NHS England

EVERYONE COUNTS:

PLANNING FOR PATIENTS 2014/15 TO 2018/19

THE NHS CONSTITUTION
the NHS belongs to us all

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FOREWORD

Sir David Nicholson KCB, CBE Chief Executive

NHS England is a new organisation. We were established in 2011 but only took on our full powers in April 2013. Put simply, our role is to invest the £96 billion we receive from the government each year to deliver great outcomes for our patients.

We have been established as an independent organisation, at arms-length from government. Each year the government gives us a mandate[1] setting out its ambitions for the NHS. This details the outcomes that the government wants us to achieve for patients, but gives us the flexibility to determine *how* to deliver the mandate through our own direct commissioning and through Clinical Commissioning Groups. Delivering the mandate is central to our work but we also are determined to go further.

Our vision and purpose flow from the single idea that we exist to ensure ***high quality care for all, now and for future generations***. We want everyone to have greater control over their health and wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving.

Our work is underpinned by the following values:

- We prioritise patients in every decision we take.
- We listen and learn.
- We are evidence-based.
- We are open and transparent.
- We are inclusive.
- We strive for improvement.

Significant advances have already been made as a consequence of last year's planning guidance. Now for the next phase.

1 https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015

This planning guidance sets out how we propose that the NHS budget is invested so as to drive continuous improvement and to make ***high quality care for all, now and for future generations*** into a reality:

High quality care. We will be driven by quality in all we do. No longer can we accept minimum standards as good enough – our patients rightly expect the best possible service.

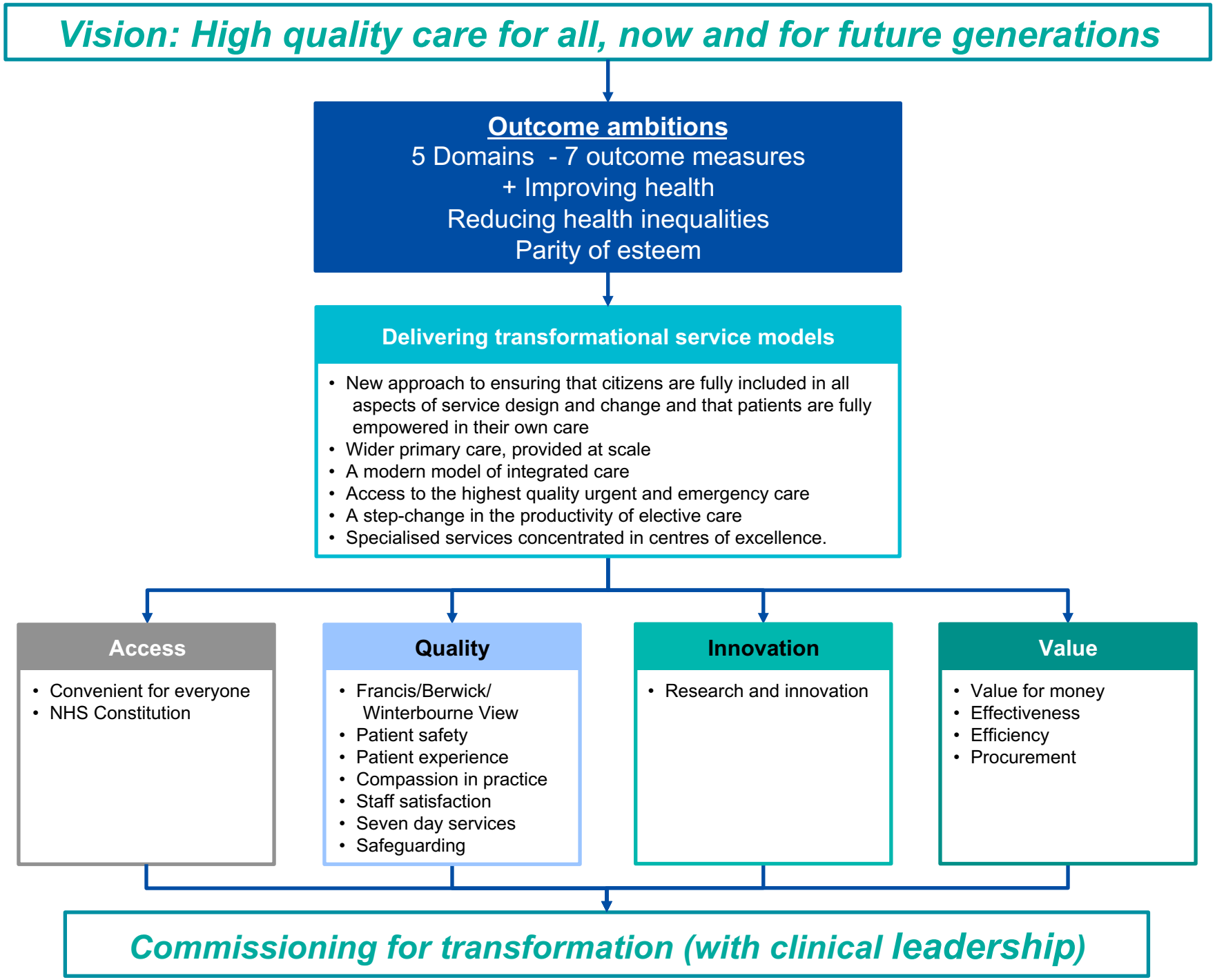
High quality care **for all**. We need to ensure that access to all services is on an equal footing whether the patient's need is for mental or physical help and support. We must put the greatest effort in providing care for the most vulnerable and excluded in society.

High quality care for all, **now**. But high quality is not just an aspiration. The NHS provides high quality care, often to the highest standards of anywhere in the world, but we need to spread excellence more widely. We have to learn from the best and get better at sharing good practice rapidly across the NHS.

High quality care for all, now **and for future generations**. We are investing not just for today but for the future. We have a responsibility to ensure that the NHS is on as strong a footing as possible, capable of remaining focused on quality through the significant economic challenges ahead. There is great urgency to plan strategically to start making the changes that are required to deliver models of care that will be sustainable in the longer term.

That is why this planning guidance is bold in asking commissioners to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all, now and for future generations.

Sir David Nicholson
Chief Executive


Vision: High quality care for all, now and for future generations
Outcome ambitions
5 Domains - 7 outcome measures
+ Improving health
Reducing health inequalities
Parity of esteem
Delivering transformational service models
• New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
• Wider primary care, provided at scale
• A modern model of integrated care
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• A step-change in the productivity of elective care
• Specialised services concentrated in centres of excellence.
Access
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• Safeguarding
Innovation
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Value
• Value for money
• Effectiveness
• Efficiency
• Procurement
Commissioning for transformation (with clinical leadership)

PART 1: OUR AMBITION

HIGH QUALITY CARE FOR ALL, NOW AND FOR FUTURE GENERATIONS

1. People consistently tell us that what they want from the NHS and the wider care system is great outcomes. This requires a relentless focus on the provision of high quality care – care that is safe, clinically effective and provides as good an experience for the patient as possible. They also tell us that they want services to be available when they need them, offered in a way which is convenient for them and that their needs must be met. They want to be helped to stay well and get the best treatment when they are ill. That is why NHS England wants the delivery of high quality care and the achievement of excellent outcomes for patients to be the central focus of our work.

2. Put simply, the outcome of care or a treatment is the impact it has on a patient – on their symptoms and on their ability to live the life they want to live. An outcomes-based approach means focusing less on *what is done* for patients, and more on the *results* of what is done. It means focusing on how well patients feel after treatment and helping them to stay well, whether suffering from physical or mental ill-health.

3. Our aspiration is to develop an NHS that delivers great outcomes, now and for future generations. That means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services and supporting local leaders to go even further to tailor care to their citizens' needs.

4. This document builds on the great work done last year in response to *Everyone Counts: Planning for Patients 2013/14*[2]. Part 1 focuses on the outcomes we want for patients and describes our bold ambitions to deliver them. It describes the emerging findings from our strategy, which lead us to six new models of care which together will deliver the transformational change needed if the NHS is to deliver improving outcomes

2 http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf

at a time of increasing need, unprecedented new treatment options and economic restraint. In our role as leaders of the commissioning system we emphasise where our focus will lie – delivering the government's mandate to us and going beyond that to secure even better care. It concludes by reaffirming our commitment to a clinically led commissioning system with CCGs as local leaders. NHS England is also a local commissioner and throughout we recognise our dual role – a local commissioning partner as well as the coordinator and leader of a commissioning system on which better health and better care depend.

5. Part 2 of this document outlines the planning process and details of the plan which needs to be produced. The first chapter provides an overview of the fundamental planning considerations for all plans, outlines the strategic enablers, describes how plans will be submitted and assured and provides an overview of the support available for the process. Subsequent chapters describe in more detail the content of plans and the core financial allocations and assumptions which must underpin them.

6. Last year we made five offers:
   - NHS services, seven days a week
   - More transparency, more choice
   - Listening to patients and increasing their participation
   - Better data, informed commissioning, driving improved outcomes
   - Higher standards, safer care

7. These offers represented what we then saw as the key enablers of change. They were identified early in NHS England's life when we had not begun the work on our emerging strategy. We consider that these early choices have stood the test of time; they remain central to the next stage of development and can now be accommodated in the broader context of our strategic thinking. High standards of quality are still at the heart of everything we do, and 7 day services, a key driver of quality, now are moving from aspiration to reality. This year's guidance describes the further progress we want to see on these as well as describing in the next level of detail how transparency and more widely available information empower citizens and patients and help them make the best choices for their services and their care.

8. Much of the basis for the government's mandate to us is the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see:
   - We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.
   - We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.
   - We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.
   - We want to ensure patients have a **great experience** of all their care.

- We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

9. Our ambitions will always be focused on delivering the outcomes in these five domains.

10. However, it is vital that we translate these outcomes into specific measurable ambitions which we believe are critical indicators of success and against which we can track our progress. Working with clinicians and staff in NHS England, in CCGs and with key stakeholders we have defined seven specific ambitions:
    - Securing additional years of life for the people of England with treatable mental and physical health conditions.
    - Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
    - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
    - Increasing the proportion of older people living independently at home following discharge from hospital.
    - Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
    - Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
    - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

11. Additionally, there are three more key measures that are vitally important and on which we expect to see significant focus and rapid improvements.

12. The first is **improving health,** which must have just as much focus as treating illness. At national level we will work closely with Public Health England to create the best environment for all localities. At a local level all stakeholders will address these issues through Health and Wellbeing Boards. We need to ensure that the key elements of Commissioning for Prevention are delivered and that every contact really does count in taking the opportunity to promote a healthy environment and healthy lifestyles. Everyone must make sure they work with all partners so that all those things which affect the broader determinants of health are addressed.

13. And as we strive to improve outcomes, we must place special emphasis on **reducing health inequalities**. We need to ensure that the most vulnerable in our society get better care and better services, often through integration, in order to bring an acceleration in improvement in their health outcomes.

14. We are absolutely committed to moving towards **parity of esteem,** making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then

don't get the best care for their physical health problems.

15. This is our ambition for the NHS and the wider care system – not only delivering the key elements in the government's mandate but also going beyond those ambitions in our national thinking and unleashing the power of local systems to deliver the ambitions of their population. This will not be a task for the NHS alone. CCGs, as the local leaders of the NHS supported by Commissioning Support Units, NHS England, and all NHS providers, will need to work closely with all the key partners on the Health and Wellbeing Boards. It will be vital that NHS commissioners work closely with Local Authorities, who have such an important part to play in securing the broader determinants of health as well as delivering high quality social care services, and Healthwatch who will ensure the patient perspective is paramount.

16. Working together we can make the biggest difference, ensuring great outcomes for everyone delivered through convenient services, under strong financial discipline, with enthusiastic and committed staff, adopting the 6Cs in *Compassion in Practice*[3], truly empowering patients and citizens and making everyone's lives better, both now and for future generations.

DELIVERING TRANSFORMATIONAL CHANGE

17. Fulfilling our long-term ambitions will require a change in the way health services are delivered. People are living longer, and our ability to treat and help to manage conditions that were previously life-threatening is improving all the time. With this has come a change in what can be delivered safely, effectively and efficiently in different settings. For example, patients can be cared for in their own homes, supported by experienced clinicians and technology which enables them to monitor their condition and get expert help to manage it. The result is that patients who would previously have needed hospital treatment can now stay at home.

18. That is why in July 2013, NHS England along with our national partners launched *A Call to Action*[4] which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. Put starkly, we need to find ways to raise the quality of care for all in our communities to the best international standards while closing a potential funding gap of around £30 billion by 2020/21. This was a call for creativity, innovation and transformation. It will require a significant shift in activity and resource from the hospital sector to the community. The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, including by reducing emergency admissions; hospital emergency activity will have to reduce by around 15 per cent. CCGs will need to make significant progress towards this during 2014/15.

3 http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

4 http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

19. The response to this Call to Action has been impressive. Over 250 local events involving clinicians, patients and public have been held to debate the future shape of services. Nationally, we have opened up discussion on the future of those services NHS England commissions with Calls to Action on general practice, community pharmacy and specialised services. And we have brought together patients, public and clinical and managerial experts in a series of events to share the best analysis and thinking on prevention, mental health and parity of esteem, and future landscape for providers, learning from the best in class in the world. In parallel, the development of integration pioneers and the ministerial focus on vulnerable older people have been strong influences on the Call to Action.

20. There is a good degree of consistency in the themes emerging. The strongest message is that citizens must be at the centre of all our planning; their interests and aspirations must be the organising principles for the future of health and care.

21. Taking this principle as our starting point, we know that different, identifiable groups within our population have different needs, and that the way services organise themselves to respond has a direct impact on outcomes and best use of resources. For many years, local health systems in this country and overseas have tested and developed new approaches for some groups covering some services. NHS England believes it is now time to draw out the lessons and propose a direction of service development, based on meeting the needs of whole populations, to be applied consistently across the country.

22. That means identifying the models of care that will apply in five years' time and determining the steps needed to realise that vision. NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
- Wider primary care, provided at scale.
- A modern model of integrated care.
- Access to the highest quality urgent and emergency care.
- A step-change in the productivity of elective care.
- Specialised services concentrated in centres of excellence.

