

NHS Operational Planning and Contracting Guidance

2017-2019

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Introduction and context: implementing Sustainability and Transformation Plans

1. This document explains how the NHS operational planning and contracting processes will now change to support Sustainability and Transformation Plans (STPs) and the 'financial reset'. It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19.
2. Our shared tasks are clear: implement the Five Year Forward View to drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards.
3. In local STPs, these jobs come together as one. Each STP becomes the route map for how the local NHS and its partners make a reality of the Five Year Forward View, within the Spending Review envelope. It provides the basis for operational planning and contracting.
4. STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm. What makes most sense for patients, communities and the taxpayer should always trump the narrower interests of individual organisations. That is why, although STPs are relatively new, we see them as having a significant ongoing role in the NHS.
5. Good organisations cannot implement the Five Year Forward View and deliver the required productivity savings and care redesign in silos. Only through a system-wide set of changes will the NHS be sure of being able to deliver the right care, in the right place, with optimal value. This means improving and investing in preventative, primary and community based care. It means creating new relationships with patients and communities, seeing the totality of health and care in identifying solutions, using social care and wider services to support improved productivity and quality as well as people's wellbeing. We need new care models that break down the boundaries between different types of provider, and foster stronger collaboration across services – drawing on, and strengthening, joint work with partners, including local government. The solutions will not come solely from within the NHS, but from patients and communities, and wider partnerships including local government, and the third sector; and effective public engagement will be essential to their success.

6. Right across the country, NHS organisations want to spend less of their time locked in adversarial and transactional relationships. Allocating finite and stretched NHS resources between competing demands will never be easy, and the task gets harder over the next three years. But we do now have the opportunity to settle the numbers earlier and for a longer duration. This will enable us all to devote more of our energies towards getting on with the job of redesigning and delivering better, more efficient care.
7. To support the STP process and embed the 'financial reset', the annual NHS planning and contracting round will now be streamlined significantly. Our aims are to provide greater certainty and stability; simplify processes and ensure they are more joined up; cut transaction costs; and support partnership and transformation.
8. The default will be for two-year contracts in place of those currently negotiated annually. Commissioners will still have the ability to let new longer-term contracts, based on new care models and whole population budgets, revising existing contracts accordingly.
9. The 2017-19 operational planning and contracting round will be built out from STPs. Two-year contracts will reflect two-year activity, workforce and performance assumptions that are agreed and affordable within each local STP. We are issuing a two-year tariff for consultation and two-year CQUIN and CCG quality premium schemes. NHS England is engaging with the sector on the indicators and measurements for these CQUINs. For the first time, a single NHS England and NHS Improvement oversight process will provide a unified interface with local organisations to ensure effective alignment of CCG and provider plans. And, as requested by NHS leaders, the timetable is now being brought forward to provide certainty earlier – with a target deadline of all 2017-19 contracts signed by 23 December 2016.
10. To ensure that organisational boundaries and perverse financial incentives do not get in the way of transformation, from April 2017 each STP (or agreed population/geographical area) will have a financial control total that is also the summation of the individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and the overall system control total. It will be possible to flex individual organisational control totals within that system control total, by application and with the agreement of NHS England and NHS Improvement. Further details are contained in paragraphs 25-29 of this document.

Priorities and performance assessment

Nine 'must dos' for 2017-19

11. In 2016/17 we described nine 'must do' priorities. These remain the priorities for 2017/18 and 2018/19. These national priorities and other local priorities will need to be delivered within the financial resources available in each year.

2017/18 and 2018/19 'must dos'

1. STPs

- Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.
- Achieve agreed trajectories against the STP core metrics set for 2017-19.

2. Finance

- Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.
- Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.
- Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.
- Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.

3. Primary care

- Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.
- Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

4. Urgent and emergency care

- Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.
- By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.
- Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.
- Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.
- Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.

5. Referral to treatment times and elective care

- Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).
- Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.
- Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.
- Implement the national maternity services review, *Better Births*, through local maternity systems.

6. Cancer

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.
- Ensure all elements of the Recovery Package are commissioned, including ensuring that:
 - o all patients have a holistic needs assessment and care plan at the point of diagnosis;
 - o a treatment summary is sent to the patient's GP at the end of treatment; and
 - o a cancer care review is completed by the GP within six months of a cancer diagnosis.

7. Mental health

- Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:
 - o Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
 - o More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
 - o Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;
 - o Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
 - o Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
 - o Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

8. People with learning disabilities

- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism.

9. Improving quality in organisations

- All organisations should implement plans to improve quality of care, particularly for organisations in special measures.
- Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.
- Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.

Measuring and assessing performance

12. These priorities do not encompass the full breadth of NHS organisations' responsibilities. A summary of the current Government Mandate to NHS England is attached at Annex 1 and sets out the areas in which the Government expects the NHS to improve by 2020. Should these mandated objectives change for 2017/18 or 2018/19, we will issue supplementary advice as necessary. There is clear read-across from the Mandate to both the new CCG Improvement and Assessment Framework (CCG IAF) indicators and the new NHS Improvement oversight framework for NHS providers. Annexes E and F of the technical guidance list metrics for which commissioners and providers are required to submit planning trajectories. NHS England is publishing its intentions for specialised services commissioning alongside this document – these are outlined in paragraphs 63-67.
13. NHS England, NHS Improvement, Health Education England, the Care Quality Commission, Public Health England, NHS Digital and NICE are committed to working in a joined up way, together with local government, to support STP areas. NHS Improvement will use its new single oversight framework to look at providers' contribution to their STP and any associated support needs, and NHS England will do likewise through the CCG IAF. Wherever appropriate, however, we will ensure that our main point of contact to discuss progress with implementation of STPs and any support needed from national bodies is with the shared STP leadership for each area.

14. Drawing on existing data collections from the assurance frameworks, we will publish core baseline STP metrics in November 2016, encompassing as a minimum these metrics:

Finance

- Performance against organisation-specific and system control totals

Quality

Operational Performance

- A&E performance
- RTT performance

Health outcomes and care redesign

- Progress against cancer taskforce implementation plan
- Progress against Mental Health Five Year Forward View implementation plan
- Progress against the General Practice Forward View
- Hospital total bed days per 1,000 population
- Emergency hospital admissions per 1,000 population

15. STP areas will need to agree trajectories against these areas for 2017-19. The letter sent to STP leaders setting out the expectations for the content of STPs for the October 2016 submission is in Annex 4. These include:

- addressing feedback from the July 2016 conversations, including a crisp articulation of the tangible benefits to patients and communities;
- providing more depth and specificity on implementation;
- ensuring plans are underpinned by the Finance Templates;
- setting out the measurable impacts of the STP;
- describing how they envisage better integration between health and social care;
- describing the degree of local consensus amongst organisations and plans for further engagement; and
- continuing development of the STP's estates strategy.

Developing operational plans and agreeing contracts for 2017-19

16. The detailed requirements for commissioner and provider plans are set out in accompanying technical guidance. Plans will need to demonstrate:
- how they will be delivering the nine 'must-dos';
 - how they support delivery of the local STP, including clear and credible milestones and deliverables;
 - how they intend to reconcile finance with activity and workforce to deliver their agreed contribution to the relevant system control total;
 - robust, stretching and deliverable activity plans which are directly derived from their STP, reflective of the impact that the STP's well-implemented transformation and efficiency schemes will have on trend growth rates, agreed by commissioners and providers and consistent with achieving the relevant performance trajectories within available local budgets;
 - how local independent sector capacity should be factored into demand and capacity planning from the outset, and local independent sector providers engaged throughout;
 - the planned contribution to savings;
 - how risks have been jointly identified and mitigated through an agreed contingency plan; and
 - the impact of new care models, including where appropriate how contracts with secondary care providers will be adjusted to take account of the introduction of new commissioning arrangements for MCPs or PACS during 2017-19.
17. CCG and provider plans will need to be agreed by NHS England and NHS Improvement, with a clear expectation that they must be fully aligned in local contracts. This is more than a technical process. It requires a genuine commitment for local leaders to run a shared, open-book process to deliver performance and improvement within the growing, but fixed, funding envelope available to that local area. We have seen this approach in the development of STPs and expect to see it carried forward into operational plans. Further details on support, review and assurance are set out in the Technical Guidance document.

Dispute avoidance and resolution

18. We expect all contracts to be signed by 23 December 2016. The earlier timetable for operational planning should give commissioners (CCGs and direct commissioners) and providers greater scope for constructive engagement over contracts. Access to formal arbitration must be a last resort. Our expectation is that commissioners and providers sort out any differences without the need for arbitration, and failure to do so will be seen as a clear failure of collaboration and good governance.
19. To enable a more collaborative approach to contracting, we are making a number of changes to the dispute resolution process as follows:
 - increased access to technical advice on contract and tariff issues to reduce the number of technical disputes;
 - escalation to NHS England and NHS Improvement chief executives (or delegated national directors) for commissioners and providers that do not agree their contracts to the national timetable.
20. It is our expectation that any parties, including foundation trusts, that are unable to agree contracts in line with the national timetable will submit their disputes for timely resolution through the NHS arbitration process. NHS England will also ensure that any disputes regarding its specialised commissioning activities which have not been resolved according to the national timeline will be referred to the NHS arbitration arrangements. NHS Improvement and NHS England will intervene where necessary, using their oversight and regulatory powers to resolve any cases where organisations refuse to do so. In addition, where a provider refuses to follow the NHS arbitration process, they may forfeit a proportion of their Sustainability and Transformation Fund (STF) monies, and where a CCG fails to comply with the process, quality premium and transformation monies may be forfeited.

