National Planning Guidance for 2016/17

Author: Paul Gowdridge Sponsor: Paul Traynor paper M

Executive Summary

Context

Our integrated annual plan describes how we will meet the expectations of our patients, the regulator, commissioners and other stakeholders on our journey to sustainability, whilst also focusing on tackling immediate performance issues and ensuring short-term resilience.

In drafting our plan (and shaping our priorities for the coming year), we must also consider the national planning requirements prepared by NHS England, NHS Improvement (Monitor and NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE) and Public Health England (PHE).

Questions

1. What are the key messages within the national planning guidance for 2016/17 to 2020/21?
2. How do we plan to ensure our emerging plans (corporately and within CMGs) reflect the national planning requirements?
3. What are the key financial assumptions within the various planning guidance published for 2016/17 and what is the impact for the Trust?

Conclusion

1. Some of the key messages from the planning guidance include:
    - Organisations will be required to produce two separate but connected plans – a 5 year system plan and 1 year organisational plans
    - For the first time, local NHS planning (system and organisational) will become the application process for additional national funding through the sustainability and transformation fund - the guidance states that the most compelling and credible plans will secure the earliest funding
    - The key theme running throughout the guidance is one of partnerships/collaboration (system wide planning) where organisations are expected to work together much more closely
    - Our integrated annual plan for 2016/17 must reflect the 5 year system plan and form part of the delivery mechanism for that wider plan
    - There needs to be significant focus on new models of care at both a system level and within provider organisations. Transformation is seen as a fundamental requirement
    - There are 9 national must dos (see Page 4 below)
    - Given the importance of getting demand and capacity plans right, national support will be made available for the first time – colleagues within the Trust and within local CCGs are attending training events in January 2016

2. A number of different things inform our planning assumptions from local patient and partner feedback to national priorities. As such, those involved in planning (corporately and within CMGs) are given information/guidance which must be reflected in local plans that help frame the Trust's overall annual plan. To ensure both local and national priorities/intentions feature in our plans, a series of challenge and confirm sessions will be held throughout the planning process giving CMGs and Corporate Teams the opportunity to review, refine and agree plans that reflect everything they need to, where possible.

3. Financial assumptions and their impact:

    - HRG4 will remain in place for 2016/17 with consultation proposing a 2% efficiency deflator and 3.1% inflation uplift for all local and national prices, plus an additional 0.7% specifically on national tariff prices, related to increases in the CNST premium. This translates to expected income inflation of +1.1% for local prices and +1.8% for national prices; or an overall composite rate of +1.7% based on our current mix of tariff and non-tariff activity. In addition, the specialised service marginal rate is being suspended, which is positive news for the Trust. All this equates to a £11.9m increase in Income.
    - Based on basic pay level without growth, there will be additional £6.6m pay costs pressure as a result of the 3.4% change in employers National Insurance contributions.
    - As mentioned above, nationally there is a 2% efficiency requirement; the full impact of this is yet to be aligned with the internal CIP requirements in the context of underlying cost pressures and the organisational control total. At this stage, the organisation continues to plan for a CIP target of £41.4m (circa 4%)
    - 2016/17 revenue control total is £8.3m.This is net of receiving £23.4m of national funding from the Sustainability and Transformation (S&T) Fund (General element)

Input Sought

Trust Board is asked to **note** the summary of the national planning guidance below.

For Reference

The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Yes
Consistently meeting national access standards	Yes
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Yes
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Yes
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Yes

This matter relates to the following governance initiatives:

Organisational Risk Register	N/A
Board Assurance Framework	N/A

Related Patient and Public Involvement actions taken, or to be taken: Yes - PPI representatives are involved in the challenge and confirm meetings with CMGs and a further (dedicated) meeting has taken place on 21st January 2016

Results of any Equality Impact Assessment, relating to this matter: N/A at this stage

Scheduled date for the next paper on this topic: Planning updates to be shared with the Executive throughout the planning cycle – dates to be agreed

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

DELIVERING THE FORWARD VIEW: NHS PLANNING GUIDANCE 2016/17 TO 2020/21

1. This summary paper provides an overview of the key messages within the national planning guidance and follow-up technical guidance for 2016/17, which was published on 22nd December 2015 and 19th January 2016 respectively.

