Paper NHS071402

BOARD PAPER - NHS ENGLAND

Title: 2014/15 Commissioning round update
Lead Director: Dame Barbara Hakin, National Director: Commissioning Operations
Purpose of paper: • To update the Board on the 2014/15 commissioning round and the approach being taken to ensuring elective and urgent care performance; specialised commissioning; and the Better Care Fund.
Actions required by the Board: • Receive assurance on the processes in place to ensure key commitments can be delivered. • Note that an update will be brought to a future meeting.

Introduction

1. This paper summarises the progress on assuring clinical commissioning groups' (CCG) commissioning plans following the report to the Board in May 2014. It also updates the Board on joint work between NHS England, Monitor and the Trust Development Authority (TDA) to secure operational resilience through 2014/15, including the release to the NHS of additional resource to support both urgent and planned care. It includes an update on specialised commissioning, and on the Better Care Fund.

2. The Board will receive a separate paper on the overall 2014/2015 financial position.

Ongoing Assurance of re-submitted CCG operational plans

3. Our assurance work on CCG plans has continued to focus on the delivery of all key commitments. In particular, we are focussed on ensuring that:

    - CCGs are on track to improve outcomes for patients;
    - activity plans mean that patients are treated promptly and in line with their rights in the NHS Constitution;
    - there is sufficient focus on securing parity of esteem in investment in mental health services and in ensuring delivery of standards in service areas for patients with mental health problems such as dementia or those needing psychological therapies; and
    - commitments in the mandate are delivered within the resources available.

4. The first round of plans did not give adequate assurance on a number of key areas and needed further work, especially on activity and finance. In addition, they did not have sufficient detail on the use of the Better Care Fund and its implications for services. Accordingly, we have asked for a further set of plans from each CCG by 27 June 2014. CCGs will be supported by NHS England area teams in the refresh of these plans.

CCG Contracting Position

5. The Board was updated in May on the CCGs' contracting position with providers. As of 18 June 2014, 274 out of a total of 388 contracts nationally have been signed. 114 contracts are outstanding, with 88 where the contract activity and financial values have been agreed, and 26 where the contract activity and financial values have not been agreed. There are no contracts in arbitration. The latest position will be given at the Board meeting.

Operational resilience – urgent care and elective care

6. On 13 June 2014 NHS England, the TDA, Monitor and the Association of Directors of Social Services published 'Operational resilience and capacity planning for 2014/15', a framework to support planning for operational resilience during 2014/15. Building on the achievements of urgent care working groups (UCWGs) over the last year, these groups will now become the forum where capacity planning and operational delivery across the health and social care system is coordinated.

7. This shift is reflected in the name change from UCWGs to System Resilience Groups (SRGs). This wider remit is partly informed by the recent pressures that have been seen in delivery of the referral to treatment (RTT) standard, but is primarily driven by the principle of good local healthcare planning being equally focused and resilient across planned and urgent care. Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires capacity planning to be ongoing and robust. This will put the NHS, working with its partners in local authorities, in a position to move away from a reactive approach to managing operational problems, and towards a proactive system of year round operational resilience.

8. The guidance sets out best practice requirements across planned and urgent care that each local system should reflect in their local plan, as well as providing information on more general delivery requirements such as operational planning, patient experience and planning for higher dependency patient groups. It sets out the timetable for completion of local plans by SRGs and the assurance process that will be completed in relation to these over the next few months.

9. In addition, two tranches of non-recurrent funding for 2014/15 have been made available to the NHS.

10. Funding previously described as 'winter monies' this year is being directed towards this new approach to year-round system resilience planning. A portion of the money will be retained centrally e.g. for ambulance services, NHS 111 and additional specialised beds, with remaining funds allocated to CCGs in proportion to the size of their population for oversight through SRGs.

11. It is for the SRG membership to plan and agree how best to deploy this funding in support of their plans. Plans will be assured through area team and regional tripartite mechanisms, with funding transferred based upon plans being fully assured. Funding will not be released until operational resilience plans are up to standard.

12. In addition, further money has been released to secure additional elective activity to improve performance on 18 week referral to treatment standards, clear backlog and reduce the number of patients waiting for longer than they should. This money has been allocated to NHS England.

13. NHS England area teams will support local health economies to secure this additional activity, offering patients the choice of alternative provider where appropriate, with a particular push to treat as many patients as possible over the summer months.

