Planning guidance maintains focus on finance and quality

A Healthcare Finance summary of 'Everyone counts: planning for patients', the planning framework for 2013/14.

- **Across-the-board 2.3% rise in CCG allocations**
- **Reviews into allocation methods and incentives available to commissioners to improve quality**
- **Net tariff adjustment of -1.3%**
- **30% marginal rate for emergency admissions will continue**
- **CCGs to be assessed against five financial measures**
- **More information on care quality available to patients and public**

Greater information for patients, including the publication of the outcomes for individual consultants, and a continued emphasis on efficiency are features of the NHS Commissioning Board's first annual planning framework.

The framework, published on 18 December, outlines the incentives and levers in the system and said consultant-level data on survival rates and quality of care for 10 specialties would be published by the summer. The documents include clinical commissioning group (CCG) **allocations**, which show a 2.3% across-the-board nominal growth. The NCB said this was the equivalent of nominal real terms growth of 0.3%. Overall, the NCB will have a £96bn budget.

CCG allocations have not grown at different rates because of uncertainty over the **allocation formula** proposed by the Advisory Committee on Resource Allocation (ACRA). While the board said the proposed formula accurately predicts future spending needs, it would result in higher growth for areas that already have the best health outcomes. This was inconsistent with its aim to improve health outcomes for all and reduce inequalities.

An 'urgent, fundamental' review of the approach to allocations will be carried out that will draw from ACRA's expert advice. This will be ready for the 2014/15 allocations and in the meantime the uniform increase will give the new organisations stability in their first year, it added.

In total, £65.6bn will be allocated to CCGs and local authorities. This is made up of three main elements, with the bulk will be spent on **commissioning local services** (£63.4bn). The board said: 'Current assumptions suggest that an average CCG successfully delivering its QIPP [quality, innovation, productivity and prevention] schemes should in fact require less than 1% to cover expected cost pressures.'

It added £1.3bn would go to the running costs budget (confirming the previously announced £25 a head allocation), while £0.9bn will be allocated to local authorities to fund services that benefit health and social care (also announced previously).

A further £25.4bn has been allocated to the NCB's specialised healthcare commissioning, while a number of other programmes will be funded, including £1.8bn for the NCB public health responsibilities on behalf of Public Health England; £1bn for central health initiatives (which include support for private finance initiative schemes); and £0.7bn for technical accounting adjustments. The £1.2bn surplus carried forward from strategic health authorities and primary care trusts is also included. The NCB said this would be allocated to CCGs and the board for future investment.

The framework said the NCB wished to promote durable and autonomous CCGs. It will expect strong financial accountability and greater scrutiny where its risk management had identified the need for more regular, in-depth financial reporting. It will use five key **measures of financial accountability**:

- financial forecast outturn and performance against plan;
- an assessment of the range of risk inherent in plans and mitigation strategies;
- underlying financial position after adjusting for non-recurrent items;
- triangulation of spend and activity between commissioning and provider plans; and
- delivery of running cost targets.

QIPP remained essential and, after two years of largely centrally-driven initiatives, local health services had to drive transformational change through clinical service redesign. In 2013/14 this meant 'full local ownership of the clinical changes needed to ensure wider service and financial sustainability'.

The NCB would support commissioning groups in delivering QIPP, by for example eliminating out-dated service models in its direct commissioning activities and triangulating cost, activity and quality data and intelligence to provide overall system assurance.

Providers' boards must ensure there is no trade off between savings and quality – when contracting with providers, commissioners must ensure provider medical and nursing directors agree **cost improvement programmes** are safe. Additionally, CCG clinical leaders must make their own assessment on safety and quality. Commissioners should maintain close oversight of activity and local plans should include trajectories of how activity will change over the next two years.

The framework announced a **review of the incentives**, rewards and sanctions available to commissioners to improve the quality of patient care. This will inform the 2014/15 planning round. For 2013/14, the NCB called on commissioners to enforce the NHS standard contract, including financial penalties for under-performance or failure to provide data on which to assess performance. 'We will be rigorous in supporting clinical commissioning groups and our direct commissioners to

ensure the contract terms are implemented,' it added.

There will be 'zero tolerance' of any referral to treatment waits of more than 52 weeks, with intervention, including contractual fines, where this occurs. There will also be contractual fines for delays of more than 30 minutes in the handover between ambulance and A&E departments. There will be further fines for delays of more than an hour.

Commissioning for quality and innovation (**CQUIN**) will be set at a level of 2.5% of the value of all services commissioned through the standard contract and should only be paid for quality over and above that set out in the contract. One fifth of the 2.5% should be linked to national CQUIN goals, with the remainder linked to local quality aims.

Commissioners will also be rewarded for quality through the commissioning **quality premium**. This will be paid in 2014/15 to CCGs that improve or achieve high standards of quality in four measures from the 'NHS outcomes framework', including avoidable emergency admissions, the 'Friends and family' test, potential years of life lost to causes amenable to healthcare and incidence of healthcare associated infections. The quality premium will also include three local measures, agreed with the NCB.

Each commissioning organisation should plan to make a **cumulative surplus** of 1% of revenue, including any historic surplus not drawn down. PCT accumulated surpluses up to the level of the 2012/13 operating plan will be attributed to individual CCGs and direct commissioning bodies in proportion to the final 2012/13 baselines. SHA surpluses will be managed at a national level. In-year 2012/13 deficits will be the responsibility of the relevant CCG or direct commissioner. The maximum expected level of surplus drawdown is yet to be agreed with the Department of Health. Commissioners have been asked to include proposals to access historic surpluses in their operating plans and drawdown agreements will be finalised by the end of April 2013.

The framework said an organisation's **underlying financial position** after stripping out non-recurrent income and expenditure was a key measure of its financial resilience. To this end, commissioners should plan to be in 2% recurrent surplus by the end of 2013/14 – guidance on how this will be measured and defined will be published by the end of January.

Commissioners must also **manage risks** through risk pooling, setting aside 2% of revenue for non-recurrent spending, and holding a contingency of 0.5% of revenue, in addition to the non-recurrent funds. NCB area teams (ATs) must approve the non-recurrent spending and CCGs must demonstrate appropriate risk management and pooling arrangements have been established internally and between CCGs.

The **provider efficiency** requirement for 2013/14 tariff setting will be 4%, offset by estimated provider inflation of 2.7%. This gives a net tariff adjustment of -1.3%. This will also be the basis for discussion of prices for non-tariff services. The 30% **marginal tariff** for non-elective admissions will continue. ATs will administer the 70% balance, deciding on spending on demand management schemes with CCGs. Integration and pooling of budgets should be 'an explicit consideration' in local area planning.

Other areas highlighted in the framework include:

- the importance of patient rights as set out in the NHS Constitution
- the NHS will move to seven day a week access to routine services
- the introduction of a 'Friends and family' test
- a contractual obligation to provide datasets that comply with published standards.