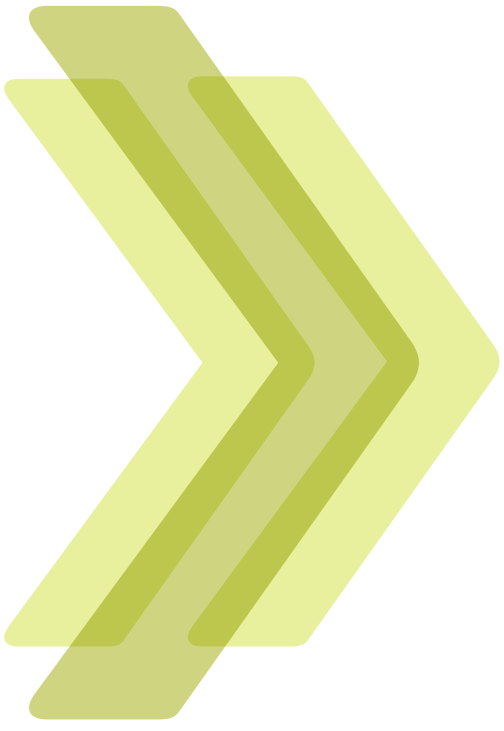
The King's Fund

BRIEFING

What the planning guidance means for the NHS

2016/17 and beyond



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Introduction

The 2015 Spending Review (HM Treasury 2015) confirmed that the NHS is halfway through the most austere decade in its history, with overall health spending increasing by much less than was expected when the NHS settlement was first announced. Since then, the number of letters, guidance and other documents issued by the national bodies has increased and the pressure on local leaders to respond has intensified.

Arguably the most important of these documents is *Delivering the Forward View: NHS planning guidance 2016/17–2020/21* (NHS England *et al* 2015). This sets out the priorities for the NHS over the next few years and includes many radical changes to policy. The deadlines for responding are very challenging.

Add to this publication of *The Government's mandate to NHS England for 2016/17* (Department of Health 2015a), *2016-17 financial directions to NHS England* (Department of Health 2015b), NHS England allocations (Baumann 2015), the *2016/17 Better Care Fund policy framework* (Department of Health 2016a), along with 375 pages of technical annexes released in mid-January to sit alongside the planning guidance, forthcoming consultations on the new clinical commissioning group (CCG) assurance framework and 2016/17 tariff, and announcements imminent on changes to the capital financing regime – and the enormity and complexity of the challenges facing health and social care leaders becomes clear. Taken together, this suite of documents marks a decisive break from the past and comprises much that is new and, in some cases, radical.

This briefing, while by no means comprehensive, attempts to consider these key publications in the round (although focusing primarily on the planning guidance), alongside other recent policy announcements, to form a picture of what it might all add up to for the NHS in 2016/17 and beyond.

It begins by pulling out the key points of note from the range of documents published to date (Part A) and then offers an assessment of what they mean in broader policy terms (Part B).

Key messages

Overall

- The approach set out for 2016/17 and beyond, in the context of a sustained squeeze on funding and ever-increasing demand, represents a watershed moment for the NHS.

Some welcome changes

- Changes to the way the system works, such as the introduction of multi-year allocations and getting areas closer to their target allocation more quickly, are welcome. So too is the shift towards place-based systems of care and the recognition that funding is required to support transformation. If implemented well, these changes will provide the NHS with strong foundations from which it has a chance of achieving sustainability in the long term.
- The place-based approach to planning represents an important acknowledgement that the now-widespread deficits are not simply a provider problem and that creating a sustainable financing model requires commissioners, providers and local authorities to work together.

Some challenges

- Guidance from central bodies signals an end to the post-Francis era, during which quality, often synonymous with staffing levels, was paramount. It has been made clear that the system has reached a point where finance must be given much greater priority.
- Gone too are core elements of the Health and Social Care Act 2012, in particular, the emphasis on competition and the principle of autonomy, with national bodies (including the Department of Health and, increasingly, HM Treasury) re-asserting control – for example, through the introduction of financial control totals for all providers in 2016/17 – in order to get a strong grip on finances and performance.

