STRATEGIC POLICY UPDATE

STRATEGY LEADS NETWORK

Miriam Deakin
Head of policy

8 September 2016
What has changed since we last met on 9 June 2016

Q1 Finances better than expected but not 'good' & financial reset package announced

Second-cut STPs and financial plans being developed as governance questions raised. Plans now increasingly 'out in the open'.

Junior doctors reject proposed contract, phased implementation and potential rolling strikes on the horizon

Brexit, new Prime Minister, new cabinet, Jeremy Hunt remains as Secretary of State for Health

NHSI Standard Oversight Framework consultation and segmentation
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Brexit and politics

• No emergency budget: next milestone in funding for NHS will be the Autumn Statement, expected November
• DH will need to compete for airtime (and parliamentary time) for the NHS v’s immigration, trade, wider social policy etc.

“Brexit means brexit”
• Social justice and reform
• A “United” Kingdom
• “Brexit” department under David Davis
• No dedicated health policy advisor at No.10
New health team

Rt Hon Jeremy Hunt MP
Secretary of state for health
With a new lead interest in MH

Philip Dunne MP, Minister of state for health
NHS operations and performance
Commissioning policy
Quality & professional regulation, failure
CSR, DH expenditure, productivity
Safety & experience
Workforce
Maternity care
CQC, NHSI, HEE

Lord Prior
Parliamentary under secretary of state for health
Leaving the EU
Spec commissioning
NHS commercial
Life sciences; industry; new drugs & tech; AHSCs
Reducing clinical variation
Prescription charging
Race equality standard
Procurement; estates
Litigation

Nicola Blackwood MP
Parliamentary under secretary of state for public health and innovation
Health protection & PHE
Health Improvement
Mental health services
Children; homelessness; prison health services
Fertility and embryology
Life sciences innovation; research; genomics; data; tech; cyber security

David Mowat MP
Parliamentary under secretary of state for community health and care
Primary care
7- day services
CCGs
Adult social care; community services; carers & integration
NHS transformation
Dementia; LTC’s; older people; end of life; disabilities; cancer
NHS England
Implications of Brexit for health and care

Much depends on the relationship the UK negotiates with Europe e.g. remaining in the single market

• A raft of considerations follow:
  • Recruitment and retention
  • Competition and procurement
  • Research and innovation
  • Regulation: professionals, drugs, devices
  • Impact for suppliers/pharma
  • Public health implications
  • Social and economic policy
NHS Providers’ activity

Chairs/CEOs survey, April 2016
- 75% see negative impact from Brexit on NHS
- 40% think positive impact on procurement and competition
- 40% think no impact on funding NHS as a whole
- 80% see negative impact on access to funding for research and innovation, and recruitment of the health and care workforce

Prioritising and working with partners:
- Proactive in new coalition led by NHS Employers to provide urgent commitments to EU citizens working in the NHS
- Understanding the impact on funding
  Exploring potential to amend competition and procurement rules
- A watching brief on the implications for research and innovation
What we will cover

1. Brexit and politics
2. Finance and performance
3. Planning and care models
4. Regulation
5. Workforce
6. Concluding thoughts
The state of provider finances

How confident are you about achieving your financial control total?

- Very confident: 30%
- Fairly confident: 30%
- Neither confident or not confident: 32%
- Not very confident: 27%
- Not at all confident: 11%

(n = 84)

Aggregate provider deficit (£m)

Q1 2015/16: -930
Q1 2016/17: -461
STF Support: -450

Reported deficit
Financial “reset”

- Outlier pay growth
- Pathology/back office
- Elective services consolidation
- Capital controls
- Provider financial special measures
- CCG special measures, consolidation
System under sustained operational pressure

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Worst A&E performance figures since the standard was introduced – 4Q 87%

Ambulance services under sustained demand and performance pressure

Elective operations cancelled

District nursing and health visiting caseloads increasing just as contracts come up for tender

Mental health referrals increasing

Source: NHS England
Longer term solutions

• We continue to push for a coherent and credible plan to deal with the U-bend
• We can no longer pretend there is no gap and ask the frontline to achieve the impossible. STPs and New Care models will not deliver savings at scale or pace we need
• There are a range of options available including more funding for health & social care in autumn statement, or ugly and difficult decisions on quality, rationing, workforce
• Risk of unmanaged and locally variable action in absence of honest and urgent debate.
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STPs and planning: what’s the exam question?

