Technical Guidance Annex E
NHS England CCG Guidance for Operational and Activity Plans

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1 Introduction

This technical annex provides further guidance and advice on some of the issues that commissioners should consider when setting out their approach to 2017/18 - 2018/19 operational plans.

2 Operational Plan priorities

The planning guidance sets out the 'must do' priorities that will need to be addressed by all commissioners when developing their 2017/18 – 2018/19 operational plans, alongside ensuring local services make progress towards the delivery of the national ambition for seven day services.

CCGs will need to give particular attention to maintaining and improving performance against the measures set out in the CCG Improvement and Assessment Framework.

For NHS England's direct commissioning, each regional team will need to complete plan templates that are relevant to the areas of commissioning for which they are responsible, from the areas below:

- primary, medical, dental, pharmacy, optical, and secondary care dental services (including primary care co-commissioning);
- 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.

NHS England's regional teams will work with CCGs and other local partners to improve the quality of primary care and deliver the commissioning intentions for 2017/18 – 2018/19, ensuring a consistent and coordinated approach across the commissioning of all NHS services and related social care provision. Engaging patients and the population in NHS England's direct commissioning will continue to be an important part of this work.

3 Commissioner Activity Planning Introduction

To support robust demand and capacity planning NHS England and NHS Improvement have agreed a common set of activity data definitions to ensure consistency between providers and commissioners. In developing their plans, providers and commissioners are expected to use the suite of demand and capacity modelling tools, which can be found here or by contacting england.demandandcapacityproject@nhs.net.

Activity submitted with the operational plans should directly reflect year 2 and year 3 of the relevant Sustainability and Transformation Plan.

In planning elective activity, account needs to be taken of the number of working days in the period. There are 255 working days in 2016/2017, but only 251 working days in 2017/18 and 253 working days in 2018/19. Past trends show that, other things being equal, we can expect the lower number of working days in 2017/18 compared to

2016/17 to have a downward effect on referrals, outpatient activity and elective admissions. In contrast, we would expect A&E attendances and non-elective admissions to be more closely related to the number of calendar days in a period. This should also be taken into account when breaking down annual activity totals by month. For example, there are 18 working days in April 2017, but 22 in June 2017.

The planning return will be submitted through UNIFY in line with the timetable of operational plan submissions in the NHS Operational Planning and Contracting Guidance. Commissioners will be provided with a 2016/17 forecast out-turn figure, for all activity with the exception of Referral to Treatment Time. This is derived from Secondary User Service data available from the Temporary National Repository, using the agreed definitions available within the Joint Technical Definitions for Performance and Activity Annex under section 4.3 within Technical Guidance for NHS Planning 2017/18 and 2018/19.

- Commissioners will be required to confirm their assumed growth and changes in activity levels due to transformational change, for example Better Care Fund, vanguards, local schemes etc. and any known contractual coding changes.

- An example of the UNIFY2 Commissioner Monthly Profiled Activity Template will be made available on the UNIFY2 planning page by mid-October. This template will illustrate what information will be required, but is not suitable for submission through UNIFY2. The functional UNIFY2 Planning Template will be available from UNIFY2.

4 Business rules

The NHS Operational Planning and Contracting Guidance 2017-19 set out a broad overview of the finance assumptions and business rules. The business rules for 2017/18 and 2018/19 are summarised in the table below, which should be read in conjunction with the detailed supporting notes that follow.

Table 1: commissioner business rules

Business Rule	CCG	Specialised commissioning	Public Health	Other direct commissioning
Minimum cumulative/ historic underspend	1%	0%	0%	1%
Contingency	Minimum 0.5%			
Non-recurrent spend	1%	0.3%	0%	1%
Admin costs	Remain within admin allocation	N/a	N/a	N/a
Quality premium	Must be applied to programme spend	N/a	N/a	N/a
Specialised co-commissioning	Joint working gain share		N/a	N/a
Transparency obligations met re information on source and use of MRET etc. to relevant stakeholders				
National policy commitments met (e.g. mental health investment standard, better care fund contributions)				

Assurance of commissioner financial plans will focus on compliance with the commissioner business rules with an increased focus on risk management. Where a commissioner does not consider that they are able to meet one or more of the business rules, this should be raised with NHS England and will result in additional scrutiny of the commissioner's financial position. Where a commissioner is unable to submit a plan that meets the business rules, this will be reflected in the commissioner's assurance rating, and may result in further interventions.
The total risk reserve for 2017/18 will be set at c.£800m, which will include a contribution of £270m from provider CQUIN, half of the CCGs' planned 1 percent non-recurrent spend totalling £360m with the balance of up to £200m being made up from a contribution from drawdown. This will allow the remaining half of the CCG 1 percent non-recurrent to be committed from the start of the year.

