BMA Briefing on NHS England’s Refreshed Planning Guidance

February 2018

Introduction

In February 2018, NHS England and NHS Improvement jointly published Refreshing NHS Plans for 2018/19, their new planning guidance for providers and CCGs for the next year. This is a technical document that has significant implications for the frontline of the NHS – setting the overall funding framework NHS bodies will have to work within, setting out what targets the NHS is expected to hit, and giving CCGs specific instructions in areas such as mental health and primary care.

This briefing provides BMA members with a summary and analysis of the implications of this guidance for the NHS. Some key points from the guidance include:

– An additional £540m in funding will be provided by the DHSC (Department of Health and Social Care) for 2018/19, but funding will slow down in 2019/20.
– No additional funding will be provided for winter pressures in 2018/19.
– CCGs and trusts will be expected to achieve financial balance over the course of 2018/19.
– STPs (Sustainability and Transformation Partnerships) are expected to play a more prominent role in the planning and management of system-wide efforts to improve services and to meet financial targets.
– ACSs (Accountable Care Systems) have been renamed ICSs (Integrated Care Systems) and the most advanced will receive additional freedoms and flexibilities.
– It is anticipated that more ACSs/ICSs will be confirmed in 2018/19.
– NHS England expects extended access to GP services in evenings and on weekends to be in place in all CCGs by October 2018.
– CCGs will be expected to actively encourage every GP practice to be part of a local primary care network by the end of 2018/19. These will be geographically contiguous, and therefore all areas of a CCG (and all practices) will be covered.
NHS funding

Funding outlook for 2018/19 and 2019/20

The planning guidance confirms that 2018/19 revenue for NHS England will grow by £2.14 billion. This comprises the £1.6 billion announced in the Autumn Budget in November 2017, and a further £540 million that the DHSC has subsequently agreed to make available. Overall this represents a 2.4% real terms increase in NHS England’s funding for 2018/19.

However, a significant funding slowdown is planned for 2019/20, with NHS England receiving just a 0.2% real terms uplift in that year, translating into a drop (-0.8%) in spending per person when age-weighted population growth is taken into account (see table 1 below).

Table 1: NHS England expected funding growth, to 2019/20

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
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</thead>
<tbody>
<tr>
<td>Revised expected NHS England budget</td>
<td>£109,637</td>
<td>£113,940</td>
<td>£115,746</td>
</tr>
<tr>
<td>% real terms growth</td>
<td>2.0%</td>
<td>2.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>% real terms growth per age cost weighted capita</td>
<td>0.9%</td>
<td>1.4%</td>
<td>-0.8%</td>
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BMA analysis: The increase for 2018/19 is bigger than originally announced in the Autumn 2017 budget (although still well below the £4 billion called for by the NHS’s own leaders). The ‘new’ £540 million has not been mentioned before and it is not clear where this money is coming from. In theory it could be new money, or it could be taken from other parts of the DHSC budget (which could mean further cuts to areas such as public health). If this is the case, the 2.4% real terms increase in NHS England funding will mask a smaller increase in overall health spending as defined by the total DHSC budget. The government should urgently clarify this. The fact that this will also be followed by a much smaller increase in funding for the subsequent year (2019/20) is worrying, and leaves the NHS without a sustainable long-term funding plan. This inconsistency makes it more difficult for the NHS to plan effectively over several years.

Achieving financial balance

NHS England is proposing to allocate £1.05 billion to help CCGs and trusts shore up existing deficits, including £650 million made available through the Provider Sustainability Fund (PSF – previously called the Sustainability and Transformation Fund) and an equivalent £400 million for CCGs. As a result, NHS England says the CCG sector is expected to achieve budget balance in 2018/19, and NHS Improvement has specified that the trust sector will do the same.

BMA analysis: This means roughly half of the additional funding for 2018/19 is being spent on shoring up existing deficits in the system. However even this may not be enough to close the NHS’s underlying deficit – analysis from the Nuffield Trust last year estimated that NHS trusts have a real deficit of around £5.9 billion once non-recurrent savings are discounted. Depending on the scale of efficiency savings trusts can make, this means that in order to achieve budget balance the NHS will need to make further one-off savings, divert funding from elsewhere in recurrent budgets or raid capital budgets intended for investment in equipment and infrastructure.