NHS Standard Contract

21. We are proposing minimal changes to the NHS Standard Contract for the next two years. To support two-year local plans and contracts, the NHS Standard Contract will be set for two years. NHS England is publishing the revised NHS Standard Contract for consultation, alongside this document.
22. To enable more seamless care for patients, and as set out in the General Practice Forward View, we have strengthened the requirement for transmitting letters to GPs following clinic attendance. The current timescale for production (within 14 days of attendance) will reduce progressively to ten days (from 1 April 2017) and seven days (from 1 April 2018). A new requirement for electronic transmission of clinic letters, as structured messages using standardised clinical headings, will take effect from 1 October 2018. NHS England is also proposing:
 - from April 2017, stronger requirements on commissioners to facilitate hospital discharge and on providers to comply with recent NICE guidance;
 - from April 2017 mandated use of the e-Referral system (ERS); and from October 2018, non-payment for activity resulting from non-ERS referrals and the right for providers to return such referrals to GPs. We will work with the GP community to resolve practical issues which currently hinder use and uptake of the e-referral system in general practice;
 - from April 2017, mandatory data-sharing agreements for urgent and emergency care providers, enabling commissioners to access cross-provider data about utilisation and effectiveness of services;
 - from November 2017, the four priority standards for seven-day hospital services for all urgent network specialist services; and
 - compliance with new data security standards (April 2017), new conflicts of interest guidance (June 2017) and new interoperability requirements for clinical IT systems (January 2019).
23. In addition, NHS Digital intends to amend its guidance to support daily submission of electronic Secondary User Service (SUS) data from April 2018. There will be further engagement with providers before introducing these changes. NHS Digital will also shorten the turnaround of data to improve its utility for providers, commissioners and national bodies, which will in turn reduce burden on the system in providing aggregate data and the same data to multiple organisations. This will also improve the quality of data at source and on source systems.
24. Where providers accept their financial control totals and any associated conditions and are therefore eligible for payments from the Sustainability and Transformation Fund, contract sanctions for key performance standards are currently suspended. We propose to extend this suspension until April 2019.

Timetable

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Planning Guidance published	22 September 2016
Technical Guidance issued	22 September 2016
Commissioner Finance templates issued (commissioners only)	22 September 2016
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September 2016
National Tariff draft prices issued	22 September 2016
Provider control totals and STF allocations published	30 September 2016
Commissioner allocations published	21 October 2016
NHS Standard Contract consultation closes	21 October 2016
Submission of STPs	21 October 2016
National Tariff section 118 consultation issued	31 October 2016
Final CCG and specialised services CQUIN scheme guidance issued	31 October 2016
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November 2016
Submission of summary level 2017/18 to 2018/19 operational financial plans (commissioners only)	1 November 2016 (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November 2016
Final NHS Standard Contract published	4 November 2016
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November 2016 ¹
Submission of full draft 2017/18 to 2018/19 operational plans	24 November 2016 (noon)

¹ Row 16 footnote: The date 4 November for 'Providers to respond to initial offers from commissioners (CCGs and direct commissioners)' was incorrect. It has been corrected to 11 November.

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Weekly contract tracker to be submitted by CCGs, direct commissioners and providers	Weekly from: 21/22 November 2016 to 30/31 January 2017
National Tariff section 118 consultation closes	28 November 2016
Where CCG or direct commissioning contracts not signed and contract signature deadline of 23 December at risk, local decisions to enter mediation	5 December 2016
Contract mediation	5 – 23 December 2016
National Tariff section 118 consultation results announced	w/c 12 December 2016
Publish National Tariff ²	20 December 2016
National deadline for signing of contracts	23 December 2016
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December 2016
Submission of final 2017/18 to 2018/19 operational plans, aligned with contracts	23 December 2016
Final plans approved by Boards or governing bodies of providers and commissioners	By 23 December 2016
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January 2017
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January 2017

² The National Tariff publication date is dependent upon the completion of a 28-day consultation period

Finance and business rules

STP system control totals

25. STP areas are required to submit local financial plans showing how their systems will achieve financial balance within the available resources. We expect both the commissioner sector and the provider sector to be in financial balance in both 2017/18 and 2018/19. Operational plans for 2017/18 and 2018/19 are the detailed plans for the first two years of the STP.
26. We expect that:
- the transformation and efficiency plans, including activity growth moderation plans, set out in STPs will be reflected in individual organisational plans;
 - there will be aggregate financial activity and workforce plans at STP level, underpinned by financial control totals, and organisational level operational plans will need to reflect those aggregate plans;
 - accountability for delivery will sit with individual organisations but they will need to demonstrate how their organisational plans align with STP objectives and planning assumptions; and
 - STP leaders will have strong governance processes to ensure clarity as to how different organisations are contributing to agreed system working, how progress will be tracked, and how organisations will work together to manage cross-cutting transformational activity.
27. To support system-wide planning and transformation, we will be setting financial system control totals for all STP or equivalent agreed areas for planning purposes, ongoing monitoring and management. In the first instance, they will be derived from individual control totals for CCGs and provider organisations in that geography. On a by-application basis, there will be flexibility, by agreement with NHS England and NHS Improvement, for STP partners to adjust organisational control totals (both for providers and for CCGs) within an STP footprint, provided the overall system control total is not breached. This process will be managed so that two rules are met: the provider sector achieves aggregate financial balance in 2017/18 and 2018/19, and the commissioning system continues to live within its statutory resource limits. Individual organisations will continue to be accountable for managing within their organisational-level control totals.

28. This approach has a number of potential benefits, including the ability to shift money within systems to support agreed transformation plans or planned changes to patient flows; to manage financial risk across a health economy; and to pool administrative and other functions across organisations. Annex 5 provides further information.
29. Larger STP areas may wish to propose to NHS England and NHS Improvement a subdivision of their geography for these purposes, with separate system control totals (and governance arrangements) for each subdivision, where this is better suited to operational collaboration and risk management.

Approach to efficiency

30. In July 2016, the 'reset' publication 'Strengthening Financial Performance and Accountability in 2016/17 in the NHS' underscored the responsibilities of individual NHS bodies to live within the funding available. Specifically, it confirmed actions to support NHS providers in cutting the annual NHS provider deficit in 2016/17 to no more than £580m with a goal of £250m for 2016/17 and a balanced starting position for 2017/18 based on the full year effect of the measures taken. It also set out measures to sharpen the direct accountability of providers and commissioners to live within the public resources made available by Parliament.
31. As noted above, the provider sector will be expected to achieve aggregate financial balance in each of the two years of the operational plan after taking into account deployment of the £1.8bn STF. Any deterioration in the opening position for 2017/18 set out in the previous paragraph or in delivery during the plan period will require the relevant individual providers to deliver efficiency levels greater than the 2% national requirement to meet the control totals set by NHS Improvement, recognising that by definition they will have unrealised and undelivered efficiency opportunity from previous years.
32. Although there are increased resources available for the NHS in 2017/18 and 2018/19, the level of growth is significantly less than has previously been available to the NHS.
33. Therefore, the expectation is that providers and commissioners have a relentless focus on efficiency in 2017/18 and 2018/19; and that the opportunities set out in the national efficiency programmes and embedded in STPs are further developed in operational plans and delivered by providers and commissioners working together. The national transformation and efficiency programmes – RightCare, Continuing Healthcare, New Models of Care, Urgent and Emergency Care, Self Care and Prevention, Getting It Right First Time (GIRFT), and the Carter productivity programme led by NHS Improvement – will support this process, and learning from early adopters is now available.

34. Improvements in operational productivity need to be accelerated within providers and across STPs to reduce unwarranted variation in quality and costs. Particular focus should be given to:
- consolidation of pathology services and back office functions across STP footprints (and possibly wider);
 - compliance with the procurement of items on the mandated list and continuing to submit purchase order information for the Purchasing Price Benchmarking Index and taking action to move to best value items;
 - implementing Procurement, Hospital Pharmacy and Estates and Facilities Transformation Plans;
 - improved rostering systems and job planning to reduce the use of agency and increase clinical productivity, with reference to benchmarks and guidance around Care Hour Per Patient Day and Cost Per Care Hour metrics;
 - participating in the specialised commissioning savings programme for high cost drugs and devices; and
 - fully participating in the clinically led GIRFT programme by submitting any necessary data and enacting jointly agreed changes to clinical practice to reduce unwarranted variation.
35. Work to roll out Lord Carter's work in to the mental health and community provider sectors begins in autumn 2016, and providers and commissioners of these services are encouraged to participate.

National Tariff

36. The Tariff Engagement Document published in August 2016 proposed two major changes:
- first, to set a national tariff for two years; and
 - second, to move from using HRG4 currency design to using phase 3 of HRG4+ complemented by an updated system of top-up payments in order to better reflect different levels of complexity and current clinical practice.
37. Subject to consultation, cost uplifts in the national tariff will be set at 2.1% for 2017/18 and 2.1% for 2018/19. The cost uplifts include revised projections for pay drift, the costs of the apprenticeship levy and pass through drugs and exclude HRG-specific uplifts included in tariff prices for Clinical Negligence Scheme for Trusts (CNST). As previously announced, the efficiency deflator will be set at 2% in both years.

38. We proposed in the Tariff Engagement Document that we move all follow up outpatient activity to a single block payment. The rationale was to reduce inappropriate outpatient follow-ups. This proposal was not widely supported by either commissioners or providers. We therefore intend as an alternative to increase the percentage of follow-up costs bundled into first attendances as follows:
- 30% - adult surgical specialties and some medical specialties eg diabetes, cardiology and general paediatric medicine;
 - 20% - other medical specialties; and
 - 10% (ie no change) – oncology, haematology, paediatric specialties and areas where Best Practice Tariffs apply eg transient ischaemic attack.
39. We encourage local systems to consider more far reaching local payment reform to complement the redesign of first outpatient appointments and introduction of advice and guidance services under the proposed new CCG CQUIN, as well as to reduce inappropriate outpatient follow-ups, through local variations. Where local schemes are not in place, the default will be the approach set out above.
40. As announced in June, we will also publish the first new Innovation and Technology tariffs, drawing on the NHS Innovation Accelerator (NIA) programme, to incentivise take-up of the latest innovations across the NHS.

Education and Training Tariffs

41. To provide stability to providers, Health Education England (HEE) will not be introducing changes to the education and training tariff currency design before 1 April 2019. There are three possible exceptions to this:
- The non-medical placement tariff. The Department of Health (DH) consultation on education funding reforms could lead to structural changes from September 2018. HEE will continue to fund the non-medical placement tariff on the same basis as 2016/17, provided there are no material changes to placement numbers;
 - Dental undergraduate tariff, where the Department of Health is proposing changes to the structure of the tariff from April 2018; and
 - The potential expansion of the standardised education and training tariff for primary care placements.
42. The Spending Review settlement means that there will be no increase to the education and training tariffs in both 2017/18 and 2018/19, both for clinical placement settings and the salary contributions that HEE currently pays for each post graduate placement (eg F1 doctors in training). Study leave course fees may be removed from the education and training tariff for postgraduate medical placements subject to the outcome of DH proposals currently under consideration.