- Frontloading of the Spending Review settlement means that, if and when the NHS has the capacity to progress from deficit reduction to transformation, it will be doing so against a backdrop of much smaller funding increases (just 0.2 per cent and 0.1 per cent in real terms in 2018/19 and 2019/20 respectively). It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints.
- The numerous and complex demands being placed on the NHS are considerable (particularly in 2016/17, but also beyond), and come at a time when many organisations are already under huge pressure. National bodies should be clear about the most important priorities, recognising that not everything can be delivered within the funding available and that difficult choices must be made.
- Leaders will need to work collaboratively in place-based systems of care, recognising that success in the current context depends on collective action that makes best use of a common pool of limited resources. It will be critical that organisations engage staff at all levels in achieving sustainability and delivering transformation, and focus on improving value for patients rather than crude cost-cutting.

Part A: key points of note from recent publications

The financial context

The overall settlement: Spending Review 2015

Initial assessments of the 2015 Spending Review settlement for health and social care (**HM Treasury *et al* 2015**) were, on the whole, that it was a generous one, particularly for the NHS. Dig a little deeper, though, and it becomes clear that health spending will not rise over the course of this parliament as much as was initially thought. In addition, cuts to the local authority public health grant and the deal for social care also falls short, with new measures not enough to close the anticipated funding gap.

In our analysis with the Nuffield Trust and the Health Foundation of what the Spending Review means for health and social care (**The King's Fund *et al* 2015**) we found that total health spending in England will rise by 0.9 per cent a year over the course of the current parliament (almost identical to the rate of increase over the last parliament). This is considerably less than it appeared when the NHS settlement was first announced. This discrepancy is because the Spending Review defined 'NHS' spending as NHS England's budget, not the whole of the Department of Health's budget – the definition used by previous governments. So while NHS England's budget **will** rise over the period, other health spending will fall by 20 per cent. Overall, health spending in England will rise by £4.5 billion in real terms between 2015/16 to 2020/21, with a significant proportion of this frontloaded in 2016/17.

Local authority public health budgets will be cut by an average of 3.9 per cent a year in real terms over the Spending Review period. This is on top of £200 million already cut from the 2015/16 budget and will affect a wide range of services and have a significant knock-on effect on the NHS.

For social care, the overall picture is more difficult to gauge; new Better Care Fund money isn't due until 2017/18, and the National Living Wage bestows an additional cost pressure on the sector. Much hinges on how many local authorities will use new powers to raise additional funds for social care by increasing Council Tax by

up to 2 per cent. Even with these new measures, however, our analysis suggests that there is likely to be a social care funding gap of between £2.8 and £3.5 billion by 2020 (The King's Fund *et al* 2015). In the context of an increasingly fragile market and rising demand, Simon Stevens, Chief Executive of NHS England, has stated that he considers the social care funding settlement as 'unfinished business' (Stevens 2015).

Key updates to the financial framework for providers and commissioners

Numerous modifications, tweaks and updates have been included in this year's commissioning allocations, planning documents and other announcements. Some of the most significant of these include:

- the introduction of multi-year CCG funding allocations (providing three-year binding and two-year indicative allocations) (Baumann 2015), which many will find helpful for the greater certainty they provide for strategic planning. (However, a £1.8 billion fund is to be managed centrally and not issued to CCGs as part of their routine allocations, *see* pages 9–11.)