14. The nature of the standard (which measure the percentage of patients who have waited longer than 18 weeks) inevitably means this drive over the summer will result in the measured standard being missed. However, we plan to return to meeting the standard in early autumn and that this position will then be sustained.

Specialised commissioning

15. The 2014/15 commissioning round for specialised commissioning has been very challenging, predominantly due to the overspend in 2013/14. It is also related to pressures in the Cancer Drugs Fund, continued limited validation of provider invoices, difficulties in securing Quality, Innovation, Productivity and Prevention (QIPP) savings and capacity gaps in specialised commissioning infrastructure.

16. The initial plans for 2014/15 indicated a potential deficit in excess of £800m. Since then a number of actions have been taken, including:

    - the release of £400m draw-down to the specialised commissioning teams; this is the entirety of the draw-down available to NHS England and is non-recurrent, so represents an unfunded baseline pressure for 2015/16;
    - an expanded QIPP programme;
    - a new approach to the Cancer Drugs Fund is being developed; and
    - a standard operating procedure for invoice validation has been developed, supplemented by additional staff and training for CSUs and area teams.

17. A dedicated turnaround project and team is in place, bringing together all those individuals involved in specialised commissioning who were previously in several directorates. Paul Watson, Regional Director (Midlands and East) is leading the taskforce and has put in place an interim senior management team to tackle the key issues. Around fifty additional individuals have been drawn from across the organisation, coming together to support intensive focused attention in a number of workstreams. The turnaround workstreams are summarised in Annex 1.

18. This additional resource and focus has made a significant impact on our ability to oversee this function. However, many of the fundamental issues remain – growth in activity, new technologies and drugs – and our ability to manage these services, both within 2014-15 and beyond, remains a huge challenge.

19. The initial focus of the project has been on ensuring financial control in 2014/15 and other time critical projects. Some of the later work will focus on

controlling spend beyond 2014/15 and how to redesign the overall specialised commissioning process.

20. Each of the ten Area Teams that commission specialised services submitted a revised plan on 30 May 2014. The status of these plans is as follows:

Area Team	**Plan Position**
South Yorkshire & Bassetlaw (SY&B)	Balanced Plan
Cumbria, Northumberland, Tyne and Wear (CNTW)	Balanced Plan
Cheshire, Warrington and Wirral (CWW)	Balanced Plan
Birmingham, Solihull and the Black Country (BBC)	Balanced Plan
Leicestershire and Lincolnshire (L&L)	Balanced Plan
East Anglia	Balanced Plan – but requires additional £7.5m QIPP savings
London	Deficit plan of £65m
Bristol, North Somerset, Somerset and South Gloucestershire (BNSSG)	Balanced Plan – but depends on £12m budget transfer from Wessex/Surrey and Sussex which is not yet secured plus £16m of additional QIPP savings
Wessex	Balanced Plan – but requiring £20m transfer from CCG budgets
Surrey and Sussex	Balanced Plan – but requiring £30m transfer from CCG budgets

21. Most of our 300 plus contracts are now complete. NHS England and the NHS Trust Development Authority have completed arbitration proceedings for NHS Trusts and all contract issues are resolved. However, there is a total of £91m in dispute, of which £75m relates entirely to one particular Foundation Trust in Central London. Area teams have been given guidance and support in formulating their dispute positions and have been asked to initiate arbitration proceedings.

22. In summary, good progress has been made on specialised commissioning, but significant risks remain with further work needed to achieve a balanced position. There will be further risk to delivery if activity continues to rise or if QIPP plans are not effective.

Better Care Fund

23. The Fund will be created from £1.9bn of existing pooled funding across the health and wider care system, and a further £1.9bn of NHS funding from 2015/16. In 2015/16 the £3.8bn will be allocated to local areas, where it will be pooled, under formal joint governance arrangements, between CCGs and Local Authorities.

24. Stakeholders and people in local areas will wish to be assured that the Fund is being used for its intended purpose, and that local plans credibly set out how improved outcomes will be achieved. The most important element of assurance for plans is the requirement for them to be signed-off by the Health and Wellbeing Board (HWB), which is best placed to decide whether the plans will deliver real benefits for the locality.

