Technical guidance for NHS planning 2017/18 and 2018/19

Annex F: NHS Improvement guidance for operational and activity plans

September 2016

About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Contents

1. How to use this guidance

This technical document is Annex F of *Technical guidance for NHS planning 2017/18 and 2018/19*,[1] which supports the main planning guidance *Operational planning and contracting guidance 2017/18 and 2018/19*[2] (published 22 September 2016). It should not be read in isolation, but alongside and in the context of, those joint planning guidance documents.

It is detailed guidance for all NHS trusts and NHS foundation trusts on their 2017/18 – 2018/19 operational plans only. It outlines our objectives and requirements for provider plans, our view of what operational plans should contain, and our approach to the review of, and response to, those plans.

Throughout the document we refer to NHS trusts and NHS foundation trusts collectively as 'trusts', except where we specifically make separate reference to either group.

2. Objectives for providers' 2017/18 to 2018/19 operational plans

Operational planning and contracting guidance 2017/18 and 2018/19 is the main planning document setting out the planning assumptions and priorities for the NHS for the coming two years. It builds on the sustainability and transformation plans (STPs) produced by local health and care systems and takes forward implementation of the Five Year Forward View.

As highlighted in the financial reset and the publication of *Strengthening financial performance and accountability in 2016/17*, the STPs for each footprint are the key starting point for two-year, organisation-level operational plans for 2017/18 and 2018/19, with collaborative actions across local health and care systems.

The joint planning guidance will help each STP area move swiftly from submitting its STP in October to agreeing two-year operational plans and contracts that will underpin delivery in 2017/18 and 2018/19. The aim is to provide certainty and stability for a two-year planning and contracting cycle and enable operational planning and contracting to be completed by 23 December 2016 (collections will close on 30 December) with submission of final operational plans and signing of contracts. Moving into 2017, organisations will then be able to focus single-mindedly on delivery of the next two years of their STPs, building on the solid financial foundation created through joint actions in 2016.

Providers as a whole, irrespective of their NHS trust or NHS foundation trust status, currently face significant financial, operational and clinical challenges, as well as opportunities for improvement. It is therefore important for NHS Improvement to

[1] www.england.nhs.uk/planning-guidance
[2] www.england.nhs.uk/planning-guidance

share a defined set of objectives for providers that will address these challenges and opportunities.

The quality standards for patient services are clearly set out in the NHS Constitution[3] and in the fundamental quality and safety standards published by the Care Quality Commission (CQC).[4] These quality standards continue to define the expectations for provider services. The NHS Constitution and CQC standards are available in *Guidance for providers on meeting the regulations*.

For providers to achieve and maintain high quality services, those services also need to be underpinned by affordable and sustainable financial plans. Building on the joint financial improvement actions in 2016/17, a key focus of the two-year planning round will be to achieve break-even or better for the provider sector in each of the two years, after deployment of the £1.8 billion Sustainability and Transformation Fund (STF) in each year.

Technical guidance for NHS planning 2017/18 and 2018/19 sets out the arrangements for NHS commissioners and providers to submit operational plans for 2017/18 to 2018/19. This annex outlines our requirements for the 2017/18 to 2018/19 operational plans. We will release more detail of the templates to be used for submissions on 1 November 2016.

NHS Improvement's overarching objectives for 2017/18 to 2018/19 planning

All providers will have robust, integrated operational plans for 2017/18 - 2018/19 that demonstrate the delivery of safe, high quality services that meet NHS Constitution standards or delivery of recovery milestones within available resources.

Provider actions to improve efficiency will result in at least a break-even position for the provider sector in each of the two years, after deployment of the Sustainability and Transformation Fund.

3. Requirements of operational plans

In line with the overarching objectives for operational planning above and underpinned by the expectations for the NHS summarised in the main planning guidance, NHS Improvement expects the following from providers' operational plans for 2017/18 to 2018/19:

- operational plans must be realistic and deliverable:

[3] www.gov.uk/government/publications/the-nhs-constitution-for-england
[4] www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

- based on reasonable assumptions for activity, that the provider has sufficient capacity to deliver
- supported by contracts with commissioners, signed by 23 December 2016, that reflect this level of activity and balance risk appropriately
- underpinned by coherent and well-modelled financial projections
- supported by agreed contingency plans wherever risks across local health system plans have been jointly identified.