Citizen participation and empowerment

23. We know that citizens want to be fully engaged in making positive choices about their own health and lifestyles; participating in the shaping and development of health and care services; well served by access to transparent and accessible data and advice about health and services; and able to choose which health services they can use and how to access them. We know that the public want a much greater say in how health services are organised, and we know that patients and their carers want much more say in how their personal care is delivered. We also know that patients and the public want much more and better information about how they can stay well or help to manage their own illness and to have

information that is of high quality and readily accessible about different services and different treatments so that they can make informed choices about what will be the best for them. Empowered in this way, citizens and patients become co-providers of and active participants in health care.

i) Listening to patients' views

24. We need to make sure that public, patient and carer voices are at the centre of our healthcare services from planning to delivery. We also want commissioners to be informed by insightful methods of listening to those who use and care about services. The extension of the Friends and Family Test to maternity services in October 2013, to community and mental health services by December 2014, to GP Practices from the end of December 2014 and to the rest of NHS services by the end of March 2015, will enhance the information that patients can use to make choices, such as for their maternity care. The Friends and Family Test provides real time feedback on the quality of services and gives front line staff a powerful incentive to make practical and timely improvements to the services they provide. There are two duties for NHS commissioners to support better patient and public participation. The first requires commissioners to ensure patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services they commission. The second requires the effective participation of the public in the commissioning process itself, so that services reflect the needs of local people. We have set out our approach to supporting CCGs with these important duties in *Transforming Participation in Health and Care*[5]. The stronger role for user voice within services will also be strengthened through the roll-out of Personal Health Budgets from April 2014. CCGs will be able to offer Personal Health Budgets, including as a Direct Payment, to all patients who may benefit, and NHS Continuing Healthcare patients will have a right to have a Personal Health Budget from October 2014. In addition, we will expand existing programmes of patient reported outcome measurement to give patients and carers the greatest ability to manage and share data on their own care.

ii) Delivering better care through the digital revolution

25. Changes in technology and the way we communicate have made vast differences to everyone's lives. We need to ensure that the NHS harnesses the use of this to deliver better care and to make it more convenient for patients. For example, we expect all people with a long-term condition to have a personalised care plan which is accessible, available electronically and linked to their GP health record, and that conforms to the best-practice standards that we will be developing. That will mean they receive safer care and don't need to repeat their details at every new contact. Greater access to web tools like NHS Choices and the creation of a digital 'front door' will help transform the way patients, their families and

5 http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

carers access information about NHS services and will provide self-management materials and information to further empower them to manage their own condition. Greater use of telehealth and telecare will also be important in supporting people with long-term conditions to manage their own health and care. We are committed to ensuring that nobody is left behind as we give patients and citizens greater control. For this reason, we have launched a major health literacy programme with the Tinder Foundation, which will help 100,000 people each year learn how to use the Internet for health benefit, and Care Connect, an initiative to test how telephone and social media channels can improve public participation.

iii) Transparency and Sharing Data

26. For too long the NHS has been unable to share the information patients need to understand their condition and make choices about the best treatment for them; including where and how they receive it. We are determined to make apparent the different clinical outcomes that different treatments, organisations and individual specialists achieve. Consultant level activity and clinical outcomes data for ten surgical specialties have now been published. This gives patients and citizens, as well as their commissioners and clinicians, enhanced access to data and information. We plan to extend this so that data from all appropriate NHS funded national clinical audits is made available before 2020. This will continue to provide vital insight for both patients and healthcare professionals about the care that is provided and lead to improvements in quality.

27. We also know that effectively collecting, sharing and interpreting data is fundamental to the transformation we need to deliver. The steps we have already taken include the promotion of a single set of data and data transmission standards to facilitate a nationwide exchange of health information. Called ***care.data*** this will safely join up existing clinical data sets, held securely within the Health and Social Care Information Centre, and extend and expand them so that they provide the data that commissioners need to support the delivery of high quality care and improved outcomes. Offering the opportunity for patients to access their own health information also forms part of this ground breaking work. These opportunities need to be factored into commissioner plans. By the summer of 2014 we anticipate that data in at least 5 per cent of GP practices will be linked to hospital data. By the end of March 2015 this will have increased to 90 per cent. We expect strategic plans to set out when 100 per cent coverage will be completed.

28. *Everyone Counts: Planning for Patients 2013/14* set out the expectation of universal adoption of the NHS number as the primary identifier by all providers. However, a significant number of providers are still not compliant. Such behaviour can have a detrimental impact on patient outcomes, as it hinders the effective flow of information between primary and secondary care. Working with EHI Intelligence we have developed the Clinical Digital Maturity Index (CDMI) which will allow us to identify the

scale of digitisation in each provider, including use of the NHS number. As a first step, we shall work with CCGs to secure immediate improvement from those providers who are in the bottom quartile of digitisation. Following that, our intention is to consider the possibility of introducing a range of increasingly stringent sanctions on poorly performing providers, from contractual fines through to the withdrawal of contracts.

29. The 2014/15 GMS contract will help empower patients by enabling practices to register patients from outside traditional catchment areas, thereby creating greater patient choice. It introduces a new requirement for practices to promote and offer to all patients the ability to book appointments, order repeat prescriptions and access their medical notes online. NHS England will develop metrics to identify the number of practices with access to online services.

30. The 2014/15 GMS contract introduces a new requirement for GP practices to upload information about medicines, allergies and adverse reactions onto the Summary Care Record. Commissioners should encourage out-of-hours, NHS111 and A&E providers to access this information to improve quality and outcomes. The contract also requires that practices use the NHS number as the primary identifier for all clinical correspondence from April 2014 and use electronic systems to transfer patient records between practices.

Wider primary care, provided at scale

31. For those patients with a moderate mental or physical long-term condition (about 20 per cent of the population) we need to secure access to all the support and care they need from wider primary care, provided at scale. This will mean access to a broader range of services in primary care, in their own homes and in their communities, centred on a much more pivotal and expanded role for general practice to co-ordinate and deliver comprehensive care in collaboration with community services and expert clinicians.

i) Transforming primary care services

32. Our strategic framework for commissioning of general practice services, to be published in 2014, will set out the action we are taking at national level to support commissioners in developing joint strategies for primary care as part of their five year strategic plans. One of our key aims is to enable general practice, community pharmacy and other primary care services to play a much stronger role, at the heart of a more integrated system of community-based services, in improving health outcomes. It is clear from the Call to Action that there is a widespread appetite for developing new models of primary care that provide more proactive, holistic and responsive services for local communities, particularly for frail older people and those with complex health needs; play a stronger role in preventing ill-health; involve patients and carers more fully in managing their health; and ensure consistently high quality of care. NHS England and CCGs have a joint responsibility to drive up all aspects of quality in primary care services.

33. There is a growing consensus that this will mean enabling general practice to work at greater scale and in closer collaboration with other health and care organisations, whilst retaining personal continuity of care and strong links with local communities. NHS England will create the strategic framework for this approach and work with CCGs to stimulate new models of care and in developing innovative forms of commissioning and contracting to support these new models.

A modern model of integrated care

34. For the 5 per cent of patients with multiple, often complex, mental or physical long-term conditions, often compounded by being elderly and perhaps frail, we need a modern model of integrated care with a senior clinician taking responsibility (through a personal relationship) for active co-ordination of the full range of support from lifestyle help to acute care.

i) Ensuring tailored care for vulnerable and older people

35. The government has determined that there will be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. Our expectation is that similar arrangements will apply to increasing numbers of people with long-term conditions in future years.

36. CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund.

37. In some instances, practices may propose that this new funding be used to commission new general practice services that go beyond what is required in the GP contract and the new enhanced service. We will make arrangements for NHS England to be involved under these circumstances in order to help identify the contractual arrangements and help provide appropriate oversight and governance. In other instances, practices may propose that this money be invested in other community services to secure integration with primary care provision. Practices should have the confidence that, where these initial investment plans successfully reduce emergency admissions, it will be possible to maintain and potentially increase this investment on a recurrent basis.

38. In addition, CCGs will need to demonstrate how individual practices can have as much influence as they need over the commissioning of associated community

services, community nursing, especially district nursing, and end of life care, so that their accountable GPs can discharge their responsibilities and so as to ensure that these services are co-ordinated with the services provided by the practice itself and provide integrated care for patients.

39. The 2014/15 General Medical Services (GMS) contract will support more proactive, integrated and personalised care, through:

- ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care;
- introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs; and
- giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working with out-of-hours services.

ii) Care integrated around the patient

40. Delivering care in a way which is integrated around the individual patient is essential to a new way of working which truly puts the patient at the heart of what we do. Our early focus will be the integration of care around the most frail, often elderly patients but it will be important for all those who receive complex care. This may mean integration across health and social care and across different elements of NHS care. It may mean integrating specific services or integrated provider organisations. It may mean integrated commissioning between CCGs and NHS England and Local Authorities. But what matters is that patients experience holistic care which is joined up and is a single tailored package for them. Each integrated care model will look different depending on the community served but is likely to include the following features:

- senior clinicians (within a team) taking full responsibility for people with multiple long-term conditions;
- full responsibility lasting from presentation to episodic care, including personalised care planning for those who would benefit; and
- co-ordination of care including lifestyle support and advice, social care, general practice care and hospital episode co-management.

41. With CCGs assuming responsibility for Special Educational Needs commissioning from September 2014, they will need to work closely with Local Authorities and schools to meet the wider pledge for better health outcomes for children and young people.

42. We have also begun to shift our focus from treating the consequences of poor care to the causes of preventing poor care. The £3.8 billion Better Care Fund that comes into operation in 2015/16 is aimed at supporting the integration of health and social care. The fund is an opportunity for local services to transform and improve the lives of the people that need it most. The fund will be available in 2015 but the planning has already started across the country. We expect commissioners to include in their

plans their vision for how health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes. All CCGs must include in their plans the actions they will take in 2014/15 to create the funding required to make the Better Care Fund affordable when it is introduced in 2015/16 in order to fulfil their duty to commission sustainable services for patients.

Access to the highest quality urgent and emergency care

43. All citizens deserve access to the highest quality urgent and emergency care. The report on the first phase *Urgent and Emergency Care review*[6] sets out an exciting vision for how we deliver NHS services in a way that complements modern day lifestyles and preferences. It suggests that the quality of urgent and emergency care would be enhanced if patients were treated as close to home as possible and if networks were established, with major specialised services offered in between 40 and 70 major emergency centres, supported by other emergency centres and urgent care facilities.

44. The review will take some time to implement. Meanwhile, there are immediate issues around planning for seasonal variation, emergency situations and times of varying demand.

45. NHS 111 services will be a key component of the urgent care service. NHS 111 services will be rolled out to cover the whole of England. In addition, NHS England and CCGs will produce a new service specification for 111 to support the future commissioning of a comprehensive and high quality service.

46. We expect local resilience planning, led through Urgent Care Working Groups (UCWGs), to be a continuous process, with preparations simply continuing on from this winter to lead us into next winter. UCWGs should refresh their membership and ensure that all relevant stakeholders are involved at an appropriately senior level when the full group convenes. We recognise that a smaller core group will be needed to support day to day activities. It is essential that GP practices and out-of-hours providers, as well as all those who deliver other community and mental health services, are fully involved. UCWGs must also engage effectively with local independent and voluntary sector providers, and we are developing a framework to support UCWGs in doing this. UCWGs should agree an appropriate mechanism for providers such as ambulance trusts, who will relate to many UCWGs, to engage with them all effectively, e.g. through lead commissioning arrangements. It is similarly equally important that all local CCGs whose patients use the acute trust at the centre of urgent care plans have a mechanism for full engagement through the lead CCG.

6 http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

47. We expect UCWGs will build on their plans for 2013/14 in the spring and will have a fully refreshed set of plans before summer 2014. NHS England, working with NHS Trust Development Authority (TDA), Monitor and partners in local government, will assess the effectiveness of each UCWG and, for those where there are concerns, will oversee the necessary changes required to ensure that these groups are well led and can play a comprehensive and effective role in the management of urgent care in 2014/15 especially during the winter. In particular, we expect UCWGs to be the vehicle for reaching agreement on the investment plans to be funded by the retained 70 per cent from the application of the marginal rate rule. Prior to any contracts being in place there must be absolute transparency about the use of this money to reduce pressures on A&E departments over the winter, and the acute trust must be satisfied that the plans for the use of that money addresses their needs.

A step-change in the productivity of elective care

48. For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity. We expect to see centres that can deliver high quality treatment, treating adequate numbers to be expert, and with the most modern equipment available. If we are going to transform out of hospital care and look to concentrate specialised services in fewer sites then we need to review how we deliver routine planned admissions for patients for less complex treatments. International comparisons suggest that, as well as quality improvements, there are significant productivity gains to be made if we can change our model of delivering elective care – giving us the opportunity to treat even more patients at the same or lower cost.

Specialised services concentrated in centres of excellence

49. For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered. Maximising quality, effectiveness and efficiency means working at volume and connecting actively to research and teaching. Specialised services are currently being delivered out of too many sites, with too much variety in quality and at too high a cost in some places. Through NHS England's direct commissioning we shall be looking to reduce significantly the number of centres providing NHS specialised services, require standards of care to be applied consistently across England and maximise synergy from research and learning. Our strategy for specialised services is still in the early stages of development, but we can foresee a concentration of expertise in some 15 to 30 centres for most aspects of specialised care. Academic Health Science Networks will play an important role as the focus for many of these.

Implementation choices determined locally

50. These characteristics of a high-performing health system will not need to be delivered in the same way everywhere. Local communities need to come together to

determine the best way to deliver services for patients. For example, integrated care models for the 5 per cent of our population with greatest need could be developed out of existing NHS Trusts or NHS Foundation Trusts, out of extended primary care built on general practice, or through new offers. The outcome is what matters rather than the process or organisational form. NHS England wants local partners to determine the delivery vehicle which best suits local geographies and capabilities.

MAINTAINING THE FOCUS ON ESSENTIALS

51. There are a number of essential elements that will apply to all of the characteristics of every successful and sustainable health economy:
    - quality;
    - access;
    - innovation; and
    - value for money.

52. We expect to see how a specific focus will be maintained on each of these in local plans in a way which clearly demonstrates how they will be implemented to drive up outcomes for patients and local communities.

Quality

53. In everything we do, quality – covering effectiveness, experience and safety – must be the central theme. All NHS commissioners must put quality at the centre of all their discussions with providers. Where feasible, NHS England will work with the Care Quality Commission (CQC) to agree the quality standards that apply to NHS services, with the CQC making the definitive judgements on quality in providers. The lessons from the Francis Report, Winterbourne View and the Berwick Report are that quality is as much about our behaviours and attitudes to patients as human beings as it is about the transactions we need to make to ensure services improve. There are three non-negotiable items that we expect to be part of every relationship between a commissioner and provider:

- The *Francis Report*[7] into the systemic failings at the Mid Staffordshire NHS Foundation Trust provides us all with important learning to ensure we expect and deliver the best possible care for our patients. NHS England supports the government's response set out in *Hard Truths*[8]. The National Quality Board's *How to ensure the right people, with the right skills, are in the right place at the right time*[9] sets out an approach to improving nursing, midwifery and care staffing for the benefit of patients. Getting the right staff with the right skills to care for our patients all the time is not something that can be mandated or secured nationally. Providers and commissioners, working together in partnership, listening to their staff and patients, are responsible for making these expectations a reality.

