7 December 2016

Your questions answered: issues and queries raised at CEO / Chair events on 3/4 November

Those of you who attended the CEO / chairs events that NHS Improvement hosted in November will remember that we promised to share answers to the questions raised during the Q&A sessions. You can find our responses in this document to the issues/queries (in bold below) that were raised at the events. If you have further questions, please get in touch with your NHS Improvement relationship manager.

1. Control totals

- My 2017/19 control total is undeliverable. What do you want me to do?
- Do you really and honestly think we can deliver everything you’re asking for on the money available?
- On a business rules basis the 2017/18 control total is deliverable for my acute but not affordable or acceptable to CCG. We can only support CCG if we do not agree to control total. What do I do?

The 2017/18 control totals were set to move the sector to overall breakeven in 2017/18. We appreciate that this is not an easy task and that collaboration between providers and commissioners to build robust plans to moderate activity so they are affordable for all parties is becoming increasingly important. Should you believe that your trust is unable to achieve its control total for the year, or you have been told the activity and income plans underscoring your control total are not affordable or acceptable to your commissioners, please contact NHS Improvement to discuss. We have a range of supportive interventions to help organisations get on track, and a joint mediation and arbitration process with NHS England to support contracting conversations.

The original 2018/19 control totals were more challenging, and having listened to your feedback, we have now offered some flexibility with respect to 2018/19 control totals. The flexibility at organisation level must be managed in such a way that the provider sector delivers at least a breakeven position in 2018/19 after application of the £1.8bn Sustainability and Transformation Fund (STF). Under this revised earned autonomy arrangement, trusts will have the flexibility to agree with NHS Improvement their own control totals for 2018/19 within the following framework:

- trusts will only earn entitlement to 2018/19 flexibility if they have delivered their 2016/17 control totals and signed up to their 2017/18 control totals
• if a trust is in surplus (before application of the STF) in 2017/18, it must maintain at least the same surplus position in 2018/19
• if a trust is in deficit (before application of the STF) in 2017/18, it must improve upon its 2017/18 control total in 2018/19 as part of an agreed recovery trajectory.

2. Demand

• What do you expect us to do if there is only enough money to buy a certain amount of activity, and we know that our projections show demand to be greater than this? We know the answer is "demand management" - but this does involve risk - even if we are all committed to making this happen!

• There is already a demand and capacity mismatch. We can probably buy off some growth but not all. Agreeing activity plans that are deliverable within the performance and quality agenda risks being little more than a paper exercise with increasing numbers of patients. How do you want us to articulate this?

In developing your Sustainability and Transformation Plans (STPs), providers and commissioners have been working together to jointly agree realistic activity levels over the coming years - both before and after the implementation of solutions. While some solutions such as efficiencies will be delivered by individual organisations, many of the transformational solutions will be developed at a system level to directly address the challenges specific to the area. We acknowledge that there is a risk that solutions will not be delivered so would ask you to clearly articulate what those risks are in your plans and the mitigations should the activity exceed planned levels.

Opportunities for moderating growth include:

• combining cross-system preventive actions with the implementation of national programmes such as RightCare, the urgent and emergency care review, self-care and new care models
• local organisations working together to manage demand and capacity so that individual organisations achieve their control totals
• rolling out national programmes to support the implementation of new care models.

Moderating activity growth at the same time as meeting quality and performance requirements is not a simple task and is not without risk. We hope that you continue to work together to develop agreed approaches to risk management and jointly implement solutions.

It is vitally important that plans to confront demand-capacity-affordability issues are not just a paper exercise, but are grounded in reality and owned and led by providers and commissioners. This may mean making difficult choices to close the gap, but unless those options are on the table, we can’t have a discussion about them.
Finally, please consider the role that you as a provider are taking in your local system in managing demand, ask yourself whether you could do more to help partners in your system (particularly primary care providers) to moderate demand.

**In terms of contract negotiation, CCGs may say they cannot afford to buy any capacity gap to meet increasing demand. Will NHS Improvement accept a position whereby some targets are unachievable?**

Delivery of national performance standards, or agreed improvement trajectories if appropriate, is a key requirement for providers to access the performance element of the STF. It is therefore essential that the activity assumptions underpinning delivery of the plan are clearly agreed and documented between provider and commissioner. If the assumptions change (e.g. demand is substantially higher than assumed levels), and performance suffers as a result, the provider may use the appeals process to put forward their case and restore access to the STF.

With regard to contract negotiation, the NHS England / NHS Improvement joint Dispute Resolution guidance may help trusts to take forward these discussions locally. The guidance includes:

- the approach to reflect the activity impacts of QIPP plans including scale, timing, underpinning robust plans with clinical engagement, KPIs;
- setting the baseline for activity plans
- how commissioners should determine demand requirements to inform activity plans and constructively engage with providers
- requirement for providers to be cognisant of the level of capacity that they have in order to meet demand in a safe and sustainable way when agreeing contracts
- requirement that, unless agreed by both parties, commissioners should not cap activity based payments or otherwise distort a provider’s incentives to attract additional patients.