What’s the question?
- Focussed on addressing the financial crisis, or a means to also address the quality and health inequity gaps identified in the 5YFV?
- A means to build and invest in local relationships and solutions or ‘top down’?
- A unit of planning, delivery, or both?
- The primary footprint we work within, or one of many competing for space?
- Acute focussed or inclusive across MH, community, ambulance and primary and social care?
  - A vehicle for involving stakeholders and the public in transformative change, or a closed shop?
  - Worth investing the time in, or too rushed?

NHS Providers’ view and work underway
- STPs have huge potential to bring together key local players to resolve deep seated issues
- However for STPs to succeed we must;
  - ensure STPs are underpinned with appropriate governance
  - improve non executive and board involvement in the process
  - ensure transparency and appropriate consultation of governors, and the public
- We are keen to use the collective expertise of our members and be solutions focussed:
  - Meeting of chairs to gather views (July); roundtable with the ALB chairs on governance issues underway;
  - Tracking emerging practice; more blogs and thought-pieces to follow.
2017-19 planning brought forward

Timetable

• Tariff consultation closed end August; stability, 2 year settlement, 2% efficiency
• 16 September: finance submissions including more detail on capital, efficiency sources and investments for all STPs
• By end September: publication of NHS planning guidance for 2017/18 and 2018/19
• 21 October: full STP submissions including an updated finance template
• End-November: CCGs and NHS providers to share first drafts of operational plans for 2017/18 and 2018/19
• End-December: CCGs and NHS providers to finalise two-year operational plans

Emerging messages

• Continuation from last year rather than further radical change: continue with STPs
• Finances will be tough
• As always, seen as a means to implement other key government initiatives
• We’ll be pushing for realism and prioritisation.
New care models: latest

- Draft MCP contract for voluntary use from 16/17
- Similar version for PACs due soon
- ‘Accreditation’ process for groups and chains
- Considerable variety in approach and model being adopted across acute, MH and community sectors
- Strong ministerial interest in ‘chains’ but this is not the only collaborative model
- NHS Providers learning event on groups and collaborations, 8 December

Secondary MH providers taking on tertiary MH services
New care models: our analysis

| Steady progress in the vanguards and in developing new models outside of the vanguard programme |
| STPs expected to act as vehicles for wider spread of new care models but important for localities to be able to align different footprints |
| Increasing recognition that this is a 7-10 year journey not a quick fix |
| Concerns around future funding; more mainstreaming through transformation and sustainability fund |
| Progress in publishing draft contracts for MCPs and PACs but questions around contracting and the impact on wider reconfiguration still to be answered |
| Some local areas are using different elements of all the models |
| Overall what do STPs, NCMs and devo mean for commissioning? Reform through the back door? |
# What we will cover

1. Brexit and politics  
2. Finance and performance  
3. Planning and care models  
4. Regulation  
5. Workforce  
6. Concluding thoughts
NHSI single oversight framework

Segmentation expected October

4 Critical issues (basically special measures)
3 Serious issues
2 Emerging concerns/minor concerns
1 No evident concerns

Autonomy

Universal support
Targeted support
Mandated support
### Playback of your views...