4.1 Overall financial management

CCGs and primary care direct commissioning are required to deliver a minimum cumulative 1 percent underspend in 2017/18 and 2018/19. The cumulative underspend must be the higher of 1 percent and the amount carried over from the previous financial year, subject to the approval of any drawdown. Typically the cumulative underspend will be funded through return of the carry forward from the previous year, and will not need to be created from the current year's allocation. This means that the majority of CCGs will plan to spend their allocation for the year in full.

Specialised commissioning and public health services are required to achieve a breakeven position in 2017/18 and 2018/19.

A commissioner with a relatively high per capita growth in allocation is encouraged to plan for a higher level of cumulative underspend if that would avoid poor value investment decisions and allow them to make smart medium term investment decisions. CCGs with an increase in allocation above the average of 2.1 percent

should be prepared to provide detail to demonstrate that they are investing their new monies effectively.

CCGs that will not meet the cumulative/historic 1 percent underspend requirement are required as a minimum to improve their in-year position by 1 percent of allocation per year plus any growth above average until cumulative deficit repayment has been completed and 1 percent cumulative underspend business rule is achieved. Any CCG that is not currently meeting the cumulative underspend requirement is expected to plan to do so over the strategic planning period.

Any CCG that does not submit a plan that meets these requirements will be entered directly into the special measures regime.

If these expectations are delivered in plans (and subsequent in-year performance), from 2018/19 onwards the net in-year deficit will be eliminated and there will be a net repayment of cumulative deficit creating headroom in available drawdown to cover:

- primary care drawdown;
- return of any risk reserves released as underspend to cover provider deficits in 2016/17 or subsequent years;
- new emerging deficits; and/or
- additional transformation funding requirements.

Any CCG that is unable to meet the 1 percent cumulative underspend requirement will be required to submit (or refresh if relevant) a financial recovery plan, which will be subject to regional scrutiny and approval. Draft recovery plans must be submitted in time to support the plan submission on 24 November 2016.

4.2 Drawdown

Drawdown is either the use of prior year historic underspends to fund additional expenditure or an in-year operating deficit. Mathematically it is a reduction in cumulative underspend or an increase in cumulative deficit between the opening and closing position for a year.

Necessarily, the first call on available drawdown for a given year will be CCGs with an unavoidable operating deficit. However, deficit drawdown limits the funds available for deployment for other purposes, therefore it is critically important that in-year deficits are kept to a minimum to maximise the amount of drawdown available for investment. The remainder of the drawdown pot will be applied to contribute to the risk reserve, to be returned to CCGs with higher levels of cumulative historic underspends to fund non-recurrent investment plans and if possible one-off pressures and to fund drawdown for primary care.

The process and eligibility for accessing drawdown of historic underspends will be similar to 2016/17; the conditions are as follows:

- the commissioner has cumulative underspends sufficient to drawdown from;

- the investment will be used non-recurrently, which must be confirmed via the business case process;
- the CCG will still meet the business rules regarding the required underspend, so commissioners carrying forwards underspends of less than 1 percent from 2016/17 will be ineligible; and
- The commissioning system can afford for the commissioner to do so.

Business cases will be required for underspend drawdown, which will be reviewed and approved by regions in advance of finalising plans, and will be subject to overall affordability until conclusion of the planning process. This includes any drawdown related to primary care.

Subject to overall affordability, it is the intention of NHS England that CCGs should plan to drawdown all cumulative underspends in excess of 1 percent over the next four years. This will enable the drawdown mechanism to become a more fluid system of managing financial pressures across the year-end boundary.

4.3 Non-recurrent spend

Consistent with previous years, CCGs will be required to plan for investment of 1 percent of their allocation non-recurrently. For 2017/18 and 2018/19 no more than half of this amount may be committed from the start of each financial year, the balance must be held in reserve as a contribution to the risk reserve until its release is authorised.