1 Table reproduced from ‘NHS Planning and Financial Allocations for 2018/19’, NHS England Board Paper, 8 February 2018
Mental health funding
Each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs’ auditors will be required to validate their 2018/19 year-end position on meeting the MHIS. Related to resourcing, the guidance also states that all inpatient stays for children and young people will be as close to home as possible, within a context of 150-180 additional beds, and all inappropriate adult acute out of area placements should be reduced by 2020/21.

BMA analysis: The requirement for CCGs to increase their investment by not only the same rate as their overall programme funding, but by an increased rate, is a welcome step forward in line with the BMA’s call for mental health to be adequately funded. We welcome the emphasis on individual CCGs having to meet the MHIS, as 2016/17 data shows that a significant proportion of CCGs did not meet the standard. In addition to validating this commitment by auditing, CCGs that fail to meet the MHIS should be required to produce robust spending plans for how they plan to meet it, and extra support should be provided to them.

2017 research by BMA News found that between 2014/15 and 2016/17 there was a rise of almost 40% in out of area placements for mental health patients. We welcome a focus on reducing out of area placements; however, there remains a lack of specific detail on how NHS England will achieve its ambitions to eliminate out of area placements for both children and adults by 2020/21, as stated in the Five Year Forward View for Mental Health.

Targets and system pressures
NHS England’s 2018/19 allocations are based on forecasted increases in activity which are predicated on recent trends. NHS England expects an improvement in A&E performance in 2018/19, despite a projected 2.3% growth in non-elective admissions and ambulance activity and 1.1% growth in A&E attendances (in aggregate for England). This is in addition to an expected 4.9% growth in total outpatient attendances and up to 3.6% growth in elective admissions. GP referrals are expected to increase by 0.8%.

The guidance also anticipates that the Government will restate the previous commitment to return to 95% performance against the four-hour wait target by 2019. Commissioners and providers must demonstrate how they will meet capacity needs despite activity growth, either through additional beds or reductions in delayed transfers of care or length of stay. Providers will be expected to submit plans for bed numbers to ensure sufficient capacity is available throughout the year.

NHS England has also mandated that the RTT (referral to treatment) waiting list must be no higher in March 2019 than in March 2018 (and reduced where possible). The number of patients waiting over a year to begin treatment should be halved by March 2019, despite anticipated increasing demand.

BMA analysis: It is likely the NHS will find it difficult to meet the performance targets set out in the planning guidance even with the additional funding made available. Growth in demand is extremely difficult to predict: between 2015/16 and 2016/17, A&E attendances increased by 1.9% and over the past three years the average annual increase has been 2.3%. Similarly, non-elective (i.e emergency) attendances are increasing at a faster rate than the 2.3% mentioned in the guidance. NHS England’s forecasted increases therefore seem optimistic, and projected improvements against key targets will be challenging. Performance against the four-hour wait target, for example, has deteriorated every year for six years, and A&Es saw 89% of patients seen, discharged or admitted in four hours in 2017. Increased funding would help to stabilise this figure, but a return to 95% seems extremely unlikely without additional staff, beds and significant investment in community and social care services.
It is encouraging that NHS England is taking steps to address the dangerously high occupancy figures recorded during the 2017/18 winter by requiring providers to demonstrate how they will meet demand for beds through the year, although should activity exceed expectations, funding allocations will likely prove insufficient and resources and staff will continue to be stretched thin during periods of high demand.

**Winter pressures**
The guidance confirms that there will be no additional winter funding in 2018/19. NHS England expects health systems to embed winter planning in their operating plans for the year. To support this there is a requirement for each system to produce a separate winter demand and capacity plan, with a deadline of April 2018 for these plans to be submitted.

**BMA analysis:** It is disappointing that no funding has been earmarked for winter planning for 2018/19. Given the disastrous effects of the winter crisis facing the NHS in 2017/18, the government should provide further funding that can be set aside to plan for winter next year.