2. In addition, this paper summarises the high level impact of key financial assumptions of the national planning guidance and the follow-up letter from NHS Improvement which set out the organisational control total.

The Planning Guidance

3. This year's guidance has been published in the context of the recent spending review announcements and is explicitly positioned to set out how the sector is expected to deliver the Five Year Forward View by 2020, 'restore and maintain financial balance' and 'deliver core access and quality standards for patients'.

4. This year, organisations within the NHS will be required to produce two plans:

   - All local health and care systems will be required to develop **a five year sustainability and transformation plan** (STP), covering the period October 2016 to March 2021 subject to a formal assessment in July 2016 following submission in June 2016
   - All NHS Trusts are required to develop and submit **one year operational plans** for 2016/17 (Year One of STP). These plans will need to be 'consistent with the emerging STP' and in time to enable contract sign off by end of March 2016

Local health system sustainability and transformation plans

5. The STP should be a holistic and ambitious local footprint for accelerating the implementation of the Five Year Forward View and closing the gaps in health inequalities, quality and finance.

Access to future transformation funding

6. Local NHS planning will become the application process for additional national funding through the sustainability and transformation fund. This protected funding is for initiatives including the spread of new care models, primary care access and infrastructure, technology roll-out and clinical priorities such as diabetes, learning disability, cancer and mental health. Many of these funding streams will form part of the recently announced 'Sustainability and Transformation Fund' (STF), however for 2016/17 separate processes will continue to operate to allocate any additional funds. The guidance states that the 'most compelling and credible sustainability and transformation plans will secure the earliest funding'.

   In releasing funding for STPs, NHS England will consider:

- The quality of plans, scale of ambition, track record of delivery, evidence of learning from others
- Reach and quality of the engagement process with partners and the community
- Strength and unity of local partners and governance
- Their confidence that implementation actions will be delivered as intended, underpinned by governance and capability

Agreeing 'transformation footprints'

7. Local health and care systems are asked to consider their planning footprint and make proposals to NHS England and NHS Improvement by 29th January 2016**.** These footprints should be locally defined, but will require national agreement. They should be based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required.

8. Further guidance on the STP process will be issued in January 2016, along with new support and engagement events. Providers are also invited to volunteer to work with NHS England to develop 'exemplar, fast-tracked plans' and to provide early reactions on the STP process.

National 'must do's' for 2016/17

9. NHS Trusts are required to submit one year operational plans for 2016/17 and must be submitted earlier than STPs but the one year plan should reflect the emerging STPs. It also articulates nine "must do's" for the year ahead:

    1. Develop a high quality and agreed STP and subsequently deliver agreed milestones in 2016/17
    2. Return the system to aggregate **financial balance**, including NHS providers engaging with **Lord Carter's productivity work programme**, and complying with agency rules and CCGs delivering savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality
    3. Developing and implementing a local plan to address the sustainability and quality of general practice including workforce and workload issues
    4. Getting back on track with access standards for **A&E and ambulance waits**
    5. Improvement and maintenance of NHS **Constitution standards for referral to treatment** (more than 92% patients on non-emergency pathways wait no more than 18 weeks from referral to treatment) including offering patient choice
    6. Deliver **Constitutional standards on cancer care**, including the 62 day cancer waiting standard and the constitutional two week and 31 day cancer standards, making progress in earlier diagnosis and improving one year survival rates
    7. Achieve and maintain the two new **mental health access standards** (more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved package within two weeks of referral; 75% referrals to IAPT will be treated within six weeks and 95% within 18 weeks). Continue to meet dementia diagnosis targets

8. Deliver actions in local plans to transform care for people with **learning disabilities** including enhanced community provision, reducing inpatient capacity and rolling out care and treatment reviews
9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the **annual publication of avoidable mortality rates** by individual Trust

In addition, this section of the planning guidance document draws particular attention to:

- The delivery of **seven day services**: by March 2017, 25% of the population will have access to acute hospital services that comply with four priority clinical standards every day, and that 20% of the population will have enhanced access to primary care. The document articulates three challenges with regard to implementing seven day working: reducing excess deaths at the weekend; improving access to out of hours care; and increasing capacity within primary care to improve access to services at weekends and in the evenings
- The document also articulates an expectation that the '**development of new care models** will feature prominently within STPs'. In addition to existing approaches, two new approaches will be trialled with volunteers in 2016/17 which are:

  - Secondary mental health providers managing care budgets for tertiary mental health services
  - The reinvention of the acute medical model in small district hospitals

Organisational operational plans 2016/17

10. In line with the principles we (UHL) developed at the beginning of the planning round, the national guidance stresses that local leaders are asked to 'run a shared and open-book operational planning process for 2016/17 covering activity, capacity, finance and 2016/17 deliverables emerging from the STP. Commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement based on contracts, signed by March 2016.

