22 September Month 2016

on the day BRIEFING

2017-2019 OPERATIONAL PLANNING & CONTRACTING "PLANNING GUIDANCE" – ON THE DAY BRIEFING

Today the national bodies NHS England (NHSE) and NHS Improvement (NHSI) have published their "planning guidance" *2017-2019 NHS Operational planning and contracting*. This briefing paper summarises the proposals, and gives NHS Providers view on them.

The planning guidance outlines the expectations of the national bodies for system level planning over the next two years, focussing on contracting and sustainability and transformation plans (STPs) as well as introducing a range of new national business rules. Alongside the planning guidance the draft standard contract has also been published today (summarised in a separate briefing document, to follow on our website) as well as the draft National Tariff prices and draft national CQUINs.

WHAT HAS BEEN PUBLISHED TODAY?

- 2017-2019 Operational planning & contracting "planning guidance"
- Technical guidance for NHS planning 2017/18 and 2018/19
- Draft standard contract for consultation
- Draft Tariff prices for 2017/18 and 2018/19
- Specialised services commissioning intentions and Specialised CQUIN Scheme Guidance for 2017-2019

KEY PROPOSALS

The key proposals from the planning guidance focus on several areas – changes to contracting processes, STP financing measures and performance metrics, and some further details on sustainability and transformation funding.

The key deadlines and information on publication dates relating to these items can be found in Annex 2.

STP planning, control totals and performance metrics

STP areas are required to submit local financial plans showing how their systems will achieve financial balance within the available resources, with NHSI and NHSE expecting both the commissioner sector and the provider sector to each be in financial balance in both 2017/18 and 2018/19.

The position of each provider's plan (on finance, activity and workforce) has to be consistent with the STP footprint financial plan for 2017/18 and 2018/19 that will be submitted on 21 October 2016 and with the system control for that STP area (see below for more detail), with the aggregate of all operational plans in a footprint needing to reconcile with the overall STP position. All organisations will be held accountable for delivering both their individual control total and the overall system STP control total.

From April 2017 each STP will have a financial control total derived from all the individual control totals for CCGs and provider organisations in that geography. It will be possible to flex individual organisation's control totals within that system control total via an application to NHS England and NHS Improvement, the purpose being to allow better balance, integration and planning across different organisations.

STPs can also propose to NHS England and NHS Improvement a subdivision or cross-STP boundary arrangements of their geography, with separate system control totals (and governance arrangements) for each sub-division, if they feel it is better suited to operational collaboration and risk management.

The document notes STP leaders "will have strong governance processes to ensure clarity as to how different organisations are contributing to agreed system working, how progress will be tracked, and how organisations will work together to manage cross-cutting transformational activity."

Drawing on existing data collections from the assurance frameworks, NHSI and NHSE will also publish core baseline STP metrics in November, encompassing, as a minimum, the following metrics:

- *Finance*
  - Performance against system control totals
- *Quality*
  - Operational Performance
  - A&E performance
  - RTT performance
- *Health outcomes and care redesign*
  - Progress against cancer taskforce plan
  - Progress against mental health FYFV implementation plan
  - Progress against the General Practice Forward View
  - Hospital total bed days per 1,000 population
  - Emergency hospital admissions per 1,000 population

STP areas will need to agree trajectories against these areas for 2017-19.

Sustainability and transformation funding (STF)

The planning guidance and its technical annex outline the following on future allocations of the STF funding:

- £1.8bn of *sustainability* funding will again be available in 2017/18: a £1.5bn general fund allocated on the basis of emergency care; a £0.1bn general fund allocated to non-acute providers; and a £0.2bn targeted fund.
- NHSE and NHSI have reviewed the approach to the STF for 2017/18 to 2018/19 in the light of experiences in 2016/17, and made changes based on an impact assessment model at an individual provider level. Based on this work they have allocated individual providers an indicative share of the STF and a provisional control total for 2017/18 and 2018/19. These are being communicated in a letter to each provider on 30 September 2016.
- The operating rules will be subject to agreement with the Department of Health and HM Treasury. However, as in 2016/17, the payment of STF will depend on providers meeting their financial control totals and meeting the core access standards.
- The baseline for 2017/18 trajectories will be the same as the agreed trajectories for 2016/17. Any provider whose plan for 2016/17 did not deliver one or more of the national standards for operational performance will not be able to reduce this baseline, and will have a trajectory to reach the national standards during 2017/18.

