07 April 2017

To:

By email: p.mettam@nhs.net
Phil Mettam, Accountable Officer, Vale of York CCG

By email: simoncox1@nhs.net
Simon Cox, Chief Officer, Scarborough and Ryedale CCG

By email: patrick.crowley@york.nhs.uk
Patrick Crowley, Chief Executive, York Trust

Dear Phil, Simon and Pat,

Capped Expenditure Process - Requirement to produce affordable Operating Plans by 5 May 2017

As outlined in the *Next Steps on the Five Year Forward View*, financial performance has improved across the NHS over the past year. Commissioners have generated an £800 million managed underspend and most Trusts are on track to meet their control totals, but as the NHS goes in to the next two years of intensified financial challenge, financial success will require managing a number of important risks and dependencies. The importance of individual trusts and CCGs meeting their financial control totals and sticking to their budgets is critical.

Some organisations and geographies have historically been substantially overspending their fair share of NHS funding. In effect they have been living off bail-outs from other parts of the country, this is no longer affordable or desirable. So going into 2017/18 it is critical that those geographies that are significantly out of balance now confront the difficult choices they have to take.

As we enter the new financial year, commissioners and/or providers within the York, Scarborough and Ryedale health economy have not yet been able to agree a set of affordable 2017/18 operating plans, nor confirm delivery of financial control totals. To help you NHS Improvement and NHS England have together devised the Capped

Expenditure Process, to support you to produce a set of affordable 2017/18 operating plans by 5 May 2017.

This process will enable your health economy to achieve the best possible clinical outcomes for the public we serve whilst limiting expenditure to the funding available to the NHS in your area. The focus of this process is the overall expenditure of the health economy, so systems must look beyond individual organisational boundaries in establishing viable plans which will ensure financial delivery within allocated financial control totals in 2017/18.

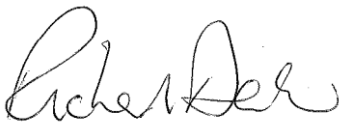
The resulting plans should be agreed jointly to ensure the delivery of both provider and commissioner control totals in 2017/18 and deliver the Government's Mandate requirement for the NHS to balance its books. The plans should be based on shared activity assumptions, should include an agreed plan for managing winter pressures and should set out how delayed transfers of care will be managed across the health economy.

Further details of the process and ongoing support and oversight will be provided through your local Director of Commissioning Operations and Director of Improvement and Delivery. We will ensure that these processes are aligned with other current initiatives including Special Measures.

Given the importance of this work and the limited time available to develop affordable proposals, an update meeting will be arranged with you in mid-April to review progress. In addition, the plans submitted on 5 May will be reviewed with National Directors of both NHS England and NHS Improvement at meetings to be scheduled for mid-May.

We thank you for your commitment to this programme, its importance is self- evident and the need to agree workable solutions is paramount.

Yours sincerely,



Lyn Simpson
Executive Regional Managing Director (North)
NHS Improvement

Richard Barker
Regional Director (North)
NHS England

Cc Moira Dumma, Warren Brown, Emma Latimer

Enc – CEP process paper

Capped expenditure process for achieving financial balance

Introduction

For the majority of providers and commissioners that are not currently meeting their control total a conventional approach to addressing the gap is likely to be sufficient. However, in reviewing the latest financial plans position across the NHS it is clear that in a small number of places the gap between the latest plan and the control total is too great, and therefore an alternative approach will be required which focuses the organisations on reducing their spending and their risk profile so that the health economy as a whole can live with the available resources for 2017/18.

This paper summarises the key characteristics of the Capped Expenditure Process and describes the steps to be followed. This is to assist regions in their assessment of the health economies that should be put through this approach and provide a guide to the approach to take with each economy. The aim is to construct a balanced and deliverable set of plans for each health economy, so adaptations to this approach to fit local circumstances are expected.

Key characteristics

- The CEP will be applied where a health economy cannot produce plans which fit within the available financial envelope for that health economy, or where the plans are highly unlikely to be deliverable e.g. efficiency plans that far exceed the levels normally achievable;
- The available financial envelope comprises the CCGs' allocations, adjusted for the CCG and provider control totals and any STF funding;
- The process will require the health economy to agree deliverable expenditure plans which will remain within that envelope and are underpinned by contract mechanisms that materially de-risk the delivery of plans; and
- The process will require conscious choices about value-based prioritisation and deprioritisation of proposed expenditure to live within the required limit. It will involve a clear articulation of the impact of these decisions on the scope and quantity of services available to the local population. No decisions will be taken which compromise patient safety;
- The approach will be overseen jointly by NHS Improvement and NHS England nationally and regionally.

Approach and timescales

The approach to be followed is set out below.

1. Review the existing plans to ensure that they are appropriately 'lean', i.e. that growth is set at reasonable but not excessive levels, that any discretionary investments have been stripped out and efficiency savings are set at an appropriate (i.e. challenging but achievable) level.
2. Where the above is not the case, revise the plan as necessary. This is especially important where plans have been structured with excessive growth or investments.
3. Where there is concern as to the deliverability of the efficiency plans, consider additional support (e.g. through the national QIPP programme for CCGs).

4. Assuming that the above does not significantly close the gap to the system control total, review the resulting spend profile from the above steps & decide from which areas further expenditure reductions will be made. This should be grounded in a transparent and detailed analysis of the CCG & provider spend profile with comparison to similar organisations **(analysis is available from your local DCO team).** This analysis should include an assessment of areas such as prescribing and CHC and should consider how spend in these areas can be minimised. This needs to be done with the understanding that decisions to reduce spend in specific areas must be accompanied by a high level of certainty of making it happen with system clarity and agreement about resultant implications and the management of those impacts.
5. The result of step 4 should be an implementable expenditure profile that fits within the total envelope available to the health economy in 2017-18 (i.e. the in-year allocation plus any overspends allowed for in the provider and commissioner control total, plus any STF funding).
6. The health economy needs to consider how the resulting envelope for each area of spend will be broken down across the individual organisations responsible for those areas, in a way that provides certainty that spend can be controlled.
7. Where the resulting envelopes between organisations (after taking account of the provider control total and STF funding) differ from the agreed contract values, these will need to be reviewed to re-cut the spend profile to fit within the revised envelope. Certainty of expenditure control may also require the form of the contract to be revised.
8. An initial assessment should be made of the patient and policy impact of the changes to the spend profile (e.g. the impact on patient waiting list numbers, RTT performance, levels of investment in mental health and primary care). The resulting outline plan and impact assessment should be discussed with relevant boards and governing bodies and with NHS England and NHS Improvement.
9. Mechanisms will need to be developed to ensure that patient safety is not jeopardised and that urgent cases are not overlooked.
10. Commissioners should also include an assessment of the risks in areas such as prescribing and CHC and should consider how the risks of overspends in these areas can be minimised. This may also require revisions to contractual form.
11. It will be important to include primary care clinicians in the development of revised plans to ensure that they understand their role in securing change in referral patterns and A&E attendances.
12. Plans should include a review of any pass through costs to ensure that that these are well controlled to minimise the expenditure, and where this is not the case tighter controls should be imposed.
13. Systems will also need to consider the implications of working to a fixed financial envelope, including dealing with seasonal pressures and ensure that appropriate allowances are made.
14. Successful delivery of this process will require collaboration between commissioners and providers and the support of NHS England and NHS Improvement. It will require complete transparency and alignment of commissioner and provider plans.