Correspondence from the Department of Health, NHS England and NHS Improvement

Dear Chair of the Committee of Public Accounts,

PROGRESS ON SUSTAINABILITY AND FINANCIAL PERFORMANCE OF ACUTE HOSPITAL TRUSTS

In May we undertook to write jointly to you with an update for the Committee on our progress to date in implementing the recommendations made by both the Public Accounts Committee (in report HC 709) and the National Audit Office (in report HC 611), concerning the financial sustainability and performance of acute hospitals.

Controlling costs

In July 2016, NHS Improvement and NHS England published a document entitled Strengthening Financial Performance and Accountability in 2016/17. This confirmed action by NHS England to ensure the commissioning sector ends 2016/17 in balance and action by NHS Improvement to cut the annual trust deficit to a control total of £580 million while seeking further reductions towards a goal of £250 million. The measures sharpen the direct accountability of trusts and CCGs to live within the available resources in 2016-17, and the measures announced, as well as wider actions with individual organisations and local health and care systems, are designed to give us the best opportunity to bring the NHS back onto a sustainable footing. This series of actions included:

- allocating £1.8 billion to trusts to cut the provider deficit in 2016-17 to help support the provider position to enter 2017-18 in run-rate balance;
- replacing generic fines with trust-specific incentives linked to agreed organisation-specific performance improvement trajectories;
- confirming the ‘financial control totals’ for which trusts and CCGs will be held accountable in 2016/17; and,
- introducing new intervention regimes of special measures to be applied to trusts and CCGs if they are not meeting their financial commitments.

These actions complemented a wider set of measures to support the NHS in reaching financial balance, including accelerated implementation of the RightCare programme in all health economies during 2016-17, national action to implement Lord Carter’s recommendations on operational efficiency, and the development of transformational efficiency programmes in STP footprints across the country.

We have taken a series of measures to cut the cost to the NHS of agency staff while improving frontline care. All NHS trusts and foundation trusts are required to stay within a specified annual expenditure ceiling for total spending on agency staff (expressed as a percentage of staff costs) and to use only approved frameworks to procure all agency staff. Price caps have been introduced which limit the amount a trust can pay to an agency for the provision of temporary staff.
Agency controls have had a significant impact. Between April and August 2016 the NHS has spent £188 million less on agency staff than in the same period in 2015 (spending is £555 million less than projected spending before controls were introduced). However, we recognise that there is still more to do to drive down spending and the Department is working in partnership with NHS Improvement to further curtail agency spending. The intention behind the introduction of caps on the prices paid for agency staff is to reduce the incentive for staff to work via an agency and to encourage a return to substantive roles.

Furthermore, NHS Improvement wrote to NHS providers earlier in the summer, setting out three specific areas where further action is required to improve their financial position in 2016-17. These areas are:

- Tackling excessive pay bill growth: analysis of 2015-16 cost trends and 2016-17 plans indicates significant growth in excess of inflation and pension effects in some trusts
- Implementation of Lord Carter’s recommendations on back office and pathology consolidation: all STP areas were required to report back on opportunities in this area by the end of July, with a particular focus on opportunities for quick wins with impact in 2016-17 and 2017-18.
- The consolidation of unsustainable services: providers are particularly focusing on areas where planned care services are being delivered using locums and agency staff, with a view to early decisions to re-provide at nearby units operating at efficient scale and with greater assurance of quality.

The series of actions initiated in the summer ‘reset’ document above also included new controls to cap the cost of interim managers across CCGs and CSUs.

**Improved financial sustainability through efficiency**

As you will recall back in May 2016 NHS England set out a further breakdown of the efficiency opportunities against the originally modelled £22 billion.

Of this, £6.7 billion of efficiencies against the NHS’ counterfactual cost growth could be nationally delivered. These include: the Government’s 1% public sector pay policy to 2019–20; the Department of Health renegotiating the community pharmacy contract with the pharmacy sector and a variety of other nationally delivered cost efficiencies; implementing income generating activities overseen by the Department as agreed in the SR; and, reducing NHS England central budgets and administration costs.

The implication of the SR settlement is therefore that local health economies now need to find around £15 billion in efficiencies. The majority of this will be delivered through improvements in secondary care provider productivity, including reducing reliance on costly agency staff; and, moderating levels of activity growth.

