Delivering the Forward View: NHS Shared Planning Guidance 2016/17 to 2020/21

Summary for Members

Introduction

Following the publication of the Five Year Forward View, the NHS-wide planning guidance for 2016/17 was published on 22 December 2015. The shared planning guidance was produced by NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission, Health Education England, National Institute of Health and Care Excellence and Public Health England. It is relevant to commissioners, NHS trusts and NHS foundation trusts. The guidance sets out the national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules.

This note provides a summary of the key financial messages within the planning guidance, their context and links to the currently available relevant documents. It is important to note that the NHS England Mandate for 2016/17 now sets the objectives for the NHS as a whole, not just for commissioners.

Overview

All organisations are required to construct and submit two separate but linked plans:

1. A sustainability and transformation plan (STP) – a five-year plan from October 2016 to March 2021 for the local health and care system. This is a placed-based plan for the local population and must reflect local health and well-being strategies
2. An operational plan for 2016/17 – this is organisation specific and forms the first year of the STP.

The plans must address three gaps:

1. The health and well-being gap
2. The care and quality gap
3. The finance and efficiency gap.

The planning guidance also includes the efficiency assumptions and business rules to be included in the National Tariff statutory consultation document to be published in February 2016.

Sustainability and Transformation Plans (STPs)

The purpose of the STP is for ‘every health and social care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View’. The emphasis is on developing a plan that meets the needs of local populations and
is not focused on individual organisations. STPs' scope includes health, local government and voluntary organisations (where appropriate) within the locality. STPs require strong local leadership and the appropriate governance structures.

Fundamentally, the STP must demonstrate how the ‘…NHS locally will balance its books’. The guidance makes clear that the STP process will be the single way that organisations are accepted onto programmes for transformational funding from 2017/18 onwards. The guidance makes it clear that the ‘most compelling and credible’ STPs will receive the earliest additional funding from April 2017 onwards.

Content of STPs

The STPs are expected to address ‘national challenges’ set out in the guidance, but the emphasis is on creating a clear vision and plan for the area and answering the following:

How will you close the health and well-being gap?
How will you drive transformation to close the care and quality gap?
How will you close the finance and efficiency gap?

‘Local health systems’ will be required to ‘develop their own system wide local financial sustainability plan a part of their STP’. It is expected that these plans cover both commissioners and providers and will set out plans for ‘demand moderation, allocative efficiency, provider productivity and income generation required for the NHS locally to balance its books’.

Transformation Footprints

The geographical area covered by the STP is called the ‘transformation footprint’. Local health and care systems are required to submit proposals for their transformation footprint and together they must cover the whole of England. It is expected that the footprints will be developed by looking at ‘natural communities, existing working relationship, patient flows and take into account the scale needed to deliver the services, transformation and public health programmes required and how it best fits with other footprints’.

If an area is already involved in the Success Regime or devolution programme, these ‘footprints’ continue and apply to the STP process.

There is an expectation that footprints will develop over time.

Operational Plans 2016/17

The guidance sets out nine ‘must dos’ for 2016/17 as follows:

1. Develop a ‘high quality and agreed’ STP
2. Return the system to aggregate financial balance through cost reduction (organisations must implement productivity gains through Lord Carter’s work; commissioning for value through the RightCare approach; maximum agency spend requirements in line with national guidelines)
3. Plan for sustainable and high quality general practice
4. Meet accident and emergency and ambulance wait times in line with the NHS Constitution (more than 95% of patients wait no more than four hours in A&E and all ambulance trusts respond to 75% of category A calls within eight minutes)
5. Meet referral to treatment timescales (92% within 18 weeks for non-emergency pathways)
6. Meet the 62 day cancer waiting standard and make progress in improving one-year survival rates
7. Achieve and maintain two new mental health access standards. Continue to meet the dementia diagnosis rate
8. Transform learning disabilities services
9. Develop and implement an affordable plan to make improvements in quality.

There is also an expectation that progress will be made on the delivery of seven day services.