7 http://www.midstaffspublicinquiry.com
8 https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
9 http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

- *Transforming Care: A national response to Winterbourne View Hospital*[10] set out the basis on which CCGs, Local Authorities and specialised commissioners should work together to implement the core specification. This describes the core principles that must be present in all education, health and social care services for children, young people, adults and older people with learning disabilities and/or autism who either display, or are at risk of displaying, behaviour that challenges.

- Further to the government's response to the *Berwick review into patient safety*[11], CCGs are expected to take an active part in their local patient safety improvement collaborative and address how their commissioning can support local improvement. Commissioners should ensure they have systems in place to satisfy themselves that the providers they commission services from are effectively reporting and learning from safety incidents and implementing patient safety alert actions in a timely manner.

54. To ensure local autonomy and flexibility in how NHS organisations plan and deliver service re-designs, plans need to demonstrate robust evidence against four tests, which are that there should be:
    - support from clinical commissioners;
    - clarity on the clinical evidence base;
    - robust patient and public engagement; and
    - support for patient choice.

55. A number of vital aspects of quality need to be considered:

i) Patient safety

56. Knowing that they will be safe in our care is of paramount importance to patients. We are introducing a number of approaches to improve patient safety and reduce avoidable harm:
    - Regional and Area Team Quality Surveillance Groups to provide a wealth of evidence and intelligence to support early intervention when issues develop;
    - a new Patient Safety Alerting System to support organisations to understand and take rapid action in relation to patient safety risks;
    - continued zero tolerance of MRSA bloodstream infections and ongoing focus on reducing *Clostridium difficile* infections;
    - we will set up and support the Patient Safety Collaborative Programme to create a comprehensive, effective and sustainable collaborative improvement system that underpins a culture of continual learning and patient safety improvement; and
    - we will create new NHS Safety Thermometers for mental health care, medicines safety and maternity that can be used by organisations to support local improvement activity.

10 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
11 https://www.gov.uk/government/publications/berwick-review-into-patient-safety

57. From January 2014 the CQC will provide definitive quality ratings on all providers of NHS services. Commissioners are expected to take prompt action with all providers that are judged by the CQC as "require improvement" or "inadequate". The CQC has committed to sharing information with commissioners through its Intelligent Monitoring, and we expect commissioners to inform the CQC if they believe a provider might have quality or risk issues.

58. We also need commissioners to be more proactive in responding to complaints and concerns expressed by patients, the public and NHS staff, whether expressed through whistleblowing or other means. CCGs should have a strong and collaborative working relationship with their local Healthwatch so that issues of concern can be dealt with early.

ii) Patient Experience

59. Plans are expected to demonstrate measurable improvement in patient experience as well as continued investment in generating feedback. Improvement will be supported through:

- tools to help establish who is receiving poor care and where poor care is to be found;
- proven methods to enhance feedback and insight from vulnerable patient groups;
- tools to measure and improve the experience of carers;
- independent evaluation of improvement methodologies and easier access to proven techniques and support for their implementation, including train the trainer and master classes;
- recommended methodologies to strengthen forms of staff engagement which can support improvements in patient experience through better staff experience;
- support for the collaborative sharing of learning and good practice; and
- a strategy to learn from complaints and improve the experience of making a complaint.

iii) Compassion in Practice

60. *Compassion in Practice,* the national nursing, midwifery and care giving vision and strategy, provides a challenge for commissioners to support providers through the adoption of the 6Cs: care, compassion, competence, communication, courage and commitment. The 6Cs now have wide acceptance and reach throughout the nursing, midwifery and care staff workforce in the NHS across England in order to address six areas of action.

- help people to stay independent, maximising well-being and improving health outcomes;
- work with people to provide a positive experience of care;
- deliver high quality care and measure impact;
- build and strengthen leadership;
- ensure the right staff, with the right skills in the right place; and
- support a positive staff experience.

61. Each area of action has an implementation plan with national, local and individual actions. This is a nursing, midwifery and care staff strategy which is being delivered by the NHS healthcare system, with national bodies and regulators leading on a range of initiatives. CCGs are asked to ensure that the local areas of action within the Compassion in Practice implementation plans are reflected in the services they commission.

iv) Staff satisfaction

62. Staff satisfaction is an important indicator of quality. There is good evidence that happy, well-motivated staff deliver better care and that their patients have better outcomes. NHS staff work very hard, often under great pressure; and we must ensure that we work with all providers of NHS services to make it possible for them to do the best job they can. We must ensure that clinical leadership in front line teams flourishes and drives innovation and better care. The results of the staff survey and, as it comes on stream, the staff Friends and Family Test should be used when considering the quality of services being provided.

v) Seven Day Services

63. The NHS Services, Seven Days a Week Forum, chaired by the National Medical Director, has reported to NHS England on how NHS services can be improved to provide a more responsive and patient centred service across the seven day week[12]. The Forum was asked to focus, as a first stage, on urgent and emergency care services and their supporting diagnostic services. The Forum's review points to significant variation in outcomes for patients admitted to hospital at the weekend across the NHS. This variation is seen in mortality rates, patient experience, length of stay and re-admission rates.

64. There is no 'one size fits all' answer to introducing seven day urgent and emergency care services. Local solutions will need to be found. We shall work with Health Education England on the workforce implications of transforming services. The Forum has developed a set of clinical standards describing the standard of urgent and emergency care that all patients should expect to receive seven days a week. The standards have been developed through extensive engagement with stakeholders and include a comprehensive supporting evidence base. Local contracts for 2014/15 should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section, and a local CQUIN should be considered, based on the clinical standard for time from arrival to initial consultant assessment.

65. Consideration is being given to how data and information on the extent to which the clinical standards are being delivered, and the provision of seven day services, can be published in an accessible format that lends itself to comparisons. There is work to be undertaken both nationally and locally to determine how these standards can be delivered affordably.

12 http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/

vi) Safeguarding

66. The safeguarding of all those who are vulnerable is an enormous obligation for all of us who work in the NHS and partner agencies. There is still much to do to ensure this happens. In March 2013, NHS England published the *Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework*[13]. The Framework provides a clear set of principles and guidance to ensure the new system delivers improved outcomes for children and vulnerable adults. A strategic national steering group has been established to ensure the framework is embedded, and it provides a national forum to enable safeguarding leaders in NHS England to implement cross governmental policy. A number of key priorities are emerging which include policies to prevent child sexual exploitation, female genital mutilation, sexual violence and domestic abuse, and which will ensure effective implementation of national legislation and policies relating to vulnerable children and adults.

67. Demonstrating how safeguarding duties will be discharged needs to be reflected in all local plans and NHS England will seek continuous assurance on this important issue.

Access to services – Convenient for Everyone

68. Our patients have consistently told us how important it is that they don't have to wait for treatment. They tell us that waiting can be the most distressing part of their illness. And we know that waiting can make clinical outcomes worse and can even make services unsafe. We also know that our services can only improve outcomes for patients if they are available to them, and they receive those services quickly, when they need them, and in a way which is convenient for them and fits with their daily lives.

69. Disadvantaged and minority groups need specifically tailored services which suit their circumstances or they will simply not be accessible to them. There are many minority groups who will struggle to get the care they need if they are expected simply to fit in with what works for the majority.

70. During 2014/15, we will also oversee pilots designed to extend access to general practice services and stimulate innovative ways of providing primary care services, supported by the Prime Minister's £50 million challenge fund. There will be at least nine pilots covering around half a million patients and testing new ways of providing evening and weekend access, making greater use of email and phone consultations, joining up urgent care and out-of-hours care, and providing a range of other flexibilities in how citizens access services.

71. The NHS Constitution identifies a range of standards to which patients are entitled and which NHS England has committed to deliver. Every local plan will need to identify both how they will make services generally accessible but also how they will specifically deliver the standards in the constitution.

13 http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf

Driving Change through Innovation

i) Supporting our staff to innovate

72. NHS England is committed to innovation to deliver significant improvements in quality and efficiency in the NHS. In 2013/14 we introduced a Regional Innovation Fund to support and promote the adoption of innovation and the spread of best practice across the NHS. We will be looking to facilitate fresh perspectives or partnerships, bringing in different types of expertise or capacity to support the adoption of current innovations or the development of new ideas.

ii) Research

73. Research and evaluation across the whole patient pathway including with partners in local government and Public Health England will contribute to improving outcomes and spreading innovation and economic growth. A marker of quality within NHS organisations is those with research activity able to demonstrate evidence of improved patient outcomes and health service delivery. Commissioners should actively seek out research opportunities, understand where research is taking place within the providers with whom they contract and support that activity wherever possible, through their commissioning decisions.

Value for money, effectiveness and efficiency

74. Of course, all of this must be delivered against the backdrop of ensuring that patients and citizens get the very best out of every pound that is spent and that all parts of the system play their part in delivering better care within their allocated resource.

75. We have already set out that there is a potential funding gap of around £30 billion by 2020/21. Plans need to be explicit on how they will close this gap in a local context whilst maintaining or enhancing the quality of services provided to patients. NHS England does not underestimate the scale of this task and will do all in our power to support local health communities to take the bold decisions they need to transform services. We shall review our funding mechanisms so that they are truly supportive of improving outcomes.

76. In helping to deliver value for money for the taxpayer, commissioners and providers should support the implementation of *Better Procurement, Better Value, Better Care*[14]. This is a procurement development programme which includes an ambitious package of measures to help the NHS save £1.5 billion to £2 billion through improved procurement whilst supporting economic growth by improving access of opportunity for small and medium enterprises and ensuring the NHS is transparent in all its commercial relationships and procurement information.

77. It is absolutely critical that all commissioners can demonstrate a systematic approach to securing value for money, so that our patients can be assured that the best possible quality of care is secured for every pound spent on their behalf.

14 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226835/procurement_development_programme_for_NHS.pdf

LEADING THE WAY THROUGH COMMISSIONING

78. Last year's guidance identified stronger commissioning as a key theme for driving change. This section has set out those things which local commissioners need to include in their plans which will deliver the change they want to see. CCGs and NHS England, supported by CSUs, must work as a coordinated whole and with other non-NHS commissioners of care.

79. Our commitment to clinical commissioning remains strong, ensuring that commissioning decisions are firmly based on clinicians' close relationships with their patients and their understanding of clinical processes.

80. In this first section of the document we have:
    - reiterated the five domains of the outcomes we want to deliver for our patients;
    - translated those into a set of practical measurable ambitions which describe the progress we want to see in delivering the outcomes;
    - identified a further three measures which it is vital that we deliver;
    - signalled six patterns of service, emerging from our early Call to Action work, which we believe will be necessary to deliver the transformation we need; and
    - identified four essential elements for the delivery of services.

81. It is now for local communities and all those who commission or deliver care to them to create the robust plans which will be their roadmap to better outcomes for their citizens. CCGs as the local leaders of health commissioning will take the lead in working with all key stakeholders, especially Local Authorities, to develop those plans. NHS England will be alongside them in this planning as co-commissioners and in providing support and oversight. Health and Wellbeing Boards will be a key forum for agreeing plans with all stakeholders and accounting to the local community that these plans meet their needs and are delivered.
In some instances, CCGs will work together to create a bigger footprint as their unit of planning. In all instances, CCGs will need to work with their neighbours to ensure that each plan demonstrates how services delivered across a broader geography, such as ambulance services or specialised services, are commissioned and delivered consistently and cohesively. They will need to demonstrate how they deliver all the aspects of the government's mandate to the commissioning system. They will need to take account of NHS England's ambitions and steers on strategic approach. They will need to include their own ambitions for the things their citizens tell them will meet their needs.

82. This approach will allow us to articulate and quantify what we are aiming to achieve for the patients and communities we serve, both locally and nationally. The scale of our ambitions will be determined by how bold we, and the communities we serve, are prepared to be and by how well we collaborate with partner organisations, particularly local government and the

voluntary and community sector. Outcomes based commissioning is now fundamental to our approach and will maximise health gain for the citizens of England and value for money for taxpayers.

83. Plans must be owned locally and driven by local needs. Unlike previous years, this document is not prescriptive in how CCGs achieve this ambition, nor does it attempt to apportion to individual CCGs specific targets across a host of areas where our collective action will need to deliver and exceed the government's mandate. It makes the assumption that individual patches will want to go even further in delivering the best for their citizens. NHS England does, however, have a key role in assuring that all plans are sufficiently robust, that they will collectively deliver our commitments and that all citizens across England are supported by equally high quality services. We also need to make sure the commissioning system is effective and efficient and that local flexibility does not translate into inefficiency or duplicated effort.

84. Part 2 of this guidance sets out in greater detail our expectations of these plans, but most importantly it creates the framework for planning which will help everyone to deliver. We expect each local system to use this framework and the associated tools to make the right changes happen. The five year strategic plans are the starting point for the whole planning process. Each strategic plan needs to be tested against the six characteristics of a sustainable health and care system, ensuring that it reflects the needs of local citizens, the conclusions of local Call to Action conversations and insights from modelling tools such as Any town (see section 2 paragraph 41). The two year operational plans and the local approach to the Better Care Fund will need to demonstrate how they are driven by the strategic plan.

85. Part 2 also identifies the comprehensive range of support which is on offer.

86. Nationally, NHS England will organise and prioritise our work to support a move in this strategic direction. There is an important set of changes in day to day practice which will support these patterns of care, as well as a set of enablers we need to develop nationally to give local systems the freedom to innovate. As the Call to Action work draws to a conclusion in the spring/early summer 2014, we shall be working with national health and local government partners to identify the further financial, regulatory, leadership and workforce development enablers which will accelerate the move towards high quality, sustainable health and care systems across the country.

87. We expect the strategic vision work locally to be open and inclusive, involving patients, citizens and providers as well as commissioning partners on Health and Wellbeing Boards. We will harness the very best of what new technologies and new ways of working now offer to the changing needs of local populations and groups, relentlessly focusing on improving outcomes. In every part of the country this will be brought together into a compelling description of the local care delivery system that local health and social care communities want to build, underpinned by a clear and credible local plan to get there.

PART 2: HOW WE ARE GOING TO ACHIEVE THESE AMBITIONS

1. Part 2 of this guidance is structured to provide an overview of the planning process and details of the plans which need to be produced. It comprises four sections:
   - The Strategic and Operational Planning process – provides an overview of the fundamental planning considerations for all plans, describes how plans will be submitted and assured and provides an overview of the support available for the process.
   - Strategic, Operational and Financial Planning – provides a high level overview of the structure and requirements of the 3 plans, sets out the financial allocations and core financial planning assumptions and outlines the related strategic enablers.
   - Direct Commissioning – provides an overview of planning for direct commissioning and the associated financial planning assumptions.
   - Better Care Fund – provides an overview of Better Care Fund planning and the funding for integrated care.

THE STRATEGIC AND OPERATIONAL PLANNING PROCESS

A NEW APPROACH TO PLANNING

2. NHS planning has in the past been successful in supporting the delivery of annual incremental improvement. However, the NHS is facing an unprecedented challenge. We are committed to transforming outcomes for patients and to playing our role in minimising inequalities within and between communities. *A Call to Action* forecasts a financial gap of around £30 billion by 2020/21, and the affordability challenges in 2014/15 and 2015/16 are real and urgent.