NHS Improvement is working hard to improve costing data, leading a programme to implement the rollout of Patient Level Costing (PLC) across the NHS. This will provide national standards on how to cost services consistently, allow benchmarking to establish best practice, and provide the opportunity to create efficiencies and improve clinical
practice. 62 Acute Trusts have volunteered to be early implementers and we hope to receive a critical mass of PLC data in September 2017. We are planning to mandate the use and submission of PLC data in 2018/19.

Through implementing the recommendations of the Carter report, NHS Improvement has also developed the Model Hospital prototype portal. As well as being populated with the data generated in the Carter report, the Model Hospital contains additional data on nursing productivity, estates and facilities and pharmacy and medicine. The range of data included will be significantly expanded over coming months. In addition, a Procurement Price Index and Benchmarking tool has been developed. This tool collates purchase order data from all acute trusts enabling complete transparency of prices paid for products across the sector, and is now available to a trained first wave of providers.

The Department, NHS England and NHS Improvement have taken significant steps, with further work ongoing, to set out the contribution that local health bodies need to make in these areas and how they can achieve this. However, change on this scale can only be delivered if it is locally led – in order to be realistic and meaningful, plans need to be developed bottom-up and take account of local needs and context. It is only right that local health economies determine what their ambition should be that would meet the needs of their local populations but also realise the efficiencies required. That is why, as part of their STPs being developed this autumn, the 44 footprints have been asked to set out their own plans for delivering key local efficiencies.

Planning process and oversight

To support the local Sustainability and Transformation Plans (STPs) which are driving partnership working, this year NHS England and NHS Improvement have significantly streamlined the annual NHS planning and contracting round to provide greater certainty and stability, simplify processes, and support partnership and transformation.

On 22nd September, the NHS published 2017-18 and 2018-19 NHS planning guidance. This early publication, three months earlier than usual, will help providers and commissioners complete operational plans and sign contracts by 23 December, so that the NHS can move into January focusing on delivery.

This approach has the following key benefits:

- a population-based framework within which all organisations in local health economies can plan effectively.

- Two-year operational and funding plans, underpinned by two-year pricing arrangements and a two-year NHS Standard Contract, will provide greater stability and certainty for planning local health services.

- Financial control totals for each NHS organisation and STP will allow a new process of managed flexibility between the control totals of individual organisations, where this makes sense for local health economies. NHS Improvement has now issued proposed 2017/18 and 2018/19 control totals to each trust.
• For the first time, there will be a single NHS England and NHS Improvement oversight process with local organisations to ensure effective alignment of CCG and provider plans.

Alongside these new mechanisms DH, NHS England and NHS Improvement have set in place programme management arrangements for the efficiency programmes for which they are each responsible.

Payment system

NHS Improvement and NHS England propose to set a two-year national tariff for 2017-18 and 2018-19, to give providers and commissioners greater certainty and support financial forward planning. It is also proposed to set prices on the basis of the most up-to-date currency design, known as HRG4+ phase 3. This change will be complemented by an updated system of specialised service top-up payments in order to better reflect different levels of complexity and current clinical practice.

Alongside this NHS England and NHS Improvement are working with Multispecialty Community Providers and Primary and Acute Care Systems to develop a ‘whole population budget’ approach for implementation in parts of the country from April 2017. This will support service and financial sustainability and incentivise prevention, service integration and effective risk management across the system. They are also proposing more transparent and robust payment approaches for mental health services from April 2017, by changing the Local Payment Rules to require mental health providers and commissioners to link prices to locally agreed quality and outcome measures, including the delivery of access and waiting standards.

They will also both continue to develop currencies and support improvements in costing as ‘building blocks’ for any future payment system. Local health economies are also explicitly encouraged and supported to innovate through approved local variations to national tariff arrangements, where these are better suited to the strategies for sustainability they are pursuing.

We will present a further update on the PAC recommendations at the next round of Treasury Minutes in early 2017.

Yours sincerely,

Chris Wormald,
Permanent Secretary Department of Health

Simon Stevens,
Chief Executive NHS England

Jim Mackey,
Chief Executive NHS Improvement