- If a provider does not deliver its performance trajectory during 2016/17 as a result of "exceptional circumstances outside of its control", it can use an appeals process to NHS England and NHS Improvement.

From 2017/18 onwards, the guidance states streams of *transformation* funding will increasingly be targeted towards "the STPs making most progress". This funding will be focused on delivery of specific national programme objectives "rather than spread thinly everywhere". To minimise the administrative burden, NHSE and NHSI will "ensure that the different application processes for different programmes are more co-ordinated."

Contracts and the contracting round

The document reaffirms that the contracting round will be completed by the end of this calendar year, and the contracts signed within this contracting round will last two financial years, starting from April 2017.

With regard to the process for signing off contracts, the document states:

- "We expect all contracts to be signed by 23 December".
- "Access to formal arbitration must be a last resort… and [resorting to arbitration] will be seen as a clear failure of collaboration and good governance."
- "NHS Improvement and NHS England will intervene where necessary, using their oversight and regulatory powers to resolve any cases where organisations refuse to do."
- "To enable a more collaborative approach to contracting [there will be] increased access to technical advice on contract and tariff issues… [and] escalation to NHS England and NHS Improvement Chief Executives (or delegated national directors) for commissioners and providers that do not agree their contracts" on time.
- "Where a provider refuses to follow the NHS arbitration process, they may forfeit a proportion of their Sustainability and Transformation Fund (STF) monies, and where a CCG fails to comply with the process, quality premium and transformation monies may be forfeited."

Regarding the content on the contracts, the planning guidance outlines the following:

- The 2017-19 planning and contracting round "will be built out from STPs". Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. They must include "how they support delivery of the local STP, including clear and credible milestones and deliverables"
- It also requires that plans include:
  - The planned contribution to savings at an STP level,
  - How risks have been jointly identified and mitigated
  - The impact of new care models, including where appropriate how contracts with secondary care providers will be adjusted to take account of the introduction of new commissioning arrangements (MCPs, PACs)
  - The technical guidance published alongside the main planning guidance states that providers plans must be "stretching from a financial perspective: planning to deliver (or exceed) the financial control total agreed with NHS Improvement, thus qualifying the provider for receipt of STF; taking full advantage of efficiency opportunities including those identified by the Carter review and the agency rules."

Where providers accept their financial control totals and any associated conditions and are therefore eligible for payments from the Sustainability and Transformation Fund, contract sanctions for key performance standards will continue to be suspended until April 2019.

Nine 'must dos' for 2017-19

These are the same as outlined in 2016/17 planning guidance, and they remain for the priorities for 2017/18 and 2018/19. Commissioner and provider plans need to demonstrate how they will deliver these nine 'must-dos'.

2017/18 and 2018/19 'Must dos'
1. STPs – includes: Implement agreed STP milestones, on track for full achievement by 2020/21, and achieve agreed trajectories against the STP core metrics set for 2017-19.
2. Finance – includes: Deliver individual CCG and NHS provider organisational control totals and achieve local system financial control totals. Also implement local STP plans, moderate demand growth, increase provider efficiencies, including Carter proposals
3. Primary care – includes: Implement the General Practice Forward View., ensure local investment meets or exceeds minimum required levels., Increasing the number of doctors working in general practice, improve weekend and evening access, and Support general practice at scale and the expansion of MCPs or PACS,.
4. Urgent & emergency care – includes: Deliver the four hour A&E standard and standards for ambulance response times. By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. Implement the Urgent and Emergency Care Review.
5. Referral to treatment times and elective care – includes: Deliver the NHS Constitution standard that more than 92 per cent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment. Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by April 2018 in line with the 2017/18 CQUIN. Implement the national maternity services review
6. Cancer – includes: Implement the cancer taskforce report. Deliver the NHS Constitution 62 day cancer standard. Make progress in improving one-year survival rates and ensure all elements of the Recovery Package are commissioned.
7. Mental health – includes: Deliver in full the implementation plan for the mental health five year forward view for all ages. Ensure delivery of the mental health access and quality standards including 24. Increase baseline spend on mental health and eliminate out of area placements for non-specialist acute care by 2020/21.
8. People with learning disabilities – includes: Deliver Transforming Care Partnership plans with local government partners, reduce inpatient bed capacity. Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.
9. Improving quality in organisations – includes: Implement plans to improve quality of care, particularly for organisations in special measures.

Other key items

National Tariff

Draft Tariff prices for the next two years have been published today and are available here.

Subject to consultation, cost uplifts in the national tariff will be set at 2.1% for 2017/18 and 2.1% for 2018/19. As previously announced, the efficiency deflator will be set at 2% in both years.