- Operational plans must also be stretching, representing the maximum that each provider can reasonably be expected to deliver:
  - providers must agree and then deliver financial control totals for 2017/18 and 2018/19 as a condition of receiving their STF funding. Delivering (or exceeding) control totals will enable the service to return to at least a break-even financial position in aggregate in both years, and will form a core part of the new financial oversight regime, the Single Oversight Framework that NHS Improvement is putting in place this year (the STF guidance published on 30 September will provide more detail)
  - acute non-specialised providers should take advantage of the opportunities identified in the Carter review for improved productivity[5]
  - providers should continue to apply the rules on agency spend[6] introduced by NHS Improvement and restrictions on the growth of their paybill. Information is available in the guidance on Rules for all agency staff working in the NHS
  - where they have not already done so, providers should take advantage of extra efficiency opportunities in consolidating back office and pathology services
  - providers should engage with commissioners to ensure alignment with local adoption of the RightCare programme
  - actions should be taken to make better use of the NHS estate.
- Providers' capital plans should be consistent with their clinical strategy, and clearly provide for the delivery of safe, productive services with business cases that demonstrate affordability and value for money. They should:

[5] www.gov.uk/government/publications/productivity-in-nhs-hospitals
[6] www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

- demonstrate that the highest priority schemes are being assessed and taken forward
- continue to ensure that they look to their own internally generated capital resource to fund repayment of existing and new borrowing related to capital investment
- be aware that Department of Health (DH) financing is likely to be available only in pre-agreed and very exceptional cases
- continue to procure capital assets more efficiently, maximise and accelerate disposals and extend asset lives
- highlight where capital investment plans support opportunities for improved productivity identified by Lord Carter's review
- where applicable, also clearly demonstrate which schemes are above their delegated limits.

- Operational plans should be consistent with sustainability and transformation plans:
  - the position of each provider (on finance, activity and workforce) should be consistent with the STP footprint financial plan for 2017/18 and 2018/19 to be submitted in October 2016 and with the system control for that STP area
  - the aggregate of all operational plans in a footprint will need to reconcile with the STP position
  - they should reflect the strategic intent of the STP and the organisational impact of the three to five issues critical to their locality.
- Operational plans should demonstrate improvement in the delivery of core access standards as set out in the NHS Constitution and national planning guidance (A&E and ambulance response times, referral to treatment, cancer, mental health and the transformation of care for people with learning disabilities):
  - Payment of a proportion of the general element of the STF is conditional on providers in 2017/18 and 2018/19 either delivering the NHS Constitution standards for operational performance or (where providers do not achieve those standards by March 2017 based on current performance trajectories) agreeing and delivering new performance trajectories
  - the STF guidance published on 30 September 2016 will provide more details.

- Providers must be assured that the individual activity, workforce and finance elements of their plans are cross-checked and internally consistent.
- In relation to quality and workforce, it will be important that providers can demonstrate:
    - development and implementation of an affordable plan to make improvements in quality, particularly for providers in special measures
    - application of a robust quality improvement methodology
    - a plan for achieving the four priority standards for seven-day hospital services in an affordable way
    - the application and monitoring of an effective quality impact assessment (QIA) approach for all cost improvement programmes (CIPs)
    - workforce productivity, particularly through effective use of e-rostering and less reliance on agency staffing
    - triangulation of quality, workforce and finance indicators.

In short, provider operational plans must:

- provide for a reasonable and realistic level of activity
- demonstrate the capacity to meet this
- provide adequate assurance on the robustness of workforce plans and the approach to quality
- be stretching from a financial perspective: planning to deliver (or exceed) the financial control total agreed with NHS Improvement, thus qualifying the provider for receipt of STF; taking full advantage of efficiency opportunities (including those identified by the Carter review and the agency rules)
- demonstrate improvement in the delivery of core access and NHS Constitution standards (or, if applicable, performance improvement trajectories)
- contain affordable, value-for-money capital plans that are consistent with the clinical strategy and clearly demonstrate the delivery of safe, productive services
- be aligned with commissioner plans, and underpinned by contracts that balance risk appropriately
- be consistent with and reflect the strategic intent of STPs, including the specific service changes, quality improvements and increased productivity and efficiency identified in the STPs, and with the system control total for the STP area
- be internally consistent between activity, workforce and finance plans.