3. Therefore, we now need to take a longer term view of the planning of services to reflect the step changes required to tackle these unprecedented challenges.

The planning process has changed to address this:

- Stretching local ambitions for outcomes should be developed against each of the outcomes ambitions set out in Part 1 paragraph 10 of this guidance, along with credible and costed plans to deliver them.
- Through this guidance we are setting out a challenge for commissioners to plan for the transformation of services on a five year basis. Each commissioner's five year plan must drive its decisions to ensure its providers are best placed to deliver high quality and sustainable services for patients, and in particular we would expect to see alignment with the six service models outlined in Part 1.
- Each five year plan should include the first two years of operational delivery in detail so that patients, their carers and other key stakeholders can be satisfied that progress is being made against the longer term goals and the service transformation needed to realise them.
- As set out in Part 1 paragraph 18, plans must be explicit in dealing with the financial gap and contain appropriate risk and mitigation strategies.
- The planning process and timeline have been aligned with our national partners, including NHS commissioners, Monitor, the NHS Trust Development Authority, the Local Government Association and Health Education England.
- In addition to completing a complete set of plans for their own organisation, CCGs have been asked to choose their own footprint for strategic health and social care planning. This may involve working as part of a larger 'Unit of Planning' to enable wider issues which affect more than one commissioner to be dealt with at scale.

How could this planning process look different?

	2013/14 planning round	2014/19
Period of time covered by plans	Requirement for the planning round was one year.	Strategic plans covering a five **year period with first two years at operating plan level of detail**
Integration between providers and commissioners	Cooperation encouraged between providers and commissioners.	**Cooperation will be encouraged formally through guidance issued and aligned process with Monitor/TDA**
Integration with social care	Local cooperation with Local Authorities to inform planning round.	**Widest possible scope of integration. Cooperation with Local Authorities for BCF planning**
Extent of support to commissioners preparing plans	Published guidance	**Support extended** to include benchmarking data, a comprehensive universal support offer and additional on-site support for challenged commissioners

- a stratified support programme has been put in place to support the new planning process.

4. Both short-term transactional change and long-term transformation need to be guided by an explicit model of change and to be supported by a strong research and evidence base. The NHS Change Model[15] has been created to support the NHS to adopt a shared approach to leading change and transformation. Developed with hundreds of our senior leaders, clinicians, commissioners, providers and improvement activists and supported by a robust evidence base, the NHS Change Model brings together collective improvement knowledge and experience from across the NHS. Application of the eight components of change brings together improvement in a systematic and sustainable way, and we would expect to see this approach reflected in local strategic and operational plans.

PLANNING FUNDAMENTALS

5. Strategic and operational plans must be explicit in dealing with local ambitions for outcomes within funding available. They should also be developed based on some fundamental planning principles. Plans should be:
   - bold and ambitious;
   - developed in partnership with providers and Local Authorities; and
   - locally led.

6. Either through submission of the planning templates or separately, each strategic and operational plan must explicitly set out in detail the approach to delivering the fundamentals set out in the table opposite, the five year ambition and the plans for the first two years to move towards the long-term ambition.

IMPROVING OUTCOMES

7. Part 1 paragraph 10 of this guidance sets out our seven ambitions which the NHS is striving to achieve for the people of England.

8. The seven outcomes ambitions are set out in Annex A of this document, together with the measures that CCGs should use in planning. NHS England Area Teams should use the same measures, where relevant to their commissioning responsibilities, with further measures also included in Annexes D-G of this guidance.

JOINT WORKING AND INVOLVEMENT

9. NHS England is working closely with Monitor and the NHS Trust Development Authority to ensure plans are sustainable and deliverable across commissioning and provision in local health economies. For plans to be deliverable, we are committed to ensuring that one organisation's plan does not put another's at risk or generate behaviours that work against patients' interests.

15 http://www.changemodel.nhs.uk

Fundamental elements of commissioner plans

		Fundamental	Key features to be demonstrated in plans
1	Outcomes	Delivery across the five domains and seven outcome measures	• your understanding of your current position on outcomes as set out in the NHS Outcomes Framework • the actions you need to take to improve outcomes
2		Improving health	• working with H&WB partners, your planned outcomes from taking the 5 steps recommended in the "commissioning for prevention" report
3		Reducing health inequalities	• identification of the groups of people in your area that have a worse outcomes and experience of care and your plans to close the gap • implementation of the 5 most cost effective high impact interventions recommended by the NAO report on health inequalities • implementing EDS2
4		Parity of esteem	• the resources you are allocating to mental health to achieve parity of esteem • identification and support for young people with mental health problems • plans to reduce the 20 year gap in life expectancy for people with severe mental illness
5	Patient services	New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	• how you will commission services so that patients and citizens have the opportunity to take control • how you will put real time patient and citizen voice at the heart of decision making • how you will include authentic citizen participation in the design of your plans • how you will promote transparency in local health services

		Fundamental	Key features to be demonstrated in plans
6	Patient services (continued)	Wider primary care, provided at scale	• your understanding of the potential contribution of primary care to delivery of your ambition • working with partners and the public to develop an integrated approach to primary and community services, with joint commissioning as appropriate • how you will enable primary care to operate at greater scale to improve access and continuity of care and to enable your urgent and emergency care network to function effectively
7		A modern model of integrated care	• what you are doing to ensure people with multiple long-term conditions and clinical risk factors are offered a fully integrated experience of support and care
8		Access to the highest quality urgent and emergency care	• how your strategic plan is in line with the vision set out in the Urgent and Emergency Care Review Phase One Report http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf • how you will you be ready to determine the footprint of your urgent and emergency care network during 2014/15, working with key partners and informed by a detailed understanding for your area of: a) patient flows; b) the number and location of emergency and urgent care facilities; c) the services they provide; and d) the most pressing needs for your population • how you will be ready in 2015/16 to begin the process of designation for all facilities within your network
9		A step-change in the productivity of elective care	• how you have considered your model of elective care for your local providers to achieve a 20% productivity improvement within 5 years, so that existing activity levels can be delivered with better outcomes and 20% less resource

		Fundamental	Key features to be demonstrated in plans
10	Patient services (continued)	Specialised services concentrated in centres of excellence.	• how your strategic plans address whether your providers are seeing and treating a sufficiently high enough volume of patients to meet specified clinical standards, in line with the need to concentrate specialised services in 15-30 centres of excellence, linked to Academic Health Science Networks • how your plans are ensuring that specialised services in your area are connecting actively to and maximising the opportunities of working with research and teaching
11	Access	Convenient access for everyone	• how you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups
12		Meeting the NHS Constitution standards	• that your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods
13	Quality	Response to Francis, Berwick and Winterbourne View	• how your plans will reflect the key findings of the Francis, Berwick and Winterbourne View Reports
14		Patient safety	• how you will address the need to understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement • how you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement

		Fundamental	Key features to be demonstrated in plans
15	Quality (continued)	Patient experience	• how you will set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice • how you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients • how you will demonstrate improvements from FFT complaints and other feedback
16		Compassion in practice	• how your plans will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans • how the 6Cs are being rolled out across all staff
17		Staff satisfaction	• an in-depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others • how your plans will ensure measureable improvements in staff experience in order to improve patient experience
18		Seven day services	• that the action plans submitted by your providers (a requirement within the Service Development and Improvement Plan section of the NHS Standard Contract) give you confidence that they will be able to comply with all ten of the Seven Day Service Clinical Standards by 2016/17 • if not, how your strategic and operational plans are going to ensure these standards are being met for patients • how your strategic plans are addressing the need to provide consistently high quality urgent and emergency care services outside of hospital across the seven day week

		Fundamental	Key features to be demonstrated in plans
19		Safeguarding	• how your plans will meet the requirements of the accountability and assurance framework for protecting vulnerable people • the support for quality improvement in application of the Mental Capacity Act • how you will measure the requirements set out in your plans in order to meet the standards in the prevent agenda
20	Innovation	Research and innovation	• how your plans fulfil your statutory responsibilities to support research • how you will use Academic Health Science Networks to promote research • how you will adopt innovative approaches using the delivery agenda set out in *Innovation Health and Wealth: accelerating adoption and diffusion in the NHS*
21	Delivering value	Financial resilience; delivering value for money for taxpayers and patients and procurement	• meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure. • clear and credible plans for QIPP that meet the efficiency challenge and are evidence based, including reference to benchmarks • the clear link between service plans, financial and activity plans

10. Plans need to reflect local priorities, as determined by each Health and Wellbeing Strategy, with the assumption that local discussions will resolve any differences. We expect commissioners and providers to cooperate in planning, and to be able to explain any differences in their assumptions. The assurance processes described later in this section will have a particular focus on localities where there are significant differences in plans.

11. *A Call to Action* has reinforced the need for active and on-going participation with local communities and the people within them. These participation activities need to be extensive, rigorous and demonstrably central to every five year strategic plan.

ALIGNED PLANNING ACROSS HEALTH ECONOMIES

12. Each CCG is accountable for developing a Strategic, Operational and Financial plan. To enable wider and more strategic health economy planning, all CCGs will work in close collaboration with relevant Area Teams, providers and Local Authorities and where appropriate they may also choose to join with neighbouring CCGs in a larger 'Unit of Planning' to aggregate plans, ensure that the strategies align in a holistic way and maximise the value for money from the planning resources and support at their disposal.

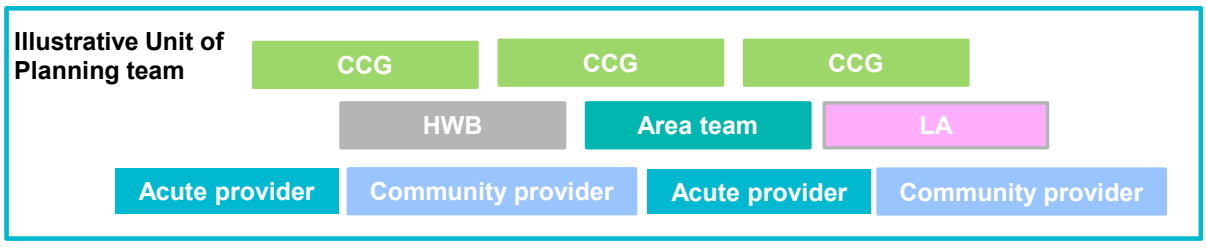
13. Where CCGs choose to associate to form a 'Unit of Planning' they should consider the following principles:

- each CCG to belong to one unit only;
- the Unit has been locally agreed and has clear clinical ownership and leadership;
- it is based on existing health economies that reflect patient flows across Health and Wellbeing Board areas and local provider footprints with no CCG to be split across boundaries;
- it has sufficient scale to deliver geography wide clinical improvements;
- it enables the pooling of resources to reduce the risk associated with large investments;
- it does not cut across existing locally agreed collaboration agreements;
- engagement has been secured from Local Authorities; and
- engagement has been secured from the Local Education and Training Board (LETB).

14. The diagram below demonstrates the potential components of a Unit of Planning.

15. Commissioner plans need to be submitted on the templates issued alongside this guidance. There are five templates:

- Strategic plan;
- Operational plan;



- Financial plan;
- Direct Commissioning plan; and
- Better Care Fund.

16. Broader strategic plans constructed by Units of Planning will be a consolidation of individual organisations' strategic plans.

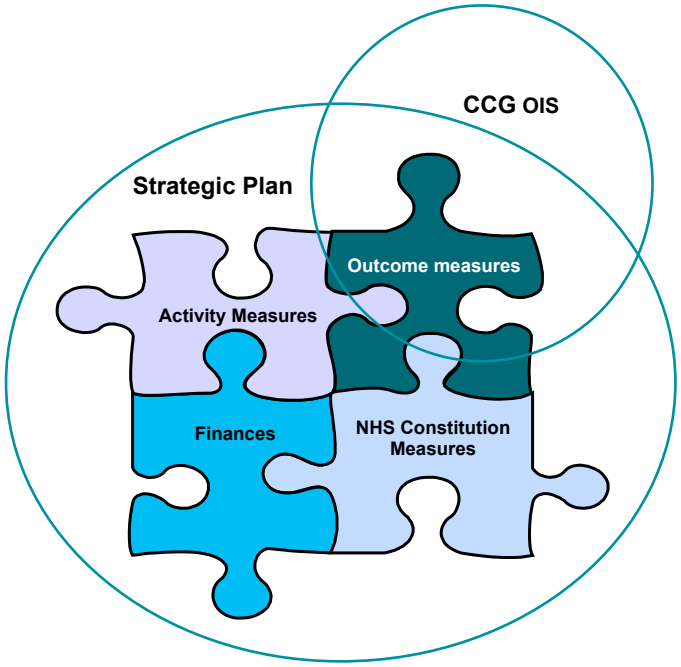
17. The Better Care Fund plan is developed at Health and Wellbeing Board level. This will mean that in some cases more than one CCG will be involved in the development of this plan.

18. Further details on plans for the Better Care Fund are included in Annex I of this guidance.

19. NHS England's plans for directly commissioned services may not always fit neatly to a single Unit of Planning, so Area Teams will ensure their plans dovetail into all relevant Units of Planning. Similarly, on some occasions a provider's plan may need to be reflected in more than one Unit of Planning, and when that happens, commissioners need to be satisfied that they are sighted on the totality of the Trust's plan.

BALANCING PLANS

20. It is important that plans are balanced and aligned across the respective strategic, operational and financial elements illustrated below.



21. The CCG Outcomes Indicators Set[16] (CCG OIS) should be used by CCGs as a tool to understand trends in outcomes and to help them identify potential priorities for improvement and for inclusion in plans. Not all outcomes will be relevant for every plan. CCGs and NHS England may wish to refer to indicators in the CCG OIS to help them gain a rounded picture of local outcomes as part of the assurance process.

22. NHS England will look to ensure that plans are consistent across primary, secondary and specialist care (i.e. that CCG and Area Team plans are aligned). We will work with Monitor and the NHS Trust Development Authority to develop a shared view about the recovery action that might be required where health economies are demonstrating pressure to such an extent that the quality of services provided to patients may be at risk of deterioration.

16 http://www.england.nhs.uk/ccg-ois/

23. The operational plans must demonstrate that the strategic plan is the driving force behind transformational change. The operational plans should contain outcomes and relevant local metrics which show the journey towards the tangible achievement of the overarching strategy.

PLANNING TIMETABLE

24. This guidance is issued at the same time as our allocations to commissioners. The planning timetable is detailed in the table opposite. It will be challenging for everyone; but it is important that we lay strong foundations for delivery during what will be a testing time for all NHS organisations.