On a quarterly basis NHS England and NHS Improvement will review delivery of commissioners' and providers' plans and, in discussion with local health systems, will decide whether the local system needs to continue to hold the reserved portion of the non-recurrent budget, or whether it can be released for investment. The remainder of the non-recurrent budget can be committed from the start of the year.

Primary care will also be required to invest 1 percent of its total allocation non-recurrently, though this may be committed in full from the start of the financial year to support delivery of the General Practice Five Year Forward View.

For the first time specialised commissioning will be required to invest 0.3 percent of funds non-recurrently in both 2017/18 and 2018/19, and will be expected to increase this level of non-recurrent spend over the strategic planning period. To cover specialised commissioning risk the non-recurrent spend must be held in reserve from the start of the financial year until its release is authorised.

For 2017/18 and 2018/19, commissioners will be required to describe the key financial risks across the planning footprint. Mitigation plans should be developed in conjunction with providers, and describe how the risks will be managed. The identification and proposed management of risk will form part of the plan assurance process.

4.4 CCG Financial Planning 2017/18 - Mental Health Investment Standard (formerly known as Parity of Esteem PoE)

In line with the previous two years CCGs are required to continue to focus on investment in mental health services to ensure parity with other areas of investment. For 2017/18 and 2018/19 mental health expenditure for the purposes of assessing the level of investment should exclude expenditure on learning disabilities and continuing healthcare. The guidance for Completion of Commissioner Finance Templates (Annex D within the technical guidance) includes further detail of how the Mental Health Investment Standard will be measured.

Where a commissioner fails to achieve the mental health investment requirements without valid cause, NHS England may consider regulatory sanctions including in exceptional circumstances imposing directions on the CCG to increase its level of investment.

To support this assessment, NHS England is embedding other data collections that will help identify outcomes and prevalence indicators that can be monitored alongside financial investment levels to give a more balanced picture of mental health service commissioning. CCGs should ensure that all providers are making full and timely returns to the Mental Health Services Data Set to support this.

Further information please see: Mental Health Implementation Plan

4.5 Management costs

In aggregate, CCG Management Cost Allowances have been held at the level set in 2015/16 for the years to 2020/21. Individual CCG allowances will reflect differential population growth, and are included in the allocations notification. CCGs must ensure that they do not exceed their management costs allowance in each financial year.

4.6 Other considerations for financial planning

Specialised co-commissioning incentive scheme

CCGs are encouraged to collaborate with specialised commissioning to improve service efficiency. To support this aim, CCGs can share on a 50/50 basis with specialised commissioning in 2018/19 onwards the benefits of any underspends achieved in specialised commissioning budgets in the preceding year.

CCGs will receive a non-recurrent uplift to their allocation in the year following the year in which the savings are realised, equivalent to 50 percent of the underspend achieved by reference to the previous year. This will continue far as long as the savings stream continues. The foot print over which this will operate will be determined according to the participating CCGs and the relevant service pathway.

CCGs should send expressions of interest to NHSCB.financialperformance@nhs.net

5 NHS Operational Planning Measures 2017/18 and 2018/19

The attached table shows the alignment between the national "must do" deliverables and the CCG Improvement and Assessment Framework indicators, being clearer on how they will be measured and where nationally collected planning trajectories are not appropriate, how progress will be tracked.

There are inevitably a number of things in the CCG IAF that are not covered in the planning documentation because they do not lend themselves to translating into trajectories. However, these are still important to delivering quality commissioning, which should be reflected in how CCGs measure their ambition.

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
STPs		
• Implement agreed STP milestones, so that you are on track for full achievement by 2020/21. • Achieve agreed trajectories against the STP core metrics set for 2017-19.	Sustainability and Transformation Plan	STP assurance
Finance		
• Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19. • Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies. • Demand reduction measures include: implementing	Financial plan	Finance trajectories
	In-year financial performance	Finance trajectories
	Outcomes in areas with identified scope for improvement	Not suitable for trajectories - data not currently available
	Expenditure in areas with identified scope for improvement	Not suitable for trajectories - data not currently available

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
RightCare; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes. • Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.		
Primary Care		
• Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes. • Ensure local investment meets or exceeds minimum required levels.	Management of long term conditions	Metric not suitable for nationally-collected trajectories - monitored in-year
	Patient experience of GP services	Metric not suitable for nationally-collected trajectories - monitored in-year via General Practice Patient Survey (GPPS)