3.1. The Sustainability and Transformation Fund

Part of the process of managing an aggregate bottom-line position of break-even or better for the service in 2017/18 to 2018/19 is understanding the impact of a range of known factors at individual provider level and agreeing robust plans that include the deployment of the STF and a control total by providers for 2017/18 and 2018/19.

We have reviewed the approach to the STF for 2017/18 to 2018/19 in the light of experiences in 2016/17 and made changes to reflect this.

We have developed an impact assessment model for a range of known factors at an individual provider level. Based on this work we have allocated individual providers an indicative share of the STF and a provisional control total for 2017/18 and 2018/19. These are being communicated in a letter to each provider on 30 September 2016.

As in 2016/17, the payment of STF will depend on providers meeting their financial control totals and meeting the core access standards. The provision of assurance statements, and (where necessary) the agreement of performance improvement trajectories, will be required from trusts for 2017/18 and 2018/19.

As in 2016/17, where a provider:

- is granted funding from the general element of the STF and agrees an annual financial control total with NHS Improvement and
- with regard to its performance against key national quality standards either agrees performance improvement trajectories with NHS Improvement and NHS England, and/or provides NHS Improvement with assurance statements

then the operation of certain financial sanctions under the NHS Standard Contract will continue to be suspended for both 2017/18 and 2018/19.

The suspension is described in Service Condition 36.37A and General Condition 9.26 of the Contract and in the executive summary of the Contract Technical Guidance. The standards and sanctions affected are:

- those covering 4-hour A&E waits, RTT 18-week incomplete pathways and 62-day cancer waits (for which providers will either have to submit an assurance statement to NHS Improvement, confirming their commitment to deliver the national standard in full on an ongoing basis or will have to agree with NHS Improvement and NHS England a monthly performance improvement trajectory, setting out their commitment to improving their performance, over time, towards the level required by the national standard) and

- those covering 12-hour trolley waits, RTT 52-week waits, 6-week diagnostic waits, other cancer waits, ambulance response times (Red1, Red 2, other Category A) and ambulance handover standards (affecting both A&E and ambulance providers), for which providers will have to submit an assurance statement to NHS Improvement, confirming their commitment to deliver the national standard in full on an ongoing basis.

If, during the two-year period of the contract, revised national standards are introduced for ambulance response times (following completion of the ongoing pilots), NHS Improvement and NHS England may also decide to require specific performance improvement trajectories on the new standards from the relevant providers.

Detailed guidance for the STF in 2017/18 and 2018/19 will be published on 30 September 2016.

4. Summary of operational plan submissions

Our two-year operational plan collections are designed to enable us to test delivery of the requirements articulated in section 3 above.

Table 1 below summarises the plan submission requirements, identifying what needs to be submitted, where and when.

This year, for both NHS trusts and NHS foundation trusts, the operational plan submissions will include:

- contract tracker returns: updated and submitted throughout the contracting timetable in accordance with the weekly submission schedule detailed in Annex G to *Technical guidance for NHS planning 2017/18 and 2018/19*
- a finance return
- an activity return through the Portal (for draft plan and final plan):
    - this will contain annualised activity data for the 2016/17 forecast out-turn (pre-populated) and 2017/18 to 2018/19 operational plan, supporting the alignment process of provider−commissioner activity plans
    - for both NHS trusts and NHS foundation trusts this submission is required of acute and specialist trusts only
    - NHS mental health, community and ambulance trusts do not need to submit activity returns
- a workforce return
- a triangulation return:

- a linked file detailing the required triangulation checks between finance, activity and workforce plans
- review of alignment between financial plan revenue and contract revenue
- an operational plan narrative (maximum 16 pages), which should take forward the local health and care system's STP and outline the provider's approach to activity, quality, workforce and financial planning for 2017/18 to 2018/19. See section 5 for further details
- as described in Section 3, assurance statements from all NHS trusts and foundation trusts, and, where necessary, agreed improvement trajectories (applies to a sub-set of NHS trusts and foundation trusts only). Submissions should be made in accordance with the national planning timetable and should be emailed to NHSI.returns@nhs.net

Providers' draft, two-year operational plans for 2017/18 to 2018/19 should be submitted to NHS Improvement by midday on Thursday, 24 November 2016.