**3. Competition**

- **Can you put more pressure to improve focus on co-operation rather than competition and stop CCGs continuing to tender out services which diverts resources away from delivery?**
- **When can we stop wasting resource and cash on non-value-adding transactions between CCGs and trusts?**

We have clarified the position on competitive procurement including pointing out that it is not true that all contracts have to be awarded using a competitive tender process – see the note here.
This note also emphasises that the regulations require that commissioning processes are proportionate – CCGs should not be embarking on approaches that are not necessary to deliver the best possible outcomes for patients.

The important thing is that both commissioners and providers are acting in a way that gets the best outcome for patients. The rules as they stand are not a barrier to that happening and shouldn't be used as an excuse not to work constructively together to improve services locally. If that's not happening – because of a perception that the rules don’t allow it – or for any other reason, then NHS Improvement can help.

4. PFI

You have addressed the agency market. Can you take a similar approach to PFI contracts, where there is huge profit being made and money being taken out of the NHS?

We've got a working group that’s looking at PFI and what we can do ranging right from a buy-out to the more straightforward route – i.e. better contract management.

A buy-out won’t be possible in every case because of the way they’re structured. But there is a real risk that we don’t take advantage of borrowing levels which are at their lowest point since the Napoleonic War. We are trying to support some providers where there might be structural solution. PFI was the only show in town at the time. But the borrowing levels are 7-8%, and in some cases this is hard to justify. M&S wouldn’t be doing this, Marriott wouldn’t be doing this.

There are also other PFIs which technically, contractually, aren’t performing. There are ways of dealing with that and we are not doing that as robustly as we need to. Again, we’ll be having conversations to make sure that is addressed and that the NHS is getting value for money.

5. NHS Improvement ways of working

Welcome the point about honesty, standing together, co-operation and finding solutions together. These sentiments do not always play out when NHS Improvement interacts with providers in trouble. Why is this?

NHS Improvement’s ways of working was a theme in the Q&A sessions at the events on the 3rd / 4th. I acknowledge this issue – and the challenges and confusion it can create for colleagues in the provider sector – and I am working with my executive team to fix it. This may be partly a symptom of two very different organisations coming together, but we are trying to move towards a more consistent and supportive approach as quickly as we can. This is a work in progress and you should challenge us when we have not got it right.
• We are being encouraged by our NHS Improvement regional team to report our finances as being on track in Q2 when we're not. They're saying lay a breadcrumb trail in the commentary but keep the figures as being on plan. What do you want us to do?
• We're clearly behind our 16/17 control total but we're coming under a lot of pressure from NHS Improvement regional teams to not reveal this. What do you want us to do?

There are times when we need to have difficult discussions with colleagues in providers – this is inevitable in the current context where we are attempting transformation and change in a challenging context. However, NHS Improvement needs to be better at ensuring that these are constructive discussions – i.e. discussions that address the challenges head-on and don't just kick the ball down the road. And when this is not the way a conversation goes, we – i.e. the senior leadership team – need to know about it from you so that we can fix it.

It is part of NHS Improvement's role to help providers manage their risk effectively, but we cannot do that without a full understanding of the options that might be available in a given system – so we need providers to come to us having considered these options, which may not be obvious and may not be without difficulty. We cannot easily create solutions, but if the solutions you have identified come with challenges, we can do our best to work with you to help you overcome them.

In no circumstance should financial problems or risks be hidden. Neither should we assume that they are manageable.

6. NHS Improvement and NHS England joint working

How will NHS Improvement take equal responsibility for calling shots on STPs? Seems NHS England determining a lot of the strategic issues

We are working closely with NHS England to make sure that we learn from our experience so far in developing STPs and better harness our resources to support STPs. We want to do more to support providers and local health economies in making sure that STPs are based on grounded and transparent assumptions about the relationship between activity, workforce, outcomes and expenditure. To do this effectively, we need to work collaboratively with providers to make sure we have a shared understanding of the challenges and possible solutions facing local health system.

How will the regional and local leaders of NHS Improvement improve their working with their opposites in NHS England?

We are committed to making the process as coordinated as possible for STP leaders and local health organisations. A number of joint forums are already in place, such as the regional STP boards and the national Five Year Forward View CEOs group. Our regional teams are continuing to develop more integrated day-to-day working
arrangements with their NHS England colleagues, and we are making an increasing number of joint appointments at regional level. But we know that STPs and local health organisations haven’t always experienced as joined-up a process as we want, and we will be working with STPs to improve this further in the next phase.

To support STPs that are moving towards new care models and ACO-type arrangements, we and NHS England have introduced the Integrated Support and Assurance Process to give us a single, unified process for supporting these new models and for completing any necessary assurances.

7. STP governance and collaboration

What are we to do about STP governance without primary legislation, particularly for providers involved in more than one STP?

Decisions about STPs will continue to require agreement across the different commissioners and providers in each area.