25. Because the Better Care Fund is not new money, much of it will have to be re-invested from existing NHS services. The Fund will support the development of social care and community health services which prevent unnecessary emergency admissions to hospital, reduce admissions to care homes, support discharge from hospital, and allow people to live more independently in the community. NHS commissioners will bear a significant financial risk if the local changes are not successful in reducing demand for hospital care.

26. To minimise this risk, the planning guidance for the Fund has emphasised the requirement for existing service providers to be involved in, to support the local plan for re-shaping services and to take out the capacity associated with services that are no longer required. The process for assuring local plans includes an emphasis on testing the alignment between commissioner and provider plans. This involves a joint process with NHS England, Monitor, the NHS TDA and the Local Government Association (LGA).

27. Draft plans were submitted by HWBs in February 2014 and revised in April. They were subject to an assurance process led by NHS England's Area Teams, working with local government peer reviewers to assess the extent to which the plans met the conditions set by Government and set out a credible and robust plan for change. This process was moderated to ensure rigour and

consistency by Regional and national Teams and the Local Government Association.

28. Early assessment of the plans suggested that they lacked the rigour and granularity that we would expect. We need to be sure this pooled budget will deliver better care for patients but also that it will reduce demand for unnecessary admissions to hospitals and care homes. If the appropriate reduction is not seen, both the NHS and local authorities will face financial challenge since this activity will still need to be funded.

29. We have therefore initiated a series of actions both within the NHS and across Government to mitigate the risk of these savings not being realised:

    - All areas have been asked to submit plans which have clear evidence based interventions, which both quantify the benefits to patients and how these interventions will reduce unnecessary admissions in return for the funding used on each specific intervention.

    - We are securing additional advice and support, initially to those areas deemed to have made the most progress, to ensure these exemplars can set an example and identify best practice for others to learn from.

    - Further advice and support will be secured for all economies over the summer to support them to make rapid progress with their plans.

    - Central resource and programme management arrangements have been increased and strengthened to ensure a comprehensive process is in place to provide both support to local economies but also to provide assurance that benefits will be realised. A cross-Government team is being created, reporting to a Ministerial Programme Board, with Dame Barbara Hakin taking on SRO responsibility. A dedicated senior programme director will be appointed and a joint team across the Department for Communities and Local Government, the Department of Health and NHS England will be created.

    - Arrangements for the performance element of the Fund are being strengthened to ensure that the costs of any activity which results from planned reductions not being realised can be covered.

    - CCG Accountable Officers will be required to provide written attestation that the money that will be spent locally through the Fund is being used appropriately.

30. The intention remains that all plans will be signed off in September but with the appropriate arrangements to mitigate risk if delivery of the plans does not ensue.

Conclusion

31. There is considerable further work in hand. The Board is asked to:

    - Receive assurance on the processes in place to ensure key commitments can be delivered;
    - note that an update will be brought to a future meeting.

Dame Barbara Hakin

National Director: Commissioning Operations

July 2014

Annex 1

Specialised commissioning turnaround workstreams

Workstream 1: Core operations
Objective: Ensuring core operations and progress of key projects. The development of a prioritisation framework for commissioning specialised services for 2015/16 is a specific deliverable.
Workstream 2: Strategy
Objective: Development of the specialised commissioning financial strategy (15/16 onwards) and strategic redesign of specialised commissioning (including range of prescribed specialised services and co-commissioning).
Workstream 3: Clinically driven change
Objectives: Provision of clinical support to commissioning objectives (e.g. QIPP, financial planning and strategic programmes); standardisation of workflow and alignment of teams across the system; development of clinical engagement processes.
Workstream 4: Operational leadership
Objectives: Design of future operating model and improvement of current internal working arrangements for specialised commissioning; development of communications and engagement processes and assurance system; delivery of 14/15 QIPP programme and design of 15/16 QIPP programme.
Workstream 5: Commercial and technical delivery
Objectives: Closure of contracts; development of pricing strategies and commissioning intentions for 2015/16; improvement of performance management and reporting; strengthening of supplier management capabilities.
Workstream 6: Strong financial control
Objectives: Review of the balance between CCG and AT budgets within specialised services with recommendations about rebalancing for 15/16 and support to a discrete piece of work on budgets within Wessex and Surrey and Sussex for 14/15.
Workstream 7: Analytical capability
Objectives: Improvement of information quality and industrialisation of invoice validation and contract challenge processes; provision of support to ATs and CSUs to enable analysis of performance; identification and implementation of remedial action to improve contract monitoring.