East Suffolk and North Essex NHS Foundation Trust

2019/20 Annual Delivery Plans - NHS Planning Guidance Summary

Board update

31st January 2019

Following the publication of the NHS Long Term plan in early January, detailed guidance for 2019/20 operational plans, plus technical annexes, were published last week

This report summarises the required content of our **operational plan** to be submitted to NHSI. This sits alongside the submission of:

- Finance return
- Activity and performance trajectory
- Workforce return
- Triangulation return
- Assurance statements
- An STP led contract and plan alignment template

The Trust's plan will be evaluated against these requirements and must be under 20 pages in length as "the inability to summarise coherently and concisely will itself be considered as part of the assessment of risk."

NHSI's overarching objectives for 19/20 planning, which they expect to see in provider's plans, are:

- improve productivity and efficiency
- eliminate provider deficits
- reduce unwarranted variation in quality of care
- incentivise systems to work together to redesign patient care
- improve how we manage demand effectively
- make better use of capital investment.

Trust's operational plans must:

- provide for a reasonable and realistic level of activity profiled to take account of seasonality i.e. elective activity profiled in the early part of the year and effective winter plans
- demonstrate the capacity to meet this
- introduce digitally enabled operating models to reduce outpatient visits
- provide adequate assurance on the robustness of workforce plans (including delivering a 'bank first' temporary staffing model and mitigation of retention risks) and the approach to quality
- make digital and mobile tools available to staff
- be stretching from a financial perspective, planning to deliver the financial control total agreed with NHS Improvement, thus qualifying the provider for receipt of PSF, FRF and MRET funding
- take full advantage of efficiency opportunities (including Carter reviews, GIRFT reports and the Model Hospital) and demonstrate improved rostering of clinical staff, accelerated procurement savings, improved energy efficiency and space utilisation, efficient corporate services, pathology and imaging networks, ePrescribing and biosimilar adoption, and growing commercial income
- demonstrate improvement in the delivery of core access and NHS Constitution standards
- contain affordable, value-for-money capital plans that are consistent with the clinical strategy and clearly demonstrate the delivery of safe, productive services
- be aligned with commissioner plans and underpinned by contracts that balance risk appropriately
- be consistent with and reflect the strategic intent of STPs, including the specific service changes, quality improvements and increased productivity and efficiency identified in the STPs, and with the system control total for the STP/ICS area
- be internally consistent between activity, workforce and finance plans.

The Autumn Budget 2018 confirmed additional funding for the NHS of £20.5 billion more a year in real terms by 2023/24

The uplift in the national tariff will be set at 3.8% for 2019/20, including 18/19 AfC uplifts

The uplift excludes the transfer of a proportion of the PSF and the transfer into national and local prices of 1.25% from CQUIN and the pensions impact

The tariff efficiency factor will be 1.1% + 0.5% for Trusts in deficit. National and local prices will be reduced to cover the costs of the new procurement towers

A new Market Forces Factor (MFF) will be phased in over 5 years

A system control total will be set for each STP/ICS which will be the sum of individual control totals. Net neutral changes to organisational control totals may be proposed by 1st February, if agreed by all parties.

The financial framework has been revised to support delivery of these priorities:

- Provider Sustainability Fund (PSF) - £1bn nationally transferred into urgent and emergency care prices:
    - Providers only eligible if they sign up to control totals
    - For every £1 in PSF providers must improve their bottom line position by £1
    - Quarterly payments made based on delivering the planned year to date performance only
- Financial Recovery Fund (FRF) created to secure financial sustainability of essential NHS services
- Marginal Rate Emergency Tariff funding will be deducted from contracts but repaid from central income
- Trusts in deficit will have a further 0.5% efficiency requirement on top of 1.1% tariff efficiency, which will be retained by the trust to support financial recovery. This is adjusted for as a stretch in the control total requirement.
- Agreement of control total qualifies for PSF, FRF and MRET, plus suspension of contact penalties except 52+ week waits which stand at £2,500 for the provider and commissioner.
- CQUIN is being halved in value to 1.25% and simplified with the expectation that it is “realistically earnable”. Tariff prices are being uplifted by a corresponding amount on top of the 3.8% uplift.
- Maternity Incentive Scheme will continue into 19/20 – 10% rebate on CNST premium is available for providers who can demonstrate compliance with the 10 safety actions
- Rate of interest payable on debt, plus process for restructuring historic debt, is under review.

A Control Total for 2019/20 was issued at the time this report was being prepared (15 January)

NHSI believe that "Control totals have been set so they are stretching, deliverable and reflect the distributional impact of the changes that have been made to the financial architecture of the NHS".