11. The 2016/17 Operational Plan should be regarded as 'year one of the five year STP' and contribute to the transformation agenda. All operational plans will need to demonstrate:

    - How to reconcile finance with activity (and where a deficit exists, how to return to balance)
    - Planned contribution to efficiency savings
    - Plans to deliver the 'must do's' for 2016/17 set out above
    - How quality and safety will be maintained and improved for patients
    - How risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan
    - How the plan links with and supports local emerging STPs

12. A support programme is under development by the national bodies to assist in preparing robust plans for 2016/17 and beyond.

Joint assurance process

13. The operational plan of each commissioner and provider will need to be approved by its individual Board or governing body. To support this, NHS England and NHS Improvement will undertake a joint assurance process, working with local organisations in a coherent and joined-up way.

14. This joint assurance approach will focus on supporting organisations to deliver operational plans which demonstrate how the following requirements will be met:

    - Agreement of robust demand and capacity plans – considering whether sufficient and affordable activity is planned for, and the capacity of providers to meet this
    - Finance and activity projections supported by reasonable and deliverable planning assumptions
    - Coherence with other planning and output assumptions – checking the consistency of planning assumptions across provider and commissioner plans
    - Identification of risks outside of the direct control of the organisation, and how these might be mitigated

Joint assurance submissions

As part of joint assurance processes, all providers are required to submit the following returns:

- A baseline agreement return by midday on Monday 18th January 2016
- Contract tracker returns: updated and submitted throughout the contracting timetable in accordance with the weekly submission schedule
- A provider-commissioner activity return through Unify (for draft plan and final plan)

Planning timetable

Timetable item (applicable to all bodies unless specifically referenced)	Revised timetable
National Tariff S118 consultation	**Jan-Feb**
Submission of updated full draft plans (CCGs, NHS England only)	2 March
Contract signature stocktake	**14 /15 March**
Where contracts not signed and contract signature deadline of 31 March at risk, local decisions to enter mediation	15 March
Contract mediation	15 March – 7 April
Publish National Tariff	**Early March**
National deadline for signing of contracts	**By 31 March**
Budgets and final plans approved by Boards of providers and commissioners	**By 31 March**
Final contract signature date for avoiding arbitration	8 April (noon)
Submission of arbitration paperwork where contracts not signed	8 April (noon)
Submission of final 2016/17 operational plans, aligned with contracts	**11 April (noon)**
Contract arbitration panels and/or hearings	11 - 25 April
Arbitration outcomes notified to commissioners and providers	Within 2 working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 3 May

15. Further details of the timetable for the completion of place-based sustainability and transformation plans (STPs) by July 2016 will be issued separately in January 2016.

NHS FUNDING ALLOCATION FOR 2016/17 AND PERCENTAGE CHANGE FROM 2015/16

The Trust received a letter from NHS improvement on 15th January 2016 (attached). This letter provided additional information on the 2016/17 financial framework following on from the National Planning Guidance. In addition, the letter contained specifics regarding the Sustainability and Transformation Funding (S&T Fund) with its conditions and measurements, a 2016/17 revenue control total and their expectations for the 2015/16 outturn.

- Almost 40% of NHS England's additional allocation for 2016/17 will be made up of a £2.1bn Sustainability and Transformation Fund, **linked to the planning process and submission**. This will consist of:

    - £340m for transformation which is intended to support on-going development of new care models and implementation of policy commitments in areas e.g. 7 day services, GP access, cancer, mental health and prevention
    - £1.8bn for sustainability which is to support NHS Improvement to bring the provider sector back to financial balance in year
    - Over the five year period, the split between sustainability and transformation requirements for local health economies will change, if the provider sector's finances improve

16. **The distribution of sustainability funds will be calculated on a Trust by Trust basis by NHS Improvement and then agreed with NHS England and will replace direct Department of Health funding to providers**. In short, we need a robust integrated plan that triangulates well and demonstrates further movement towards our longer term goals and those of LLR on our journey to sustainability.