- a move towards a greater pace of change in CCG allocations, thereby moving areas closer to their target 'equitable' funding allocation much faster (Baumann 2015)

- a shift to looking at the sum totality of allocations (Baumann 2015) – encompassing CCG, primary medical care and specialised formulas – which is welcome, and creates a consistent narrative when viewed alongside the place-based approach set out in the planning guidance

- a requirement on CCGs to continue to increase investment in mental health services above the rate of increase in their overall allocation each year, and if they fail to meet this, commensurate funds may be 'clawed back' from their allocation (NHS England 2016)

- changes to the proposed 2016/17 tariff, including an efficiency factor of 2 per cent and a 3.1 per cent inflation uplift (Monitor 2016), which are likely to be welcomed by many. (However, this lower efficiency requirement is predicated on the provider sector not breaching its £1.8 billion end-of-year deficit forecast for 2015/16; if the deficit is higher, the tariff remains unchanged and will be met by delivering higher efficiencies (NHS England *et al* 2015).)

- a 'constrained level' of capital resource from 2016/17, with the planning guidance setting out that 'repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases' (NHS England *et al* 2015, p 13)

- introduction of financial control totals for all NHS providers in 2016/17, alongside a number of other stringent financial controls (*see* pages 11–12).

Changes to the capital financing regime and the calculation of Public Dividend Capital (which broadly reflects the public sector's stake in a trust and can also be used to provide financial support by the Department of Health) dividends were due to be announced in January (NHS England *et al* 2015), although at the time of writing had not been published. The impact of these changes is therefore not yet known, although potentially could be significant.

What is being asked of the NHS?

The NHS planning guidance is an annual suite of documents that sets out the national priorities and longer-term challenges for local systems, together with financial assumptions and business rules for the coming year. The guidance also reflects the settlement reached in the Spending Review, and the requirements set out in *The Government's mandate to NHS England* (Department of Health 2015a). For the first time, this year's guidance requires NHS leaders to produce two separate but connected plans:

- a one-year operational plan for 2016/17, focused on individual organisations
- a five-year sustainability and transformation plan (*see* box below), place-based and driving the *NHS five year forward view* (Forward View), for the period October 2016 to March 2021.

What are the five-year sustainability and transformation plans?

- Sustainability and transformation plans will cover all areas of NHS England and CCG-commissioned activity and will include better integration with local authority services. As well as outlining how they will deliver the mandate, plans will need to address a series of 'national challenges', which fall broadly into three themes: improving health and wellbeing, improving quality and developing new models of care, and improving efficiency to achieve financial balance.
- The first step is for local areas to come together to agree the geographical footprint covered by their sustainability and transformation plan, noting that the plan will be an 'umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints' (**NHS England *et al* 2015**, p 6). Success regime and devolution areas are expected to use these boundaries as their footprints.
- From 2017/18 onwards, sustainability and transformation plans will 'become the single application and approval process for being accepted onto programmes with transformational funding' (**NHS England *et al* 2015**, p 5), with the most credible plans – judged on a number of criteria – securing the earliest funding.
- Full sustainability and transformation plans are due for submission at the end of June 2016. NHS England and NHS Improvement have committed to publishing further guidance on sustainability and transformation plans (forthcoming).

The focus for 2016/17, and thus the operational plans, is very clearly on restoring financial balance within the NHS provider sector. Key points of note are included below.

- The plans need to address nine 'must dos', which in summary cover: developing, agreeing and making progress on a sustainability and transformation plan; returning the system to aggregate financial balance; developing and implementing local plans to address the sustainability and quality of general practice; maintaining or improving performance against a number of standards (including ambulance waits and access to accident and emergency (A&E), those in the NHS Constitution, those relating to cancer and new mental health access standards); transforming care for those with learning disabilities; and developing and implementing an affordable plan to make quality improvements (particularly for trusts in special measures).