The ambition is that the introduction of FRF will mean the end of the control total regime and PSF for all trusts from 2020/21.

Financial Control Total and PSF, FRF amd MRET funding for 2019/20		**£ million**
Rebased baseline position excluding PSF		**-45.721 Deficit**
£1bn Provider Sustainability Fund (PSF) transferred into urgent and emergency care prices	The transfer of resource from part of the Provider Sustainability Fund (PSF) into urgent and emergency care prices.	11.843
CNST net change in tariff income and contribution	Changes to tariff income and CNST contribution levels between 2018/19 and 2019/20. National Tariff for 2018/19 overestimated the actual amount of CNST contributions collected by £330 million. The 2019/20 national tariff prices have been reduced to more accurately reflect the level of contributions made.	-5.848
Other changes	Include the impact of pricing changes in the national tariff, the impact of Agenda for Change cost increases, the impact of changes to MFF, and other changes including increases in overseas patient income, commercial income and inflationary impacts.	-3.288
Additional efficiency requirement up to 0.5%	The tariff efficiency factor has been set at 1.1%. An additional efficiency is required of the Trust because it is in deficit. This is drive a staged return to financial balance.	3.221
MRET central funding	The marginal rate emergency tariff (MRET) has been abolished for 2019/20. Providers will recurrently receive additional income equal to this value. This payment will be centrally funded and there are no in year financial or other performance requirements linked to receipt.	4.97
Subtotal before PSF and FRF allocations		**-34.823 Deficit**
Non recurring Provider Sustainability (PSF) allocation	In 2019/20 all providers will continue to receive a share of the PSF linked to acceptance and delivery of a control total, with cash payments made quarterly in arrears dependent on year to date financial performance compared to plan. There are no other performance requirements linked to the ability to earn PSF in year.	11.401
Non recurring Financial Recovery Fund (FRF) allocation	Where a provider remains in deficit after the control total has been rebased and adjusted for key changes (i.e. policy changes, MRET and PSF), the provider will be eligible to access additional resources on a non-recurring basis from the FRF. Access to the FRF allocation is conditional on the provider signing up to the control total, with payments made quarterly in arrears dependent on year to date financial performance compared to plan. There are no other performance requirements linked to the receipt of FRF funding.	14.807
2019/20 control total (including PSF, FRF and MRET funding)		**-8.615 Deficit**

The national timetable has been updated to reflect delays in issuing guidance. However submission dates have not changed.

The Trust is still awaiting technical guidance covering:

- agency ceiling
- CQUIN
- contract dispute resolution
- Better Care Fund

Planning timetable

Month	Date	Delivery Plans	Corporate	National
Oct	31	Templates issued	'How to' guidance issued	
Nov	14	Activity workshop		
Dec	5	Finance workshop		
	7	First draft divisional plans		
	11	Cross divisional workshop		
Jan	7			NHS Long Term Plan published
	10			19/20 Operational Planning guidance
	early			Control totals and associated guidance
	14		19/20 initial activity plan submission to NHSI	
	17			19/20 tariff consultation starts
	18	Second cut budget and CIPs	Review divisional plans against planning guidance	
	28		TX reviews first draft ESNEFT plan	
	tbc	Workforce & OD workshop		
	31		Trust Board approves draft ESNEFT budget Procurement CIP to NHSI	
Feb	1			STP control total changes agreed by regional teams
	12		Draft 19/20 ESNEFT operating plan to NHSI	
	11	*Workforce & OD workshop (tbc)*		
	19			Aggregate system 19/20 operating plan
	22	Final draft divisional plans		19/20 NHS standard contract published
Mar	5		19/20 contract/plan alignment submission	
	11	*Cross divisional workshop (tbc)*		National tariff published
	21		Contract signature deadline	
	25			STP control total changes agreed by regional teams
	28	Final divisional plans approved		
	29		Board/Governing body approval of 19/20 budgets	
April	4		Final 19/20 ESNEFT operating plan submission	
	11			Aggregated 19/20 system operating plan submission
May/June			Public version of plan published on website	

- Timetable may be subject to change as final planning guidance is issued
- Dates for contract arbitration and STP activities have not been shown above

Other Budget Setting Deadlines

In addition to the timetable on the previous slide there are a number of other internal deadlines that have been set in relation to budget delivery.

These are outlined here.

28 February 2019	Update on Budgets to Finance Committee
28 March 2019	Final Budgets to Finance Committee
30 March 2019	Complete Budget Books and circulate draft to services
04 April 2019	Final Budget to Trust Budget for approval

Specific requirements by section

A new 'blended payment' model will cover non-elective admissions, A&E attendances and ambulatory/same day emergency care for contract values >£10m

This will comprise of two elements:

- a fixed element based on locally agreed planned activity levels; and
- a variable element, set at 20% of tariff prices.