17. The approach of quarterly instalments of funding based on meeting conditions implies a different approach to contract performance management for 2016/17. The planning guidance notes that providers who are eligible for sustainability and transformation funding in 2016/17 will not incur penalties as well as losing access to funding – a single penalty will be imposed.

Update on the national tariff

18. HRG4+ is the new currency design proposed for the admitted patient care national tariff. It is assumed that this currency design will more accurately reflect the complexity of the work providers undertake but has been postponed to 2017/18.

19. Final prices are unlikely to be available until early March 2016. Therefore, as an aid to planning only, an update on the national tariff and indicative prices for 2016/17 was published on 22nd December 2015 and this has been modelled internally to identify the estimated £11.9m income increase.

National Business Rules

- The **specialised service marginal rate is being suspended** from 2016/17 from national price contracts
- The **marginal rate for emergency admissions is retained at the 70%** level agreed for providers on the enhanced tariff option (ETO)
- No significant changes to the market forces factor (MFF)
- The significant proposed changes to specialist top ups for 2016/17 (based on the new Prescribed Specialised Services methodology) will be delayed until 2017/18
- Draft prices have been published alongside the planning guidance, in advance of the statutory consultation notice in order to support negotiations between providers and commissioners

Key Financial assumptions and Impact for UHL

Income Assumption

Inflation

20. The NTDA have specified a 2% efficiency deflator and 3.1% inflation uplift for all local and national prices, plus an additional 0.7% specifically on national tariff prices, related to increases in the CNST premium. This translates to expected income inflation of +1.1% for local prices and +1.8% for national prices. This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes and CNST.

MRET

21. There will be no application of a specialised services marginal rate in 2016/17.

22. A consultation on the marginal rate will form part of the engagement on the implementation of HRG4+ in 2017/18. The marginal rate for emergency admissions will remain at 70%.

Inflation and MRET Assumption Impact on Trust

23. When we have modelled the impact of the draft prices using 12 months of our own activity, the actual impact is +1.4% (£9.2m) for tariff inflation against the expectation of +1.7% described earlier in Section 3, although when we take into account the removal of the specialised marginal rate, this increases to +1.8% (£11.9m). This excludes high cost drugs, devices and resilience funding which are not subject to inflation (See Appendix 1). Currently, there is very little guidance to accompany the prices, so there may be further changes in this amount during the full road test in January/February.

Pension and National Insurance (NI) changes

24. Currently, members of the NHS Pension Scheme are contracted out of the additional state pension. This means members do not receive the additional state pension and pay a lower rate of National Insurance (NI). As an employer, the Trust also pays lower NI contributions for those members. From April 2016, employers will pay additional NI

contribution costs of 3.4 per cent on an employee's earnings (for members on the pension scheme) between the lower earnings limit of £5,824 per year and the upper accrual point of £40,040 per year.

Pension and NI changes Impact on Trust

25. Using the basic pay of the current staff in post, initial impact modelling suggests this equates to approximately £6.6m pay cost pressure.

Efficiency Factor

26. As mentioned above, the guidance states a 2% efficiency factor. This % efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement

Sustainability and transformation funding (S&T Fund)

27. The S&T Fund for 2016/17 replaces the need for the current scale of direct Department of Health (DH) cash funding. The fund will be used to support providers move to a sustainable financial footing and will be deployed in a way that creates a balanced aggregate financial position in the NHS Trust and Foundation Trust sector in 2016/17.

    As such, the 2016/17 S&T Fund will have **two elements:**

    - A **'general element'** which will be distributed to all providers of emergency care and be linked to the setting of agreed control totals
    - A **'targeted element'** to support Trusts drive efficiencies and go further faster; this will be targeted at leveraging greater than 1:1 benefits from providers

28. The general element that will be made available to the Trust subject to provider eligibility and conditions is £23.4m. These conditions are based on delivering the agreed capital and revenue control total 2016/17, achieving the access standards and agreeing the Local Sustainability and Transformation Plans (details of requirements are in Appendix 2). In terms of the targeted element of the fund details, this will be made available later in the planning process.