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
• Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of IAPT in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems. • By no later than March 2019, extend and improve access in line with requirements for new national funding. • Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.	Primary care access	Coverage of extended access (evenings and weekends) achieved in GP Access Fund sites and Transformation areas.
	Primary care workforce	Metric not suitable for nationally-collected trajectories - captured through annual census
Urgent and Emergency Care		
• Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan. • By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services. • Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and	Emergency admissions for urgent care sensitive conditions	Metric not suitable for nationally-collected trajectories - monitored in-year
	Percentage of patients admitted, transferred or discharged from A&E within four hours	A&E Waiting Times – Total time in the A&E department
		Total non-elective admissions (Specific Acute)
		Total A&E attendances excluding Planned Follow Ups

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. • Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department. • Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.		Ambulances - Proportion of calls closed by telephone advice
		Ambulances - Proportion of incidents managed without need for transport to Accident and Emergency departments
	Delayed transfers of care attributable to the NHS per 100,000 population	Delayed transfers of care per 100,000 population (attributable to NHS, social care or both)
	Population use of hospital beds following emergency admission	Metric not suitable for nationally-collected trajectories - monitored in-year
	Achievement of milestones in the delivery of an integrated urgent care service	Metric not suitable for nationally-collected trajectories - monitored in-year
Referral to Treatment Times		
• Deliver the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment. • Deliver patient choice of first outpatient appointment, and	Patients waiting 18 weeks or less from referral to hospital treatment	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral
		Total Referrals (General and Acute)

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018. • Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups. • Implement the national maternity services review, Better Births, through local maternity systems.		Total GP Referrals (General and Acute)
		Total Other Referrals (General and Acute)
		Consultant-led1st outpatient attendances (Specific Acute)
		Consultant-led follow up outpatient attendances (Specific Acute)
		Total elective admissions (spells) (ordinary admissions and daycases) (specific Acute)
		Number of completed RTT admitted pathways
		Number of completed RTT non-admitted pathways
		Number of New RTT pathways (clockstarts)
		E-Referral Utilisation
Cancer		
• Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report. • Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards. • Make progress in improving one-year survival rates by	Cancers diagnosed at early stage	N/A
		Diagnostic Test Waiting Times
		All cancer two week wait
		Two week wait for breast symptoms (where cancer was not initially suspected)

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission. • Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types. • Ensure all elements of the Recovery Package are commissioned, including ensuring that: ○ all patients have a holistic needs assessment and care plan at the point of diagnosis; ○ a treatment summary is sent to the patient's GP at the end of treatment; and ○ a cancer care review is completed by the GP within six months of a cancer diagnosis.	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer
		Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')
		31-day standard for subsequent cancer treatments-surgery
		31-day standard for subsequent cancer treatments - anti cancer drug regimens
		31-day standard for subsequent cancer treatments - radiotherapy
		Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service
		Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status
	One-year survival from all cancers	Metric not suitable for nationally-collected trajectories - monitored annually

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
	Cancer patient experience	Metric not suitable for nationally-collected trajectories - monitored through annual surveys
Mental Health		
• Deliver in full the implementation plan for the mental health Five Year Forward View for all ages, including: ○ Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care; ○ More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018; ○ Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral. ○ Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline.	Improving Access to Psychological Therapies recovery rate	IAPT Roll-Out
		IAPT Recovery Rate
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period
		IAPT Waiting Times - The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period
	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within two weeks of referral	Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
○ Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases. ○ Reduce suicide rates by 10% against the 2016/17 baseline. • Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. • Increase baseline spend on mental health to deliver the Mental Health Investment Standard. • Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support. • Eliminate out of area placements for non-specialist acute care by 2020/21.		Percentage of patients receiving first definitive treatment for eating disorders within four weeks from a routine referral
		Percentage of patients receiving first definitive treatment for eating disorders within one week from an urgent referral
	Crisis care and liaison mental health services transformation	Metric not suitable for nationally-collected trajectories - monitored in-year
	Children and young people's mental health services transformation	Improve access rate to CYPMH
	Out of area placements for acute mental health inpatient care – transformation	Metric not suitable for nationally-collected trajectories - monitored in-year
	Estimated diagnosis rate for people with dementia	Estimated diagnosis rate for people with dementia
	Dementia care planning and post-diagnostic support	Metric not suitable for nationally-collected trajectories - monitored in-year
People with Learning Disabilities		