The proposal for follow up outpatient activity to move to a single block payment was not widely supported by either commissioners or providers during the Tariff Engagement over the summer. As a result NHSI and NHSE "intend as an alternative to increase the percentage of follow-up costs bundled into first attendances as follows:

- 30% - adult surgical specialties and some medical specialties e.g. diabetes, cardiology and general paediatric medicine;
- 20% - other medical specialties;
- 10% (i.e. no change) – oncology, haematology, paediatric specialties and areas where Best Practice Tariffs apply e.g. transient ischaemic attack."

Education and Training Tariffs

To "provide stability to providers", Health Education England (HEE) will not be introducing changes to the education and training tariff currency design before April 2019. There are three possible exceptions to this:

- The non-medical placement tariff. The Department of Health consultation on education funding reforms could lead to structural changes from September 2018;
- Dental undergraduate tariff, where the Department of Health is proposing changes to the structure of the tariff from April 2018; and
- The potential expansion of the standardised education and training tariff for primary care placements.

CCG Business Rules and Allocations and "Risk reserve"

In 2016/17 CCGs had to ensure the 1% non-recurrent investment was uncommitted at the beginning of the year in order to create a risk reserve for the NHS worth c£800m. For 2017/18 and 2018/19 both commissioners and providers are required to help create the risk reserve. As in 16/17, release of the risk reserve to each local system will be dependent on delivery of its control total, subject to a satisfactory national risk profile. The risk reserve will be created from three components, totalling c. £830m:

- CCGs will again be asked to ensure that 1% of their allocation is planned to be spent non-recurrently, but only half of this – equivalent to £360m – has to be uncommitted at the start of the year, with the other half being available for immediate investment;
- NHS England will add c.£200m to this;
- 0.5% of the local CCG CQUIN scheme will also be held within the risk reserve, contributing £270m. Where systems are delivering their control total, this element of the risk reserve will be released for investment by the providers to whom the CQUIN is payable, with no other conditions attached.

Other salient items include:

- Commissioner allocations may be refreshed to reflect the impacts of new tariff pricing and updated Identification Rules for specialised services. Any adjustments will be published on 30 September.
- In deficit CCGs are expected to achieve at least breakeven position in-year and plan for return to cumulative underspend over the Spending Review period. Where this is not possible, they will be required as a minimum to improve their in-year position by 1% of allocation per year plus any above average allocation growth until the cumulative deficit has been eliminated and the 1% cumulative underspend business rule is achieved.

CQUINs

The current CQUIN scheme enables providers to earn up to 2.5% of annual contract value if they deliver objectives set out in the scheme. For 2017/18 and 2018/19, the full 2.5% will continue to be available to providers. NHS England is intending to make two changes to the scheme.

Continuing the arrangement of the current year, 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types. For acute and community services, the proposed national indicators cover six areas; there are five in mental health, and two in ambulance services. The national indicators include:

- NHS staff health and wellbeing (all providers)
- proactive and safe discharge (acute and community providers);
- reducing 999 conveyance (ambulance providers)
- NHS 111 referrals to A&E and 999 (NHS 111 providers);
- reducing the impact of serious infections (acute providers)
- wound care (community providers);
- crisis liaison (acute and mental health providers);
- physical health for people with severe mental illness (community and mental health providers);
- transition for children and young people with mental health needs (mental health providers);
- advice and guidance services (acute providers);
- e-referrals (acute providers, 2017/18 only;) and
- preventing ill health from risky behaviours (acute providers 2018/19 only; community and mental health providers, both years)

The remaining 1% will be assigned to support providers locally. 0.5% of this will be available subject to full provider engagement and commitment to the STP process. To support the introduction of system-wide risk pooling at STP level, the remaining 0.5% will be held as a reserve to cover risks in delivery of the relevant system control total. Where the system as a whole is on track to deliver within its system control total, this 0.5% will be payable to providers.

Specialised Services commissioning intentions and CQUINs

NHS England's commissioning intentions for specialised services are published today alongside the planning guidance. These set out national priorities for the six programmes of care, and region-specific priorities, as well as priorities for clinical and service reform, quality improvement and peer review including the payment system for secure mental health and critical care.

The specialised services CQUIN scheme will remain as now with 2% of contract value for all acute providers, 2.5% for mental health providers, and 2.8% for Hep C lead providers.