Control total

29. The control total for UHL has been set at £8.3m.This is net of receiving the £23.4m general Sustainability and Transformation (S&T) Fund. This means the Trust will have to deliver a minimum of £31.7m deficit in 2016/17 and meet the requirements for the general S&T Fund. The capital control total is still to be confirmed and the Trust is working with the NTDA through the planning process to confirm what this will be.

Appendix 1

2016/17 Draft Tariff - Impact Summary

	Estimated Annual Value at 15.16 Tariff £m	Estimated Annual Value at 16.17 Tariff £m	Movement £m	Movement %
Items Affected by Price			-	
Inpatients & Daycase	£319.3m	£325.0m	£5.7m	1.8%
Outpatients	£105.1m	£106.2m	£1.0m	1.0%
ED	£19.2m	£19.7m	£0.5m	2.7%
Critical Care	£52.9m	£53.5m	£0.6m	1.1%
Diagnostic Imaging	£12.6m	£12.7m	£0.1m	1.1%
Renal Dialysis	£22.8m	£23.1m	£0.3m	1.3%
Radiotherapy	£6.0m	£5.7m	(£0.3m)	-5.2%
Unbundled Activity	£12.8m	£13.0m	£0.1m	1.1%
Maternity Tariffs	£21.9m	£22.2m	£0.2m	1.1%
Other Items (eg ECMO, BMT, PTS, Cystics etc)	£77.7m	£78.5m	£0.9m	1.1%
Sub Total	£650.4m	£659.6m	£9.2m	1.4%
Specialised Marginal Rate	(£2.7m)	-	£2.7m	-100.0%
Sub Total	£647.7m	£659.6m	£11.9m	1.8%

Expected Uplift

	Headline Rate	Impact
Inflation	3.1%	3.1%
CNST Uplift (National Prices, estimated at 80%)	0.7%	0.6%
Efficiency	-2.0%	-2.0%
Overall Expected Uplift		1.7%

Appendix 2

Table 1: S&T Fund conditions and measurement

Objective	Conditions/measurement
Deliver agreed control total Provider deficit reduction/ surplus increase	Q1: Agreement of milestone-based recovery plan (OR surplus increase) with NHS Improvement AND agreed **control total for 2016/17**. Agreement to capital control total. Plans to include milestones for Carter implementation (including reporting and sharing data in line with the national timetable) and compliance with the NHS Improvement agency controls guidance. Q2 to Q4: Delivery of plan milestones AND **capital and revenue control totals.**
Access standards	Q1: Agreeing with NHS England and NHS Improvement a credible plan for maintaining agreed performance trajectories for delivery of core standards for patients, including the four-hour A&E standard, the 18-week referral to treatment standard and, for appropriate providers, the ambulance access standards. Q2 to Q4: Delivery of agreed performance trajectories.
Transformation	Q1 to Q3: Local Sustainability and Transformation Plans (STPs) – to work with commissioners and develop an integrated five-year plan in line with the national STP timetable. Q4: STP agreed with NHS England and NHS Improvement. Providers will also have the option to volunteer to join an accelerated 2016/17 transformation cohort.

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

NHS Improvement
(Monitor and the NHS Trust Development Authority)

John Adler
Chief Executive
and
Paul Traynor
Director of Finance

Wellington House
133-155 Waterloo Road
London
SE1 8UG

020 3747 0000

15 January 2016

University Hospitals of Leicester NHS Trust

2015/16 Outturn and 2016/17 Plan including Sustainability and Transformation Fund

As announced in the recent Spending Review, the government has committed to provide an additional £8.4 billion real-terms funding for the NHS by 2020/21. The increase in funding available for 2016/17 totals £3.8 billion in real terms, a £5.4 billion cash increase. It includes a £1.8 billion Sustainability and Transformation Fund (S&T Fund) for the provider sector in 2016/17, to be targeted primarily at providers of emergency care. This is a good settlement for the NHS in times of public spending constraint when the majority of government departments are facing real-terms funding reductions.

However, this settlement is dependent on the NHS provider sector delivering a deficit of not more than £1.8 billion in 2015/16 and breaking even in 2016/17 after application of the fund. To realise this settlement, this letter sets out what your board must urgently do during the remainder of the 2015/16 financial year.

2016/17 Financial framework and planning

On 22 December 2015 we published *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21.* This sets out the steps to help local organisations deliver a sustainable, transformed health service and improve quality of care, wellbeing and NHS finances. The planning guidance includes details of the operational planning approach for the next financial year and sets out a pragmatic approach to tariff setting and business rules, with the aim of supporting system stability and recovery in 2016/17. The key details of this package, which is favourable for most NHS providers, are set out in Appendix 1.

