensure "no surprises" and will publish the tariff itself by mid-December, after extensive road testing with the NHS. We are committed to learning from others. Experts from health communities in other countries which have already introduced prospective payment systems will help guide our tariff design and implementation. Professor Miriam M. Wylie (Eire) and Dr Frank Heimig (Germany) have agreed to become advisory members of the PbR Project Transition Board. Peter Donnelly, who worked on the introduction of a similar system in Victoria, Australia, will join our DH PbR team. We are committed to learning from our own experience, for example the South Yorkshire "PbR Laboratory" (a health community which has been on the "fast track" to PbR implementation). We will look at utilities and other UK non-health regulators with respect to the management of stakeholders and operating a transparent and accountable process. We will be open to other issues such as how they use incentives to drive behaviour, the relationship between targets, benchmarking and price signals and the boundaries between price and public policy.
We will map our processes and refine our organisation	We are in discussion with external organisations to produce end to end mapping of our processes in order to identify interdependencies, risks and bottlenecks. In the light of this we will redesign the process as necessary and produce a robust, credible end to end timetable for the tariff setting process.

	We will also set out the work we are doing to examine individual components of the tariff setting model (eg data sources, casemix and classification tools, costing policy etc) with a view to achieving the optimal approach. Getting the "building blocks" of PbR right is an essential pre-requisite for further enhancement and expansion.
We will improve our governance arrangements	We will restate the objectives of PbR, and use this as the starting point of our autumn *Future of PbR* document. We will develop a clear transition pathway to reaching those objectives. We will continue to monitor the objectives over time to ensure the best fit between them (for PbR and wider health reform) and actions. We will establish a new Programme Board which will be complementary to the existing Project Transition Board. The new Programme Board will be responsible for delivery of the published project to published timescales. This will include reviewing plans and timetable, ensuring decisions reflect stakeholder views, overseeing risk management and holding the DH PbR team to account. We will investigate the creation of an independent, external advisory group, e.g. along the lines of the US approach. In the light of the findings from our process mapping exercise, we will put in place robust service level agreements between DH, Connecting for Health and the Information Centre to manage interdependencies. We will use the conclusions of process mapping to consider the case for any organisational change including out-sourcing. We will obtain audit sign-off of our new processes.
We will improve the way we test and pilot the tariff	We will establish a formal quality assurance process including sensitivity analysis around the use of provisional data. We will also invite NHS volunteers to help run dual modelling as the tariff is developed to ensure tariff accuracy. We will establish a group of NHS representatives to provide a "sense check" on the impact of any proposed changes. We will road test the draft tariff with the NHS, allowing a

	six week period in the timetable for this to take place. We will work with the NHS to further develop the tariff, for example inviting volunteers to pilot specific proposals. We will work with the NHS to increase the availability of good quality meaningful base data including considering the prioritising of data collection and using sample data. It is a joint responsibility of DH and the NHS to ensure that we use the best data available and we will explain the consequences for the tariff of the submission of poor data, using worked examples to illustrate the point.
Engagement and communications	We will consult on the contents of a communications strategy to explain the PbR process and not just to keep all stakeholders informed but also engaged in the process. We will make central our commitment to building real clinical input into the development of PbR. We will hold a workshop to examine the ways in which other regulators behave in discharging their responsibilities and in engaging stakeholders.