Providers' final, two-year operational plans for 2017/18 to 2018/19 should be submitted to NHS Improvement by noon on 23 December 2016 (collections will close on the 30 December). The final operational plan should include updated versions of:

- finance return
- activity return (acute and specialist providers only)
- workforce return
- triangulation return
- the operational plan narrative
- assurance statements and, where necessary, improvement trajectories.

Note on planning templates: In light of the alignment of NHS foundation trust and NHS trust planning requirements, we have made changes to the operational plan templates. We will issue detailed template guidance on 1 November 2016.

Table 1: NHS Improvement plan submission requirements

Submission requirement	Technical Guidance Reference	Deadlines	Submission details
Operational plan narrative	Annex F	24 November (noon) and 23 December*	Through online portal
Financial plan	To be published 1 November	24 November (noon) and 23 December*	Through online portal
Activity plan	Annex F	24 November (noon) and 23 December*	Through online portal
Workforce plan	To be published 1 November	24 November (noon) and 23 December*	Through online portal
Contract tracker	Annex G	Weekly from 21 November to 30 January	Via a provider return on UNIFY2
Triangulation form	Annex F	24 November (noon) and 23 December*	Through online portal
Assurance statements, and where necessary agreed improvement trajectories (selected providers only), for selected national standards	Annex F / NHS Standard Contract	24 November (noon) and 23 December*	NHSI.returns@nhs.net

* The submission deadline for final operating plans is 23 December, and collections close on 30 December

5. Operational plan narrative (both draft and final plans)

As outlined above in section 4, as part of their draft and final operational plans, all providers are required to submit an operational plan narrative that supports the finance, activity and workforce returns. This narrative should address NHS Improvement's key requirements of provider plans, as set out in section 3.

The supporting narrative submitted at 24 November, although 'draft', should represent a full account of the operational plan as at that date.

Although there is no template for the narrative element of operational plans, we set out below what the plans need to demonstrate. We recommend providers use this structure as far as possible to help with the consistency of plans.

5.1. Structure, format and length

Based on the guide below, the operational plan narrative should not be longer than 16 pages. Quality is far more important than quantity: we want to be able to understand each plan. A provider's inability to summarise its plan coherently and concisely will itself be considered as part of the assessment of risk.

It should be easy for us to reconcile the content in the written narrative with data in the finance, activity and workforce templates.

Activity planning (maximum 2 pages)

A fundamental requirement of the 2017/18 to 2018/19 operational planning round is for providers and commissioners to have realistic and aligned activity plans. It is therefore essential they work together transparently to promote robust demand and capacity planning.

To help support this process, the national Demand and Capacity Programme has provided regional training events to more than 1,000 attendees and will continue to provide one-day events up to early December 2016. These focus on the principles and practice of demand and capacity modelling for elective care and include content for commissioners around the general principles of external assurance of provider demand and capacity workstreams. In response to feedback from previous events, there will also be two specific one-day events in November focused on the NHS Improvement Intensive Support Team demand and capacity models. More information will be shared on the Demand and Capacity events in due course.

In the operational plan narrative, therefore, providers should support their activity returns with a written assessment of activity over the next year, based on robust demand and capacity modelling and lessons from previous years' winter and system resilience planning.

They should provide assurance to NHS Improvement that:

- the activity plans for 2017/18 to 2018/19 are based on outputs from:
    - the demand and capacity approach for 2016/17
    - demand and capacity modelling tools that have been jointly prepared and agreed with commissioners
- activity returns are underpinned by agreed planning assumptions, with explanation about how these assumptions compare with expected growth rates in 2016/17
- they have sufficient capacity to deliver the level of activity that has been agreed with commissioners, indicating plans for using the independent sector to deliver activity, highlighting volumes and type of activity if possible

- activity plans are sufficient to deliver, or achieve recovery milestones for, all key operational standards, in particular accident and emergency (A&E), referral to treatment (RTT), incomplete, cancer, diagnostics and mental health waiting times. They should also refer to any explicit plans agreed with commissioners around:
    - extra capacity as part of winter resilience plans, for instance extra escalation beds
    - arrangements for managing unplanned changes in demand.

Quality planning (maximum 4 pages)

Quality standards for patient services are clearly set out in the NHS Constitution and in the CQC quality and safety standards. They continue to define the expectations for the services of providers.