43. Transition to national education and training tariff price, which has limited provider gains and losses on a year by year basis, will continue in line with original transition plan. The cap on annual losses will remain at £2m or 0.25% of income. In addition, the non-recurrent supplementary tariff relief provided by DH this year will not be repeated for 2017/18. That relief effectively negated for 12 months the 2% reduction across all education and training tariffs in 2016/17. The Department of Health intends to provide further guidance on the education and training tariffs for 2017/18 and 2018/19 in due course¹.

Sustainability and transformation funding

44. The provider sector is required to return to aggregate financial balance in 2017/18, including through use of the £1.8bn STF. This is again being made available to providers in 2017/18 and 2018/19. Our expectation is that sustainability funding must deliver at least a pound-for-pound improvement in the aggregate financial position.

45. It is intended that the overall disposition of the £1.8bn will be as follows: a £1.5bn general fund allocated on the basis of emergency care; a £0.1bn general fund allocated to non-acute providers; and a £0.2bn targeted fund. The operating rules of the existing £1.8bn STF are subject to agreement with the Department of Health and HM Treasury, and we will set out further details in due course.

46. The baseline for 2017/18 trajectories will be the agreed trajectories for 2016/17. Any provider whose plan for 2016/17 did not deliver one or more of the national standards for operational performance will not be able to reduce this baseline, and will have a trajectory to reach the national standards during 2017/18. All other providers will be expected to deliver the national standard and will submit assurance statements to this effect to NHS Improvement. If a provider does not deliver its performance trajectory during 2016/17 as a result of exceptional circumstances outside of its control, it can use the appeals process to NHS England and NHS Improvement and, if successful, NHS England and NHS Improvement may jointly agree to adjust its trajectory, but this will only very rarely be the case.

¹ The Department of Health and Health Education England are currently in discussion with NHS Improvement about the impact of the proposed changes to Education Tariffs

47. The 2016/17 Spending Review provided additional dedicated funding streams for core priorities, including mental health, cancer care, general practice, and technology, building up over the next five years:

- **Primary Care:** For 2017/18, NHS England has allocated around £8bn in primary medical care allocations (central and local), an increase of £301m over the previous year, and around £8.3bn in 2018/19 a further £304m increase. CCGs should also plan to spend approximately £3 per head (totalling £171m non-recurrently) in 2017/18 and 2018/19, from their existing allocations, for practice transformational support, as set out in the General Practice Forward View. Additional information is available in the General Practice Forward View Planning Requirements in Annex 6.
- **Mental Health:** To support the transformation of mental health services, dedicated funding will be available. This includes centrally-held transformation funding of £215m in 2017/18 and £180m in 2018/19.
- **Cancer:** Most of the extra funding needed to improve and expand cancer services is contained within CCG and specialised commissioning growing core budget allocations. However, there are several specific elements of the Cancer Taskforce which will be “kick started” with national funds, and these will be announced shortly.
- **Technology:** £4.2bn of additional transformation funding for technology programmes will be subject to a consolidated approvals process which brings together NHS England, DH and NHS Digital funding as part of the National Information Board and associated new Digital Delivery Board (DDB). Programme plans for the period from 2017/18 to 2020/21 have been developed at a national level, and are subject to confirmation and challenge by DDB. During 2016/17, health economies organised themselves into digital footprints and developed Local Digital Roadmaps which are their plans of how they will digitise the providers in their area and achieve integration of information across care boundaries over the coming years. During the next period, NHS England and NHS Digital will work with STPs to agree allocation of transformation funding to support delivery of their Local Digital Roadmaps.
- **Diabetes:** The NHS Diabetes Prevention Programme will be scaled up in 2017/18 and 2018/19 in two further phases of expansion, with appropriate national funding to support this. Additionally, we intend to launch a wider programme of investment in supporting the treatment and care of people who already have diabetes, for which CCGs will have the opportunity to bid for additional national funding of approximately £40m per year to promote access to evidence based interventions - improving uptake of structured education; improving access to specialist inpatient support and to a multi-disciplinary foot team for people with diabetic foot disease; and improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs.

48. From 2017/18 onwards, the different streams of transformation funding will increasingly be targeted towards the STPs making most progress. However, this funding will need to be focused on full delivery of specific national programme objectives, rather than spread thinly everywhere. To minimise the administrative burden, we will ensure that the different application processes for different programmes are more co-ordinated, following the submission of STPs in October 2016. This will enable NHS England's Investment Committee to make investment decisions in time for the beginning of the 2017/18 financial year. Transformation funding will only be available to systems whose operational plans meet their required control total and performance trajectories.
49. Improving value in the NHS is at the heart of the Five Year Forward View. Over the course of this year NHS England has used the Best Possible Value (BPV) framework to make investment decisions for year two of vanguard funding and for transformation funding for mental health, cancer and maternity. The BPV framework is a structured approach to assessing the value of a particular project. It uses logic models and success hypotheses to estimate both quality benefits as well as financial return on investment and provide a robust mechanism for tracking the delivery of these benefits. For 2017/18 and 2018/19, the BPV framework will be used to assess most applications for transformation investments that are available for the NHS. We expect all STPs to have adopted value-based decision making processes based on the BPV framework, embedded from April 2017.
50. The capital environment remains very challenged with capital resources severely constrained. STPs will enable a clearer view of how capital funding can help deliver transformation. Provider capital plans will need to be consistent with clinical strategy and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. Providers will need to continue to procure capital assets more efficiently, maximise and accelerate disposals and extend asset lives. We will shortly issue guidance on commissioner and provider capital processes for 2017/18 and 2018/19.

Risk reserve

51. In 2016/17 we asked CCG and primary care commissioners to ensure the 1% non-recurrent investment was uncommitted at the beginning of the year in order to create a risk reserve for the NHS, which could then be spent later in the year if commissioners and providers are on track to deliver their financial plans. In total this was worth circa £800m. To make sure we can manage the risks that both commissioners and providers face in 2017/18 and 2018/19, we will require a similar level of risk reserve, whilst nevertheless maximising purchasing power available to frontline services early in the year.

52. For 2017/18 and 2018/19 we will be looking to both commissioners and providers to help create the risk reserve, as part of a more collaborative and system-wide approach, and to complement the introduction of system control totals at STP level. As in 2016/17, release of the risk reserve to each local system will be dependent on delivery of its control total, subject to a satisfactory national risk profile. The risk reserve will be created from three components, totalling circa £830m:

- CCGs will again be asked to ensure that 1% of their allocation is planned to be spent non-recurrently, but only half of this – equivalent to £360m – has to be uncommitted at the start of the year, with the other half being available for immediate investment.
- NHS England will add circa £200m to this, funded from drawdown.
- 0.5% of the local CCG CQUIN scheme will also be held within the risk reserve, contributing £270m. If a provider delivers its control total in 2016/17, the CQUIN will be paid at the beginning of 2017/18 to the provider, who will be required to hold it as a reserve until release is authorised (with CQUIN for 2018/19 linked to delivery in 2017/18). For providers that do not accept or deliver their control totals in the prior year the 0.5% CQUIN will be held by the CCG prior to potential release. In both instances this element of the risk reserve will be released for investment by the relevant providers when it is demonstrated that the system in question is delivering its control total.

CCG Business rules and allocations

53. The business rules for commissioners for 2017/18 and 2018/19 are set out in full in Annex E of the technical guidance. The key requirements are:

- all CCGs are required to aim for in-year breakeven, with expectations set for the minimum level of improvement in deficit CCGs;
- as in previous years, CCGs should plan for 1% non-recurrent spend:
 - o 0.5% to be uncommitted and held as risk reserve (see above); and
 - o 0.5% immediately available for CCGs to spend non recurrently, to support transformation and change implied by STPs;
- as was the case for 2016/17 and previous years, CCGs should also plan for 0.5% contingency to manage their in-year pressures and risks; and
- £0.4bn drawdown will be available supplemented by an increasing level of repayment of cumulative deficits, which will be used to fund:
 - o a contribution to the risk reserve;
 - o in-year CCG deficits (subject to the financial improvement rules set out in Annex E); and
 - o drawdown for CCGs and primary care budgets, which have built up cumulative underspends above 1% in previous years.

54. Commissioner allocations may be refreshed to reflect the impacts of new tariff pricing and updated Identification Rules for specialised services. Any adjustments will be published on 21 October 2016.
55. The commissioner sector needs to continue to achieve a balanced position, and within this those CCGs that are currently in cumulative deficit need to recover their position as rapidly as possible. Deficit CCGs are expected to achieve at least breakeven position in-year and plan for return to cumulative underspend over the Spending Review period. Where this is not possible, they will be required as a minimum to improve their in-year position by 1% of allocation per year plus any above average allocation growth until the cumulative deficit has been eliminated and the 1% cumulative underspend business rule is achieved. Any variation from this to reflect exceptional circumstances will need to be agreed with the relevant NHS England regional team. Annex E of the technical guidance sets out further details of the expectations for CCGs in deficit.
56. In addition centrally held transformation funding to support delivery of the General Practice Forward View and Mental Health Forward View will be allocated to CCGs for 2017/18 and 2018/19. More details of the approach to this are set out in Annexes 6 and 8 of this document.

CQUIN and Quality Premium

57. The current CQUIN scheme enables providers to earn up to 2.5% of annual contract value if they deliver objectives set out in the scheme. For 2017/18 and 2018/19, the full 2.5% will continue to be available to providers. NHS England is intending to make two changes to the scheme.
58. First, continuing the arrangement of the current year, 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. The indicator set has been streamlined, and with different indicator sets for different provider types. For acute and community services, the proposed national indicators cover six areas; there are five in mental health, and two each in ambulance services, NHS 111 and care homes. The indicators and their rationale are set out in Annex A of the technical guidance. NHS England will seek views over the next month on the measures and thresholds proposed for each indicator, through a new engagement exercise.
59. The national indicators include:
- NHS staff health and wellbeing (all providers)
 - proactive and safe discharge (acute and community providers);
 - reducing 999 conveyance (ambulance providers)
 - NHS 111 referrals to A&E and 999 (NHS 111 providers);
 - reducing the impact of serious infections (acute providers)
 - wound care (community providers);
 - improving services for people with mental health needs who present to A&E (acute and mental health providers);
 - physical health for people with severe mental illness (community and mental health providers);
 - transition for children and young people with mental health needs (mental health providers);

- advice and guidance services (acute providers);
- e-referrals (acute providers, 2017/18 only); and
- preventing ill health from risky behaviours (acute providers 2018/19 only; community and mental health providers, both years).