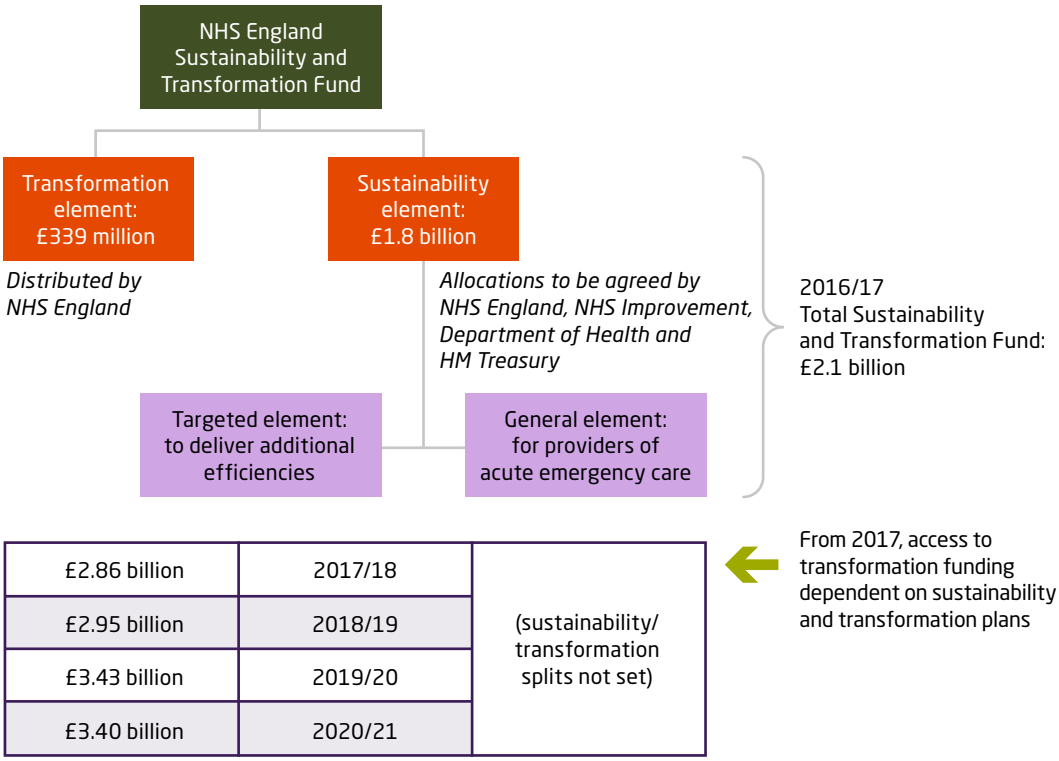
- NHS Improvement will seek to assess all provider plans against a set of specified criteria (which will be the same for both acute trusts and foundation trusts) (Monitor and NHS Trust Development Authority 2016a).
- Providers and commissioners are expected to take a fully transparent 'open book' approach to activity planning for 2016/17 (Monitor and NHS Trust Development Authority 2016a).
- Final commissioner and provider plans are to be agreed by NHS England and NHS Improvement by April 2016.

Sustainability and financial control

Most of NHS England's additional frontloaded investment will be swallowed up dealing with provider deficits, since this funding has now largely been included within NHS England's budget. This comes in the form of a Sustainability and Transformation Fund (*see* Figure 1).

Despite 'holding' this money, NHS England is not free to allocate it as it pleases. Instead, the £1.8 billion sustainability strand for 2016/17 comes with a ring-fence and, as the financial directions to NHS England set out (Department of Health 2015b), can only be released with agreement from both the Department of Health and HM Treasury. Other NHS England funding streams for transformation (amounting to £339 million) have been pooled and added to this, creating a total Sustainability and Transformation Fund of £2.1 billion for 2016/17. This total pot grows significantly in future years – reaching £3.4 billion by 2020/21 (though the splits between sustainability and transformation have not been set).

Figure 1 The Sustainability and Transformation Fund



Source: Baumann 2015

The sustainability funding is composed of two elements, described as 'general' and 'targeted'. NHS Improvement recently made clear in an unpublished letter to all trust chief executives that the first of these is intended for providers of acute emergency care, with mental health, ambulance and community services providers 'unlikely to be eligible' to access it. The 'targeted' element is intended to help providers deliver additional efficiency gains (Monitor and NHS Trust Development Authority 2016c). How the £1.8 billion is apportioned to each of these elements and how to access the targeted element is not yet known, so it remains to be seen how much is left for non-acute trusts.

