Healthy London Partnership

Planning guidance

2019/20 – summary

January 2019

Contents

1. Overall summary

The planning guidance for 2019/20 was published the day after the NHS Long Term Plan. Whilst clearly influenced by the new priorities, 2019/20 will be a transition year, with every NHS trust, foundation trust and clinical commissioning group (CCG) expected to agree single year organisational operating plans and contribute to a single year local health system-level plan.

Existing commitments in the Five Year Forward View (FYFV) and national strategies will all continue to be implemented in 2019/20 and 2020/21 as originally planned for cancer, mental health, learning disability, general practice and maternity. However, for mental health and primary care in particular, we see the addition of new guidelines and requirements that reflect the increase in funding that has been made available.

System planning:

All sustainability and transformation partnerships (STPs) should produce a single operating plan which shows how the money will be spent to provide the capacity needed to meet the assumed activity; and how organisation plans align to this system plan. The Regional Director must assure these. Then system control totals will be put in place.

Finance:

This is the first year of a re-set NHS finance framework, which includes:

- Taking steps to reduce the difference between national costs and prices.
- Simplifying urgent care payment arrangements.
- Change to market forces factor (MFF) – implemented over 5 years.
- Rebasing control totals for all providers.
- Creating a new £1.05bn fund to support the sustainability of essential NHS services.
- Setting tariff efficiency requirements of 1.1%, a reduction in the tariff efficiency from 2% since 2016/17. A deficit control total will be expected to deliver additional efficiency of 0.5% which will be retained by the trust to support financial recovery.
- STPs to develop estates strategies and sell surplus land.
- STPs to work with RightCare of cardio, respiratory and one other area of their choice.

- CCGs to make sure they are not prescribing certain drugs and doing certain procedures.

- All providers to develop efficiency plans based on The Model Hospital and which look at a range of savings, although those from service reconfiguration, setting up of networks etc.

- More investment in mental health, including children and young people (CYP) with workforce plans required to underpin this.

- Specific commissioning services to be more localised.

- Lower Commissioning for Quality and Innovation (CQUIN) rates and a simplified system.

- **Mental health investment:** CCGs must continue to increase investment in mental health services, in line with the Mental Health Investment Standard (MHIS), paying particular attention to CYP. Workforce plans are needed to align with the increased investment.

Operational plan requirements

- **UEC:** Continued push on usual emergency care measures, including ambulance handover delays, with introduction of same day emergency care (AEC) and acute frailty services to be established in Type 1 A&Es. Ambulance Trusts expected to fully comply with the Ambulance Response Programme (ARP).

- **Referral to treatment time**: Continued push to reduce waiting lists, although no specific standards with the exception that no more than 1% of patients should wait six weeks or more for a diagnostic test.

- **Cancer**: Remains a priority with a continued focus on delivery of all 8 cancer standards.

- **Mental health**: Increased funding to CCGs for mental health and a continued focus on access standards. A requirement for STPs to “proactively prioritise” focusing on mental health workforce and using data and digital to improve service delivery.

- **Learning disabilities and autism**: Continued focus on in community rather inpatient treatment.

- **Primary care and community**: Continuation of the FYFV targets alongside STP development of primary care strategy which includes a primary care network development plan (including proposal to give them access to

datasets) and workforce strategy . Investment in primary and community services to be above average revenue growth and further guidance will be issued.

- **Workforce**: production of workforce plans based on more recent supply and retention estimates that are detailed and aligned to finance and activity plans. Reduce agency staff and cost – using bank staff instead and identify new roles and ways of working. Brexit mitigations should be developed and all locally trained nurses should be offered a place.

- **Digital**: Mandation of core digital standards, roll out of NHS app with STP support required and continued roll out of digital access in maternity and diabetes prevention.

- **Personalised health budgets**: to be expanded.

Longer term deliverables:

A number of longer term deliverables were included in the planning guidance that align with the NHS Long Term Plan and signal the direction of travel:

- Each area of the country to be an Integrated Care System (ICS) by April 2021.

- All local health systems to develop a health inequalities plan during 2019, including setting out how those CCGs benefiting from the health inequalities adjustment are targeting that funding to improve the equity of access and outcomes.

- **Maternity:** Specific targets around prevention, continuity of care and better outcomes

- **Mental health:** Focus on delivery to CYP, including through schools teams and specifically to those with eating disorders. Continue to expand Improving Access to Psychological Therapies (IAPT) services to adults, particularly those with long term conditions. Deliver multi-agency plans to reduce suicides.

- **Learning disabilities and autism:** Reduce over medication.

- **Cancer:** Expand the human papilloma virus (HPV) vaccine to boys and lung checks. Roll out rapid diagnosic centres. Implement a stratified approach to breast, prostate and colorectal cancers.