In addition, the planning guidance introduces the £1.8 billion S&T Fund for 2016/17. The fund is to support providers move to a sustainable financial footing. It will be primarily allocated to providers of emergency care that have been under the greatest financial

pressure, although it will include an element to support providers achieve overall sustainability by driving maximum efficiencies. The fund will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and NHS foundation trust sector in 2016/17. Payments will be made by commissioners, but approved by NHS Improvement. The fund replaces the need for the current scale of direct Department of Health (DH) cash funding for providers. Details of the fund and of eligibility to access it are attached in Appendix 2.

This additional funding is conditional on the NHS provider sector breaking even in 2016/17. To ensure this happens, every NHS trust and NHS foundation trust will have to deliver an agreed financial control total for 2016/17. This will be a core part of the new financial oversight regime that NHS Improvement will put in place.

An impact assessment model has been developed by NHS Improvement that models a range of known factors at an individual provider level. The outcome of this work will be used to allocate emergency care providers with an indicative payment from the S&T Fund and all providers with a control total for 2016/17. The key assumptions and the detail for your trust are attached in Appendix 3.

The offer of payment to your trust from the S&T Fund, explained in Appendix 3 and to be made by your lead commissioner, is for a limited period only. Please confirm by **8 February 2016** that your trust accepts this offer and in doing so agrees to the conditions. It is then our expectation that the operational plans you submit in February and April will be consistent with, or better than, the control total outlined.

The NHS settlement for 2016/17 relies on tight financial management of the capital budget. We will need to work very closely with providers to develop a capital framework which enables them to operate within the resource available. Providers should develop their capital plans for 8 February 2016, distinguishing essential expenditure from strategic investments. This should prepare providers for restrictions to both access to external finance and deployment of existing cash reserves to ensure the NHS does not exceed its capital budget. Providers that have agreed local capital to revenue transfers for 2015/16 will not be disadvantaged by these agreements in 2016/17.

2015/16 Outturn

As you will be aware, the scale of what we need to do in the future depends on how well we end this financial year. Collective urgent action is required now to ensure we contain the aggregate provider deficit position to within a £1.8 billion control total in 2015/16.

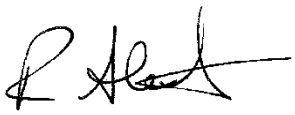
To limit the scale of the financial distress that will be carried forward into 2016/17, we would like your continued commitment to take the actions necessary to improve your current year financial position, while ensuring that safe care is delivered. We also ask you to review your plan for the remainder of 2015/16, focusing particularly on the areas

listed in Appendix 4, with the aim of improving your financial position in quarter 4 (Q4; January to March) 2015/16. These areas include both operational efficiencies and technical or one-off measures that we will need to deploy to deliver the £1.8 billion control total.

In addition, we will be meeting a number of challenged providers this month to agree a set of actions, including headcount reduction, additional to the current plan, with the clear intention of improving the financial position of those individual providers.

We cannot over emphasise that the 2016/17 Spending Review settlement that we have outlined above depends on every NHS organisation delivering the best possible financial outturn for 2015/16.

Many thanks for your continued support.



Bob Alexander
Deputy Chief Executive
NHS TDA

Stephen Hay
Deputy Chief Executive
Monitor

Copy to:

Jim Mackey, Chief Executive NHS Improvement
Elizabeth O'Mahony, Director of Finance, NHS TDA
Jason Dorsett, Director of Finance, Reporting and Risk, Monitor
Dale Bywater, Director of Delivery and Development (Midlands and East), NHS TDA
Jill Robinson, Business Director (Midlands and East), NHS TDA

Key details of the 2016/17 financial framework for providers

We recognise that the planning documents include a large amount of technical information. Given this, we would like to draw your attention to the key details of the favourable financial framework we have secured for 2016/17 with the aim of delivering maximum stability and financial recovery.