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
• Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism. • Reduce inpatient bed capacity by March 2019 to 10-15 CCG-commissioned beds per million population, and 20-25 NHS England-commissioned beds per million population. • Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check. • Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.	Reliance on specialist inpatient care for people with a learning disability and/or autism	Reliance on inpatient care for people with a learning disability and/or autism
	Proportion of people with a learning disability on the GP register receiving an annual health check	Metric not suitable for nationally-collected trajectories - monitored through annual collection
Improving Organisations		
• All organisations should implement plans to improve quality of care, particularly for organisations in special measures. • Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services. • Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.	Use of high quality providers	Metric not suitable for trajectories

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
Maternity		
• CCGs and providers should come together in local maternity systems to design and deliver maternity services improvements in line with the recommendations in the national maternity review, Better Births.	Neonatal mortality and stillbirths	Metric not suitable for nationally-collected trajectories - monitored through annual collection
	Women's experience of maternity services	Metric not suitable for nationally-collected trajectories - monitored through survey data (every 3 years)
	Choices in maternity services	Metric not suitable for nationally-collected trajectories - monitored through survey data (every 3 years)
	Maternal smoking at delivery	Metric not suitable for nationally-collected trajectories - monitored through survey data (every 3 years)
Diabetes		
• Develop and implement plans to tackle obesity and diabetes, including referring 500 people per 100,000 population annually to the National Diabetes Prevention Programme and improving GP participation in the National Diabetes Audit.	Diabetes patients that have achieved all the NICE-recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	Metric not suitable for nationally-collected trajectories - monitored through annual audit data
	People with diabetes diagnosed less than a year who attend a structured education course	Metric not suitable for nationally-collected trajectories - monitored through annual audit data
Seven Day Services		

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
• Building on the delivery of the four priority standards for seven day hospital services by completing implementation for a further 25 percent of the population by the end of 2017/18 and ensuring that other health economies are on track to complete implementation by the end of 2019/20.	Achievement of clinical standards in the delivery of seven day services	Trajectories collected through seven day Services programme
Personal Health Budgets		
• Commissioners should make progress on implementing Mandate commitments that 50,000-100,000 people will have Personal Health Budgets in 2020/21 and set trajectories for this purpose.	Personal health budgets	Proportion of patients with a Personal Health Budget based on number of patients and demographics
Continuing Healthcare		
• Improving processes to provide speedier assessments for patients and to implement emerging best practice; and mainstream delivery model for NHS Continuing Care and continuing care for children.	People eligible for standard NHS Continuing Healthcare	Metric not suitable for nationally-collected trajectories - monitored in-year
Wheelchair Access		
• CCGs should set out improvement plans to halve the number of children waiting 18 weeks by Q4 2017/18 and eliminate 18 week waits for wheelchairs by the end of 2018/19.		All children requiring a wheelchair will receive one within 18 weeks from referral
Better Care Fund		

Must Do	CCG IAF 2016/17 Metrics	Planning Guidance - National Trajectories 2017/18 – 2018/19
• Via the Better Care Fund (BCF) planning guidance, all CCGs to work with local authority partners at a Health and Wellbeing Board level to pool budgets and develop and agree an integrated spending plan for using their BCF allocation.		Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
		Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
Other		
		Total Bed Days

6 NHS Operational Planning Trajectories 2017/18 and 2018/19

The table below lists the measures against which we require CCGs to develop a plan trajectory.

Trajectories	Standard	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Primary Care				
Coverage of extended access (evenings and weekends) achieved in GP Access Fund sites and Transformation areas.	100%	Six Monthly	Yes	Yes
Urgent and Emergency Care				
Ambulances - Proportion of calls closed by telephone advice	N/A	Monthly	Yes	Yes
Ambulances - Proportion of incidents managed without need for transport to Accident and Emergency departments	N/A	Monthly	Yes	Yes
A&E waits				
A&E Waiting Times – Total time in the Accident and Emergency departments	95%	Monthly	Yes	Yes
Activity – Joint Collection with NHS Improvement and NHS England				
Total non-elective admissions (Specific Acute)	N/A	Monthly	Yes	Yes
Total A&E attendances excluding Planned Follow Ups	N/A	Monthly	Yes	Yes