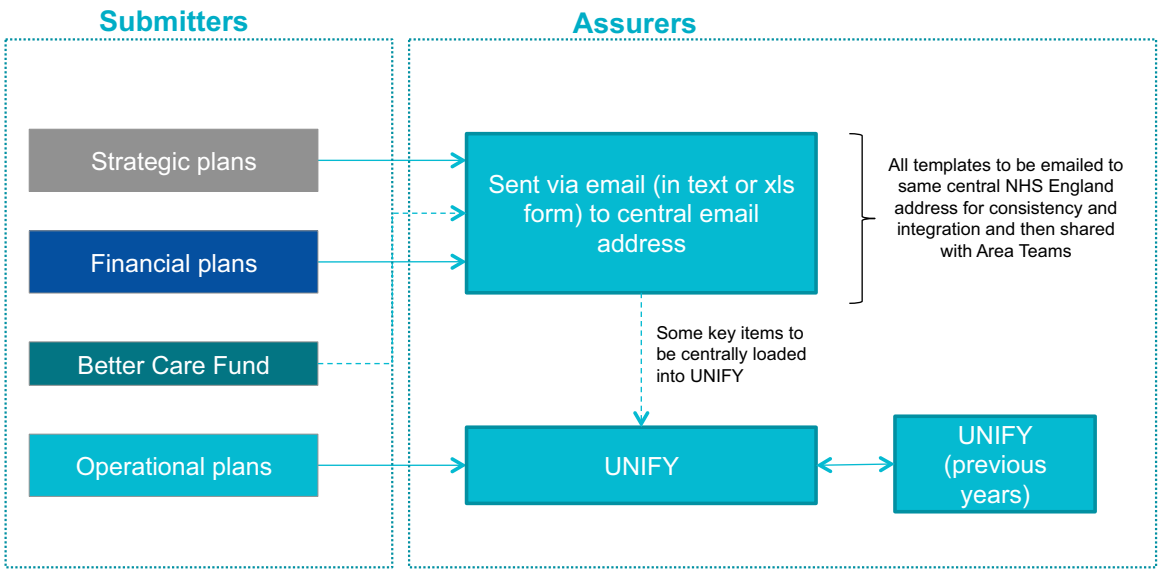
25. We will work closely with Monitor, NHS Trust Development Authority and Health Education England throughout this process to provide feedback to CCGs and providers and to ensure alignment and deliverability. This will be an iterative process as providers respond to commissioner plans.

Activity	Deadline
First submission of plans	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Reconciliation process with NHS TDA and Monitor	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year operational plans and draft 5 year strategic plan	4 April 2014
Submission of final 5 year strategic plans Years 1 & 2 of the 5 year plan will be fixed per the final plan submitted on 4 April 2014	20 June 2014

PLAN SUBMISSION

26. The diagram below illustrates the submission process.

Submission process



27. The central email address for strategic and financial plan submission is: NHSCB.financialperformance@nhs.net

ASSURANCE OF PLANS

28. Plan assurance will address the scale of ambition and plans for implementation of the planning fundamentals set out in paragraph 6 of Part 2 of this guidance, in the two and five year time horizons.

29. To maximise opportunities for mutual assurance across all health and social care services and minimise complexity, we will adopt the following principles for the assurance process:

- Assurance of the overall strategic plan will be at Unit of Planning level, including engagement with patients and public in the local community;
- Operational plans will be assured at CCG and at Health and Wellbeing Board level, and at Area Team level for NHS England's directly commissioned services;
- Area Teams to lead the assurance of CCG plans;
- Regional Teams manage the assurance of Direct Commissioning plans;
- Area Teams to assure the overall consolidated commissioning position and strength of local partnerships;
- Area Teams and CCGs to ensure mutual assurance of Direct Commissioning plans, with escalation by exception; and
- Boards and governing bodies should satisfy themselves that the outcomes or recommendations of the plan assurance process have been appropriately addressed prior to plan sign off.

30. The lead responsibilities for plan production and assurance are shown in the following table.

31. The NHS England national support centre will support regions and areas throughout the process, providing challenge and advice through a series of risk-based checkpoint meetings.

32. The review and triangulation of plans will include:

- the finances to secure delivery of the output objectives and adherence to the requirements outlined in the planning guidance;
- ensuring the finance and activity projections are supported by reasonable and deliverable planning assumptions including level of assumed QIPP delivery and underlying activity growth;
- triangulation of finance and activity;
- coherence with the other planning and output assumptions; and
- testing the strength of local relationships, which are key to ensuring delivery.

Plan	Produced by…	Engaged	Triangulation	Formal assurance
	Responsible for driving development, completing & submitting plan	***Contribute to plan development***	***Responsible for ensuring that their work triangulates with plan***	***Responsible for providing formal assurance of plan***
Strategic	Unit of Planning	• Patients & carers • Healthwatch • CCG • Provider • HWB • Local Authority • NHS England Area Team • Health Education England • Local Education and Training Board (LETB)	• CCG • Provider • HWB • Local Authority • Area Teams	NHS England Regional Team
Operational	CCG	• Provider • Local Authority (contracts with community/social care providers)	• Provider • HWB • Local Authority • Unit of Planning	NHS England Area Team
Financial	CCG	• Provider • Local Authority (contracts with community/social care providers)	• Provider • HWB • Local Authority • Unit of Planning	NHS England Area Team

NHS England

Plan	Produced by…	Engaged	Triangulation	Formal assurance
	Responsible for driving development, completing & submitting plan	***Contribute to plan development***	***Responsible for ensuring that their work triangulates with plan***	***Responsible for providing formal assurance of plan***
Provider	Provider	• CCG • Local Authority (depending on provider type)	• CCG • HWB • Local Authority • NHS England Area Teams • Unit of Planning	Monitor NHS Trust Development Authority
Better Care Fund	HWB	• Patients and carers • Healthwatch • Local Authority • NHS England Area Teams • PHE • Monitor • NTDA	• CCGs • Provider • Units of Planning	Ministers HWB NHS England Area Team LGA
Direct Commissioning	NHS England Area Team	• NHS England Regional Team • Provider	• Provider • CCG	NHS England Regional Team

ON-GOING ASSURANCE

33. NHS England has published assurance frameworks for both CCGs[17] and our direct commissioning[18] functions. These are integral to our approach to assurance of plans. In line with the principles set out in the assurance frameworks, discussions will take place on the basis of six consistent assurance domains.

34. Assurance will be informed by robust and diverse sources of evidence, underpinned by a developmental and supportive approach. Where delivery concerns are identified, improvement actions will be agreed. NHS England has broad powers available through legislation to ensure that these improvements are made. This guidance sets out the expectations for NHS commissioners, and the assurance process will be an important way of ensuring that both NHS England and CCGs are mutually accountable for delivering the improvements we want to see delivered.

OVERVIEW OF PLANNING SUPPORT

35. The support package that we will provide puts these requirements at the centre of the development and delivery of five year strategic plans. It has been developed in consultation with commissioners in CCGs and Area Teams and will be made available for commissioners to draw on where needed. A detailed communication on support will be published by the end of December.

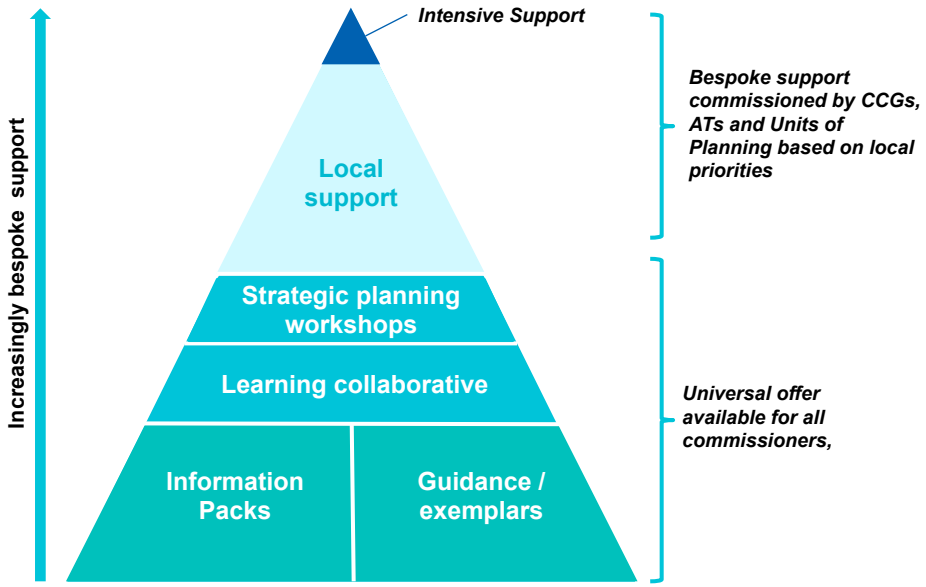
36. The support programme includes:

- universal, nationally developed tools, including information packs, exemplars and Strategic Planning Workshops that will bring together local partners to support them in agreeing their approach and priorities in developing and delivering aligned strategic plans;
- bespoke support based around ten key specifications;
- an intensive support package for economies with deep financial and/or quality issues, developed and owned jointly by NHS England, NHS Trust Development Authority, Monitor and the Local Government Association; and
- support to a number of Health and Wellbeing Boards aligned and interwoven across both the universal and bespoke elements of support.

37. The diagram that follows shows the support package which will be made available to support the planning process.

17 http://www.england.nhs.uk/wp-content/uploads/2013/11/ccg-ass-frmwrk.pdf

18 http://www.england.nhs.uk/wp-content/uploads/2013/11/dc-ass-frmwrk.pdf



UNIVERSAL SUPPORT PACKAGE

38. The universal support package, available to all commissioners, will include:

- **Practical support on participation** – Our interactive web based *Transforming Participation in Health and Care* tool already provides advice, good practice, evidence and case studies on approaches to good public participation. This will be supplemented by resources that will be made available through Commissioning Support Units (CSU) aimed at engaging local communities in developing and commissioning services that meet their needs, and using insight and market research techniques to better understand those needs. The expectation is that local and regional voluntary sector organisations will work to make certain that public participation reaches all parts of local communities. There should be particular focus on seeking and achieving input from communities which have traditionally not provided sufficient input into NHS decision-making.

- **Any town health system and Better Care Fund models** – To support CCGs in preparing plans, the Any town health system model will be published in January. The Better Care Fund modelling tool enables HWBs to model high level integration interventions.

- **Data packages** – data and analysis packs showing the local opportunities for improvement and relative performance e.g. Commissioning for Value packs released in October.

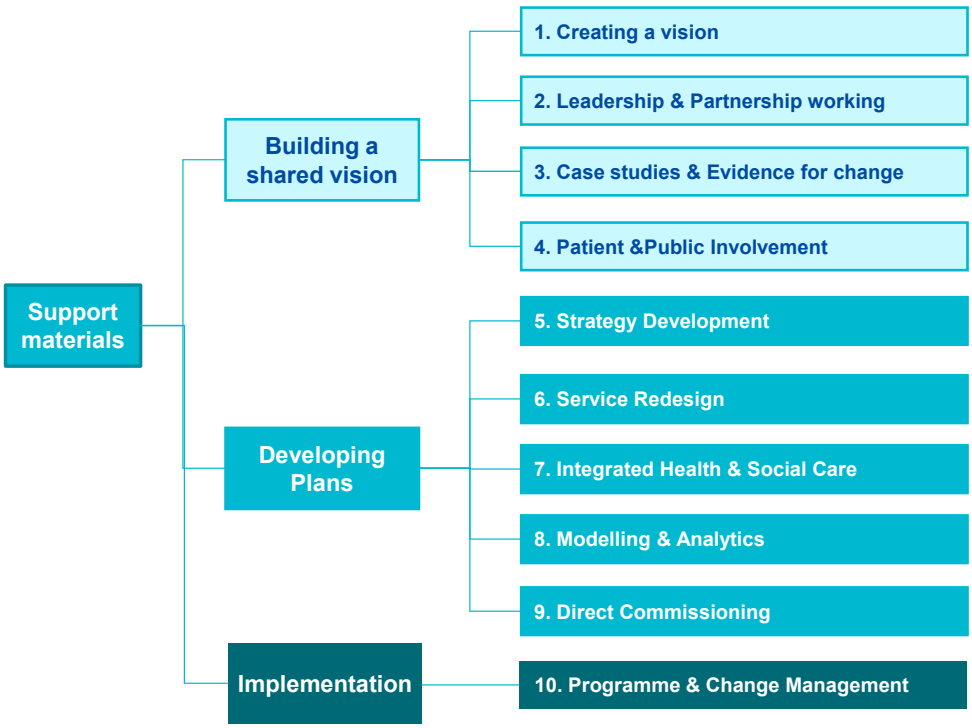
- **Strategic planning workshops** – Local workshops designed to kick-start the planning process and build local relationships to create a joint vision and prepare for planning submissions. They will provide practical and technical advice about translating a strategy into a financial and operating plan and will support joint ways of working through advice on creating local governance arrangements aimed at galvanising action and initiating stakeholder discussions.

- **Learning collaborative** – This will support the spread and adoption of learning, best practice and technical expertise. We are planning to create a programme of webinars and learning events on key topics across three broad areas; best practice sharing; thought leadership; and support for the technical aspects of planning and delivery.

TAILORED LOCAL SUPPORT TO MEET LOCAL CHALLENGES

39. The local support offer will be available to CCGs, Area Teams and Units of Planning that would benefit from additional more bespoke support in key areas.

40. Ten different specifications have been identified, which relate to the three main areas of planning activity: building a shared vision for health and social care across multiple partners in the Unit of Planning; development of plans which deliver that vision; and implementation of plans. These are shown in the following diagram.