<table>
<thead>
<tr>
<th>Welcome focus on support but need to make it real</th>
<th>A pragmatic approach with welcome efforts to align with CQC</th>
<th>Concern around different statutory basis for trusts and FTs</th>
<th>Greater clarity needed on 7DS expectations</th>
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<tbody>
<tr>
<td>How does the SOF align with financial special measures, success regime etc?</td>
<td>More detail needed on when, how and why moving through segments</td>
<td>More latitude to intervene? How practical are the benefits of earned autonomy?</td>
<td>Tension between institutional regulatory framework and STPs</td>
</tr>
<tr>
<td>Clarity on voluntary support &amp; regulatory intervention</td>
<td>What about mental health, community and ambulance? Metrics are acute focussed</td>
<td>Much more alignment with CQC and NHSE needed</td>
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Cannot be viewed in isolation from wider NHS policy to “reset” the finances
CQC new strategy to 2020

Encourage improvement, innovation and sustainability
- More flexible registration e.g. NCMs
- Assessing use of resources
- Views of quality across populations and local areas

Intelligence-based approach
- Development of CQC Insight
- Risk-based; comprehensive inspection exception not norm

Promote a single, shared view of quality

Improve CQC efficiency
- Focus on VfM and changes to fees

1. **Horizontal integration** at national level i.e. NHSE, NHSI, CQC agree on what good quality care looks like

2. **Vertical integration** e.g. boards and CQC can speak in same currencies (e.g. Frimley and Barking) and CCGs on same page
Update on inspection results

Now completed all comprehensive inspections and rated 211 providers...

34% rated ‘good’ or outstanding'

CQC published ratings by sector*
(*sector classification based on services registered with CQC)

<table>
<thead>
<tr>
<th>Sector</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires Improvement</th>
<th>Inadequate</th>
<th>Not yet rated</th>
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<tr>
<td>Acute</td>
<td>7%</td>
<td>53%</td>
<td>16%</td>
<td>7%</td>
<td>(n = 57)</td>
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<tr>
<td>Acute &amp; Community</td>
<td>10%</td>
<td>68%</td>
<td>16%</td>
<td>10%</td>
<td>(n = 79)</td>
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<tr>
<td>Ambulance</td>
<td>24%</td>
<td>60%</td>
<td>47%</td>
<td>10%</td>
<td>(n = 10)</td>
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<tr>
<td>Community</td>
<td>24%</td>
<td>53%</td>
<td>30%</td>
<td>24%</td>
<td>(n = 17)</td>
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<tr>
<td>Mental Health</td>
<td>11%</td>
<td>47%</td>
<td>29%</td>
<td>24%</td>
<td>(n = 19)</td>
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<tr>
<td>Mental Health &amp; Community</td>
<td>11%</td>
<td>57%</td>
<td>27%</td>
<td>11%</td>
<td>(n = 37)</td>
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<tr>
<td>Specialist</td>
<td>10%</td>
<td>50%</td>
<td>33%</td>
<td>10%</td>
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Following the publication of their new strategy...we expect CQC to consult on their new inspection approach in December
Other key national initiatives

**New Health and safety investigations branch (HSIB)**
- Hosted by NHS Improvement, but impartial
- New chief investigator Keith Conradi from airline industry
- One of the primary purposes of the investigations will be working out where safety could be improved through greater standardisation and incorporation of human factors into clinical systems and processes

**National and local “freedom to speak up” guardians**
- Dr. Henrietta Hughes appointed as National Guardian, hosted by the CQC
- Leads cultural change within NHS trusts and FTs so staff feel confident and supported to raise concerns about patient care
- Learning events, training for guardians, sharing good practice.

**CQC review of deaths**
- By April 2018 NHS will have medical experts independently review every death
- Standard method developed by NHS England and Royal College of Physicians
- Will cover all deaths so 300 doctors trained by April 2018 to administer
- Exploring role of coroners and NHS
But is this the right approach?

The goal

The reality

Source: Professor Don Berwick
What we will cover

1. Brexit and politics
2. Finance and performance
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6. Concluding thoughts
Lack of a national workforce strategy

Given the size of the NHS, workforce planning will never be an exact science, but we think it clearly could be better than it is.