To meet these standards, providers should have a series of quality priorities for the next two years set out in a quality improvement plan. This plan needs to be underpinned by the local STP, the provider quality account, the needs of the local population and national planning guidance. To create these priorities providers need to consider:

- national and local commissioning priorities
- the provider's quality goals, as defined by its strategy and quality account, and any key milestones and performance indicators attached to them
- an outline of existing quality concerns (from internal intelligence, CQC, the quality account or other parties) and plans to address them
- key risks to quality and how these will be managed.

For the 2017/18 to2018/19 operational plan narrative, providers should self-assess and outline their approach to quality in a narrative split into four sections:

1. Approach to quality governance
2. Summary of the quality improvement plan (including compliance with national quality priorities)
3. Summary of the quality impact assessment process
4. Summary of triangulation of quality with workforce and finance.

We will use this narrative to seek assurance that the approach to quality is sound and robust. Where appropriate, we may ask individual providers for more information, such as their detailed quality improvement plan.

We suggested the following content for each section.

Section 1: Approach to quality improvement

Providers should outline their approach to quality improvement including:

- a named executive lead for quality improvement
- a description of the organisation-wide improvement approach to achieving a good or outstanding CQC rating (or maintain an outstanding rating) including the governance processes underpinning this
- details of the quality improvement governance system, from the ward to the board, with details of how assurance and progress against the plan are monitored
- how quality improvement capacity and capability will be built in the organisation to implement and sustain change
- measures being used to demonstrate and evidence the impact of the investment in quality improvement.

Section 2: Summary of the quality improvement plan (including compliance with national quality priorities)

Providers should detail their quality improvement plans in relation to local and national initiatives to be implemented in the next two-year period, including (but not limited to):

- national clinical audits
- the four priority standards for seven-day hospital services
- safe staffing
- care hours per patient day
- mental health standards(Early Intervention in Psychosis and Improving Access to Psychological Therapies)
- actions from the Better Births review
- improving the quality of mortality review and Serious Incident investigation and subsequent learning and action
- anti-microbial resistance
- infection prevention and control
- falls

- sepsis
- pressure ulcers
- end of life care
- patient experience
- national CQUINs
- confirmation that the provider's quality priorities are consistent with STPs.

Section 3: Summary of quality impact assessment process

Each provider should have an effective QIA process for service developments and efficiency plans in line with National Quality Board (NQB) guidance (examples include 7-day services and CIPs). This section should include:

- a description of the governance structure surrounding scheme creation, acceptance and monitoring of implementation and its impact (whether positive or negative)
- a description of this governance structure that clearly articulates:
    - how frontline/business unit-level clinicians are creating schemes and what challenge there is regarding potential risks and acceptance of schemes
    - the QIA process and whether this is assessed against the three core quality domains (safety, effectiveness and experience) or the wider five CQC domains (safe, effective, responsive, caring and well led), allowing insight into staff impact
    - how schemes received executive sign-off by the medical and nursing directors (including an articulation of whether all schemes are seen, or whether there is a risk-based process to sign off such as monetary value, risk score, etc)
- identification of key performance metrics aligned to specific schemes to facilitate early sight of potential impact on the quality of care.

It is important that providers have clear monitoring mechanisms for initiatives so that they can identify when care is being compromised. The provider board needs clear visibility of these monitoring arrangements. In this section providers should articulate:

- how appropriate baseline data have been recorded before implementation of the change, including the duration of this data, eg to capture seasonal variations

- where the provider does not define specific metrics but use generic quality measures, how they interrogate and challenge poor performance to make sure the efficiency plans do not drive any deterioration
- how the board receives oversight of any potential cumulative impact of several schemes on a particular pathway, service, team or professional group.

This is particularly important for providers experiencing transactions, mergers or in special measures.

Section 4: Summary of triangulation of quality with workforce and finance

We expect each provider to triangulate intelligence, for example quality, workforce and financial indicators, on at least a six-monthly basis. In this section, they should outline:

- their approach to triangulation
- the key indicators used in this process
- how the board intends to use this information.

They should also give assurance that this information will be used to improve the quality of care and enhance productivity.