The scheme provides a limited number of CQUINs per contract, proportionate to the financial value of CQUIN investment. The largest acute and mental health provider will have between ten and five CQUINs respectively, with an average three CQUINs per contract. NHS England will seek further views on the proposed specialised CQUIN indicators as part of the wider CQUIN engagement exercise in October, and will publish any changes to the final scheme at the end of October.

NHS PROVIDERS VIEW ON THE PLANNING GUIDANCE

We welcome the action NHS England and NHS Improvement have taken to create a more effective planning cycle for 2017/18-2018/19. There are clear themes in the planning guidance of:

- Setting a more realistic, though stretching, ask on provider efficiency with a 2% headline efficiency requirement
- Providing greater planning certainty and stability through a two-year tariff, contract and consistent list of 'must do' performance commitments
- Supporting collaboration between providers and commissioners to reduce the time spent on transactional contractual disagreements and coming to earlier agreement on contracts
- Signalling further moves towards system-based working, including the development of STP metrics and control totals.

We acknowledge the aims of this new approach in reducing the transactional costs in the system and creating more time and focus on the delivery of longer-term transformation of services. However, there are several significant practical and policy issues to address if the aims of the planning guidance are to be realised.

Deadlines for agreeing contracts

The aim to have contracts signed off earlier is laudable and many providers are already accelerating their internal planning process to meet this new deadline. However, there is a clear trade-off between developing a plan quickly, and developing a well thought-through plan that has appropriate clinical input and board oversight. We would not wish to see providers or commissioners penalised for following good governance and planning processes where this entails missing a brought-forward deadline.

Many providers are also exploring complex new contracting arrangements that involve alliances between social care, primary care and third sector providers. Developing these contracts requires considerable time and resource, and partners in these alliances may not always be bound by the requirements of the NHS planning timeline. We welcome the assurance that commissioners will still have the ability to let new longer-term contracts and revise existing contracts accordingly, but contracting teams have finite time available and will be developing both these longer term contracts and the standard annual or biannual contract in parallel. It would be helpful if NHS England and NHS Improvement could provider a clearer signal on whether resources should be prioritised in developing the standard contract over the next three months, or these longer-term contracts that may have greater benefits for patients.

There is welcome recognition in the guidance that less time should be spent in adversarial and transactional contracting disagreements between CCGs and providers in the forthcoming contracting round. It would be helpful to see how NHS England will provide oversight on whether opening offers from CCGs in the contracting round are credible and supportive of a good faith negotiating process. It must also be recognised that many of the challenges in agreeing contracts between CCGs and providers in 2016/17 did not always arise from local issues but sometimes from seemingly conflicting guidance from the national bodies. We will be seeking greater clarity from NHS England

and NHS Improvement on how we will avoid issues where CCGs and providers simply can not agree a contract due to their commitments to organisation control totals and risk reserves.

Finally, while the planning guidance is clear in its view that failure to avoid arbitration is a failure of collaboration and good governance, we would argue that it would be a greater failure of governance for autonomous provider boards to sign-up to contracts that are neither fair nor deliverable, and this must be respected as part of the dispute resolution process and wider discussions with NHS Improvement and NHS England.

National tariff and standard contract

As noted earlier we welcome the retention of a more credible 2% efficiency factor.

We strongly opposed the introduction of a single block payment for outpatient activity, and welcome the changes that have been made to this policy. However, the proposed changes to the payment system are still relatively blunt and will potentially penalise providers offering outpatient follow-ups at clinically appropriate levels.

Provider finances and control totals

The planning guidance sets out how sustainability and transformation funding and control totals will operate over the next two years. We will be continuing our discussions with NHS Improvement over the longer-term strategy for control totals and how providers will be supported to return to greater autononomy in financial decision-making and control.

We will also be working closely with Health Education England to understand how changes to education and training funding will affect provider income over the course of the parliament. Although there is initial stability to provider income from education and training in 2016/17 from non-recurrent top-up payments, changes to the HEE budget in 2017/18 and 2018/19 may result in significantly increased pass-through costs to providers.

The planning guidance reiterates that the target NHS provider deficit for 2016/17 should be no more than £580m with a goal of £250m, and that any slippage against this target will lead to higher cumulative efficiency asks on providers in 2017/18-2018/19 as we will have 'unrealised and undelivered efficiency opportunity from previous years.' We will continue our influencing work with the national bodies to argue that the planning guidance must-dos must in fact be doable, and there is little to be gained by setting unachievable financial or performance targets that are then missed.