60. Secondly, the remaining 1% will be assigned to support providers locally. 0.5% will be available subject to full provider engagement and commitment to the STP process. In effect, this will be a cost free indicator for providers with clear scope for earning the full amount. The remaining 0.5% is discussed in paragraph 52 above.

61. The Quality Premium scheme will continue to be offered to CCGs. This will also become a two-year scheme. The 2017/18 to 2018/19 scheme has evolved from the 2016/17 scheme, in that NHS England has streamlined the indicator set and:

- retained indicators on Cancer Stage of Diagnosis and Patient Experience of Accessing their GP;
- evolved the existing Anti-Microbial Resistance measure into a measure on Bloodstream Infections;
- retained a locally selected indicator towards delivering the aims of the RightCare programme; and
- introduced two new indicators, one to be selected from a Mental Health menu, and one focused on delivery of Continuing Healthcare.

62. The previous Gateway tests will continue to operate for the scheme, covering Finance, Quality and measures within the NHS Constitution. More detail is set out at Annex A of the technical guidance.

Specialised services and other direct commissioning

63. NHS England's commissioning intentions for specialised services are being published alongside this document. These set out national priorities for the six programmes of care, and region-specific priorities. Reviews that will impact in 2017/18 include Hyperbaric Oxygen Therapy, Prosthetics, Spinal Cord Injury, Paediatric Burns, Children's Epilepsy Surgery, Metabolic Medicine, Intestinal Failure and Paediatric critical care, transport, surgery and extra corporeal membrane oxygenation. The document also sets priorities for clinical and service reform, quality improvement and peer review including the payment system for secure mental health and critical care.
64. The new specialised services framework will enable STPs to include the contribution of specialised care to population based health services and outcomes. Through the continuation of the existing gain-share arrangements, CCGs will also be encouraged to unlock efficiencies across whole patient pathways. The national adoption of information rules by all providers will enable clearer identification and action on unwarranted variation in utilisation, efficiency and outcomes.
65. The contracting approach for specialised services is aligned to implementation of the Carter review. It includes: locally priced services reform, to reduce cost per weighted activity unit; a comprehensive multi-year medicines optimisation approach underpinned by CQUIN; and further reforms to the medical device supply chain, high cost drugs reimbursement and data flows.
66. The specialised services CQUIN scheme has been simplified and updated following engagement with providers over the summer. The multi-year approach introduced after dialogue in 2016/17 was supported and is continued. The overall funding structure for the scheme will remain as now with 2% of contract value for all acute providers, 2.5% for mental health providers, and 2.8% for hepatitis C lead providers. Furthermore, the incentive payment will be increased from "typical provider cost + 25%" to "typical provider cost + 50%". The scheme provides a sufficient range of CQUINs to be relevant to the service diversity of specialised providers whilst setting a limited number of CQUINs per contract, proportionate to the financial value of CQUIN investment. The largest acute and mental health provider will have ten and five CQUINs respectively, with an average three CQUINs per contract. NHS England will seek further views on the proposed specialised CQUIN indicators as part of the wider CQUIN engagement exercise in October 2016, and will publish any changes to the final scheme at the end of October 2016.

67. The approach outlined in this planning guidance will also apply to NHS England's other areas of direct commissioning as appropriate, including public health services, services for the armed forces, and healthcare for people in secure and detained settings.

Commissioning in the evolving system

68. Over half of CCGs now have delegated responsibility for commissioning primary medical care. CCGs indicate that this number will increase very significantly by April 2017, with almost all having delegated responsibility by the end of 2018/19. CCGs are also playing a bigger role in specialised services commissioning through the regional collaboration hubs. As part of devolution policy, joint working with local government is being strengthened across the country.
69. CCGs and Upper Tier Councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) for 2017/18 and 2018/19 via the Health and Wellbeing Board. The plan should build on the 2016/17 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care. Further guidance on the BCF will be provided later in the autumn.
70. CCGs' role will continue to evolve. As new care models are established, the boundary between what is done by CCGs and by new integrated care providers will shift. However, there will continue to be a need for an effective commissioning function in the NHS. This includes acting as funder, setting local priorities and incentives, oversight of contracts, ensuring best value for the taxpayer, and ensuring the provision of a comprehensive local NHS within the available resources.
71. As part of this operational planning process, and within the context of STPs, CCGs will need to consider the opportunities for establishing new care models, the likely timetable for this and the implications for contracting. CCGs have a key role here in defining the scope of services for MCPs and PACS, engaging with local communities and providers over proposals, and running procurement processes. In particular, where the scope of MCP services includes services previously provided in hospitals, CCGs will need to agree revised contracts with the providers of these services. As part of the process for setting up new care models, NHS England will work with CCGs to ensure they have the capability and capacity to operate effectively in the changing provider landscape. This will include building on locally-led initiatives up and down the country for CCGs to work together across larger geographical footprints, for example, through joint appointments, integrated management and governance arrangements.

Annex 1

The Government's Mandate to NHS England, 2020 goals

1.	Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.
1.1: CCG performance	Overall 2020 goal: <ul style="list-style-type: none">• Consistent improvement in performance of CCGs against new CCG assessment framework.
2.	To help create the safest, highest quality health and care service.
2.1: Avoidable deaths and seven day services	Overall 2020 goals: <ul style="list-style-type: none">• Roll out of seven day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week.• Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements.• Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures.• Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50% by 2030 with a measurable reduction by 2020.• Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients.• Measurable improvement in antimicrobial prescribing and resistance rates.

<p>2.2: Patient experience</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96%), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
<p>2.3: Cancer</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Deliver recommendations of the Independent Cancer Taskforce, including: <ul style="list-style-type: none"> ◦ significantly improving one-year survival to achieve 75% by 2020 for all cancers combined (up from 69% currently); and ◦ patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
<p>3.</p>	<p>To balance the NHS budget and improve efficiency and productivity.</p>
<p>3.1: Balancing the NHS budget</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3% each year), including from reducing growth in activity and maximising cost recovery.
<p>4.</p>	<p>To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.</p>
<p>4.1: Obesity and diabetes</p>	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.

4.2: Dementia	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Measurable improvement on all areas of Prime Minister’s challenge on dementia 2020, including: <ul style="list-style-type: none"> o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
5.	<p>To maintain and improve performance against core standards</p>
5.1: A&E, Ambulances and RTT	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • 95% of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100% of the population. • 75% of Category A ambulance calls responded to within eight minutes. • At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.
6.	<p>To improve out-of-hospital care.</p>
6.1. New models of care and general practice	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • 100% of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50% of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.
6.2: Health and social care integration	<p>Overall 2020 goals:</p> <ul style="list-style-type: none"> • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG Improvement and assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the Government’s key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.

6.3: Mental health, learning disabilities and autism	Overall 2020 goals: <ul style="list-style-type: none"> • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: <ul style="list-style-type: none"> o 50% of people experiencing first episode of psychosis to access treatment within two weeks; and o 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks.
7.	To support research, innovation and growth.
7.1: Research and growth	Overall 2020 goals: <ul style="list-style-type: none"> • Support the Department of Health and the Health Research Authority in their ambition to improve the UK’s international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
7.2: Technology	Overall 2020 goals: <ul style="list-style-type: none"> • Support delivery of the National Information Board Framework ‘Personalised Health and Care 2020’ including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95% of GP patients to be offered e-consultation and other digital services; and 95% of tests to be digitally transferred between organisations.
7.3 Health and work	Overall 2020 goals: <ul style="list-style-type: none"> • Contribute to reducing the disability employment gap. • Contribute to the Government’s goal of increasing the use of Fit for Work.

Annex 2

The CCG Improvement and Assessment Framework

NHS England introduced a new Improvement and Assessment Framework for CCGs (CCG IAF) from 2016/17 onwards, to replace both the previous CCG Assurance Framework and separate CCG performance dashboard. In the Government's Mandate to NHS England, this new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS.

The Five Year Forward View (5YFV), NHS Planning Guidance and the Sustainability and Transformation Plans (STPs) for each area, are all driven by the pursuit of the "triple aim": (i) improving the health and wellbeing of the whole population; (ii) better quality for all patients, through care redesign; and (iii) better value for taxpayers in a financially sustainable system. The new framework aligns key objectives and priorities, including the way we assess and manage our day-to-day relationships with CCGs.

The CCG IAF has been designed to supply indicators for adoption in STPs as markers of success. In turn those plans will provide vision and local actions that will populate and enrich the local use of the CCG IAF.

The NHS can only deliver the 5YFV through place-based partnerships spanning across NHS commissioners, local government, providers, patients, communities, the voluntary and independent sectors. To ask CCGs to focus solely on what resides exclusively within their own organisational locus would miss out what many are doing, and artificially limit their influence and relevance as local system leaders. In both the CCG IAF, and STPs, we give primacy to tasks-in-common over formal organisational boundaries.

The CCG IAF is available on the [NHS England website](#).

Annex 3

NHS Improvement Single Oversight Framework

In September 2016 NHS Improvement published the Single Oversight Framework which has five themes:

- Quality of care (safe, effective, caring, responsive): we will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive, in combination with in-year information where available. We will also include delivery of the four priority standards for seven day hospital services.
- Finance and use of resources: we will oversee a provider's financial efficiency and progress in meeting its financial control total, reflecting the approach taken in strengthening financial performance and accountability. We are co-developing this approach with CQC.
- Operational performance: we will support providers in improving and sustaining performance against NHS Constitution standards and other, including A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services. These NHS Constitution standards may relate to one or more facets of quality (i.e. safe, effective, caring and/or responsive).
- Strategic change: working with system partners we will consider how well providers are delivering the strategic changes set out in the 5YFV, with a particular focus on their contribution to sustainability and transformation plans (STPs), new care models, and, where relevant, implementation of devolution.
- Leadership and improvement capability (well-led): building on the joint CQC and NHS Improvement well-led framework, we will develop a shared system view with CQC of what good governance and leadership look like, including organisations' ability to learn and improve.