Approval of the overall additional sustainability funding is conditional on the NHS making progress towards a plan for achieving seven-day services by 2020, and the provider sector breaking even in 2016/17. To try to ensure the latter, the recent (unpublished) letter from NHS Improvement stated that as part of NHS Improvement's new financial oversight regime, every NHS provider – whether trust or foundation trust, in deficit or surplus – will 'have to agree to deliver an agreed financial control total for 2016/17' (*see* box) (Monitor and NHS Trust Development Authority 2016c).

The introduction of control totals for 2016/17

- In 2016/17, all NHS providers will 'have to deliver an agreed financial control total' (providers' 2016/17 operational plans are expected to meet this control total – or better it).
- This has been introduced to try to ensure that the provider sector achieves financial balance in 2016/17, a condition associated with the additional sustainability funding allocated to the NHS for 2016/17.
- The control totals have been calculated by NHS Improvement on a trust-by-trust basis, using 2015/16 end-of-year forecasts at month six (adjusted for the effect of agency controls and other measures) as a baseline and taking into account other elements such as changes to the tariff.
- The baseline, control total and performance against this control exclude gains on disposals of assets.
- If a provider's 2015/16 year-end position is worse than forecast at month six, it will need to deliver higher efficiencies in 2016/17 to meet its control total.
- Agreeing to deliver this control total is a condition of access to the general element of the Sustainability and Transformation Fund (encompassing capital and revenue control totals).

Source: Monitor and NHS Trust Development Authority 2016c

In order to gain access to their slice of the general element of the Sustainability and Transformation Fund, all acute emergency providers will need to agree and adhere to a set of conditions. They have been given a deadline of 8 February to accept this 'offer', and the strings attached. The planning guidance emphasises the 'hard-edged' conditionality of this funding, stating that 'where trusts default on the conditions access to the fund will be denied and sanctions will be applied' (NHS England *et al* 2015, p 12). The conditions include:

- **deficit reduction:** agreeing and delivering a control total (*see* box), a capital control total and a milestone-based recovery plan (including implementing Lord Carter's forthcoming recommendations on efficiency and complying with controls on agency staffing)
- **access standards:** agreeing and delivering a plan for maintaining performance trajectories for the delivery of key standards (including the four-hour A&E standard)
- **progress on transformation:** developing and agreeing a sustainability and transformation plan.

In an effort to contain this year's (2015/16) overall deficit, all providers have also been asked to consider and report on a number of 'opportunities' at month nine, aimed at improving quarter four figures. This includes (among other things) how to manage the carry-over of annual leave and short-term non-medical staff sick leave, and to 'remove prudence' from their handling of bad debts, deferred income and a range of other balance sheet items (Monitor and NHS Trust Development Authority 2016c). The letter also states that NHS Improvement will be meeting with a number of challenged providers to agree actions that could include headcount reduction.

Further action to enforce financial control in the NHS includes extending measures to tackle locum and agency spend, the total cost for which could reach around £4 billion this year (**Mackey 2016**). Announced in mid-January, these include:

- reducing the price caps for agency staff from 1 February 2016 (as previously proposed)
- an intention that, in the future, the price caps will be expressed in terms of how much the worker receives
- requiring all agency procurement – including, from 1 April 2016, for doctors and other staff groups, not solely for nurses – to happen via approved frameworks
- making compliance with the agency rules a core condition of access to the Sustainability and Transformation Fund (**Monitor and NHS Trust Development Authority 2016b**).

There are likely to be further controls coming into play as more documents are released. These include, for example, the final publication from Lord Carter's review of hospital efficiency. In this regard, the planning guidance sets out that providers are expected to provide details of their expected savings in 2016/17 operational plans, performance against which will be monitored by NHS Improvement.