The current shortage of nurses is largely of the health, care and independent sectors’ own making.

Workforce is a relatively neglected area of policy which is often pursued as an afterthought.
## Workforce issues

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<th>Rolling junior doctor strikes</th>
<th>Consultant contract negotiations on slow down</th>
<th>Agenda for change changes on back burner</th>
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<tr>
<td>Brexit uncertainty</td>
<td>Uncertain impact of end of bursaries</td>
<td>New ways of working and care models</td>
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<td>CQC and NHSI aligned on safe and sustainable staffing?</td>
<td>Leadership pipeline and new roles e.g. managing directors in chains</td>
<td>Coded signs that HEE no longer planning for balance by 2020/21</td>
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1. **Staffing-quality-finance balance** - ugly and difficult decisions on paybill will have inevitable impact on quality and consequences for current Gov’t narrative of platinum quality supported by intensive inspection process and workforce growth.

2. **Strategy & planning** – are STPs and LWABs the vehicles for grappling with consequences of new care models and u-bend funding?
Junior doctors: renewed industrial action?

- Provisional agreement on new contract not ratified by referendum
- Royal Colleges and other commentators becoming more active in commenting on industrial action
- Govt plan still to introduce contract in phases
- Additional costs to providers including pension contributions; duties for monitoring safe working hours and breaks and rotas
- Concerns from junior doctors around implementation
Renewed focus on commitments of boards

- Diversity
- Junior doctors (JDC engagement and honouring contractual terms)
What we will cover

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Closing thoughts

• **Brexit raises questions** but answers will be a long time coming

• **Honesty and realism needed**: the ‘ask’ isn’t getting easier – finance, quality, access

• **Increasingly operating ‘in spite of’ the 2012 Act** – STPs, collaboration not competition, NCM, devo-deals and future of commissioning?

• **Innovative and interesting work underway** but unlikely to deliver to the 5YFV timescale

• **Key risk in diluting the role of boards** for the longer term.
Q&A
THANK YOU
This year our conference focuses on how the NHS provider sector can stay fighting fit and continue to deliver the world-class standards of care we are so rightly proud of.

Our event will be the best opportunity for senior leaders of provider organisations to come together in 2016 to share learning, celebrate success and be inspired.

Confirmed speakers include the chief executives of CQC, NHS England and NHS Improvement.

Delegates can take advantage of group discounts of up to 25%.

Please see our website for further details and to book your place:

www.nhsproviders.org/2016
£5.5bn cash uplift (£3.8bn real)

£0.1bn Central policy initiatives e.g. MH, Cancer, Diabetes, IT

£3.5bn commissioning budgets inc. pass through pension costs

£1.6bn General (for emergency care providers)

£1.8bn Sustainability funding

£0.2bn Targeted (for everyone)

- 70% released based on financial control total delivery
- 30% released where operational trajectories achieved with tolerance and control total delivered (assumed you play ball in the STP)
- Better than binary pass/fail on everything, not handed back to HMT, not gummed up in system, maintains incentive to hit your YTD even if you miss a month as you can earn missed payments
- But still lots of financial uncertainty, working capital, appeals process, control total primacy, ratcheting up of cumulative ask
2016/17 finances

89.5% of providers signed up to control totals (213 of 238 providers)

£580m deficit by end of 2016/17 under do-nothing position

£800m CCG side reserves from 1% holdback, but contingent on considerable CCG efficiency and would not expect to see any non-recurrent investment
Consultant contract

- Radical contract reform
  - All change is painful, so change in one go
  - Put forward joint position from as least worst option available through negotiation

- Less radical reform
  - Negotiate a package that achieves delivery of 7DS but at a cost
  - Avoid strike of juniors and consultants at same time

- Defer reform
  - Scale back 7DS ambitions