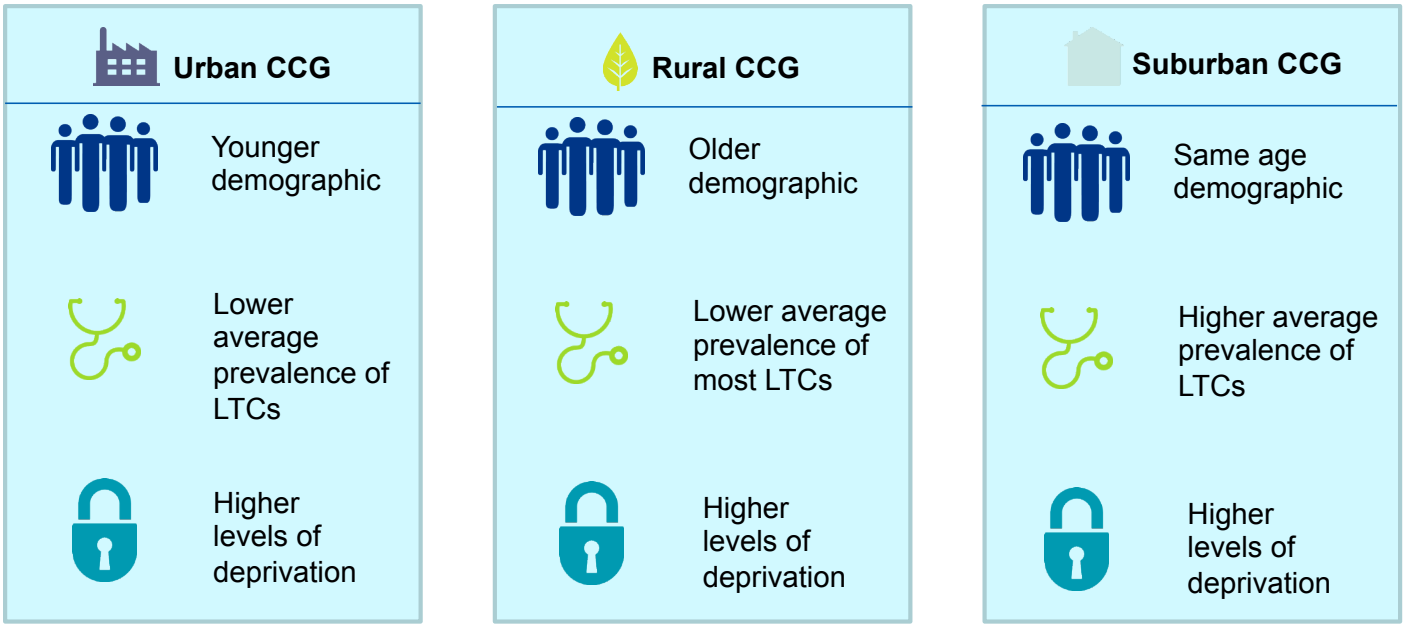


ANY TOWN HEALTH SYSTEM

41. The Any town health system model is a resource designed to help local areas identify potential improvements to service delivery, and enable them to understand what the quality and financial impacts of those improvements may be. The tool provides case studies and analysis of a number of interventions that could be applied in a local health economy to achieve improved clinical outcomes and financial performance. It shows how a typical CCG could achieve financial balance over the strategic period covered.

42. A number of 'High Impact Interventions' have been fully impact assessed and included in the report. Twelve 'Early Adopter Interventions' are also included; these have not been impact assessed to the same specification as the 'High Impact Interventions', but are innovative, cutting edge ideas which may be promising.

43. To help understand the impact different interventions will have in different settings, three scenarios have been created: Urban CCG, Suburban CCG and Rural CCG. There is a version of Any town for each scenario CCG. Local areas are, therefore, able to understand how each intervention might affect performance in an area that is demographically similar to their own.



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1 STRATEGIC, OPERATIONAL AND FINANCIAL PLANNING

STRATEGIC PLAN OVERVIEW

44. Each strategic plan needs to have the ownership and buy-in of the whole local health economy and reflect a joint vision for the area, including the road map required to attain this. All organisations should be satisfied that the plan will support the delivery of improvements for patients and service users. The plan should be short and focused, and it should describe to those outside the system what the system plans to achieve in a way that informs and engages.

45. It is essential for these plans to be at the forefront of the planning process; they set the vision, ambitions and framework against which operational and financial planning will be determined.

46. Plans should be clear on proposed future activity levels, referenced to historical trends and future service proposals. The plans must demonstrate a clear link between activity and finances.

47. The strategic plan will require the creation of a:

- System narrative 'plan on a page'; and
- Organisation specific key highlights.

48. Details regarding the content of the Strategic Plan template can be found in Annex J.

OPERATIONAL PLAN OVERVIEW

49. The operational plan will include the key operational metrics needed to support the assurance of, and measure performance against, strategic plans. The plan will be structured around the four headings:

- Outcomes;
- NHS Constitution;
- Activity; and
- Better Care Fund.

50. Details regarding the content of the Operational Plan template can be found in Annex J.

FINANCIAL PLAN OVERVIEW

51. The financial plan will provide the detailed financial breakdown of each plan. It will include the key financial metrics to support the assurance of, and measure performance against, strategic plans. It will require information under the following headings:

- Revenue resource limit;
- Planning assumptions;
- Financial plan detail 14/15-18/19;
- QIPP 14/15-18/19;
- Risk;
- Investment;
- Statement of financial position;
- Cash;
- Capital; and
- Contract value 14/15-18/19.

52. Details regarding the content of the Financial Plan template can be found in Annex J.

FINANCIAL ALLOCATIONS AND THE EFFICIENCY CHALLENGE

53. The 2014/15 and 2015/16 income allocated to CCGs and direct commissioning has been published alongside this guidance.

54. The funding objectives contained within the mandate require NHS England to run a transparent allocation process to ensure "equal access for equal need". The 2012 Health & Social Care Act also requires NHS England to have regard to reducing inequalities in access to and outcomes from healthcare. Consequently, the intention is to implement an approach to allocation of funding that has regard for population on a per capita basis and takes into account both inequalities and the impact of an ageing population on demand for healthcare.

55. For CCGs, NHS England has adopted a revised funding formula recommended by the Advisory Committee on Resource Allocation. For direct commissioners of primary care, NHS England is adopting a new funding formula which aims to allocate primary care funding based on need. Adjustments are made to both formulae to reflect the need to address unmet or inappropriately met need, particularly relating to our most deprived communities. Funds for specialised commissioning, health and justice and armed forces in 2014/15 and 2015/16 will continue to be allocated on a national basis and the investment made by NHS England in public health will be budgeted on a programme basis.

56. The implication of the distribution of resources is a differing level of efficiency challenge in 2014/15 and 2015/16 by commissioner. In 2014/15, specialised commissioning remains the area with the most challenging efficiency requirement. In 2015/16, with the introduction of the Better Care Fund, CCGs face a more significant efficiency challenge. Over the two years the efficiency challenge for both CCGs and specialised commissioning is similar at approximately 9 per cent, including the provider efficiency deflator.

57. To support commissioners to manage this challenge over the two year period we propose to prioritise access to drawdown of surpluses from prior years for specialist commissioning in the first year and CCGs in the second year.

58. For 2016/17 to 2018/19 commissioners as a whole should assume a continuity of the current allocations policy, although no decisions on allocations beyond 2015/16 have yet been taken. For subsequent years, commissioners should assume that income growth increases in line with the GDP deflator.

2016/17	2017/18	2018/19
1.8%	1.7%	1.7%

59. Continuity of the current policy would mean that CCGs and primary care commissioners would continue to move towards target on

the basis of the trajectory set in 2014/15 and 2015/16.

60. From 2014/15 commissioners will be required to count the use of provisions as a utilisation of their allocated resource, in line with HM Treasury accounting rules.

PROGRAMME AND ADMINISTRATIVE COSTS

61. Income is allocated separately for programme and administrative costs. Expenditure against these allocations will be monitored separately. Commissioners are asked to ensure that plans are in place to ensure administrative costs are not overspent. Underspends on administrative costs may be spent on programme costs.

62. Overall running cost assumptions for the commissioning sector were set out in the allocations paper to the NHS England Board on 17 December 2013. The assumption that the planned 10 per cent reduction in overall health sector administration costs in 2015/16 will be applied to CCGs and NHS England will be confirmed in due course. For planning purposes, commissioners should assume that the overall running cost envelope will remain flat in cash terms for 2014/15 and reduce by 10 per cent in 2015/16. Individual CCG running cost allocations will be adjusted to take into account population change. Commissioners should assume for years 3 to 5 of the planning period that the overall running cost envelope remains flat in cash terms. As in 2014/15 and 2015/16, at individual CCG level running costs in years 3 to 5 will be adjusted to take into account population change. These will be based on the latest available ONS population projections. Running cost projections for the five year period for each CCG will be made shortly available.

CCGs		
Demographic growth	Local determination using age profiled population projections.	
Non-demographic growth	Local determination based on historic analysis and evidence.	
Tariff changes	See below.	
Price inflation – prescribing	Local determination – expected to be in a range of 4% to 7% per annum increase.	
Price inflation – continuing health care	Local determination – expected to be in a range of 2% to 5% per annum increase.	
Business rules	**2014/15** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend (including 1% for transformation).	**2015/16-2018/19** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 1% non-recurrent spend • Better Care Fund spend as notified separately.

FINANCIAL PLANNING ASSUMPTIONS

63. Published alongside this planning guidance is the Call to Action technical paper. This sets out the key financial and activity assumptions that underpin the £30bn challenge which was published in July. This guidance is based on additional work which has been undertaken to develop these assumptions further.

64. The core financial planning assumptions for CCGs to use are shown in the table on the previous page. More detail is included in subsequent paragraphs.

65. Surpluses and deficits accumulated at 31 March 2014 and subsequent years will be carried forward into the following financial years. Commissioners are asked to include proposals for access to historical surpluses, if required, in their plans. The plans will be assessed with reference to the impact on outcomes and subject to the maximum drawdown available. The maximum expected level of the national surplus drawdown will be finalised with the Department of Health and HM Treasury.

66. The National Tariff for 2014/15 was published jointly by NHS England and Monitor on 17th December. The tariff prices are generally the 2013/14 prices rolled forward and adjusted for inflation and efficiency. The cost uplift for 2014/15 is 2.5 per cent and the efficiency requirement is 4 per cent, giving an overall adjustment to tariff prices of (1.5) per cent. This should be also the starting point for adjustments to the price for services without a national price.

67. For emergency admissions, commissioners should budget for all admissions at 100 per cent of the tariff. They should only pay 30 per cent for emergency admissions over the 2008/9 baseline with the 70 per cent to be invested in relevant demand management schemes. Full details of the operation of these rules are set out in the 2014/15 National Tariff Payment System which can be found at: http://www.england.nhs.uk/resources/pay-syst/national-tariff/. Commissioners need to engage with relevant providers with input from Urgent Care Working Groups when developing plans for the investment of the 70 per cent balance. These plans should be published on the commissioner's website and shared with all relevant stakeholders. The tariff document also contains details of the specific circumstances in which baselines should be adjusted, e.g. for service change.

68. NHS England and Monitor are currently developing a medium term pricing strategy for 2015/16 and beyond. As set out in our joint consultation in May, we will be considering how best to develop an approach to pricing that supports improved outcomes and in particular more integrated services for patients. As part of our work we will consider the case for implementing new currencies and contracting models, and whether a more segmented approach to pricing is more appropriate. However, for the purposes of planning, commissioners should assume continuity of current pricing policy. Where appropriate, they should also consider the scope to use the local flexibilities introduced in 2014/15, specifically regarding local pricing variations where they are in the best interests of patients.

Tariff assumptions					
	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Secondary Care health cost inflation	2.3%	2.2%	3.0%	3.4%	3.4%
Provider sector efficiency	4.0%	4.0%	4.0%	4.0%	4.0%
Tariff uplift	-1.7%	-1.8%	-1.0%	-0.6%	-0.6%

69. Commissioners should plan on the basis that the underlying level of provider efficiency remains in the 2 to 2.5 per cent range over the five year period. To support delivery of this range, for planning purposes, commissioners should assume that the efficiency factor in tariff remains at 4 per cent. The difference is currently referred to as "leakage" which we believe is the result of some providers and commissioners working together to balance budgets without delivering the full headline level of real efficiency improvement. NHS England and Monitor are however committed to introducing greater transparency into pricing and therefore expect that over time, the difference between underlying efficiency and the efficiency factor will converge. As evidence of greater transparency emerges over time, we project that the headline efficiency factor could begin to move towards the second row in the table below.

STRATEGIC ENABLERS

THE NHS STANDARD CONTRACT

70. The NHS standard contract remains the form of contract which commissioners must use for all contracts for clinical services, other than primary care.

71. After a significant re-drafting for 2013/14, the 2014/15 contract will retain the same structure and much of the same detailed content, allowing commissioners and providers to become familiar with using it in practice.

Tariff assumptions					
	2014/15	2015/16	2016/17	2017/18	2018/19
Projected underlying provider efficiency	2%	2.5%	2%	2%	2%
Efficiency factor assuming reduced leakage	4%	4%	3.1%	2.8%	2.6%
Efficiency factor assuming constant leakage	4%	4%	4%	4%	4%

72. There will be significantly greater flexibility for commissioners to determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition. The standard contract enables innovative contracting models such as the prime provider approach; with increased flexibility on contract duration, together with new tariff flexibilities (Local Payment Variations). Commissioners will be equipped with the tools to enable longer-term, transformational, outcomes-based commissioning approaches.

73. The framework of sanctions within the standard contract has been reviewed in depth, with significant input from stakeholders. The contract for 2014/15 will contain a more consistent and proportionate set of sanctions. We expect commissioners to enforce the standard terms of the contract, including the application of sanctions.

74. An online system for completing the NHS standard contract (the eContract) was made available in February 2013 and an improved, more robust system will be available for use for 2014/15. The eContract approach has significant benefits, for instance in enabling the tailoring of contract content to reflect the specific range of services being commissioned. We strongly encourage CCGs and CSUs to use the eContract during the 2014/15 contracting round. NHS England anticipates that use of the eContract approach will become the norm for directly commissioned services in 2014/15.

75. We expect commissioners to ensure that robust, good value contracts are signed by 28 February 2014.

PRICING AND INCENTIVES

76. A strategic review of pricing and incentives is underway as part of the Call to Action work. It has the aim of developing a fully integrated set of arrangements which support the emerging strategic priorities and provide the flexibility to implement the new service models which will be required. Arrangements for 2014/15, described below, aim to preserve stability in the short term while providing sufficient local flexibility to enable innovation to flourish.

The Quality Premium: rewarding commissioners

77. The measures to be used to determine the Quality Premium paid to CCGs in 2015/16 on the basis of performance during 2014/15 align with our outcomes ambitions and reflect local decision-making with Health and Wellbeing Boards. NHS England will publish the full methodology to be used for calculation of the Quality Premium in December 2013.

Commissioning for Quality and Innovation (CQUIN)

78. A CQUIN scheme will be in place for 2014/15. The key aim is to secure improvements in the quality of services and better outcomes for patients. Providers will be able to earn up to 2.5 per cent of their annual contract outturn, excluding any income for high cost drugs and devices excluded from national prices.

79. One fifth of the CQUIN scheme will be for achievement of national improvement goals, as follows:

- Friends and Family Test – where commissioners will be encouraged to incentivise high performing providers;
- Improvement against the NHS Safety Thermometer, particularly pressure sores;
- Improving dementia and delirium care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR); and
- Improving diagnosis in mental health – providers will be rewarded for better assessing and treating the mental and physical needs of their service users.

80. Following three years of funding through the national CQUIN scheme, the VTE CQUIN scheme will not be in place for 2014/15. Providers will be expected to continue to improve their management of VTE risk, and any deterioration in risk assessment from current performance will result in a contract sanction being applied.

81. NHS England will publish separate guidance on the 2014/15 CQUIN scheme in December 2013, including detailed descriptions of the mandated national indicators and guidance on developing local CQUIN indicators and setting improvement trajectories, along with a list of quality assured indicators for optional use.