A 'break glass' clause will apply if actual activity is significantly different from the planned level, with final payment subject to local negotiation

Maternity pathway tariffs will be non-mandatory but still used for contracting.

It is confirmed that where systems are operating under a 'Guaranteed Income Contract' it is not expected that this contracting arrangement will revert to the national minimum requirements.

Operational planning guidance outlines a number of expectations for Trusts:

- ❑ the move to Same Day Emergency Care (SDEC) model by all providers by September 2019 will improve day of attendance discharges from a fifth to a third. A new 'A&E type 5' mandatory dataset is also being introduced
- ❑ the proportion of beds occupied by long stay patients (LoS>21 days) should be reduced by 40% against 17/18 baselines, and local targets should be set for reduction in >7 days and >14 days length of stays
- ❑ CCG and HWBs to continue to focus on delayed transfers of care
- ❑ "A&E by default" selections on the DOS to be less than 1% by March 2020
- ❑ zero tolerance on ambulance delays over 30 minutes, and no patient to be cared for in a hospital corridor
- ❑ NHS Constitution standards remain in place until new standards agreed and implemented from October 2019
- ❑ patients waiting over 6 months to be contacted and offered faster treatment elsewhere
- ❑ waiting list to decrease, and sanctions in place for waits over 52 weeks
- ❑ acceleration of non-face to face redesign of outpatients and aligning of diagnostics with appointments (one stop shops)
- ❑ reduce cancellations, DNAs, frequent attenders and improve clinic utilisation
- ❑ ensure patients have direct access to MSK first contact practitioners
- ❑ start collection of 28-day faster diagnosis standard for cancer

The **Operational Plan** should provide assurance to NHSI that:

- ❑ activity returns are underpinned by agreed planning assumptions, with explanation about how these assumptions compare with expected growth rates in 2019/20
- ❑ We have sufficient capacity to deliver the level of activity that has been agreed with commissioners, indicating plans for using the independent sector to deliver activity, highlighting volumes and type of activity if possible and describing assumptions about length of stay
- ❑ activity plans are sufficient to deliver, or achieve recovery milestones for, all key operational standards, in particular A&E, RTT incomplete pathways, cancer, and diagnostics waiting times
- ❑ extra capacity can be mobilised if needed as part of winter resilience plans – for instance, extra escalation beds arrangements are in place for managing unplanned changes in demand.

Quality planning (maximum four pages)

The Trust has agreed local quality priorities:

- 7 day services
- GIRFT reviews
- Lessons from research and audits
- Implementing College and other clinical guidance, with a focus on reducing unwarranted variation
- Quality concerns from Accountability Framework
- Quality initiatives highlighted through national and local priorities:
  - Deteriorating patient
  - Sepsis
  - End of life
  - Better births
  - QI faculty
  - Mental health

Operational plans are required to outline the approach to quality in three sections:

1. Approach to quality improvement, leadership and governance, covering

❑ named executive lead for quality improvement
❑ description of the organisation-wide improvement approach to achieving a good or outstanding CQC rating
❑ details of the quality improvement governance system
❑ how quality improvement capacity and capability will be built in the organisation
❑ measures being used to demonstrate and evidence the impact of the investment in quality improvement.

2. Summary of the quality improvement plan

❑ existing quality concerns and plans to address them
❑ the top three risks to quality and how the trust is mitigating these
❑ learning from relevant national investigations, including the Gosport Independent Panel
❑ compliance with the four priority standards for seven-day hospital services via the board assessment framework
❑ how the provider is learning from deaths in line with the National Quality Board guidance
❑ plans to reduce Gram-negative bloodstream infections by 50% by 2021
❑ confirmation that a national early warning score (NEWS2) is fully embedded, and that the recognition, response and appropriate escalation of patients who deteriorate are measured and improved
❑ consideration the Long Term Plan and any relevant initiatives

3. Summary of quality impact assessment process and oversight of implementation

❑ a description of the governance structure for creating CIPs, including acceptance and monitoring of implementation and scheme impact (whether positive or negative)
❑ a narrative setting out how the governance structure operates, including:
  - ❑ how frontline/business unit-level clinicians create schemes
  - ❑ how potential risks are considered and how schemes are challenged before they are accepted
  - ❑ how key metrics are aligned to specific schemes and monitored through the year during and after implementing CIPs
  - ❑ how intelligence is triangulated, particularly quality, workforce, activity and financial indicators
  - ❑ the QIA process
  - ❑ how QIAs receive sign-off by the trust medical director and nursing director
❑ a description of the process for board oversight of implementing CIPs, including how the board will identify and address potential deterioration in the quality of care.