Part B: Commentary

The return of top-down command and control

The introduction of multi-year allocations to CCGs should be strongly welcomed by areas, as it gives them greater certainty and enables more strategic planning. The move towards a greater pace of change in CCG allocations, aimed at improving equity between areas, will result in winners and losers.

These changes, along with the decision to take a place-based approach to planning and delivering health and social care services, are the right things to do. Despite the difficulties that will undoubtedly be experienced across the NHS in the coming years, these changes lay important foundations from which a more sustainable future might be achieved.

The introduction of financial control totals for all NHS providers (regardless of whether they are in deficit or not) represents a dramatic extension of central control. These financial controls extend to an organisation's use of its own reserves and enforce a range of other central must-dos – for example, they give instructions on how to manage annual leave, short-term sick leave and deferred income.

The way in which access to the general strand of the sustainability funding will work favours providers of acute emergency care (*see* page 10). While to some extent this makes sense, given that the sustainability element exists specifically to manage deficits, which are at their worst in the acute sector, it also risks penalising other types of provider – that is, mental health, community and ambulance trusts – for not running deficits. Providing most of the additional funding to the acute sector also goes against the overall strategic intention of achieving parity of esteem and investing in out-of-hospital settings, at least in relation to 2016/17.

The diminishing significance of the Health and Social Care Act 2012

A central motif of the 2012 Act (and enshrined in the 'duty of autonomy') was the 'liberation' of the NHS from central command, empowering providers and professionals and giving them more autonomy (Health and Social Care Act 2012; Department of Health 2010). These aims have been steadily eroded over time, culminating in planning guidance, which significantly extends central controls over local decision-making. The autonomy of foundation trusts has been heavily circumscribed to the extent that there now remains little difference between them and NHS trusts.

Financial control of the NHS has taken priority over the principle of autonomy – with regard to the autonomy both of local bodies in relation to national ones, as well as between national bodies and central government. On the first of these relationships, the use of control totals for all NHS providers, as well as other restrictions (*see* pages 11–12), represents a dramatic extension of national control over NHS trusts and, more radically, NHS foundation trusts.

Withholding £1.8 billion in funding from commissioner allocations, which can be unlocked only by submitting deficit reduction plans (in 2016/17) and then transformation plans acceptable to the national bodies (from 2017/18, when the central fund rises to £2.86 billion), also clearly represents a switch back towards central control – particularly given the number of conditions that areas must meet for plans to be considered 'acceptable'.

The independence of the national bodies from central government has been similarly curtailed, with the *2016–17 financial directions to NHS England* (**Department of Health 2015b**) making it clear that allocations from the sustainability element of the Sustainability and Transformation Fund must be agreed in advance with HM Treasury as well as the Department of Health. The formal and public arrival of HM Treasury into the process for agreeing deficit-funding for NHS providers 'must surely underline the anxiety in central government over NHS finances, and could be interpreted as a Whitehall version of "special measures" for the Department of Health and its partners' (**Murray 2016**).

Another key plank of the 2012 Act was the establishment of Monitor as the economic regulator for the health sector, including powers to prevent anti-competitive behaviour and promote patient choice. The bringing together of Monitor and the NHS Trust Development Authority to form NHS Improvement appears to signal a shift of emphasis, with competition and choice taking more of a back seat. Since being appointed Chief Executive of NHS Improvement, Jim Mackey has made clear that Monitor's focus will shift from enforcing competition to helping providers to improve (Dowler 2015). The planning guidance does not refer to 'competition' at all. While choice policy is referenced (in relation to maternity, end-of-life care and for people with long-term conditions), it is done so sparingly.

Finally, the new sustainability and transformation plans required of the NHS and its partners represent a significant shift from the original reform vision of 2010. Instead of a market where autonomous commissioners choose between equally autonomous providers to fund via the tariff, local areas are expected to come together to plan for the populations they serve. While local health and care systems have been asked to

develop the geographical scope of their sustainability and transformation plan, the planning guidance suggests that NHS England and NHS Improvement will step in to 'help secure remedies' where areas are unable to reach agreement.