NON RECURRENT FUNDS

82. As in previous years, commissioning organisations are required to set aside some of their funding for non-recurrent expenditure. Recognising the need to accelerate efficiencies in 2014/15 both to prepare for the challenges in 2015/16 and to create funding for service change, we have increased the level of resource reserved for non-recurrent expenditure in 2014/15 to 2.5 per cent. Of the total 2.5 per cent, commissioners are asked to plan for 1 per cent of this spend to be applied to transformation of local services. This transformation fund is intended to be used at a local health economy level by commissioners working together to develop and implement plans for change, focusing in particular on any actions required to prepare for the introduction of the Better Care Fund.

2 NHS ENGLAND DIRECT COMMISSIONING

DIRECT COMMISSIONING OVERVIEW

83. NHS England has statutory responsibilities to commission services for patients across five areas:

- primary, medical, dental, pharmacy and optical services and secondary care dental services;
- specialised services;
- public health section 7A services;
- services for members of the Armed Forces and their families; and
- services for people in the justice system.

84. In planning for the delivery for those services, NHS England's Area Teams will ensure they are aligned with CCG commissioning plans. The approach we will adopt is that each Area Team with responsibility for one or more of the above areas will:

- develop a strategic plan for that service within which there will be greater granularity on the first two years;
- ensure that each of those strategic plans is visible within relevant Units of Planning;
- work with CCGs and other local partners to ensure a consistent and coordinated approach across the commissioning of all NHS services and related social care provision; and
- ensure services are planned on the basis of affordability and securing the best possible outcome for patients.

85. The approach will be nationally consistent to deliver quantifiable improvements for patients within principles of:

- equity of offer;
- equity of access; and
- equity of outcome.

CONTENT OF PLANS

86. NHS England's Area Teams will produce strategic and operational plans for the services they commission on the same basis as CCGs. For each of the five areas of NHS England's commissioning responsibilities, Area Teams will:

- set out a five year strategic plan for how that service will improve within available resources, including dealing with any structural deficit;
- include more granular detail for the first two years; and
- use the measures in the Annexes D-G to identify improvement.

87. For each aspect of our commissioning, the objectives we expect to be achieved are set out below and should be read alongside the measures to be included in plans as set out in Annexes A to G of this guidance, with supporting information in Annex H.

88. Details regarding the content of the Direct Commissioning Plan template can be found in Annex J.

FINANCIAL PLANNING ASSUMPTIONS

89. The core financial planning assumptions for direct commissioning are set out below.

Direct commissioning excluding public health		
Demographic growth	Primary care: Local determination based on resident population in line with crude population projections. Other: Local determination using age profiled population projections for population covered by Area Teams.	
Non-demographic growth	Local determination based on historic analysis and evidence.	
Tariff changes	See above.	
Primary care cost increase	To be confirmed.	
Business rules	**2014/15** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend.	**2015/16-2018/19** • Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2% non-recurrent spend.
Public health		
Demographic growth	Local determination using age profiled population projections for population covered by Area Teams.	
Business rules	• Minimum 0.5% contingency • 0% cumulative surplus carry forward • 0% underlying surplus • 0% non-recurrent spend.	

3 BETTER CARE FUND PLANNING

BETTER CARE FUND OVERVIEW

90. The Better Care Fund plan requires local areas to formulate a joint plan for integrated health and social care and to set out how their single pooled Better Care Fund budget will be implemented to facilitate closer working between health and social care services. Joint plans should be approved through the relevant local Health and Wellbeing Board and be agreed between all local CCGs and the Upper Tier Local Authority. Health and social care providers should also be closely involved in plan development.

91. The plan should demonstrate clearly how it meets all of the national Better Care Fund conditions, include details of the expected outcomes and benefits of the schemes involved, and confirm how the associated risks to existing NHS services will be managed. The measures we expect CCGs to use in considering the quality of the impact of the Better Care Fund are in Annex I, along with additional supporting information on developing Better Care Fund plans.

92. It is essential that CCGs and Local Authorities engage from the outset with all providers likely to be affected by the use of the Better Care Fund so that plans are developed in a way that achieves the best outcomes for local people. Commissioner and provider plans should have a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support service change.

FUNDING FOR INTEGRATED CARE

93. In 2014/15, a total of £1,100 million (increased from £859 million) will transfer to Local Authorities for social care to benefit health, using the same formula as 2013/14. This will become transacted through a central Section 256 transfer. In 2015/16, this funding will be part of the pooled Better Care Fund; while it will continue to be allocated to areas on the same basis as in previous years, the funding will be added to CCG allocations. For example, if a Local Authority consists of two equal sized CCGs and it received £10 million from the Section 256 transfer in 2014/15, in 2015/16 the area will still receive £10 million of the £1,100 million, but it will be divided between the two CCGs' allocations. CCGs will be required to pass this funding to the Better Care Fund pooled budget along with the funding from core CCG allocations, discussed below.

94. From 2015/16, the Better Care Fund will also include a £1.9 billion contribution from core CCG funding, over and above the existing £300 million reablement funding and £130 million carers' breaks which will also be

pooled in the Better Care Fund. Core CCG funding going to the pooled Better Care Fund will be allocated based upon the CCG allocation formula. Additional contributions to the Better Care Fund from Local Authorities, in the form of social care capital grants and disabled facilities grants, will continue to be allocated to them by central government on the same basis as for 2014/15.

GLOSSARY

A Call to Action NHS England document and programme of action focused on the challenge to staff, the public and politicians to help the NHS meet future demands and tackle the funding gap through honest and realistic debate.

Armed Forces Covenant Commitment The armed forces covenant sets out the relationship between the nation, the state and the armed forces. It recognises that the whole nation has a moral obligation to members of the armed forces and their families and it establishes how they should expect to be treated.

Better Care Fund (BCF) A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.

Care.data A modern information system which will make increased use of information from medical records with the intention of improving health services. The system is being delivered by the Health and Social Care Information Centre (HSCIC) and NHS England on behalf of the NHS.

CCG Outcomes Indicator Set (CCG OIS) The CCG Outcomes Indicator Set is part of the NHS England's systematic approach to promoting quality improvement. Its aim is to support clinical commissioning groups and health and wellbeing partners in improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes – and to support transparency and accountability by making this information available to patients and the public.

Clinical Digital Maturity Index (CDMI) The Clinical Digital Maturity Index has been developed by EHI Intelligence in partnership with NHS England. It is a unique benchmarking tool that enables NHS Trusts to better understand how investing and effectively using, information technology can achieve better patient outcomes, reduce bureaucracy, improve patient safety and deliver efficiencies.

Compassion in Practice Compassion in Practice is the three year vision and strategy for nursing, midwifery and care staff drawn up by NHS England and the Department of Health.

Commissioning for Quality and Innovation (CQUIN) The system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Everyone Counts: Planning for Patients 2013/14 outlines the priorities, incentives and levers that were used to improve services from April 2013, the first year of the new NHS, where improvement was driven by clinical commissioners.

Find, Assess and Investigate, and Refer (FAIR) Improving dementia care, including sustained improvement in finding people with dementia, assessing and investigating their symptoms and referring for support.

Friends and Family Test The Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with follow-up questions, can drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users.

Liaison and Diversion Programme The Government's commitment to having diversion services in place (for children and for adults) in all local areas by 2014. These services are fundamental to the identification and assessment of offenders with health needs and other vulnerabilities to give offenders the right health and social care services.

National Quality Board The National Quality Board (NQB) is a multi-stakeholder board established to champion quality and ensure alignment in quality throughout the NHS. The NQB is a key aspect of the work to deliver high quality care for patients.

NHS Choices NHS Choices is the online 'front door' to the NHS. It is the country's biggest health website and gives all the information citizens need to make choices about their health.

NHS Outcomes Framework The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in health outcomes.

NHS Safety Thermometer The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that we can measure and monitor local improvement and harm-free care over time.

Personalised Care Plan Personalised care planning goes beyond the normal clinical and medical conditions. It extends into other areas of the individual's life and recognises that many different issues can impact on their health and well-being.

Quality Premium The Quality Premium rewards CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

Unit of Planning A number of CCGs who have joined together with relevant Area Teams, providers, Local Authorities and Health and Wellbeing Boards to create a footprint of a size large enough to enable effective strategic planning.

ANNEXES

ANNEX A: OUTCOMES MEASURES

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)
1. Securing additional years of life for the people of England with treatable mental and physical health conditions.	Potential years of life lost from conditions considered amenable to healthcare – a rate generated by number of amenable deaths divided by the population of the area.	Improvement to be locally set and no less than 3.2%. CCGs should focus on improving in areas of deprivation in developing their plans for reducing mortality.	None
2. Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	IAPT roll-out: i. achieve 15% for CCGs below that level ii Additional locally set improvement for those over 15% or near 15%.	• Increase dementia diagnosis rate to 67 per cent by March 2015. • Achieve the IAPT recovery rate of 50%.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	A rate comprised of: • Unplanned hospitalisation for chronic ambulatory care sensitive conditions. • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. • Emergency admissions for acute conditions that should not usually require hospital admission. • Emergency admissions for children with lower respiratory tract infections.	As per outcome measure	None

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)
4. Increasing the proportion of older people living independently at home following discharge from hospital.	No indicator available at CCG level. CCGs and Area Teams will not be expected to set a quantitative level of ambition for this outcome. However, they will be expected to set out how they will improve outcomes on this ambition in their five year strategic plans.	None	A level of ambition needs to be established at Health and Wellbeing Board level on the *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services.*
5. Increasing the number of people having a positive experience of hospital care.	Patient experience of inpatient care.	Friends and Family Test: specific actions to improve low scores.	None
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Composite indicator comprised of (i) GP services, (ii) GP Out of Hours.	None	None
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.	Hospital deaths attributable to problems in care. This indicator is in development.	Improving the reporting of medication errors.	• MRSA zero tolerance • *Clostridium difficile* reduction

All CCG OIS measures are available for planning: http://www.england.nhs.uk/ccg-ois/

ANNEX B: NHS CONSTITUTION MEASURES

Referral To Treatment waiting times for non-urgent consultant-led treatment
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%
Diagnostic test waiting times
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%
A&E waits
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%
Cancer waits – 2 week wait
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%
Cancer waits – 31 days
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%
Cancer waits – 62 days
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set

Category A ambulance calls
Category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%

NHS CONSTITUTION SUPPORT MEASURES

Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%
Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

ANNEX C: ACTIVITY MEASURES

Elective
Elective – ordinary admissions FFCEs
Elective – day cases FFCEs
Non elective
Non Elective admissions FFCEs
Outpatients
All first outpatient attendances in general and acute specialties
All subsequent outpatient attendances in general and acute specialties
A&E
A&E attendances – Type 1
A&E attendances – Total all types
Referrals
GP written referrals from GPs for a first outpatient appointment in general and acute specialties
Other referrals for a first outpatient appointment in general and acute specialties
First outpatient attendances following GP referral in general and acute specialties

ANNEX D: PRIMARY CARE MEASURES

Medical
Patient satisfaction
Satisfaction with the quality of consultation at the GP practice
Satisfaction with the overall care received at the surgery
Satisfaction with accessing primary care
Referrals
Proportion of new cancer cases referred using 2 week wait pathway
Vaccinations
Flu vaccinations – at risk coverage
Mental health
Identifying the prevalence of depression compared to estimated model

Dental
Access
% Patients seen – 24 month measure
Activity
Number of course of treatments per 100,000 population
Patient experience
GPPS % Positive experience

General Ophthalmic Services
Activity
Total number of sight tests/per 100,000 population
Quality and Innovation
%of tints per voucher
% of repairs per voucher and % of replacements per voucher
% of prisms per voucher

ANNEX E: SPECIALISED SERVICES MEASURES

Referrals
% of all NHS England patients receiving treatment within 18 wks of referral
Diagnostics
% of NHS England patients waiting 6 weeks or more for diagnostic tests

ANNEX F: PUBLIC HEALTH SECTION 7A SERVICES MEASURES

Vaccinations
Population vaccination coverage – Dtap/IPV/Hib (1 year old)
Population vaccination coverage – MenC
Population vaccination coverage – PCV
Population vaccination coverage – Dtap/IPV/Hib (2 years old)
Population vaccination coverage – PCV booster
Population vaccination coverage – Hib/MenC booster (2 years old)
Population vaccination coverage – MMR for one dose (2 years old)
Population vaccination coverage – MMR for one dose (5 years old)
Population vaccination coverage – MMR for two doses (5 years old)
Population vaccination coverage – Hib/Men C booster (5 years)
Population vaccination coverage – Hepatitis B (1 year old)
Population vaccination coverage – Hepatitis B (2 years old)
Population vaccination coverage – HPV
Population vaccination coverage – PPV
Population vaccination coverage – Flu (aged 65+)
Population vaccination coverage – Flu (at risk individuals)

Screening
% of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result
% of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella leading to a conclusive result
% of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report
% of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe
% of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies)
% of babies eligible for the newborn physical examination who were tested within 72 hours of birth
% of those offered screening for diabetic eye screening who attend a digital screening event
Abdominal Aortic Aneurysm (AAA) KPI
Breast cancer screening coverage % of eligible women screened adequately within the previous 3 years on 31st March
Cervical cancer screening coverage % of eligible women screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st March
Bowel Cancer screening – uptake and coverage over 2.5 years
Family health services
No. of FTE Health Visitors

ANNEX G: HEALTH AND JUSTICE MEASURES

Health commissioned services
Deliver chronic disease care to the same standard of process and outcomes as is required by the National Service Frameworks for: Diabetes, CHD and Long Term Conditions and Mental Health and a QOF score is available
Access and waiting time
Access and waiting time
Learning disabilities
% of identified patients with a learning disability have an annual health check
Mental health
% of all prisoners returning to prison from any other Mental Health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme

ANNEX H: DIRECT COMMISSIONING SUPPORTING INFORMATION

PRIMARY, MEDICAL, DENTAL, PHARMACY AND OPTICAL SERVICES AND SECONDARY CARE DENTAL SERVICES

1. There are two central objectives to our commissioning:
   - to develop more integrated out-of-hospital services that help people stay healthy and provide proactive, coordinated support, particularly for people with long-term conditions; and
   - for our Area Teams, CCGs and Local Professional Networks to work collaboratively with local communities to develop joint strategies for commissioning primary care and wider community services, based on patient and public insight. These should be part of an integrated strategy for out-of-hospital care.

2. Local strategic plans should include specific actions to support development of general practice services in ways that reflect the six key characteristics of high-quality care set out in our general practice *A Call to Action* as follows:
   - proactive coordination of care, particularly for people with long-term conditions and more complex health and care problems;
   - holistic care: addressing people's physical health needs, mental health needs and social care needs in the round;
   - ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances;
   - preventing ill-health, ensuring more timely diagnosis of ill-health, and supporting wider action to improve community health and wellbeing;
   - involving patients and carers more fully in managing their own health and care; and
   - ensuring consistently high quality of care: effectiveness, safety and patient experience.