2. System planning

What is required?
All STPs should convene local leaders to agree collective priorities and parameters for organisational planning and produce a system operating plan.
Operating plan (draft by mid Jan) to include: 1. An overview setting out how the system will use its financial resources to meet the needs of its population and what the system will deliver in 2019/20, which should include specialised and direct commissioning as well as CCG and provider plans. The plan should make clear the underlying activity assumptions, capacity, efficiency and workforce plans, transformation objectives (including clinical and provider strategy), risks to delivery and mitigations; 2. A system data aggregation (activity, workforce, finance, contracting), demonstrating how all individual organisational plans align to the system plan.
RD responsible for reviewing, signing off and assuring these plans – including alignment of provider and CCG plans.
Elective activity to occur outside of winter as much as possible.
Produce winter plans to be RD assured.
System control totals across each STP with opportunity to produce net neutral changes agreed with RD
ICSs will be expected to link a proportion of their Provider Sustainability Fund (PSF) and any applicable Commissioner Sustainability Fund (CSF) to delivery of their system control total
Follow Brexit guidance that will continue to come from National.

3. Finance

Providers, CCGs and assumptions

What is required?
Change to MFF – now being phased in over a longer period. Need to read separate document to understand impact on London.
Where systems use Payment by Results (PbR) for Emergency Care, a blended payment model will be introduced (comprising an 80% fixed and 20% variable element), with a re-opener should activity significantly deviate from plan.
Marginal rate emergency tariff (MRET) and 30 day re-admission rule abolished.
Maternity tariff is non-mandatory but expected to be used.
Reform of the provider sustainability fund (PSF) – moving money between various pots. Can't access it unless signed up to control total.
Creation of financial recovery fund (FRF) to support financial sustainability of providers who run out of money whilst they look at unwarranted variation. Distributed by National.
Trusts with a financial surplus to share expertise and help control costs with those who have a deficit.
Rebased control totals for all providers.
Expect end of control total regime by 2020/21 as FRF will have done a good job at helping trusts to get back on their feet. National templates, guidance and agreed trajectories for those with deficits. If trajectories are missed then Regional Director intervenes.
No CCG deficits are expected so Commissioner Sustainability Fund is being ended.
CCGs to reduce admin costs by 20% in real terms after taking into account the pay award. This is around 15% in nominal terms post-award. CCGs should work together collectively to do this and might want to pilot new approaches.
STPs should develop estates strategies and sell surplus land.
All STPs to work with RightCare to implement national priority initiatives for cardiovascular and respiratory conditions and at least one other area.

All CCGs to offer flash blood glucose monitoring devices to people with type 1 diabetes who meet relevant clinical criteria.
CCGs not to prescribe things on the list not to be prescribed and to implement the Evidence Based Interventions programme (EBI).
All providers, working with their systems, will develop robust efficiency plans taking account of the opportunities identified in The Model Hospital. These should include a focus on: - Transforming outpatient services by introducing digitally-enabled operating models; - Improving quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff; - Concrete steps to improve the availability and deployment of clinical workforce to improve productivity, including a significant increase in effective implementation of e-rostering and e-job planning standards; - Accelerating the pace of procurement savings by increasing standardisation and aggregation, making use of the NHS' collective purchasing powers. Providers should make regular use of the NHS benchmarking tool (PPIB) to support this work. Make best use of the estate including improvements to energy efficiency, clinical space utilisation in hospitals and implementation of modern operating models for community services; - Improving corporate services, including commissioners and providers working together to simplify the contracting processes and reducing the costs of transactional services, for example through automation; - Supporting and accelerating the rollout of pathology and imaging networks; - Securing value from medicines and pharmacy, including implementation of electronic prescribing, removal of low value prescribing and greater use of biosimilars.
CQUIN Both the CCG and Prescribed Specialised Services (PSS), CQUIN schemes will be reduced in value with a corresponding price increase through a tariff uplift. The scheme will be simplified.

Mental health investment

What is required?
More investment in mental health: CCGs must continue to increase investment in mental health services, in line with the Mental Health Investment Standard (MHIS).

This is - at least their overall programme allocation growth plus an additional percentage increment to reflect the additional mental health funding included in CCG allocations.
The additional investment must be made against clear deliverables and workforce plans; STPs must support Commissioners and Providers to work together and assure the plans.
NHSE will continue to review mental health spend per head and as a percent of CCG allocations and other metrics.
Those CCGs that are underspending on CYP mental health must increase spend.

Specific commissioning

What is required?
Cancer: Increasing access to the latest drugs, genomic testing, proton beam therapy, implementation of eleven new radiotherapy networks, and new service specifications for children, teenagers and young adults. Streamline cancer pathways across specialised and non-specialised services.
Mental health: Integrate specialised services locally - delivering care closer to home.
Learning disabilities: Reduce inpatient treatment by supporting local health systems to manage the learning disability and autism care of their whole population.
Cardio: Specialised vascular services to meet national standards 24/7 and expand access to mechanical thrombectomy for certain types of stroke, and improving access to non-surgical specialised cardiac interventions .

4. Operational plan requirements

Emergency Care

What is required?
All type 1 A&E to have same day emergency care (SDEC) in place by this summer.
Reduce Ambulance Handover delays to 30 minutes and end corridor care.
Get Urgent Treatment Centres (UTCs) in place (this is already being done in London) and call everything UTCs and raise public awareness of this.
Introduce acute frailty service.
Ambulance Trusts to meet the new ARP standards or get fines.
The Emergency Care Data Set (ECDS) to be expanded into SDEC (type 5) and UTCs.
Clinical standards review to focus on the most ill patients.
STPs to review demand growth assumptions.
Continued focus on 21 day, 14 day and 7 day patients – use national and local targets.
CCGs and Health and Wellbeing Boards (HWBs) to deliver Delayed Transfers of Care (DTOC) targets agreed previously.
All areas to have clinical assessment service within NHS 111.