**Primary Care**

**General practice funding**
The guidance states that the new £540 million being made available by the DHSC will help support core frontline services, including primary care – however there is little further detail on how this will happen. Elsewhere in the guidance, NHS England makes clear that it expects the funding commitments in the 2016 GP Forward View (which pledged to increase general practice funding by £2.4 billion by 2020/21) to be met.

**BMA analysis:** This appears to confirm that NHS England is not planning to increase spending on general practice beyond the commitments made in the 2016 GP Forward View, despite the additional funding announced in the 2017 Autumn budget. This is a disappointing outcome given the crisis facing general practice. The BMA’s report on *Saving General Practice* outlines the action that needs to be taken to place general practice funding on a more sustainable footing. The BMA has estimated that there is at least a £3.4 billion gap between current spend and our target of 11% of health spending to be spent on general practice.

**Working at scale**
CCGs are expected to make progress against all GPFV and Next Steps of the Five Year Forward View commitments. Specifically, during 2018/2019, they are required to “actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000.”

**BMA Analysis:** While many practices are already part of local arrangements, this requirement demonstrates a strong focus from NHS England that every practice should be involved in this particular way of working at scale, supported by CCGs. This is made clear in the new requirement for geographical contiguity. Where such arrangements are not in place, practices may wish to engage with their LMC and other local practices, and ensure that any developments are GP-led and support a sustainable model of general practice. Practices may also wish to explore the BMA’s resources on collaborative working and legal guidance from BMA Law. The BMA is calling for recurrent funding, beyond the current commitment of £3 per patient over two years, to support the work at locality level.
Extended access
CCGs are required to provide extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018, and including access at bank holidays and across the Easter, Christmas and New Year periods.

BMA Analysis: The deadline for rolling out extended access has been brought forward (from April 2019), and schemes now need to be in place before this coming winter. This potentially reflects the fact that the interim target of 40% coverage by 2017/2018 was beaten (currently 52%) and also reflects NHS England’s statement that they will not provide any additional winter planning funding for 18/19.

Workforce planning
CCGs are also required to work with local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19, as part of the GPFV commitment to have an extra 5,000 doctors and 5,000 other staff working in primary care by 2020/21.

BMA Analysis: The 2020/21 target for 5,000 additional GPs is highly unlikely to be met as there has been a decline in the numbers of FTE (full time equivalent) GPs since September 2015 from 34,592 to 33,302. The 39,592 required to meet the target seems a long way off. However, despite the challenges, the BMA wants to see greater action by CCGs to expand the general practice and community workforce.

Saving general practice
Outlines the actions that need to be taken to ensure we have a general practice workforce fit for the future. CCGs, local NHS England teams, local Health Education England teams and community training hubs need to collaborate via regional Local Workforce Advisory Boards and STP (Sustainable Transformation Partnership) areas to monitor current workforce capacity trends, organise clinical and non-clinical training and education capacity and plan for future NHS workforce needs. The quality of workforce data provided to NHS Digital also needs to improve so that an ongoing accurate national picture can be maintained. The BMA has also called for workforce initiatives, such as practice-based pharmacists, to be funded recurrently.

Other requirements for CCGs relating to primary care
CCGs are also required to:
- Invest the balance of the £3/head investment for general practice transformation support.
- Ensure that 75% of 2018/19 sustainability and resilience funding allocated is spent by December 2018, with 100% of the allocation spent by March 2019.
- Ensure every practice implements at least two of the high impact ‘time to care’ actions.
- In all practices, deliver primary care provider development initiatives for which CCGs will receive delegated budgets (for example, online consultations).
- Invest in upgrading primary care facilities, ensuring completion of the pipeline of Estates and Technology Transformation schemes.