Workforce planning (maximum 2 pages)

To support the numeric workforce plan providers must demonstrate the following in their operational plan narratives:

- articulation of a workforce planning methodology linked to the strategic aims of the provider, informed by financial and service objectives and contributing to the integrated operational plan
- an underpinning workforce strategy developed with staff involvement (also linked to clinical and wider STP strategies)
- a robust governance process to offer assurance and approval and act as a means of assessing performance against plan in year
- well-modelled alignment with both financial and service activity plans to ensure the proposed workforce levels are affordable, sufficient and able to deliver efficient and safe care to patients
- achievement of workforce efficiency, capitalising on collaboration opportunities to increase workforce productivity within STPs and inform subsequent CIP development (taking into account any impact on quality and safety, with ongoing measurement to identify adverse outcomes and ensure effective mitigating actions where necessary.)

- detail the required workforce transformation and support to the current workforce, underpinned by new care models and redesigned pathways (responding to known supply issues), detailing specific staff group issues
- plans for any new workforce initiatives agreed with partners and funded specifically for 2017/18 to 2018/19 as part of the Five Year Forward View demonstrating the following:
    - a link with the STP approach to workforce resourcing and how this will be supported through the operational plan
    - how a balance in workforce supply and demand will be achieved
    - the right skill mix, maximising the potential of current skills and providing the workforce with developmental opportunities
    - underpinning strategies to manage agency and locum use including spend avoidance. (Approaches may include, but are not limited to, strengthening bank staffing arrangements and utilisation of the flexible workforce by developing shared banks with other providers in the STP footprint. Providers should also consider the effective use of technology including e-rostering and job planning systems to enable more effective rota management and staff utilisation, focused on flexibility around patient need.)
- activity to support delivery of workforce plans in conjunction with local workforce advisory boards
- engagement with commissioners to ensure alignment with the future workforce strategy of their local health system
- affordable plans for implementing the four priority standards for seven-day hospital services by March 2018 for providers in the second tranche of roll-out and by March 2020 for providers not in the first or second tranches.

Operational plans should consider the impact of legislative changes and policy developments including (but not limited to) the opportunities identified in the Carter review for improved productivity, changes to the apprenticeship levy from April 2017, the supply of staff from Europe and beyond, the immigration health surcharge and changes to NHS nursing and allied health professional bursaries, all of which should be taken into account in development of the workforce plan.

Financial planning (maximum 6 pages)

Strengthening financial performance and accountability in 2016/17 established the clear expectation that the provider sector will achieve financial run rate balance in aggregate by the start of 2017/18. Delivery of this expectation will require providers'

plans to be stretching from a financial perspective, delivering (or improving on) the financial control totals agreed with NHS Improvement, implementing transformational change through the STPs, and taking full advantage of efficiency opportunities to ensure that the control totals for 2017/18 and 2018/19 can be delivered.

Capital resources are constrained and will require prioritisation, so plans should only include schemes that are essential to the provision of safe, sustainable services, are affordable and offer value for money. Plans should be underpinned by robust financial forecasts and modelling and should be consistent with the strategic intent of the STP.

We therefore recommend providers divide their financial narratives as follows:

1. Financial forecasts and modelling
2. Efficiency savings for 2017/18 to 2018/19
3. Capital planning.

Section 1: Financial forecasts and modelling

Provider plans and priorities for quality, workforce and activity should align with the financial forecasts in their draft and final operational plans. The operational plan narrative should clearly set out how they make sure their plans are internally consistent.

To help providers demonstrate their plans are internally consistent we will make available for mandatory submission a triangulation file that will include both reconciliation points and reasonableness tests between the differing elements of the operational plan.

The plans will comprise two-year financial projections based on robust local modelling and reasonable planning assumptions aligned with national expectations and local circumstances.

The forecasts should also be supported by clear financial commentary in the operational plan narrative.

Collectively the financial forecasts and commentary should explain how the control totals will be delivered and outline the key movements that bridge 2016/17 forecasts and plans for 2017/18 and 2018/19 and also clearly set out:

- the financial impact of the planning assumptions set out in *Technical Guidance for NHS planning 2017/18 and 2018/19* plus the impact of the 2017/18 and 2018/19 national tariff (including the changes associated with the introduction of HRG4+), NHS Standard Contract and Commissioning for Quality and Innovation (CQUIN) guidance; the narrative should also highlight any significant deviations from national assumptions

- the impact of activity changes, relating to underlying demand, quality, efficiency programmes, and the impact of other commissioning intentions
- other key movements, including other changes in income expectations, revenue impact of any capital plans, or in-year non-recurrent income or expenditure
- the impact of initiatives, such as, but not limited to, CIPs, revenue-generation schemes, service developments and transactions
- the STF contingent on delivery of the control total (receipt of which should only be included in plans where providers have both agreed their financial control totals and submitted assurance statements-and, if applicable, agreed performance improvement trajectories- in relation to selected national standards).