STPs

Following the introduction of STPs in last year's planning guidance, this year's planning guidance potentially cements STPs as a new unit of financial and performance monitoring and management, in addition to their initial primary purpose as a planning vehicle.

Greater clarity is needed on what the long term strategic direction for STPs will be, what accompanying regulatory and legistlative changes are needed, and what support will be provided for the development of clearer and more accountable governance structures. Further information is also needed on what support will be provided to STP leaders who will now see their duties and responsibilities grow.

Allocating STP-wide, or sub-STP-wide, financial control totals may in some areas support the appropriate sharing of financial risk and resource to improve services for patients, and the benefits of system-based working and collaboration are considerable. However, there is significant complexity involved in designing these systems. A given

mental health provider for example may now find itself with an individual control total, an STP control total, a separate contractual arrangement for the specialised services it offers, and on-going negotiations with partner providers and commissioners on transfers of services that will affect all the control totals within the STP as well as the aggregate STP-position. Resolving these issues is not impossible, nor is this the wrong thing to aim for, but it will be a significant challenge for local health systems to achieve this within the next few months.

It is also unclear whether reporting of A&E and RTT performance at STP level is simply additive and an aggregate of individual organisational reporting, or whether this is intended to allow greater flexibility in how services are delivered at individual organisations as long as the STP-wide performance is on trajectory.

Our next steps

Separate details will be circulated on how we will be involving our members in our engagement programme with NHS England and NHS Improvement on specific issues in the planning guidance, such as the longer-term approach to education and training funding and the operation of CQUINS, and wider issues including the governance issues surrounding STPs.

If you have any questions please contact Edward Cornick (Policy Advisor – NHS Finances)
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ANNEX 1: NHS Providers press statement

Welcoming the release today of the NHS 2017/19 planning guidance, Chris Hopson, chief executive of NHS Providers, said:

"This year's planning and contracting round was one of the most difficult and frustrating in NHS history. We therefore welcome the desire of NHS England and NHS Improvement to improve and refine this year's process. The much earlier publication of the national planning framework allows frontline organisations to start their planning much earlier in the year, although this will bring some challenges.

"A two year planning and contracting period will help make the best use of resources. The clarity on key elements of the NHS landscape like the tariff, CQUINs, business rules and the standard contract will all help and are to be welcomed. We recognise the hard work of NHS England and NHS Improvement, which have worked at high speed, to get us here.

"The tariff is sensible and will help providers - together with the continuing £1.8 billion support – to eliminate or significantly reduce deficits. This year's quarter 1 results has shown, despite the huge pressure on providers from rising demand and the stretch on social and primary care, that extra investment in providers delivers concrete results for patients.

"We also welcome the recognition that the NHS is in transition from a service focussed on individual organisations to one focussed on local health and care systems.

"We also welcome the recognition that the NHS is in transition from a service focussed on individual organisations to one focussed on local health and care systems. The guidance sets out helpful, but appropriately flexible, guidance on how these two year 2017/19 operational plans interact with Sustainability and Transformation Plans.

"There are some aspects that need further exploration over the next weeks but these should not detract from the positive steps taken so far to help the NHS manage a very challenging financial challenge and plug the gap. In particular, we need to be sure that numbers of small but unfunded commitments are not added later in the year. This is critical as the gap between what the NHS is being asked to deliver and the funding available remains. But this guidance provides a helpful basis to enable the NHS to now plan how to meet the more challenging times we face."

Ends

Annex 2: Planning timeline

Key deadlines for planning and contracting processes and information publication dates	Date
Planning Guidance published + Technical Guidance issued	**22 September**
Draft NHS Standard Contract, national CQUIN scheme guidance and National Tariff draft prices issued	22 September
Initial STF 2017/2018 guidance issued to providers	30 September
Commissioner allocations, provider control totals and STF allocations published	21 October
NHS Standard Contract consultation closes	21 October
Submission of STPs	**21 October**
National Tariff section 118 consultation issued	31 October
Final CCG and specialised services CQUIN scheme guidance issued	31 October
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November
Final NHS Standard Contract published	**4 November**
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November**
National Tariff section 118 consultation closes	28 November
Where contract signature deadline of 23 December at risk local decisions to enter mediation	5 December
Contract mediation	5 – 23 December
National Tariff section 118 consultation results announced	w/c 12 December
Final National Tariff published	**20 December**
National deadline for signing of contracts, submission of final approved 2017/18 to 2018/19 operational plans, aligned with contracts (Final contract signature date for avoiding arbitration)	**23 December**
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within 2 working days after panel
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January