Further guidance on the process for developing sustainability and transformation plans is yet to be published. The basic ambition for local areas to develop place-based approaches to planning and delivering health and care services should be welcomed. As Ham and Alderwick recently argued (2015), the challenges facing public services in England require collective action across local areas – not organisations working alone. But developing these plans in the timescales available will not be simple (*see* **Alderwick 2016**). While the initial guidance focuses mainly on NHS services, developing a credible plan will require the NHS to work closely with social care, public health and other local government services, as well as third sector organisations and members of the local community.

Some major tensions

Scale of ambition is vast, timescales are tight

The first tension that becomes apparent on reading the Mandate, planning guidance and other documents is the sheer enormity of the task facing the NHS and the timescales within which it is expected to achieve it, a consequence in part of the late publication of the Spending Review. First on the 'to-do' list is the small matter of agreeing 'transformation footprints', proposals for which were due by 29 January, giving areas just under a month to come together and develop the necessary relationships. Organisations also need to be working up their one-year operational plans for 2016/17 (to be consistent with the emerging sustainability and transformation plan – *see* pages 7–8), with full drafts due just weeks after the planning guidance was published.

The requirement on local health systems to submit a five-year sustainability and transformation plan by the end of June is a bigger challenge still. As well as accelerating the Forward View and setting out how areas will play their part in delivering the mandate, they are expected to pursue the holy grail of health care: 'the triple aim – better health, transformed quality of care delivery, and sustainable finances' (**NHS England *et al* 2015**). For the plans to be considered successful, they should also engage local partners in a way that 'harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards' (**NHS England *et al* 2015**). Engagement at this scale, if done properly, takes time.

Given how tight the money will continue to be for the NHS, those responsible for drawing up their five-year plans may be taken aback to find that these will need to address more than 60 (including all the multiple parts) questions. It is also worth noting that some of the questions are of herculean proportions. For example, answers to 'how will you close the health and wellbeing gap?' are expected to include plans for a '"radical upgrade" in prevention, patient activation, choice and control, and community engagement' (NHS England *et al* 2015).

This raises the obvious question of just how deliverable this list is within the limited resources – in terms of both time and funding – on offer. It is an exceptional ask even for those with a long history of working together. For those without this track record, coming together, agreeing a footprint and developing the collaborative relationships required in the allotted time may simply not be possible.

Today versus tomorrow

Although talk of longer-term transformation is not entirely absent from the planning process for 2016/17 (for example, partial roll-out of seven-day services and achievement of the new mental health access standards are expected), there is a clear expectation that the focus for this year should be on taking the steps necessary to return the system to aggregate financial balance overall and recover/maintain performance of access standards. Although understandable, this approach means that much of the activity needed to achieve the vision set out in the Forward View will be compressed into the period 2017/18 to 2020/21. The frontloading of the settlement, while both welcome and necessary to stabilise services in the short term, means that transformation will take place against a backdrop of smaller increases, with real-terms increases of just 0.2 per cent and 0.1 per cent in 2018/19 and 2019/20 respectively.

By merging the funds for managing provider deficits with those for transformation, the link between transformation and the elimination of provider deficits is made explicit. The planning guidance is clear that the share of the pot available for transformation will grow as the amount used to stabilise NHS operational performance decreases. Therefore any delay in returning providers to financial balance will directly impact on the resources available to support transformation. This will stretch budgets to the limit, especially as the NHS will also be required to implement seven-day services and the many other priorities included in the planning guidance.

The squeeze on capital spending set out in the guidance will mean investing less in buildings and equipment. While these limits may be necessary in the short term, they are likely to have an impact on the quality of buildings and equipment over time. Reducing investment to meet short-term needs in this way is not a sustainable strategy if maintained over a number of years.