The Operational Plans for 2016/17 should be regarded as the first year of the STP and will need to demonstrate:

- How it is intended to reconcile finance with activity (and if a deficit exists, a plan to return to financial balance)
- The planned contribution to efficiency savings
- The plans to deliver the key ‘must dos’
- How quality and safety will be maintained and improved for patients
- How risks across the local health economy have been jointly identified and mitigated
- How they link with and support local emerging STPs.

Allocations

NHS England has set firm three year allocations for CCGs, followed by two indicative years. These will be announced in early January 2016. For 2016/17 CCG allocations will rise by an average of 3.4% and no CCG will be more than 5% below its target funding level. Allocations for primary care and specialised commissioned activity will also be published.

Real terms growth in clinical commissioning group (CCG) allocations for 2017/18 onwards will be contingent on the development and sign off of a robust STP in 2016/17.

Returning the NHS provider sector to balance

During 2016/17 the provider sector will be required to return to financial balance. There will be £1.8 billion in the 2016/17 Sustainability and Transformation Fund and distribution of this funding will be decided by NHS Improvement and will be dependant on achieving milestones for:

- Deficit reduction
- Meeting access standards
- Progress on transformation

The guidance sets out expectations for a ‘forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment’. The focus needs to be on cost reduction and not income growth. The reduced level of capital resources is mentioned as is notice of changes to the capital financing regime.

Efficiency Assumptions and Business Rules

The planning guidance and the National Tariff ‘headlines’ include the following key elements:

- Efficiency is set at 2% (subject to the section 118 statutory consultation)
- Cost uplift is set at 3.1% (this includes the step change to pension related costs)
- HRG version 4 is to be retained for a further year
• Existing specialist top-ups are retained for 2016/17
• The specialised services risk-share is suspended
• Marginal rate emergency tariff remains at 70%
• The market forces factor continues as currently in place
• One of the payment approaches for mental health services should be implemented if possible (year of care/ episodic or capitated). If this is not possible, the decision should be made as to the approach to be taken for 2017/18 and work undertaken to ensure implementation at that point.

Wider business rules include the following:

• Provider organisations must move to the national procurement arrangements for high cost tariff excluded devices
• Commissioners must plan for a cumulative reserve (surplus) of 1%
• Commissioners must plan to drawdown all cumulative surpluses above 1% in the next three years
• Commissioners must set aside 1% of their allocation for non-recurrent expenditure and a further 0.5% as a contingency
• Better care fund plans for 2016/17 must explicitly support reductions in unplanned admissions and delayed transfers of care
• CCGs will be subject to a new assessment framework (this will be subject to a specific consultation in January 2016).

Timetable

<table>
<thead>
<tr>
<th>Timetable</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue commissioner allocations and technical annexes to planning guidance</td>
<td>Early January 2016</td>
</tr>
<tr>
<td>Launch consultation on standard contract, announce CQUIN and Quality Premium</td>
<td>January 2016</td>
</tr>
<tr>
<td>Issue further process guidance on STPs</td>
<td>January 2016</td>
</tr>
<tr>
<td>Localities to submit proposals for STP footprints</td>
<td>By 29 January 2016</td>
</tr>
<tr>
<td>First submission of full draft 2016/17 Operational Plans</td>
<td>8 February 2016</td>
</tr>
<tr>
<td>National Tariff S118 consultation</td>
<td>January/ February 2016</td>
</tr>
<tr>
<td>Publish National Tariff</td>
<td>March 2016</td>
</tr>
<tr>
<td>NHS organisations approve budgets and final plans</td>
<td>By 31 March 2016</td>
</tr>
<tr>
<td>National deadline for signing of contracts</td>
<td>31 March 2016</td>
</tr>
<tr>
<td>Submission of final 2016/17 Operational Plans, aligned with contracts</td>
<td>11 April 2016</td>
</tr>
<tr>
<td>Submission of full STPs</td>
<td>End June 2016</td>
</tr>
<tr>
<td>Assessment and review of STPs</td>
<td>End July 2016</td>
</tr>
</tbody>
</table>

Links to key documents