3. Area Teams should also work with their Local Professional Networks and, where appropriate, CCGs to develop equivalent commissioning strategies for dental care, community pharmacy care and eye care services, again as part of an integrated out-of-hospital strategy.

PRIMARY CARE SUPPORT SERVICES

4. NHS England is responsible for primary care support (PCS) services (also known as family health services or FHS). NHS England wants all practitioners to have access to a standard range of modern, efficient and effective PCS/FHS services which meet their needs.

5. The range of PCS/FHS services provided to primary care providers currently varies from area to area. Figures from November 2012 indicated that their costs also varied from around 80p to £2.70 per head of population. NHS England wants to reduce the PCS/FHS budget from £100 million in 2013/14 to £60 million in 2014/15, although any cost reduction must be in the context of delivering safe, high quality and effective services at all times.

6. NHS England will progress work through 2013 into 2014 to achieve a safe transition in PCS services. Efficiencies will be created by:

- having a standard specification for core PCS/FHS services that will be funded by NHS England;
- achieving 'best practice' levels of quality and cost across all services;
- providing services from fewer sites;
- making more and better use of technology; and
- changing some of the ways services are delivered.

SPECIALISED SERVICES

7. As part of *A Call to Action*, NHS England is developing a five year strategy for specialised services. This will address the service specific objectives for the next five years, overarching strategic objectives for the provision of a system of specialised health care as a whole and the impact of co-dependency between service areas.

8. The published commissioning intentions for 2014-2016 commit NHS England to a six strand strategic commissioning approach:

i. Ensuring consistent access to the effective treatments for patients in line with evidence based clinical policies, underpinned by clinical practice audit.

ii. A clinical sustainability programme with all providers focused on quality and value through:

- achieving and maintaining compliance with full service specifications, and making changes to service provision where there is no realistic prospect of standards being met;
- refreshing and focusing Commissioning for Quality and Innovation (CQUIN) schemes to directly contribute to improving outcomes with challenging, but achievable goals; and
- providing transparency in service quality through the continued development of service level quality dashboards and improvements in data flows.

iii. An associated financial sustainability programme with all providers, focused on better value through a two year programme of productivity and efficiency improvement.

iv. A systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.

v. Adopting new approaches to commissioning care where it promotes integrated care and clinical oversight for patients, in particular services and care pathways to include a prime contractor model and co-commissioning with CCGs.

vi. A systematic rules-based approach to in-year management of contractual service delivery.

9. In their plans we expect NHS England's Area Teams to address any structural deficit from 2013/14. Cost growth will need to be constrained, greater consistency of provision secured and the quality of services maintained or improved.

PUBLIC HEALTH SECTION 7A SERVICES

10. It is our objective to ensure the effective commissioning of certain public health services: immunisation and screening programmes, children's public health services from pregnancy to age five, child health information systems, public health for people in places of detention, and sexual assault services.

11. We will continue the effective implementation of the section 7A agreement, of which there are two overarching ambitions:

- to increase the pace of change for the full implementation of the national service specifications; and
- to set performance 'floors' to address unacceptably low performance by local providers.

12. NHS England's Area Teams will implement the specific changes from 2014/15, in line with these ambitions:

- new trajectories for roll out of the Family Nurse Partnership and the Health Visitor Programmes;
- a revised specification for Pneumococcal Vaccination;
- introduction of HPV testing in women with mild/borderline changes in their cervical screening;
- revised performance baselines for bowel and diabetic eye screening;
- extension of the bowel screening programme for men and women up to 75;
- a minor change to the service specification for seasonal flu;
- a meningitis C catch up programme for university entrants;
- continuation of a time limited MMR campaign for people over 16 and a catch-up campaign for teenagers;
- continuation of the temporary programme for pertussis for pregnant women;
- implementation of DNA testing for sickle cell and thalassemia screening;
- a shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds; and

- a number of developments for Sexual Assault Referral Centres to develop the service and make it more equitable.

13. We intend to extend flu vaccinations to all children over time. When fully implemented this will be the largest single immunisation programme that has yet been introduced. The extent to which the programme can be rolled out in 2014/15 and the expected uptake rates have not yet been agreed. They remain subject to an assessment of NHS England's commissioning capacity, and the development of robust workforce models for delivery of the programme, which will be completed in early 2014. These will be confirmed through a variation to the section 7A agreement. Prior to this planned variation, the proposed section 7A agreement for 2014/15 confirms that NHS England shares the ambition to offer vaccines to all children between 2 and 4 years old and as many secondary school aged children as possible in 2014/15.

SERVICES FOR MEMBERS OF THE ARMED FORCES AND THEIR FAMILIES

14. We want to see the following achieved:
    - that the commissioning of services is organised in such a way as to provide the best possible patient outcomes and avoid any geographical or organisational variation;
    - to continue to embed the single operating model as described in Securing Excellence for Armed Forces and their Families;
    - full implementation of the Armed Forces Covenant Commitment;
    - to work in partnership with the Ministry of Defence (DMS Personnel and Recovery) commissioning healthcare in line with the Armed Forces National Partnership Agreement; and
    - to collaborate with CCGs to ensure services are locally integrated and to develop strong Armed Forces networks across England.

SERVICES FOR PEOPLE IN THE JUSTICE SYSTEM

15. We will continue the implementation of the single operating framework and commissioning intentions (developed jointly with National Offender Management Service, Public Health England, Youth Justice Board, Home Office Immigration Enforcement and Police Custody Healthcare) in a range of Justice services settings:
    - Prisons;
    - Young Offender Institutes;
    - Secure Children's Homes;
    - Immigration and Removal Centres;
    - Police Custody Suites; and
    - Court Liaison Services.

16. Specifically our priorities from 2014/15 are:

- to ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of Resettlement Prisons;
- to support sustainable recovery from addiction to drugs and alcohol and improved mental health services;
- promotion of continuity of care from custody to community and between establishments, working closely with Probation Services, Local Authorities and CCGs;
- development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs;
- continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme; and
- to ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.

ANNEX I: BETTER CARE FUND MEASURES AND INFORMATION

BETTER CARE FUND MEASURES

Transfers
Delayed transfers of care
Admissions
Emergency admissions
Admissions to residential and nursing care
Reablement
Effectiveness of reablement
Patient/service user experience
Patient/service user experience

WHAT IS INCLUDED IN THE BETTER CARE FUND AND WHAT DOES IT COVER?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care “pioneers” initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

WHAT IS INCLUDED IN THE BETTER CARE FUND AND WHAT DOES IT COVER?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £859m transfer already planned from the NHS to adult social care, a further £241m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	**2015/16**
A further £241m transfer from the NHS to adult social care, in addition to the £859m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: £130m Carers' Break funding £300m CCG reablement funding £354m capital funding (including £220m Disabled Facilities Grant) £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £859m transfer already announced, but NHS England will only pay out the additional £241m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.

7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to Local Authorities in 2014/15 remain consistent with the guidance[19] from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

- *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

- *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*

- *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

- *A further condition of the transfer is that Local Authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

8. Councils should use the additional £241m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

9. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement

10. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.
    i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.
    ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

WHAT WILL BE THE STATUTORY FRAMEWORK FOR THE FUND?

11. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75[20] joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

12. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

13. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and Local Authorities.

14. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that Local Authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

15. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

16. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier Local Authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

17. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach

20 Sec 75 of the NHS Act, 2006, provides for CCGs and Local Authorities to pool budgets.

local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

HOW WILL LOCAL FUND ALLOCATIONS BE DETERMINED?

18. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.

19. In 2014/15 the existing £859m s.256 transfer to councils for adult social care to benefit health, and the additional £241m, will continue to be distributed using the social care relative needs formula (RNF).

20. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

21. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £241m will be transferred directly from NHS England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

22. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

23. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

HOW SHOULD COUNCILS AND CCGs DEVELOP AND AGREE A JOINT PLAN FOR THE FUND?

24. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

25. Where a unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

26. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

- aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
- assure that the national conditions have been achieved; and
- understand the performance goals and payment regimes that have been agreed in each area.

27. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is published alongside this guidance as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

28. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

29. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.

30. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

WHAT ARE THE NATIONAL CONDITIONS?

31. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

National Condition	Definition
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help – following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans should not have a negative impact on the level and quality of mental health services.

HOW WILL COUNCILS AND CCGs BE REWARDED FOR MEETING GOALS?

32. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

33. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

34. The performance payment arrangements are summarised in the table below:

When	Payment for performance amount	Paid for
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: • delayed transfers of care; and • avoidable emergency admissions.
October 2015	£500m	Further progress against all of the national and local metrics.

NATIONAL AND LOCAL METRICS

35. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

36. The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient/service user experience.

37. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

38. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

39. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two of these metrics, on admissions to residential and care homes and the effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 – Mar 2015
Effectiveness of reablement	N/A	Apr 2014 – Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan – Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient/service user experience	N/A	Details TBC

40. For the metric on patient/service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient/service user experience should be measured specifically for the purpose of the Fund.

41. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

42. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility/ walking ability at 30/120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24i	Injuries due to falls in people aged 65 and over

43. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

44. Each metric will be of equal value for the payment for performance element of the Fund.

45. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

46. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

47. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

HOW WILL PLANS BE ASSURED?

48. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

49. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

50. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

51. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).
- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.
- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.
- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.
- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.
- Ministers will give the final sign-off to plans and the release of performance related funds.

WHAT WILL BE THE CONSEQUENCES OF FAILURE TO ACHIEVE IMPROVEMENT?

52. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

53. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

54. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

55. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

56. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

57. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

WHEN SHOULD PLANS BE SUBMITTED?

58. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by 14 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

59. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

ANNEX J: TEMPLATE CONTENTS

CONTENT OF THE STRATEGIC PLAN

Segment	Covering:	Supported by:
System vision	A statement describing what the desired state would be for the health economy in 2018/19 – this should ideally describe the health and care system rather than an individual organisation view.	Stakeholder sign up Individual organisation visions
Improving quality and outcomes	Looking at the seven improving outcome ambitions identified in Everyone counts: planning for patients, how does the health economy plan to improve these and, where appropriate, what level of improvement does it expect?	Detailed metrics will be provided in the operational template for years 3 – 5
	What other local quality improvement plans are in place and how do these align with the local strategic needs assessments?	Sign up from key stakeholders such as Health and Well-being Boards
Sustainability	In five years, what are the health economy goals for sustainability including reference to financial position, other resources and points of service delivery? This work should reference the do nothing gap calculated for the system by 2018/19 that aligns to the challenges identified in A Call to Action[21].	Detailed metrics supplied in the financial templates for each component organisation
Improvement interventions	To achieve the desired end state what are the key improvement interventions planned at an organisational level and how will these deliver the quality and sustainability outcomes required?	Contract expectations included in the financial template
Governance overview	A summary of the governance processes in place to oversee the delivery of the plans, including high level description of what success looks like and who is responsible for measuring it.	
Key values and principles	A summary of the agreed values and principles that underpin the system wide working required to deliver the vision.	

21 http://www.england.nhs.uk/2013/07/11/call-to-action/

CONTENT OF OPERATIONAL PLAN

Segment	Covering:	Further detail:
Outcomes	Improvement against the measures to support the seven outcome ambitions: • Trajectory for *Clostridium difficile* reduction. • Trajectory for dementia diagnosis. • Trajectory for IAPT coverage and recovery. • Trajectory for seven outcome ambition measures. • Trajectory for Quality Premium measures (where different from seven outcome ambitions).	Measures set out in Annex A.
NHS Constitution	Self-certification of the delivery of all NHS Constitution rights and pledges.	Measures set out in Annex B.
Activity	Trajectories for: • Elective FFCEs. • Non elective FFCEs. • Outpatient attendances. • A&E attendances. • Referrals	Measures set out in Annex C.
Better Care Fund	Improvement against the agreed BCF measures.	Measures set out in Annex I.

CONTENT OF FINANCIAL PLAN

Segment	Covering:
Financial plan summary	An overview of the financial plan.
Revenue resource limit	Detail of recurrent and non-recurrent allocations expected to be received.
Planning assumptions	Provider efficiency, inflation, activity growth (demographic and non-demographic), contingency, recurrent headroom.
Financial plan detail 14/15-18/19	Financial plan for each of the next five years (2014/15 and 2015/16 at a higher level of detail). Planned income and expenditure for each service type.
QIPP 14/15-18/19	Detail of financial impact of QIPP schemes for each of the next five years with profile for the first two years.
Risk	Details and valuation of identified risks over each of the next five years (2014/15 and 2015/16 at a higher level of detail). Details of mitigation strategies.
Investment	Details of planned investment over each of the next five years including use of headroom.
Statement of financial position	Detail of assets, liabilities and taxpayers' equity for each of the next two years.
Cash	Breakdown of receipts and payments over each of the next two years.
Capital	Planned capital expenditure by scheme for each of the next five years.
Contract value 14/15-18/19	Details of forecast spend on current contracts for 13/14 and anticipated contract value for each of the next five years.

CONTENT OF DIRECT COMMISSIONING FINANCIAL PLAN

	Segment	Covering:
	Area Team Summary	Summary of the financial plan for all directly commissioned services for Area Team.
For each Directly Commissioned service	Financial plan summary	An overview of the financial plan for each area of direct commissioning.
	Resource allocations	Details of allocation for service for each of the next five years.
	Assumptions	Provider efficiency, inflation, activity growth (demographic and non-demographic) – assumptions for each of the next five years.
	Financial Plan Detail	Financial plan for each of the next five years (2014/15 and 2015/16 at a higher level of detail).
	QIPP	Detail of financial impact of QIPP schemes for each of the next five years and saving profile for each of the next two years (2014/15 and 2015/16 at a higher level of detail).
	Investment	Details of planned investment over each of the next five years (2014/15 and 2015/16 at a higher level of detail).
	NR proposals	Proposals for non-recurrent funding over each of the next five years.
	Risk	Details and valuation of identified risks over each of the next five years. Details of mitigation strategies and funding required (2014/15 and 2015/16 at a higher level of detail).
	Contract value 14/15-18/19	Details of forecast spend on current contracts for 13/14 and anticipated contract value for each of the next five years.

CONTENT OF DIRECT COMMISSIONING OPERATIONAL PLAN: NHS ENGLAND COMMISSIONING IMPROVEMENT MEASURES

Segment	Covering:	Supported by:
Improvement Measures	Improvement against the measures identified for area of Direct commissioning.	Measures set out in Annexes D-G
NHS Constitution	Self-certification of the delivery of all relevant NHS Constitution rights and pledges.	Measures set out in Annex B.
Activity	Trajectories for relevant activity measures for direct commissioning area	Measures set out in Annex C.