Workforce planning (maximum four pages)

Operational plans should consider the impact of legislative changes and policy developments including:

- Carter opportunities
- the Long Term Plan
- changes to the apprenticeship levy
- the supply of staff from Europe and beyond
- the immigration health surcharge
- changes to NHS nursing and allied health professional bursaries.

The operational plan narrative should include:

- ❑ demonstration that providers have a board-approved workforce plan and a robust approach to workforce planning, sign-off, monitoring and reporting that ensures sufficient staffing capacity and capability throughout the year to support the provision of safe, high quality services
- ❑ demonstration that the workforce plans are well-modelled and integrated with both financial, quality and activity plans
- ❑ the current workforce challenges at both a local and STP/ICS level, including their impact.
- ❑ an outline of the current workforce risks, issues and mitigations in place to address them, capturing the impact on patient safety, service quality and national guidelines
- ❑ an outline of long-term vacancies (hard-to-fill posts over six months) and plans to fill these vacancies
- ❑ engagement with commissioners and collaborative working to ensure alignment with the future workforce strategy of their local health system, ICS/STPs
- ❑ the required workforce transformation and support to the current workforce, underpinned by new care models and redesigned pathways (responding to known supply issues), detailing specific staff group issues and how new roles/new ways of working are being used
- ❑ plans for any new workforce initiatives agreed with partners and funded specifically for 2019/20 as part of the Five Year Forward View and Long Term Plan demonstrating the following:
    - ❑ a link with the STP/ICS approach to workforce planning and how this will be supported through the operational plan, including an overview of the transformation activities which will impact on the organisation
    - ❑ how a balance in workforce supply and demand will be achieved
    - ❑ the right skill mix, maximising the potential of current skills and providing the workforce with developmental opportunities underpinning strategies to manage agency and locum use including spend avoidance.
    - ❑ effective use of technology, including e-rostering and job planning systems, to enable more effective rota management and staff utilisation, focused on flexibility around patient need.

There is a clear expectation that the Trust will plan to deliver its control total

Control totals are rebased for all providers in 19/20 based on the new financial framework

However plans will continue to be stretching from a financial perspective

Capital will also continue to be constrained and must be:

- internally funded
- or already approved for NHS funding
- and be consistent with clinical and STP estate strategies

Operational plan's financial narratives are recommended to be divided as follows:

1. Financial forecasts and modelling

❑ the financial impact of implementing the new financial framework and planning assumptions
❑ the impact of activity changes, quality, efficiency programmes, and the impact of other commissioning intent
❑ confirmation that the agreed contract values are the same as those included in the plan, or explain differences
❑ detail other key movements and impact of initiatives such as CIPs, service developments and transactions.
❑ detail key assumptions, Single Oversight Framework finance metrics and outcomes of any sensitivity analysis.

2. Efficiency savings for 2019/20

❑ key areas identified for operational efficiency, including savings arising from collaboration and consolidation both within STP areas and wider networks, together with any opportunities identified through the commissioner-led programme
❑ level of engagement with NHS Improvement operational productivity workstreams should be evident
❑ approach to identifying, quality assurance and monitoring delivery of efficiency savings, including PMO arrangements

3. Agency rules

❑ plans to contain spend within annual agency ceiling
❑ analysis of pay bill between substantive, bank and agency

4. Capital planning

❑ demonstrate consistency with clinical strategy,
❑ demonstrate that highest priority schemes are being assessed and taken forward
❑ demonstrate that internally generated capital resource funds the repayment of existing and new borrowing related to capital investment
❑ highlight where capital investment plans support Carter opportunities for improved productivity
❑ demonstrate which schemes are above their delegated limit and when business cases will be submitted for approval.

Link to STP (max two pages) and membership and elections (max one page)

Two final sections are required in operational plan narratives

NHSI also require a separate version of the final operational plan narrative in May/June 2019 suitable for external communication that can be published on our website.

This separate document should be written for a wide audience and exclude any commercially sensitive information but must be consistent with the full version.

Link to the local sustainability and transformation plan:

- ❑ how the vision for their local ICS/STP is being taken forward through the operational plan, including the provider's own role
- ❑ how priority transformational programmes are reflected in the provider's plan

Membership and elections:

- ❑ governor elections in previous years and plans for the coming 12 months
- ❑ examples of governor recruitment, training and development, and activities to facilitate engagement between governors, members and the public membership strategy and efforts to engage a diverse range of members from across the constituency over past years
- ❑ plans for the next 12 months.