By focusing on these five themes NHS Improvement will support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating. Quality of care, finance and use of resources, and operational performance relate directly to sector outcomes. Strategic change recognises that organisational accountability and system-wide collaboration are mutually supportive. Leadership and improvement capability are crucial in ensuring that providers can deliver sustainable improvement.

The Single Oversight Framework is available on the [NHS Improvement website](#).

Annex 4

October Guidance on STPs

The Five Year Forward View set out our shared ambition to improve health, quality of care and efficiency within the resources given to us by Parliament. This 'triple aim' will only be achieved through local health and social care organisations working together in partnership with the active involvement of patients, stakeholders, clinicians and staff. Sustainability and Transformation Plans are the means of delivering these objectives in each local health and care system.

In June, each STP area shared its emerging thoughts on the three to five critical issues in its locality. As discussed in our conversations during July, we now expect to see plans with more depth and specificity. We recognise that each area is at a different starting point and that you will be able to provide more detail in 17/18 than later years but the October submission should build on the previous STP guidance issued in April and:

- Set out your plan to address the feedback from our July conversation. We don't need another lengthy narrative. It would be helpful if you could provide a summary sheet or 'plan on a page' to set out your overall aims, highlighting key changes between the June and October submissions. This should also include a crisp articulation of the tangible benefits to patients and communities.
- Provide more depth and specificity on how you plan to implement the proposed schemes as annexes. Illustrative PIDs and templates that other footprints have developed will follow to support you in this process. Any proposed shifts in activity from the acute sector should be accompanied by a clear plan to build strong primary care and community based services to provide the appropriate alternative care. Whatever format you choose, your plan will need to set out a clear set of milestones, outcomes, resources and owners for each scheme, as well as overarching risks, governance and interdependencies. This should include which organisation is involved in each initiative to allow you and us to triangulate your STP with local operational plans. We recognise that your plans will be more detailed for 17/18 and 18/19 and more high-level thereafter and subject to the normal rules around consultation and engagement.
- Ensure your plan is underpinned by the finance template and shows the impact on activity, benefits (costs and returns), capacity, workforce and investment requirements over time. We expect calculations to build from a whole-system view developed in collaboration with local government colleagues. Further guidance will be provided separately.

- Set out the measurable impacts of your STP. These will reflect local priorities and show how your local metrics link to the three to five key issues identified in your June submission as well as national metrics agreed with the Department of Health. These are likely to include measurements already captured in the CCG Improvement and Assessment Framework and NHS Improvement's Single Oversight Framework such as emergency admissions, bed days per 1000, A&E and RTT performance as well as delivery against elements of the cancer, mental health and primary care plans. Further information will follow.
- Include a brief statement setting out how you envisage better integration between health and social care commissioning and services could support the overall objectives of your STP and proposals for working between the leadership of the STP and the health and social care integration plan if these are different. The LGA have also produced a tool to support integration (to follow).
- Set out the degree of local consensus amongst organisations and plans for further engagement. It would be useful to know the degree of support your proposals command, the extent that you have engaged stakeholders and the public so far, and your plans for further engagement with patients, stakeholders, clinicians, communities, staff and other partners and how you have held meaningful strategic conversations with both NHS boards, CCG governing bodies and local government leaders (Local Authority arrangements will vary across the country so you should seek the advice of your LA CEO on who best to involve and when). We have produced guidance on engagement and consultation to support you in this (published 15 September 2016).
- Continue to develop your estates strategy to deliver your service strategy; identifying and valuing the opportunities for estates rationalisation and land disposal (as well as funding sources) and any key interdependencies. The strategic estates advisers that supported CCGs in the preparation of their initial Local Estates Strategies will continue to be available to support you.

In order to plan effectively you will need to know the business rules and planning assumptions going forward, including how transformation funds and control totals will be agreed. We will therefore publish the Planning Guidance for your operational plans today – three months earlier than previous years – and we will be in touch to arrange a briefing in advance of publication.

STPs will be system-wide and set out how to deliver locally agreed objectives, how activity will flow between care settings and what each organisation needs to do to deliver the system-wide plan. Operational plans will be at the level of individual CCGs and NHS providers and capture each organisation's plans for quality improvement, activity and operational performance, including the reconciliation of finance, activity and workforce plans. This year, operational plans will cover 2017/18 and 2018/19, i.e. years two and three of the STP. The aggregate of all operational plans in a footprint need to be consistent with the STP. Operational plans will be expected to reconcile to STPs.

As you will need to move swiftly from STP to contract agreement, it is important that the key metrics in terms of activity trajectory and outline finance allocated are addressed within the STP.

Producing system wide STPs and earlier operational plans and contracts will be challenging for us all. Nevertheless, this offers a real opportunity to ensure that operational plans reflect our strategic intent rather than simply rolling forward last year's business model and to free up headroom in 2017 so that we can focus on delivering our plans rather than negotiating them.

Our Regional directors will continue to support you in this process and will provide feedback on your STP in November so you can feed this into the planning round. The role of the STP and the Footprint leader is a vital and evolving one and we will work with you to understand how we can best support each other as we move towards implementation.

Further information on available support will follow separately including a timeline of key milestones.

Submission

Plans need to be submitted by Friday, 21 October by 5pm to england.fiveyearview@nhs.net, copying in your Regional directors.

Annex 5

NHS England and NHS Improvement approach to establishing shared financial control totals

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1. Introduction

This annex covers the development and implementation of system control totals for 2017/18 and 2018/19.

The intent of system control totals is threefold:

- To sustain the commitment to collaboration developed across health economies through the STP process and reduce the incentives for individual organisations to optimise their own financial position at the expense of the wider system as the focus moves to operational planning and delivery;
- To create the flexibility for local systems to implement transformational change without being constrained by any resulting shifts in financial performance as between individual organisations;
- To maximise the likelihood of success in managing overall financial delivery risk in the system by fostering shared risk management approaches across health economies.

System-wide control totals are intended to complement rather than replace individual organisational control totals, and all organisations will therefore be held accountable for delivering both their individual control total and the relevant overall system control total.

The degree of flexibility offered to individual systems will depend on their appetite for collaborative financial management and the maturity of the processes and governance they put in place to support it. For 2017/18 this will be on a 'by application' basis. Flexible system controls will become the default from 2018/19, though each area will still be required to demonstrate that it has the appropriate mechanisms in place to ensure successful functioning of a shared control total.

2. Setting control totals

System control totals for each STP area are being developed and will be communicated to STP leaders to ensure that STP submissions in October deliver financial balance on a national basis in 2017/18 and 2018/19 and in each system by 2020/21. For 2017/18 and 2018/19 these system control totals will be derived from NHS England and NHS Improvement draft requirements of individual organisations (including direct commissioning on a basis consistent with the STPs) but will also take into account insights from the modelling undertaken to date by individual areas. These control totals should then be reflected in final STPs.

We expect individual operational plans to be a direct disaggregation of the agreed STPs to the component organisations, and the resulting individual control totals for operational planning and delivery should add up to the agreed STP control totals.

3. Scope and geography for system control totals

Control totals will be applied across providers and CCGs together.

For operational purposes, the system control total will exclude direct commissioning (other than delegated primary medical care) at least for the next two years. Ambulance trusts and highly specialised organisations with predominantly national remits will also be similarly excluded, as will local authorities. However, systems will need to consider the financial impact of their decisions on these other organisations.

The default is for operational control totals to apply to the same geography as the STP. However, larger STP areas may wish to propose to NHS England and NHS Improvement a subdivision of their geography for these purposes, with separate system control totals (and governance arrangements) for each subdivision, where this is better suited to operational collaboration and risk management. The subdivisions must cover the entire STP area between them, and each must be of a demonstrably sufficient size to provide appropriate risk pooling. System control totals are not expected to operate over a wider footprint than an STP.

4. Flexibility

Systems will also be able to apply for in-year flexibility to vary individual control totals whilst maintaining the overall system control total. System control total flexibilities can be applied within a given financial year only, not across financial years.

Shifts can only be made prospectively, for example to allow for the financial impacts of an agreed transformation plan or planned changes to patient flows. Systems may apply for changes to control totals at the planning stage and then quarterly thereafter.

Any changes will be subject to joint approval by the NHS England and NHS Improvement regional teams. As well as the inherent merits of individual proposals this will need to take into account the need for the provider sector to achieve aggregate financial balance in 2017/18 and 2018/19 and for the NHS England Group – comprising NHS England and CCGs – to live within its statutory resource limits.

The system control total approach will routinely apply to the planned underspend or deficit of the control group, but areas may also wish to explore combined arrangements for contingency, 1% non-recurrent spend, or other specific business rules. Where this option is taken, areas must ensure that such agreements are clearly documented and transparent.

Local system leaders should also give consideration to joint approaches to the accessing and deployment of national transformation resources, collaboration arrangements and pooled budgets with local authorities and gain share arrangements with specialised commissioning.

5. Local management arrangements

Areas will need to articulate the monitoring and management arrangements that will be put in place to ensure that a system control total can operate effectively. This is particularly important where they are seeking to apply the flexibilities outlined above. The arrangements will need to include the following:

- An oversight group comprising the leaders across the health economy with a named chair and including senior financial representation;
- Terms of reference which clearly articulate the limit of the group's decision making and how any escalation and dispute resolution will be managed;
- Arrangements for the operation of the group which have been approved by the boards or governing bodies of the constituent organisations;
- Reporting arrangements to receive timely financial and performance information to allow monitoring of performance against the control total and other related factors such as delivery of efficiency savings and CIPs plans; and
- Scenario planning which has been discussed and agreed by the group showing how delivery of the system control total will operate in various scenarios, where individual organisations fall short of their control total.

These arrangements will form a key part of any application for additional flexibilities and will also be subject to NHS England and NHS Improvement assurance processes.

6. Reporting

Reporting requirements for system control totals will be multi-level.

Each individual organisation will continue to report financial performance through its own governance route and in addition as part of the system control group.

NHS England and NHS Improvement will continue to monitor and report the financial performance of individual organisations against their agreed plans.

The system control total will provide a mechanism for monitoring the financial performance of an STP compared with its agreed strategy, and thus whether the STP's progress towards financial sustainability is being delivered. NHS England and NHS Improvement will put additional reporting mechanisms in place to allow us collectively to monitor performance against system control totals.