The narrative financial commentary should address:

- the assumptions underpinning these drivers
- the impact of these drivers on the overall financial forecasts: in particular on performance against the Single Oversight Framework finance metrics
- the outcomes of any sensitivity analysis.

Operational plans will be developed before a final 2016/17 year-end financial position is known so providers should use a projected year-end outturn for 2016/17 based on the most up-to-date and relevant information available. For the 24 November submission the forecast outturn position used should agree with the Month 6 returns and for the 23 December return (collections will close on 30 December) this should be updated to agree with the Month 7 position.

Section 2: Efficiency savings for 2017/18 to 2018/19

All providers should ensure they have a robust efficiency savings plan to enable them to deliver the control totals set for 2017/18 and 2018/19 by NHS Improvement.

To achieve this they should focus on the development and delivery of robust multi-year savings plans focusing primarily on cost reduction but also reflecting a growth in contribution from commercial income. Operational plan narratives should outline broad plans for operational efficiency including, but not limited to, opportunities identified in the Carter review and agency rules.

The efficiency plans should also reflect savings arising from collaboration and consolidation plans in the STP processes and any opportunities identified through the commissioner-led programme.

In operational plan narratives providers should set out their approach to identifying, quality assuring and monitoring delivery of efficiency savings.

Lord Carter's provider operational productivity work programme

Lord Carter's review *Operational productivity and performance in English NHS acute hospitals: unwarranted variation* set out productivity and efficiency opportunities totalling £5 billion in workforce, hospital pharmacy and medicines, pathology and imaging, procurement, estates and facilities, corporate and administration and through optimising the patient pathway. NHS acute providers should continue to develop plans that cover the themes and recommendations in the Carter review and fully use the benchmarking data and best practice information in the Model Hospital when developing their efficiency plans.

Acute provider efficiency plans should maximise the opportunities identified in the Purchasing Price Index Benchmarking tool, ensuring all acute providers are taking steps to ensure that they are getting the best possible price for commonly procured items.

We will monitor acute provider progress against delivering the opportunities identified within the Carter review on an ongoing basis. Lord Carter and the NHS Improvement Operational Productivity Directorate are currently reviewing the operational productivity and performance of the mental health and community sectors. The work on these reviews will start in autumn. In advance of the publication of the outcome of these reviews, non-acute providers should consider the broad themes within the acute hospital Carter review that are applicable to them.

Agency rules

Providers should outline how they will continue to make effective use of the agency rules and what they will do to ensure they will be able to contain spend within their annual agency ceiling.

Procurement

Acute provider efficiency plans should maximise the opportunities identified in the Purchasing Price Index Benchmarking tool, ensuring all acute providers are working collaboratively to get the best possible NHS price for commonly procured items.

We are working with the NHS Business Services Authority, the Department of Health Commercial Team and a number of providers (including groups like the Shelford Group) to implement a range of nationally mandated products. Providers will be expected to support the development and implementation of universal use of these products.

Providers will need to ensure that progress against their procurement transformation plans implementing the Carter procurement recommendations is consistent with delivering the metrics in full and on time.

Section 3: Capital planning

Providers should explain in their narratives how their proposed capital investments are consistent with their clinical strategies and how they demonstrate the delivery of safe, productive services.

Given the constrained level of capital resource identified in the Spending Review from 2016/17 to 2020/21, they should also demonstrate that the highest priority schemes are being assessed and taken forward.

Where they are required to submit business cases for NHS Improvement, DH or HM Treasury approval providers should present robust strategic, economic, commercial, management and financial cases including clear links between the investment case and activity and financial projections as well as workforce and productivity assumptions.

They will also need to follow the key business case documentation requirements which may require the approval of strategic outline cases, outline business cases and full business cases.

Finally, providers should outline how they plan to make better use of the NHS estate. This may include alternative methods of securing assets, maximising and accelerating disposals and extending asset lives.