Agreed trajectories	Standard	Monthly/Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Elective Care and Referral to Treatment Times				
Activity – Joint Collection with NHS Improvement and NHS England				
Total Referrals (General and Acute)	N/A	Monthly	Yes	Yes
Total GP Referrals (General and Acute)	N/A	Monthly	Yes	Yes
Total Other Referrals (General and Acute)	N/A	Monthly	Yes	Yes
Consultant led1st Outpatient attendances (Specific Acute)	N/A	Monthly	Yes	Yes
Consultant led Follow up outpatient attendances (Specific Acute)	N/A	Monthly	Yes	Yes
Total elective admissions (spells) (ordinary admissions and daycases) (specific Acute)	N/A	Monthly	Yes	Yes
Number of completed RTT admitted pathways	N/A	Monthly	Yes	Yes
Number of completed RTT non-admitted pathways	N/A	Monthly	Yes	Yes
Number of New RTT pathways (clockstarts)	N/A	Monthly	Yes	Yes
Referral To Treatment waiting times for non-urgent consultant-led treatment				
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	Monthly	Yes	Yes
Diagnostic test waiting times				
Diagnostic Test Waiting Times	1%	Monthly	Yes	Yes

Agreed trajectories	Standard	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Cancer				
Cancer Two Week Wait				
All cancer two week wait	93%	Monthly/ Quarterly	Yes	Yes
Two week wait for breast symptoms (where cancer was not initially suspected)	93%	Monthly/ Quarterly	Yes	Yes
Cancer Waits - 31 Days				
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	Monthly/ Quarterly	Yes	Yes
31-day standard for subsequent cancer treatments-surgery	94%	Monthly/ Quarterly	Yes	Yes
31-day standard for subsequent cancer treatments - anti cancer drug regimens	98%	Monthly/ Quarterly	Yes	Yes
31-day standard for subsequent cancer treatments - radiotherapy	94%	Monthly/ Quarterly	Yes	Yes
Cancer Waits - 62 Days				
Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer	85%	Monthly/ Quarterly	Yes	Yes
Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	90%	Monthly/ Quarterly	Yes	Yes
Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	n/a	Monthly/ Quarterly	Yes	Yes

Agreed trajectories	Standard	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Mental Health				
IAPT Roll-Out	16.8%	Quarterly	Yes	Yes
Estimated diagnosis rate for people with dementia	66.70%	Monthly	Yes	Yes
IAPT Recovery Rate	50%	Quarterly	Yes	Yes
IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	75%	Quarterly	Yes	Yes
IAPT Waiting Times - The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	95%	Quarterly	Yes	Yes
Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral	50%	Quarterly	Yes	Yes
Improve access rate to CYPMH	30%	Quarterly	Yes	Yes
Percentage of patients receiving first definitive treatment for eating disorders within four weeks from a routine referral	95%	Quarterly	Yes	Yes
Percentage of patients receiving first definitive treatment for eating disorders within one week from an urgent referral	95%	Quarterly	Yes	Yes

Agreed trajectories	Standard	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Learning Disabilities				
Reliance on inpatient care for people with a learning disability and/or autism*(including Asperger's syndrome)	By March 2019 no area should need more inpatient capacity than is necessary at any one time to cater to: • 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population • 20-25 inpatients in NHS England-commissioned beds (such as those in low, medium or high-secure units or CAMHS Tier 4 units) per million population	Quarterly	Yes	Yes
Better Care Fund				
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	N/A	Annual	Yes	Yes
Delayed Transfers of care per 100,000 population (attributable to NHS, social care or both)	N/A	Monthly	Yes	Yes
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	N/A	Annual	Yes	Yes

Public Health Budgets (PHBs)				
Proportion of patients with a Personal Health Budget based on number of patients and demographics	0.10%	Quarterly	Yes	Yes
Agreed trajectories	**Standard**	**Monthly/ Quarterly/ Annual Total**	**Technical Guidance**	**Planning Trajectory**
Wheelchair Service Provision				
All children requiring a wheelchair will receive one in within 18 weeks from referral	92% by Q4 2017/18 100% by Q4 2018/19	Quarterly	Yes	Yes
Activity/Other				
E-referrals Utilisation Coverage	80% by Q2 2017/18 100% by Q2 2018/19	Monthly	Yes	Yes
Total Bed Day	N/A	Monthly	Yes	Yes