There are a range of other measures, which, although seemingly necessary in the short term, may have important long-term consequences. For example, the proposed changes to the community pharmacy contractual framework for 2016/17 (Cavendish and Ridge 2015) and beyond are likely to lead to the closure of a significant number of community pharmacies (Smyth 2016).

Finances versus quality

The planning guidance suggests that, in 2016/17, the focus should be on balancing quality and finances. The tension between delivering financial targets and delivering quality outcomes is a difficult one, particularly in the current context where funding has been squeezed, quality has become synonymous with staff numbers, demand continues to rise across the board, and providers are struggling to recruit in a number of areas, often pushed to finding costly alternatives. The cost of ensuring that there are sufficient staff to meet the standards expected by the Care Quality Commission (CQC) adds to the pressures on providers.

In recent months, national bodies have announced a series of measures to tackle agency costs in an attempt to reduce spending (*see* page 12). While these measures are expected to have a positive effect on provider deficits in 2015/16 and beyond, they will not be enough to eliminate them, with estimates from NHS Improvement suggesting that the new controls will save just £160 million by the end of 2015/16 and £1 billion by 2018 (Department of Health 2016b).

In a recent letter to providers, the Care Quality Commission, Monitor and the NHS Trust Development Authority (Mackey and Richards 2016) acknowledged that in the past they may have sent mixed messages on the importance of financial versus quality objectives. Their most recent attempt at clarifying this position stated that 'quality and financial objectives cannot trump one another' and that the task of providers is to 'deliver the right quality outcomes within the resources available'. Elsewhere, the Secretary of State for Health, Jeremy Hunt, has made clear that boards that fail to both balance the books and deliver high-quality care will face suspension (Department of Health 2016c). At the same time, the National Institute for Health and Care Excellence documents on safe staffing have come into the public domain (Lintern 2016). The pressure on providers to succeed at a seemingly impossible task could not be much greater.

Beneath the rhetoric, it is possible to identify a shift in priority. The emphasis on the need to manage finances is more explicit than ever before, and while the notion of quality is still present, references to it are less frequent. Clearly, the hiring spree (previously condoned, and even encouraged, by government and the national bodies) that has been occurring since the Francis Inquiry reported (**Mid Staffordshire NHS Foundation Trust Public Inquiry 2013**) will now need to come to an end. It will be impossible to balance budgets without reducing headcount, as signalled by NHS Improvement's announcement that it intends to meet with a number of challenged providers to agree actions that could include 'headcount reduction'. Maintaining quality in these circumstances will be a huge challenge.

The importance of leadership

The planning guidance and associated requirements present three major challenges for leaders in the NHS and partner organisations. The first is the sheer size and complexity of the agenda they are faced with in achieving sustainability and delivering transformation within the timescales set out. Every organisation will need to be clear on the priorities it is pursuing, and national bodies must lend their support by recognising that not everything can be delivered. Now more than ever, honesty and realism are needed at all levels about what really matters when the health and care system increasingly appears to be on a war footing.

The second challenge is for organisational leaders to engage and support staff to lead work on sustainability and transformation with a focus on improving value for patients and not crude cost-cutting (**Alderwick *et al* 2015**). In our view there are many opportunities to deliver better outcomes at lower cost with a particular focus on changes in clinical practice. Framing the sustainability challenge in this way is critically important if clinicians are to engage in the work that now needs to be done with the support of experienced managers. The accumulation of many small changes throughout the NHS offers the best opportunity to restore financial balance – this will require every member of staff to play a part.

The third challenge is for organisational leaders to work together in place-based systems of care. This is essential in the preparation and implementation of sustainability and transformation plans and in ensuring the resources are used to deliver improvements in health and care for the populations covered by these plans (**Ham and Alderwick 2015**). Work under way in the new care models programme is showing what system leadership means and is also illustrating the challenges facing experienced organisational leaders in collaborating with their peers. National bodies need to support system leadership at a local level by themselves acting collaboratively in their interactions with providers and commissioners.

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