7. Benefits realisation

Establishing flexible system control total processes is not an end in itself but should be seen as a means for seeking improvement across the system that could not otherwise be achieved.

In designing their arrangements and applying for flexibilities, areas should consider how tangible benefits will flow from establishing the control total. Benefits may arise in the following ways:

Direct financial improvement – establishing a system control total may allow for greater certainty over income and expenditure within the health economy which may in turn allow for a more positive system control total than the sum of the individual control totals.

Improved risk management – working collaboratively across a control group may lead to an enhanced ability to manage financial risk across the health economy and hence improved risk management. This may then allow for earlier and greater release of risk reserves for investment.

Improved use of/reduction in admin resources – collaborative working across the health economy may yield benefits from a resource perspective, for example by combining programme offices, reducing the amount of resource dedicated to generating and challenging provider income claims, or negotiating contracts and disputes. Health economies may also wish to look at collaboration on common resources such as drugs purchases and call centre arrangements.

Behavioural change – in combination with the STP process, the establishment of a system control total approach may provide a better platform for medium term change by breaking through organisational barriers and helping to align the leaders of the health economy behind a common purpose. Behavioural change may provide short term measurable benefit if conflicting incentives are removed from the system and organisations are therefore acting in a goal congruent manner.

8. Application processes

Any systems wishing to manage system control totals over smaller operational footprints than the STP area should set out their proposals, including the rationale and supporting information in relation to the criteria set out above. This should be sent to NHSCB.financialperformance@nhs.net by 31st October 2016 for review and discussion with regional teams, leading to confirmation by 30th November 2016.

Those systems wishing to apply for flexibility in operating their operational control totals for 2017/18 should submit a proposal covering the following:

- A description of how the control total will operate, including the planned footprint, any initial flexibility proposals and the likely further flexibility required during the financial year;
- The accountability proposals;
- The oversight and monitoring arrangements for the operation of the control total;
- The additional reporting arrangements that will be required;
- An explanation of the expected benefits, including how these will be measured; and
- Any considerations for specialised services commissioning or provision, and any other cross border issues relevant to the application.

Annex 6

General Practice Forward View planning requirements

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1.1 Introduction

This technical annex outlines the planning requirements of CCGs to support implementation of the [General Practice Forward View \(GPFV\)](#)

The GPFV, published on 21 April 2016, sets out our investment and commitments to strengthen general practice in the short term and support sustainable transformation of primary care for the future. It includes specific, practical and funded investment in five areas – investment, workforce, workload, practice infrastructure and care redesign.

Many of the actions in the GPFV are for NHS England, Health Education England and the Care Quality Commission to take forward. This guidance focuses on the actions needed to implement the more local aspects.

Strengthening and transforming general practice will play a crucial role in the delivery of STP plans, and already many STP footprints are integrating the aims and more local elements of the GPFV into the system wide plans. To complement this, CCGs should similarly translate the aims and key local elements of the GPFV into their more detailed local operational plans. This technical annex distils the priorities that CCGs should consider as they develop these local plans. Some of these are for CCGs to consider alone; others are for CCGs to consider working in collaboration.

CCGs will need to submit one GPFV plan to NHS England on 23 December 2016, encompassing the specific areas outlined in this guidance. Plans will need to reflect local circumstances, but must – as a minimum – set out:

- How access to general practice will be improved
- How funds for practice transformational support (as set out in the GPFV) will be created and deployed to support general practice
- How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

1.2 Investment

The [NHS England allocations for primary care \(medical\)](#) were published for five years.

This sets out that in 2017/18 and 2018/19 there will be an increase in funding for core local primary medical allocations of £231 million and then a further £188 million on top respectively. In addition to those allocations, other primary care funding is available for specific purposes as part of the £500 million plus sustainability and transformation package announced in the GPFV, as detailed below, as well as specific extra funding to support improvements in access to general practice, and improvements in estates and technology.

1.2.1 Elements of the sustainability and transformation package

a) Transformational support 2017/18 and 2018/19 from CCG allocations

CCGs should also plan to spend a total of £3 per head as a one off non-recurrent investment commencing in 2017/18, for practice transformational support, as set out in the GPFV. This equates to a £171million non- recurrent investment. This investment should commence in 2017/18 and can take place over two years as determined by the CCG, £3 in 17/18 or 18/19 or split over the two years. The investment is designed to be used to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time, and secure sustainability of general practice. CCGs will need to find this funding from within their [NHS England allocations for CCG core services](#).

b) Online general practice consultation software systems

The £45 million funding for this programme (over three years), announced in the GPFV, will start to be deployed in 2017/18 with £15 million devolved to CCGs along with rules and a specification, and a further £20 million in 2018/19.

The allocations to each CCG will be based upon the estimated CCG registered populations for 2017/18 and 2018/19, which can be found in the "GP Registration Projections" tab of [Spreadsheet file B](#).

CCGs can calculate their share of the funding in 2017/18 by multiplying the £15 million total by their registered population figures in column X within the "GP Registrations Projections" tab of the [Spreadsheet file B](#), and then dividing by the total number of registered patients in England of 58,173,725.

Likewise, CCG shares for 2018/19 can be calculated by multiplying the £20 million total by their registered population figures in column Y, and dividing by the total number of registered patients in England of 58,592,211.

CCGs will be accountable for this spend to deliver the specification outlined. Further details on the specification and monitoring arrangements will be shared in due course.

c) Training care navigators and medical assistants for all practices

The £45 million funding for this programme (over five years) announced in the GPFV, totals £10 million in 2017/18 and £10 million in 2018/19, with £5 million already allocated in 2016/17. Again, this funding will be devolved to NHS England local teams or delegated CCGs based on their share of registered patients as a percentage of the England total.

The allocation for 2017/18 for each CCG area will be their total estimated registered population for that year, shown in column X of the “GP Registration Projections” tab of [Spreadsheet file B](#) divided by the total estimated registered patients in England, of 58,173,725 multiplied by the £10 million total.

Likewise, the allocation for each CCG area is the estimated CCG registered lists figure in column Y of the “GP Registration Projections” tab of [Spreadsheet file B](#) divided by the total of patients in England of 58,592,211 multiplied by the £10 million total.

CCGs will be accountable for this expenditure to deliver the specification outlined for this work, with details on the specification and monitoring arrangements being shared in due course.

d) General Practice Resilience Programme

The £40 million non-recurrent funding for the [General Practice Resilience Programme](#) (over four years) announced in the GPFV, has already begun to be deployed, with £16 million already allocated in 2016/17. Funding for this programme in 2017/18 totals £8 million, and a further £8 million in 2018/19.

This funding will be delegated to NHS England local teams on a fair shares basis as set out in the published [guidance document](#), which contains the details of the allocations. NHS England local teams should ensure these amounts are included in their plans.

A number of other elements of the package are being held centrally. Some schemes have already started and announcements will be made in due course as to how further funding for these will be spent and distributed, or how centrally commissioned arrangements can be accessed. Commissioners of GP services should not currently factor any of the funding for these schemes into their plans.

1.2.2 Funding to improve access to general practice services

This funding is being targeted at those areas of England which had successful pilot sites in 2015/16, known as the “Prime Minister’s Challenge Fund” or “General Practice Access Fund” sites.

CCGs should plan to receive £6 per weighted patient for each of these sites in 2017/18 and £6 per weighted patient in 2018/19.

The programme will expand in 2017/18, bringing the total investment up to over £138m million. This funding will be recurrent. There will be further funding coming on stream in 2018/19, totalling £258 million. This additional funding will be allocated across all remaining CCGs to support improvements in access, as £3.34 per head of population and as set out in the ‘improved access’ section of this document.

It has been agreed that, given some of the unique characteristics of London, the funding for London schemes will be available to be deployed to support improvements across the whole of the geographical area. Further information will be available through NHS England (London).

Further background details on improving access to general practice are available [here](#).

1.2.3 Estates and Technology Transformation Fund (primary care)

CCGs were invited to bid for funding from 2016/17 onwards as set out in guidance issued in May 2016. Details of the process and milestones are also included in that guidance.

CCGs will receive confirmation that a bid has been successful shortly.

1.2.4 Other funding for general practice

There will also be some non-recurrent funding held nationally to support GPFV commitments in a number of areas, including growing the general practice workforce, premises and the national development programme. In addition, there will be increases in a number of national lines to support the promised increase in investment in general practice set out in the GPFV. This includes:

- increases in funding for GP trainees funded by Health Education England;
- Increases in funding for nationally procured GP IT systems;
- Increases in the section 7A funding for public health services, which support payments to GPs for screening and immunisation services; and
- 3,000 new fully funded practice-based mental health therapists to help transform the way mental health services are delivered.

The GPFV also assumes that there will continue to be increases in CCG funding to general practice (currently totalling around £1.8 billion in 2015/16) at least equal to, and ideally more than, the increases in CCG core allocations which are 2.14% in 2017/18 and 2.15% in 2018/19.

1.3 Care redesign

As part of their GPFV plan, CCGs should have a clear, articulated vision of the care redesign that will deliver sustainable services today and transformed services tomorrow. This will be part of their STP's vision. This should include details of the changes to be made to redesign services for improved outcomes, including the ways in which greater use will be made of selfcare, technology and a wider workforce, and other actions to address challenges with general practice capacity.

CCGs should agree a plan for implementation of these changes across all member practices and other providers, with an indication of how this has been developed in co-production with primary care providers themselves.

1.3.1 Improved access

As outlined in the investment section, NHS England will provide additional funding, on top of existing primary medical care allocations to enable CCGs to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

CCGs will be required to secure services following appropriate procurement processes.

Recurrent funding to commission additional capacity and improve patient access will increase over time. In 2017/18 CCGs with General Practice Access Fund Schemes, and a number of additional geographies identified across the country which will accelerate delivery of improving GP access, will receive recurrent funding of £6 per head of population (weighted) to commission improved access. In 18/19, this will expand to enable remaining CCGs to improve access, with £3.34 available in 2018/19 for those remaining CCGs. In 2019/20 all CCGs will receive at least £6 per head extra recurrently for those improvements in general practice.

In order to be eligible for additional recurrent funding, CCGs will need to commission and demonstrate the following:

Timing of appointments:

- commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.

Capacity:

- commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

Measurement:

- ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

Advertising and ease of access:

- ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service;

- ensure ease of access for patients including:
 - o all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
 - o patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital:

- use of digital approaches to support new models of care in general practice.