BMA analysis: These requirements demonstrate the clear and increased role that CCGs are expected to play in delivering the GPFV. While the GPFV has led to the creation of certain funding streams, any additional non-contractual initiatives requested of practices must also be supported by additional resources. LMCs and practices should be aware of the support that should be made available to them from the GPFV. If LMCs or practices are aware of any difficulty in accessing GPFV funding and resources in your area then please contact us.
Prescribing
Lead CCGs are expected to commission medicines optimisation for care home residents with the deployment of 180 pharmacists and 60 pharmacy technician posts funded by the Pharmacy Integration Fund for two years. All CCGs are also being asked to consider locally how to implement guidance on the ‘18 ineffective and low clinical value items that should not routinely be prescribed in primary care’, and consider the potential impact of any developments concerning over the counter medications following the current NHS England consultation (open until 20 March 2018).

BMA analysis: The BMA has a number of concerns around the 18 items that should not be routinely prescribed in primary care, as outlined in our response to the consultation. These include the need for protection of vulnerable groups, the potential widening of health inequalities, the potential for increases in prescribing of less-suitable medicines, the need for national legislation and for any changes to be within GMS regulations, the need for the MHRA (Medicines and Healthcare Products Regulatory Agency) to change criteria for licensing drugs, and the poor evidence base used to calculate projected savings. We have similar concerns regarding the over the counter medications proposals. These will be outlined in our forthcoming response to the current consultation.

Integrated System Working

STPs
STPs are expected to play a greater role in planning and managing system-wide efforts to improve services. This includes ensuring that system-wide operating plans are credible and aligned between providers and commissioners, and working with clinical leaders to implement improvements requiring system-wide effort, such as the introducing primary care networks and improving resilience ahead of winter.

STPs are also expected to identify system-wide efficiency improvements, and to develop a system-wide plan for estates, including the ‘disposal’ of unused or underutilised estate. Additionally, although NHS England will be providing non-recurrent funding to support STP leadership teams for 2018/19, STPs are being told to move towards self-funding their own infrastructure, with the funds sourced from their constituent organisations.

BMA Analysis: This signals a greater focus on the role of STPs and STP leaders in managing and overseeing activity across their footprint, rather than on planning alone. It is important that system-wide activity is co-ordinated, particularly regarding winter planning, but it is vital that the role and authority of STP leaders is clearly set out and that their decisions are made transparently and in consultation with clinicians. The focus on efficiencies is consistent with the development of STPs thus far, but the BMA’s position is that their priority should be improving patient care and not the delivery of savings. The requirement to produce plans for estates is in line with the findings of the Naylor Report, but while in some cases there will be capacity to make better use of estates, the sale of NHS land should not be used to plug gaps in recurrent funding and is not a sustainable means of providing the additional resources needed to deliver integrated care.
Integrated Care Systems
The planning guidance confirms that the eight ‘shadow’ Accountable Care Systems (ACSs) and the devolved health and care systems in Greater Manchester and Surrey Heartlands will now be referred to as Integrated Care Systems (ICSs). These 10 systems are each expected to develop a single system operating plan encompassing NHS providers and CCGs, aligning key assumptions on income, expenditure, activity and workforce between them.

Before they can become fully operational, every ICS will need to produce a credible plan for how it will meet a system-wide financial control total (the combined required income and expenditure position for every provider and CCG within the system). A system of financial and regulatory incentives will be in place to encourage ICSs to remain within these control totals.

NHS England and NHSI anticipate that additional healthcare systems will want to become ICSs in 2018/19 and envisage that ICSs will eventually replace STPs. Applications to join the ICS development programme will be reviewed by March 2018.

BMA Analysis: This change in terminology reflects growing concern regarding the widespread negative perception of ACSs and ACOs (Accountable Care Organisations). This change is, though, cosmetic, and the underlying structural and policy changes will continue. NHS England also need to be clear about the terminology it uses and ensure that patients and staff are able to follow the changes occurring in their healthcare system, despite repeated changes in acronyms.

The imposition of system-wide control totals, and their link to the remodelled incentive payments vehicles, reinforces NHS England and NHSI’s focus on sustainability and financial control within the wider integration agenda. The BMA has continually stressed that the overriding aim of integrating health and care services must be to provide better quality care to patients and not to deliver savings. Integrated care cannot successfully be delivered without investment and the focus on control totals must not distract from patient care.