Proposals in relation to the national tariff (soon to be subject to consultation):

- A delay in the introduction of HRG4+ to provide a year of pricing stability combined with no changes to specialised top-ups.
- A cost uplift of 3.1%, reflecting a stepped change in the cost of employers' pension contributions.
- Additional funding to cover the aggregate increased cost of CNST contributions. In addition to the general cost uplift, the majority of the increase in CNST contributions will be targeted at particular HRG chapters.
- An efficiency factor of 2%, which results in a net prices uplift of 1.1%.
- An increase in the marginal rate for emergency admissions to 70% for all providers.
- No application of a specialised services marginal rate in 2016/17. A consultation on the marginal rate will form part of the engagement on the implementation of HRG4+ in 2017/18. We will also move to centralised procurement of devices with set national reference prices.

Other system management changes:

- Commissioners are required to plan to spend 1% of their allocations non-recurrently, consistent with previous years. For provider funds to insulate the health economy from financial risks, the 1% non-recurrent expenditure should be uncommitted at the start of the year.
- The introduction of a commissioner sparsity adjustment for remote areas. The financial impact of this is added to the target allocation of the relevant CCGs. This results in an adjustment for six CCGs in relation to eight hospital sites. The adjustments to target allocations total £31 million.
- The requirement for commissioners and councils to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. Further, BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care.

Sustainability and transformation funding

1. The Spending Review settlement confirms a recurrent £5.4 billion cash increase to the NHS England Mandate in 2016/17. This will be deployed as follows:

    - £3.6 billion to flow recurrently into commissioning allocations and related budgets

    - £1.8 billion to be passed through commissioners to fund a Sustainability and Transformation Fund (S&T Fund) which will be provisionally allocated to individual providers this month with the intention of eliminating the NHS provider deficit position in 2016/17 (linked in part to emergency services).

2. The S&T Fund for 2016/17 replaces the need for the current scale of direct Department of Health (DH) cash funding. The fund will be used to support providers move to a sustainable financial footing and will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and foundation trust sector in 2016/17. As such, the 2016/17 S&T Fund will have two elements:

    - a ‘general element’ which will be distributed to all providers of emergency care and be linked to the setting of agreed control totals

    - a ‘targeted element’ to support trusts drive efficiencies and go further faster; this will be targeted at leveraging greater than 1:1 benefits from providers.

3. Details on how to access the targeted element of the fund will be made available later in the planning process.

The remainder of this appendix will consider the general element of the fund.

General element of the S&T Fund

4. To be eligible to access the general element of the fund, providers must provide emergency services and formally meet all the conditions in Table 1 below:

Table 1: S&T Fund conditions and measurement

Objective	Conditions/measurement
Deliver agreed control total Provider deficit reduction/ surplus increase	Q1: Agreement of milestone-based recovery plan (OR surplus increase) with NHS Improvement AND agreed **control total for 2016/17**. Agreement to capital control total. Plans to include milestones for Carter implementation (including reporting and sharing data in line with the national timetable) and compliance with the NHS Improvement agency controls guidance. Q2 to Q4: Delivery of plan milestones AND **capital and revenue control totals.**
Access standards	Q1: Agreeing with NHS England and NHS Improvement a credible plan for maintaining agreed performance trajectories for delivery of core standards for patients, including the four-hour A&E standard, the 18-week referral to treatment standard and, for appropriate providers, the ambulance access standards. Q2 to Q4: Delivery of agreed performance trajectories.
Transformation	Q1 to Q3: Local Sustainability and Transformation Plans (STPs) – to work with commissioners and develop an integrated five-year plan in line with the national STP timetable. Q4: STP agreed with NHS England and NHS Improvement. Providers will also have the option to volunteer to join an accelerated 2016/17 transformation cohort.

5. As a condition of the overall fund being approved, the NHS has to demonstrate tangible progress towards a credible plan for achieving seven-day services for patients across the country by 2020. Recipients of funding will be expected to continue to make progress towards achieving seven-day services in 2016/17.

6. S&T funding will be made available to providers as income, which will be paid by a lead commissioner and replace the need for the current scale of DH cash support. The S&T Fund allocated to CCG(s) will be ring-fenced as pass-through payments to the relevant provider in addition to normal contractual payments.

7. This funding will be provisionally allocated at the start of the planning process to ensure providers have the maximum amount of time to prepare a credible plan in sufficient detail to meet their control total and achieve the maximum amount of financial benefit in year.