In some areas, CCGs and local authorities (with NHS England) are developing joint or lead commissioning arrangements, which will streamline decision-making on the commissioning side. Some areas are also moving towards ACO-type contracts which will give a lead provider the responsibility for managing the majority of resources, services and outcomes for that area, which will further streamline decision-making.

In most areas, however, the reality will be that there will continue to be a number of different providers, in some cases corresponding to more than one STP geography. Their boards cannot delegate to other organisations decisions about how they use resources and provide services, but there are a number of options that they can use to achieve shared decision-making with those other organisations. The recent NHS Providers report Governing for transformation: STPs and governance sets out the main options, including committees in common and the use of joint forums to align decision making. This increases the importance of strong STP leadership in bringing organisations together to develop shared plans – and the importance of all providers working closely with STP leaders and other STP partners to agree those shared solutions. We and NHS England have agreed we will work with STPs to share best practice in how organisations reach these shared decisions.

8. STP public engagement

We want to engage with our local stakeholders on the STP all through the process, when will we have licence to do so?

All areas should be publishing their STPs, if they have not already done so, in the next few weeks – and using this as the basis for broader and deeper engagement with local stakeholders on a regular basis. We anticipate that all areas will want to publish by the end of the year their plans for further engagement. Many footprints
have already published patient-facing summaries as part of their engagement work. While formal consultation (where required) will not need to take place until the next stage of the process, dialogue with local people is essential throughout.

Some of the changes we agree need to be made require formal consultation which must be led by the CCG, but the CCG has to get its GP members to agree, and they struggle to do so, and they have to satisfy an NHS England assurance process which is Byzantine and very lengthy. Meanwhile we struggle to improve our efficiency, but the necessary action is out of our control.

NHS England is responsible for assuring service change proposals against the Government’s four tests prior to public consultation. One of the tests – support for proposals from clinical commissioners – is met when a CCG governing body approves a consultation launch, but this does not in every case require all GP members to support the proposal.

Formal public consultation may not be required in every case. Decisions on consultation should be made in collaboration with the local government overview and scrutiny function. Where schemes are able to plan ahead, developing a robust case for change and clinical evidence, as well as meaningfully engaging stakeholders, means protracted assurance processes can often be avoided. We and NHS England are currently undertaking a review to ensure service change processes are aligned and proportionate. We will also continue to work with local areas that want to introduce significant service changes to help get it right first time.

9. Nurse staffing

Recent CQC inspections have led to demands to increase nursing staffing levels to meet demand and acuity. How will this be played into NHS Improvement conversations with providers regarding benchmarking on workforce numbers and costs?

NHS Improvement is leading a number of workstreams to support better staffing deployment and use of resources. These include the Efficiency program, Getting it Right First Time, rostering and also Care Hours per Patient Day (CHPPD), to support local decision making on staffing. Alongside this, NHS Improvement is leading seven workstreams on behalf of the system into safe, sustainable staffing including maternity, mental health, learning disabilities, in-patient adult care, children and young people, emergency care and community care.

These multi-professional resources, supported by the National Quality Board (NQB) and starting in December 2016, will involve engagement with key stakeholders including the CQC to ensure that alignment is created with system resources and inspection approaches.
Working as part of the NQB, NHS Improvement developed the NQB refresh document **Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.**

**10. Primary care**

- **As an A&E Delivery Board Chair I am allegedly accountable for holding primary care and social care to account whilst in STP discussions. I have to say ‘won’t / ain’t’ and at the same time further develop relationships with those two groups in particular. Do you see the dichotomy? PS - no one else has managed to hold these to account so how are we expected to?**
- **Has any system found a way to hold GPs to account for quality and access?**

It is ultimately NHS England – and, where they have taken on co-commissioning responsibilities, CCGs – that are responsible for holding GP practices to account, including for quality and access; and local authorities are responsible for social care.

At the same time, STPs are an opportunity for different partners to come together and take joint responsibility, through collaborative working, for the performance and progress of the whole health and care system locally. The focus of STP discussions should be on agreeing changes to patterns of care (and, where necessary, changes to the balance of investment and resources between different sectors) that will reduce waste and inefficiency and help all parts of the local health economy, including primary care, secondary care and social care, to use resources more efficiently. This will typically mean a negotiation with primary care to agree how it will improve quality and access, whilst at the same time agreeing what other parts of the system will do to reduce avoidable demands on general practice. For example, improving processes at the interface of hospital and primary care services or developing multi-disciplinary terms that work across primary and secondary care boundaries.

We see this as an opportunity to create new forms of peer accountability, where trusts, GP federations and other local providers agree and commit to a plan and hold each other accountable for delivering that shared plan. These new forms of peer accountability are likely to benefit from formal memoranda of understanding (or other devices to establish the ground rules for greater collaboration and shared accountability). But there will clearly also need to be a strong focus on organisational development and system development to effect changes in behaviours, relationships and day-to-day working practices.