Inequalities:

- issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

Effective access to wider whole system services:

- Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

During 2017/18 CCGs should ensure 100% coverage of extended access (evening and weekend appointments) is achieved in GP Access Fund sites and a number of additional geographies identified across the country which will accelerate delivery of improving GP access.

In 2018/19 and 2019/20, we expect this roll out to continue. Remaining CCGs will be required to start access improvement in 2018/19, with funding at £3.34 per head of population for the year, and achieve 100% coverage from April 2019, when funding will reach at least £6 per head of population in 2019/20.

CCGs will need to provide plans outlining their approach to improved access by 23 December 2016 as part of their GPFV plan. This should include trajectories on improved access coverage for their local population.

There are currently significant inequalities in different groups' experience of access. Whilst making changes designed to improve access, CCGs should ensure that new initiatives work to reduce inequalities as well as improve overall access.

1.3.2 Time for Care Programme

In July 2016, NHS England set out plans to establish a new national development programme for general practice – [Time for Care](#). CCGs will want to consider identifying a senior person to lead local work to release staff capacity in general practice. They will be an important part of championing the 10 High Impact Actions to release time for care, support the planning of care redesign programmes and act as a link with NHS England development leads. Where appropriate, they will also support local practices in [submitting expressions of interest](#) for the Time for Care and [General Practice Improvement Leaders](#) programmes.

CCGs should have clear plans for how they will support the planning and delivery of a local Time for Care development programme, to implement member practices' choice of the 10 High Impact Actions. This could include details of:

- how this piece of practice development is being aligned with other developments locally such as technology and estates investment, workforce development and improved collaboration between providers, and
- the investment being made by the CCG to create headroom for practices to engage in development.

1.3.3 Deployment of funding for reception and clerical staff training, and online consultation systems

CCGs are not required to submit a plan to the national NHS England team prior to beginning to spend funds allocated for [training in active signposting](#) and document management, or supporting the purchase of [online consultation systems](#). However, they will be required to report on their use of this funding on a regular basis, as part of wider arrangements for monitoring GPFV activity.

The funding will be allocated equally between all CCGs on a capitated basis. The first tranche of funds were transferred in September 2016, but future allocations will be made near the beginning of each financial year.

It will usually be preferable for practices to undertake training or innovation adoption in local cohorts, rather than on an ad hoc basis. CCGs may wish to consider pooling funding with others in their STP footprint. Reporting of GPFV activity will allow CCGs to indicate where this is being done.

As part of their GPFV plan, CCGs should describe how these two new funds will be used for member practices, and may wish to do this collaboratively across the STP footprint. This should include evidence that the plan:

- a) has been developed in consultation with general practices themselves;
- b) will be delivered in alignment with other development activities such as local Time for Care programmes, and wider workforce and technology strategies;
- c) includes plans to use early adopters to help spread innovations in workforce and technology; and
- d) provides assurance that this funding is ring-fenced for the intended purposes.

1.4 Workforce

In their GPFV plans, CCGs will want to include a general practice workforce strategy for the local system that links to their service redesign plans. These should be clear about the current position, areas of greatest stress, examples of innovative workforce practices, the planned future model and actions to get there.

For example, the plans could include:

- a baseline that includes assessment of current workforce in general practice, workload demands and identifying practices that are in greatest need of support;

- workforce development plans which set out future ways of working including the development of multi-disciplinary teams, support for practice nursing and establishing primary care at scale;
- commitment to develop, fund and implement local workforce plans in line with the GPFV and that support delivery of STPs;
- initiatives to attract, recruit and retain GPs and other clinical staff including locally designed and nationally available initiatives;
- actions to ensure GPs are operating at the top of their license, for example through use of clinical pharmacists in a community setting and upskilling other health care professionals to manage less complex health problems;
- actions which facilitate an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets.

NHS England has retained some national funds to support workforce developments as indicated in the investment section. This includes:

- International recruitment:** NHS England will produce a framework for CCGs along with other partners to recruit doctors internationally and will fund several overseas recruitment projects for up to 500 doctors nationally. Further information will be available by the end of December 2016.
- Clinical pharmacists in general practice:** in addition to the clinical pharmacist recruited in phase one, additional funding will be available (as set out in the GPFV) for providers over the next three years to assist in costs of establishing the role in practices. Further information will be made available by December 2016.
- HEE and NHS England will produce frameworks and models to support the expansion of physician associates, medical assistants and physiotherapists.

1.5 Workload

[Guidance for the General Practice Resilience Programme](#) sets out indicative funding allocations of £8 million each year for 2017/18 and 2018/19 for NHS England Regional teams to deliver a menu of support to help practices become more sustainable and resilient. Local teams should work in partnership with STPs and CCGs to ensure this funding is used to target support at areas of greatest need and work in line with the processes set out in the operational guidance to deliver upstream support for practices. Local teams will keep their assessments of practices to be selected for support under six-monthly review and by July and January of each financial year will be able to confirm their list of practices prioritised for support and that agreed action plans for delivery of support to these practices are in place.

For people living with long term conditions, self care is usual care. STP footprints should ensure that people living with long term conditions reporting low levels of support or confidence to self care (or for those STPs using the Patient Activation Measure, low levels of activation) undertake regular personalised care and support planning and are signposted to tailored support. Personalised care and support planning should take place in general practice and should produce a single care plan, which is owned by the patient and shared with the system.

Commissioners should also have established pathways of care that integrate with community pharmacy. For example, we would expect CCGs to have considered the value provided by a community pharmacy based minor ailments service and also the contribution to better medicines use by patients with long terms conditions – both of which are expected to have a positive impact on patient experience and practice workload.

1.6 Practice infrastructure

CCGs should have clear local estates and digital roadmaps which lay out the plans to create the infrastructure to support new models of care. These should deliver against the requirements set out in recent guidance (Local Estates Strategies: A Framework for Commissioners and the GP IT Operating Model 2016/18).

Estates and technology schemes funded or part funded by the Estates and Technology Transformation Fund must meet the specified core criteria. NHS England will work with CCGs to agree the pipeline of investments.

Digital Roadmaps, as highlighted in the GP IT Operating Model 2016/18, should set out priorities and deliverables for each year. Interoperability must feature as must the pursuit of innovative technologies to transform triage and consultations with patients to alleviate workload pressures.

Annex 7

Cancer services transformation planning requirements

2017/18	2018/19	Metrics
Strengthen existing tobacco controls and smoking cessation services, in line with reducing smoking prevalence to below 13% nationally by 2020	Strengthen existing tobacco controls and smoking cessation services, in line with reducing smoking prevalence to below 13% nationally by 2020	Smoking prevalence in adults in routine and manual occupations (PHOF 2.14; annual; PHE)
Increase uptake of breast, bowel and cervical cancer screening programmes	Increase uptake of breast, bowel and cervical cancer screening programmes	Cancer screening uptake rates (PH Outcomes Framework 2.20i-iii; annual; PHE) Stage at diagnosis
Drive earlier diagnosis by: <ul style="list-style-type: none"> A. Implementing NICE referral guidelines, which reduce the threshold of risk which should trigger an urgent cancer referral B. Increasing provision of GP direct access to key investigative tests for suspected cancer 	Drive earlier diagnosis by: <ul style="list-style-type: none"> A. Implementing NICE referral guidelines, which reduce the threshold of risk which should trigger an urgent cancer referral B. Increasing provision of GP direct access to key investigative tests for suspected cancer 	<ul style="list-style-type: none"> A. Stage at diagnosis B. GP direct access to tests used for suspected cancer in Diagnostic Imaging Dataset (official statistics; monthly; NHS England statistics)

2017/18	2018/19	Metrics
<p>Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard by:</p> <ul style="list-style-type: none"> A. Identifying any 2017/18 diagnostic capacity gaps B. Improving productivity or implementing plans to close these immediate gaps 	<p>Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard and to begin to meet the 28 day faster diagnosis standard by:</p> <ul style="list-style-type: none"> A. Identifying any 2018/19 diagnostic capacity gaps. B. Improving productivity or implementing plans to close these immediate gaps 	<p>62-day cancer waiting times (official statistics, monthly, NHS England statistics) Stage at diagnosis</p> <ul style="list-style-type: none"> A. Submission of planning trajectories for activity (diagnostic tests; endoscopy tests) (annual, NHS England) B. Diagnostic Waiting Times (official statistics; monthly; NHS England Statistics)
<p>Ensure all parts of the Recovery Package are available to all patients including:</p> <ul style="list-style-type: none"> A. Ensure all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment B. Ensure that a treatment summary is sent to the patient's GP at the end of treatment C. Ensure that a cancer care review is completed by the GP within six months of a cancer diagnosis 	<p>Ensure all parts of the Recovery Package are available to all patients including:</p> <ul style="list-style-type: none"> A. Ensure all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment B. Ensure that a treatment summary is sent to the patient's GP at the end of treatment C. Ensure that a cancer care review is completed by the GP within six months of a cancer diagnosis 	<p>Local data collection Currently piloting collection of HNA data using COSD (PHE) Developing national quality of life metric</p>
<p>Ensure all breast cancer patients have access to stratified follow up pathways of care and prepare to roll out for prostate and colorectal cancer patients</p>	<p>Ensure all breast, prostate and colorectal cancer patients have access to stratified follow up pathways of care</p>	<p>Local data collection Exploring how data may be collected nationally Developing national quality of life metric</p>
<p>Ensure all patients have access to a clinical nurse specialist or other key worker</p>	<p>Ensure all patients have access to a clinical nurse specialist or other key worker</p>	<p>CNS question in CPES (Q17 Cancer Patient Experience Survey, annual, NHS England Statistics)</p>

Annex 8

Mental health transformation planning requirements

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1 Mental health transformation

1.1 Overview

Local areas must plan to deliver in full the implementation plan for the Five Year Forward View for Mental Health, including commitments to improve access to and availability of mental health services across the age range, develop community services, taking pressure off inpatient settings, and provide people with holistic care, recognising their mental and physical health needs. As part of this, local areas must also ensure delivery of the mental health access standards for Improving Access to Psychological Therapies (IAPT), Early Intervention in Psychosis (EIP) and eating disorders.