Link to the local sustainability and transformation plan (maximum 2 pages)

Significant progress on transformation is expected through 2017/18 to 2018/19 operational plans so all providers are expected to reflect the implementation of the local health and care system's STP. See *Operational planning and contracting guidance 2017/18 and 2018/19* for more details.

Although we acknowledge that local health and care systems will be at very different stages of their strategic development, providers should briefly articulate the following in their operational plan narratives:

- how the vision for their local STP is being taken forward through the operational plan, including the provider's own role
- how the three to five critical transformational programmes articulated in the local STP affect the provider's individual, organisational operational plan (for instance, setting out the most locally critical milestones for accelerating progress in 2017/18 to 2018/19 and the key improvements in finance/activity/ workforce/quality these programmes are planned to deliver).

Membership and elections (NHS foundation trusts only) (maximum 1 page)

For 2017/18 NHS foundation trusts should provide a high-level narrative on memberships and elections, including:

- governor elections in previous years and plans for the coming 12 months
- examples of governor recruitment, training and development, and activities to facilitate engagement between governors, members and the public
- membership strategy and efforts to engage a diverse range of members from across the constituency over past years, and plans for the next 12 months.

Any NHS foundation trusts that did not have NHS foundation trust status as at 1 April 2016 should also detail the activities of their shadow council of governors and members.

Note on publication of providers' operational plan narratives

NHS Improvement and providers have a mutual duty of candour and transparency. This is particularly important in the spirit of 'open book' planning encouraged for 2017/18 to 2018/19. It is therefore appropriate to make providers' final operational plans accessible to the widest possible audience.

We are therefore asking providers to prepare a separate version of the final operational plan narrative in January 2017 suitable for external communication that can then be published online on provider websites. This separate document should be written for a wide audience and exclude any commercially sensitive information, but must be consistent with the full version.

6. NHS Improvement review of providers' operational plans

6.1. Key criteria on which plans will be assessed

In reviewing providers' operational plans for 2017/18 to 2018/19, we will seek assurance that all providers have plans that meet the requirements in section 3.

Therefore, while recognising the statutory differences between NHS trusts and NHS foundation trusts, we will seek to:

- assess all provider plans against these shared criteria
- be consistent in our responses to common risk and plan characteristics – rather than to NHS trust or NHS foundation trust status.

6.2. Methodology for review of draft operational plans

Regional teams from NHS Improvement will work with providers to support the preparation of plans. First, we will engage with STP areas as we move from the 16

September submission through to the STP submission on 21 October. Secondly, we will work with STPs and providers to ensure that operational plans are consistent with and reflect the strategic intent of the STP.

Before the submission of draft operational plans, regional teams from NHS Improvement will work with providers to support the preparation of plans.

Timing of draft plan review

NHS Improvement will undertake a risk-based review of the draft operational plans for all providers during November and December 2016.

We will do most of the review work in this period so that:

- feedback offered to providers on their draft plans can be incorporated into providers' final operational plans for 2017/18 to 2018/19
- we can focus more effectively on monitoring and supporting delivery of those plans from April 2017 onwards.

Desk-based review work

Central and regional teams will do some desk-based review for all draft plans as part of the assurance process. This is likely to include review of the:

- operational plan narrative against NHS Improvement's requirements of provider plans (see section 3)
- key assumptions underpinning the financial projections, together with an application of tests to each provider's own financial projections
- activity plans to seek assurance on the robustness of demand and capacity planning
- provider's assurances on quality and workforce to identify any areas for further follow-up
- several areas of joint risk assessment between NHS Improvement and NHS England, in recognition of the need for alignment and the impact of local health and care system interactions on individual organisations (see the joint assurance process outlined in *Operational planning and contracting guidance 2017/18 and 2018/19*.

Interactions with providers

The draft plan review process in November and December will often combine desk-based work with face-to-face discussions between providers and their NHS Improvement regional teams.

Methodology for review of final operational plans

We will conduct a high-level review of providers' final operational plans following the 23 December submission (collections will close on 30 December).

This will largely entail corroboration of the material movements we expect to see based on the discussions and feedback to the provider after the STP submissions but we will also identify and follow up on unexpected movements.

We will consider the implications for providers of their final operational plans and monitor their delivery during 2017/18 through the routine oversight and assurance processes.

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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

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