8. Release of funding will be subject to a quarterly review process in arrears. This review process will cover delivery against the S&T Fund only. Arrangements are being agreed for providers who require working capital prior to the release of funds, but are likely to involve interest-bearing working capital facilities provided by DH. Plans should be prepared on this basis until further guidance is provided.

9. Access to funding will be through a formal agreement between NHS Improvement and trust boards in advance of any funds being paid. This agreement will be embedded in a high quality board-approved plan that is fully compliant with the criteria outlined above.

10. In addition, those providers eligible for S&T funding that meet the conditions of the fund will not face a ‘double jeopardy’ scenario whereby they incur contract penalties as well as losing access to funding; a single penalty will be imposed.

11. Providers that are in deficit and that require cash support after receipt of the funding and after local efficiencies will have access to DH interim support loans, as at present via interest bearing loans.

Individual provider detail
2016/17 Sustainability and Transformation Fund

Trust Name: University Hospitals of Leicester NHS Trust

The 2016/17 financial plan for each provider will be contingent upon its 2015/16 year-end financial position. For the purpose of the provider impact assessment, the Month 6, 2015/16 forecast has been used as the baseline adjusted for the assumed effect of agency controls and other recurrent measures in Q4 2015/16. Any further deterioration in this position will require the relevant provider to deliver higher efficiency levels to achieve the 2016/17 control total.

We have also taken into account other national funding flows in setting the control total such as the impact of changes to the tariff, education and training, CQUIN, CNST, etc.

Both the setting of the baselines and the control totals, and the measurement of performance versus control totals, will exclude gains on disposals of assets.

The general element of the fund will be distributed to providers in proportion to the cost of emergency services as reported in the 2014/15 reference costs.

S&T funding and 2016/17 control total	
General element – S&T Fund Subject to provider eligibility and conditions	£23.4m
Targeted element – S&T Fund Subject to provider eligibility and conditions	To be confirmed
2016/17 Control total	£8.3m deficit

This exercise has been undertaken to set control totals for 2016/17 and considers a range of incremental common factors only. Rather than debate the method by which the numbers above have been calculated, provider boards should now consider if, with the proposed tariff/business rule changes and access to the S&T Fund, their control total is achievable in 2016/17.

Financial improvement in Q4 2015/16

All providers are requested to consider the following opportunities and to report on them in their Month 9 outturn estimates submitted to either Monitor or the NHS TDA. A simple memorandum schedule detailing how much has been attributed to each of the items below should be submitted.

Description	**Detail**
Local capital to revenue transfers	Delivery of maximum amount of safe deferral or reduction in capital expenditure to be supported by capital-to-revenue transfers as agreed with either the NHS TDA or Monitor and the Department of Health.
Accurate monthly capital forecasting	To assist with the national capital position, ensure accurate capital forecasting including identification of any underspend.
Accurate provision reporting	To assist with the national position, ensure provisions are carefully reviewed at Month 9 and, where possible, accurately estimated for the full year.
Workforce	No non-medical agency cover for short-term sickness (<3 days), implementing acting down/cross-cover arrangements to ensure patient safety.
Agency staffing	Full compliance with the policy, including completing the weekly reporting. Review self-certification in weekly reports to identify opportunities for improvement. Focus on reducing number of shifts above rate caps and remaining within nursing agency ceiling.
Reviewing in-year priorities	Reviewing priorities in all areas: revenue maximisation, cost control, efficiency and investments
Balance sheet review: prudence	Remove prudence from estimates of: • accrual; • deferred income; • injury cost recovery (formerly RTA) debtor • partially completed spells

Appendix 4

Description	Detail
Bad debt provisions	Remove prudence in bad debt provisions, including ensuring impairments to receivables are line with IFRS and are based on incurred losses and not general estimates or future expected loss events.
VAT changes	Review latest COS guidance to ensure maximum reclaim of VAT including latest position on IT spend.
Annual leave	To the maximum extent allowed under NHS contracts, manage the carry forward of annual leave. Ensure that this does not lead to the use of additional agency staff to cover leave periods. Ensure data used for calculations from HR systems are robust.
Asset valuations	Revalue operational assets at the modern equivalent asset value using the alternative site method where advantageous.
Asset lives review	Review all equipment and buildings asset lives given that less capital will be available for replacement in future. The resulting adjustment will reduce depreciation charges while creating a one-off impairment. Providers will be held to account by NHS Improvement for their financial performance before accounting for impairments.