Additional funding underpinning the delivery of the Five Year Forward View for Mental Health must not be used to supplant existing spend or balance reductions elsewhere. This new money builds on both the foundation of existing local investment in mental health services and the ongoing requirement to increase that baseline by at least the overall growth in allocations to deliver the Mental Health Investment Standard. Savings arising from new services (such as integrated Improving Access to Psychological Therapies/Long Term Conditions and Mental Health liaison in A&E) resulting from this new investment need to be reinvested to maintain services and ensure delivery of the commitment to treat an additional one million people with mental illness by 2020/21.

CCGs should commit to sharing and assuring financial plans with local Healthwatch, mental health providers and local authorities. Details of deliverables and actions are summarised below but areas should make reference to fuller guidance set out in Implementing the Five Year Forward View for Mental Health.

1.2 Transformation funding

Mental health transformation funding is available for the specific deliverables within the implementation plan. For 2017/18 and 2018/19 the new commitments which are supported by identified funding are:

- Commission additional psychological therapies from a baseline of 15% so that at least 25% of people with anxiety and depression access treatment by 2020/21, with the majority of the increase integrated with physical healthcare.
- Increase access to evidence-based specialist perinatal mental health care, in line with the requirement to meet 100% of need by 2020/21, and ensure that care is in line with NICE recommendations.
- Deliver 'core 24' standard liaison services for people in emergency departments and inpatient wards in at least 50% of acute hospitals by 2020/21.

Small amounts of transformation funding may be available locally, if not nationally delivered, in 2018/19 against the following sets of deliverables:

- Deliver community based alternatives to secure inpatient services such that people requiring services receive high quality care in the least restrictive setting.
- Deliver increased access to Individual Placement Support for people with severe mental illness in secondary care services by 2020/21; increase access to IPS by 25% on 2017/18 baseline in 2018/19.

Details of amounts of funding available both from the transformation fund and within CCG baselines are set out in Implementing the Five Year Forward View for Mental Health.

1.3 Summary table of key deliverables for mental health transformation

Deliverable	Key actions for commissioners and providers	How this will be measured
<p>Increase access to high quality mental health services for an additional 70,000 children and young people per year.</p>	<ul style="list-style-type: none"> • Implement local transformation plans to expand access to CYP services by 7% in real terms in each of 2017/18 and 2018/19 (to meet 32% of local need in 2018/19). • Ensure that all areas take full part in the CYP IAPT workforce capability programme and staff are released for training courses. • Commission 24/7 urgent and emergency mental health service for children and young people that can effectively meet the needs of diverse communities, and ensure submission of data for the baseline audit in 2017. 	<ul style="list-style-type: none"> • Access to evidence based treatment for children and young people will be measured through the MHSDS (number of CYP who have started and completed treatment) and NHSE finance tracker to monitor additional funding. • Data will be provided from HEE and the CYP IAPT programme at CCG and provider level. • 24/7 urgent and emergency response times will be measured through a baseline audit and, subsequently through the MHSDS.
<p>Community eating disorder teams for children and young people to meet access and waiting time standards.</p>	<ul style="list-style-type: none"> • CCGs should commission dedicated eating disorder teams in line with the waiting time standard, service model and guidance. • Commissioners and providers should join the national quality improvement and accreditation network for community eating disorder services (QNCC ED) to monitor improvements and demonstrate quality of service delivery. 	<ul style="list-style-type: none"> • Waiting times and access to evidence based care will be measured through UNIFY from 2016/17 and the MHSDS from 2017/18.

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<p>Increase access to evidence-based specialist perinatal mental health care.</p>	<ul style="list-style-type: none"> • Commission additional or expanded specialist perinatal mental health community services to deliver care to more women within the locality. • Ensure staff are released to attend training or development as required. 	<ul style="list-style-type: none"> • Provision of specialist community services will be monitored through MHSDS and NHSE finance tracker. • Baseline provision against treatment pathway and outcomes will be measured through CCQI self-assessment and subsequent validation.
<p>Commission additional psychological therapies for people with anxiety and depression, with the majority of the increase integrated with physical healthcare.</p>	<ul style="list-style-type: none"> • CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21. Ensure local workforce planning includes the number of therapists needed and mechanisms are in place to fund trainees. • From 2018/19, commission IAPT services integrated with physical healthcare and supporting people with physical and mental health problems. This should include increasing the numbers of therapists co-located in general practice by 3000 by 2020/21. 	<ul style="list-style-type: none"> • Increased access rates: through quarterly publications and other reports within the IAPT data set. • Therapists working in general practice: through the annual IAPT workforce census.

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<p>Expand capacity so that more than 50% of people experiencing a first episode of psychosis start treatment within two weeks of referral with a NICE-recommended package of care.</p>	<ul style="list-style-type: none"> • Commission/provide an early intervention service that provides NICE-concordant care to people aged 14-65 years, meeting the relevant access and waiting time standards in each year. • At least 25% of EIP teams should meet the rating for 'good' services in the CCQI self-assessment by 2018/19. 	<ul style="list-style-type: none"> • The RTT component of the standard will be measured through the UNIFY collection in 2017/18, moving to MHSDS as soon as possible. • The NICE-concordant component of the standard will be measured in the CCQI provider self-assessment.
<p>Reduce suicides by 10%, with local government and other partners.</p>	<ul style="list-style-type: none"> • CCGs and providers should contribute fully to local multi-agency suicide prevention plans, following the latest evidence and PHE guidance. 	<ul style="list-style-type: none"> • Suicide rates will be published by CCG in the MH dashboard, using ONS statistics.
<p>Commission effective 24/7 Crisis Response and Home Treatment Teams as an alternative to acute admissions.</p>	<ul style="list-style-type: none"> • Commissioners must have conducted a baseline audit of CRHTTs against recommended best practice and have begun to implement a funded plan to address any gaps identified. • Providers must routinely collect and monitor clinician and patient reported outcomes and feedback from people who use services. 	<ul style="list-style-type: none"> • Plans for CRHTTs to be monitored through the CCG Improvement and Assessment Framework. • Delivery of effective CRHTTs in line with standards to be assessed and validated by CCQI. • CCG funding for crisis services to be monitored through NHSE finance tracker

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Eliminate of out of area placements for non-specialist acute care.	<ul style="list-style-type: none"> Commissioners and providers must deliver reductions in non-specialist acute mental health out of area placements, in line with local plans, with the aim of elimination by 2020/21 Commissioners must ensure routine data collection and monitoring of adult mental health out of area placements, including bed type, placement provider, placement reason, duration and cost. 	<ul style="list-style-type: none"> Plans for reducing OAPs to be monitored through milestone indicator in the CCG IAF. Out of area placements to be measured through an interim CAP collection (from autumn 2016), moving to the MHSDS (from April 2017).
Deliver integrated physical and mental health provision to people with severe mental illness.	<ul style="list-style-type: none"> CCGs should commission NICE-recommended screening and physical health interventions to cover 30% of the population on GP register with severe mental illness (SMI), and 60% in 2018/19. Providers to meet the physical health SMI CQUIN requirement. 	<ul style="list-style-type: none"> NHS England to measure physical health checks in primary and secondary care through a clinical audit of people with SMI to have received a cardio-metabolic assessment and treatment within inpatient settings, EIP services and community-based teams.

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<p>Ensure that 50% of acute hospitals meet the 'core 24' standard for mental health liaison as a minimum, with the remainder aiming for this level</p>	<ul style="list-style-type: none"> • Commissioners and providers must implement funded service development plans to ensure that adult liaison mental health services in local acute hospitals are staffed to deliver, as a minimum, the 'Core 24' service specification. • Funding will be made available for mental health liaison via a two-phase bidding process. The first phase of bidding will be run in autumn 2016 for funding in 2017/18 (wave 1) and 2018/19 (wave 2). The second phase of bidding will be run in autumn 2018 for funding in 2019/20 (wave 3) and 2020/21 (wave 4). A&E Delivery Boards (formerly known as System Resilience Groups) will be invited to bid in late October. 	<ul style="list-style-type: none"> • Health Education England will commission an annual workforce survey of liaison mental health services to monitor compliance with workforce elements of the 'core 24' standard. • Access and waiting times for liaison services will be assessed and monitored through CCQI, and in due course the MHSDS. • Outcome measures in line with RCPsych standards will also be collected and monitored through CCQI assessment against standards and the MHSDS.
<p>Increase access to Individual Placement Support for people with severe mental illness</p>	<ul style="list-style-type: none"> • Using local findings from the national IPS baseline audit, CCGs should plan for improving access to IPS employment support for people with SMI across their STP area from 2018/19. • STP footprints will be invited to bid for transformation funding in autumn 2017, with bids submitted by December 2017. 	<ul style="list-style-type: none"> • NHS England will commission a national baseline audit for IPS services in Q3/4 2016, supported by regional assurance of CCG plans.

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<p>CCGs will continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.</p>	<ul style="list-style-type: none"> • Achieve and maintain a diagnosis rate of at least two-thirds, making sustained gains towards the national ambition with a view to halving the number of CCGs not meeting the ambition by March 2019. • Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral; with a suggested improvement of at least 5% compared to 2015/16 (subject to local agreement). 	<ul style="list-style-type: none"> • Monthly monitoring and reporting of CCG diagnosis rates using QOF data. • Regular monitoring and reporting of referral to treatment times using MHMDS data and self-report data from the new CCQI tool. • Annual monitoring of care plan reviews using QOF data.
<p>Ensure data quality and transparency.</p>	<ul style="list-style-type: none"> • Commissioners must assure that providers are submitting a complete, accurate data return for all routine collections in the MHSDS, IAPT MDS and to any ancillary UNIFY collections. • Providers must engage with CCQI to complete and submit self-assessment tools and subsequent validation in relation to all evidence-based treatment pathways. • Ensure a locally agreed suite of quality/outcome measures is in place which reflects mental, physical and social outcomes, in line with national guidance. 	

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<p>Increase digital maturity in mental health.</p>	<ul style="list-style-type: none"> • Commissioners should support full interoperability of healthcare records ensuring mental health services are included in local digital roadmaps, plans and sufficient investment is made in functionalities and capabilities • Commissioners should support further expansion of e-prescribing across secondary care mental health services. 	<ul style="list-style-type: none"> • Next and subsequent iterations of the digital maturity index. • Next and subsequent iterations of the digital maturity index.