Referral to treatment times (RTT)

What is required?
Patients to continue to get choice, including independent sector, supported by continued roll out of capacity alerts.
Anyone waiting longer than 6 months to be offered choice of another provider.
Expectation that by working across the STP, waiting lists will reduce.
CCGs to fund more elective activity as part of LTP funding.

Any provider that breaches 52 week wait for treatment to be fined.
Providers to use national outpatient improvement dashboard and digital tools to improve cancellation and non attendance.
Implement agreed standards as set out in the Clinical Standards Review to be published in spring 2019.
No more than 1% of patients should wait six weeks or more for a diagnostic test.
Ensure patients will have direct access to Musculoskeletal (MSK) First Contact Practitioners.

Cancer treatment

What is required?
Cancer alliances to support STPs on transformation and outcomes and to develop system wide plans.
Delivery of all 8 cancer standards remains a priority – and regional teams to work with alliances on these.
All providers must start to collect the 28-day Faster Diagnosis Standard data items in 2019/20, in preparation for the introduction of the Standard in 2020.
Standards are: - At least 93% of patients who receive an urgent GP should have their first outpatient attendance within a maximum of two weeks. - At least 93% of patients with breast symptoms should have first hospital assessment within a maximum of two weeks of referral. - At least 96% of patients should wait no more than one month for their first definitive treatment, from a decision to treat. - At least 94% of patients should wait no more than one month for subsequent treatment from decision to treat is made, where the treatment is surgery. - At least 98% of patients should wait no more than one month for subsequent treatment, from the date a decision to treat is made, where the treatment is drug treatment.

- At least 94% of patients should wait no more than one for subsequent treatment, from the date a decision to treat is made, where the treatment is radiotherapy.
- At least 85% of patients receiving an urgent GP referral for suspected cancer should wait no more than two months (62 days) for their first definitive treatment, for all cancers.
- At least 90% of patients with an urgent referral from an NHS cancer screening programme should wait no more than two months (62 days) for their first definitive treatment.
- Implement human papillomavirus (HPV) primary screening for cervical cancer across England by 2020.

Mental health (MH)

What is required?
MH funding to start flowing into CCG baselines.
CCG must deliver improved MH services as a result of funding into baselines.
STPs to proactively prioritise mental health workforce expansion including training and retention and use funds for that purpose.
STPs must understand workforce requirements.
All providers must submit comprehensive data to the Mental Health Services Dataset (MHSDS) / Improving Access to Psychological Therapies (IAPT) dataset and CCGs must review this and understand impact on local health inequalities, service delivery and transformation.
Ensuring a clearly defined mental health digital strategy is in place and is supported by a service transformation programme and board-level sign off.
Standards: - By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression). - At least 50% of people who complete IAPT treatment should recover.

- At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis.
- At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral.
- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.
- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral.
- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
- At least 60% people with a severe mental illness should receive a full annual physical health check.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21

Learning disabilities and autism

What is required?
Reduction in reliance on inpatient care for people with a learning disability and/or autism (CCG funded) to 18.5 inpatients per million adult population by March 2020. Reduction in reliance on inpatient care for people with a learning disability and/or autism (NHS England funded) to 18.5 inpatients per million adult population

by March 2020.
At least 75% of people on the learning disability register should have had an annual health check.

Primary care and community

What is required?
Real terms investment in primary medical and community services should grow faster than CCGs overall revenue growth. Further guidance will be issued on how to measure this.
STPs must support the development and implementation of a primary care strategy. This should include: - Workforce strategy - PCN development plan - Identification of local priorities and investment plan
STPs to provide primary care networks with a range of datasets.

Workforce

What is required?
Providers to update workforce plans for supply and retention estimates – these should be detailed and well modelled and aligned to finance and activity plans.
Move towards a bank first temporary staffing model.
Identify new roles and / or ways of working.
Unnecessary agency spend to be eliminated including reducing per shift costs.
All locally trained nurses should be offered places.
Providers to look at ways to mitigate Brexit.
Providers to have robust health and wellbeing plans and to consider diversity.

Data and technology

What is required?
Providers should submit all commissioning datasets to Secondary Uses Service+ (SUS+) on a weekly basis.
Continue to expand the Global Digital Exemplar and Local Health and Care Record Exemplar programmes with more organisations and localities coming onstream and in 2019.
Mandating core standards (across interoperability, cyber security, design, commercial etc.).
NHS App to be rolled out – initially to 111 online. STPs expected to support uptake.
100,000 women across 20 accelerator sites will be able to access their maternity records digitally with the expectation that other organisations to follow their lead on route for universal coverage in future years.
Digital access for all to the successful Diabetes Prevention Programme and providers and commissioners to support people to use this.