NHS England

Delivering the Forward View: NHS Planning Guidance

2016/17 – 2020/21

Annex 2 to the Technical Guidance: Guidance on Commissioner Operational Plans

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Version number: 1

First published: January 2016

Prepared by: NHS England

Classification: OFFICIAL

Publications Gateway Reference 04437

Contents

Introduction

1. This Technical Annex provides further guidance and advice on some of the issues that commissioners should consider when setting out their approach to 2016/17 operational plans.

Operational Plan priorities

2. The planning guidance (pages 8-9) sets out the 'must do' priorities that will need to be addressed by all commissioners when developing their 2016/17 operational plans, alongside ensuring local services make progress towards the delivery of the national ambition for seven-day services.

3. We are also producing a CCG assessment framework, which will be published in the near future. CCGs will need to give particular attention to maintaining and improving performance against the measures set out in the new framework.

4. 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 (including impact of transfers of activity);
   - public health Section 7A services;
   - services for members of the armed forces and their families; and
   - services for people in the justice system.

5. 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 2016/17, 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.

Business rules

6. *Delivering the Forward View* set out a broad overview of the finance assumptions and business rules. Further details of the business rules for 2016/17 are provided in the table below, which should be read in conjunction with the supporting notes that follow.

Table 1: commissioner business rules

Business Rule	CCG	Specialised Commissioning	Public Health	Other Direct Commissioning
Minimum cumulative underspend	1%	0%	0%	1%
Contingency	Minimum 0.5%			
Non-recurrent spend	1%	0%	0%	1%
Management 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
Strategic planning	Completion and sign off required to secure growth funding			
NHS Constitution commitments met as applicable eg Mental Health Minimum Investment, Better Care Fund contributions				
National contract & PbR rules applied in full including sanctions, MRET and readmissions.				
Transparency	Provide information on source & use of sanctions, MRET etc to relevant stakeholders			

7. Assurance of commissioner financial plans will focus on compliance with the commissioner business rules. 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.

Overall financial management

8. CCGs and primary care direct commissioning are required to deliver a minimum cumulative 1 percent underspend in 2016/17. 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 spend their allocation for the year in full.

9. Specialised commissioning and public health services are required to achieve a breakeven position in 2016/17. Specialised commissioning will not be required to invest funds non-recurrently in 2016/17, but will be expected to increase the level of non-recurrent spend over the strategic

planning period.

10. A commissioner with a relatively high per capita growth in allocation is encouraged to plan for a higher level of underspend if that would avoid poor value investment decisions and allow them to make smart medium term investment decisions.

11. CCGs that will not meet the cumulative 1 percent underspend requirement in 2015/16 (ie those that will bring forward a cumulative deficit from 2015/16, or a cumulative underspend of less than 1percent) must as a minimum achieve in-year breakeven in 2016/17. Any CCG that is not currently meeting the cumulative underspend requirement must plan to do so over the strategic planning period.

12. CCGs that will not meet the 1 percent underspend requirement in 2015/16 will be required to demonstrate that any growth in allocation they receive above 1.39 percent (being the minimum level provided to all commissioners to fund new policy commitments), has been applied in full to eliminating or reducing any in-year deficit in 2016/17.

Management of risk

13. For 2016/17, 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.

14. The identification and proposed management of risk will form part of the plan assurance process, and will also be linked to the provision of financial support from the Sustainability and Transformation Fund.

15. The 1 percent non-recurrent spend required by the business rules (see above) should be uncommitted at the start of the year, to enable progressive release across the year. 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 1 percent non-recurrent budget in reserve, or whether it can be released for investment.

Drawdown

16. Drawdown is caused by either the use of prior year 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.

17. The first call on available drawdown for a given year will be CCGs with an unavoidable operating deficit; the remainder will be available to CCGs with cumulative underspends, to fund non-recurrent investment plans and one-off pressures and to primary care.

18. The process and eligibility for accessing drawdown of historic underspend will be similar to 2015/16; the conditions are as follows:

- The commissioner has cumulative underspend sufficient to drawdown from;
- It intends to use the investment non-recurrently, which must be confirmed via the business case process;
- It will still meet the business rules regarding the required underspend, so commissioners with 2015/16 carry-forward underspends less than 1 percent will be ineligible; and
- The commissioning system can afford for the commissioner to do so.

19. Business cases will be required for drawdown to 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.

20. Any CCG that is unable to meet the 1 percent cumulative underspend requirement will be required to submit a financial recovery plan, which will be subject to regional scrutiny and approval. Draft recovery plans must be created/ refreshed by deficit CCGs and submitted in time to support the first draft plan submission on 8 February 2016.

21. 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 three years. This will enable the drawdown mechanism to become a more fluid system of managing financial pressures across the year-end boundary.

Mental health minimum investment

22. Commissioners are required to continue to increase investment in mental health services above their overall increase in allocation each year, to move forward with increased investment in mental health. This can include investments in primary or secondary mental health services aligned with delivery of the forthcoming Mental Health Taskforce Report.

23. Where a commissioner fails to invest in mental health services in line with its plan without providing adequate justification, the resulting underspend may be clawed back from the commissioner's allocation for the year.

Management costs

24. In aggregate, CCG Management Cost Allowances will be held at the level set in 2015/16 for 2016/17 to 2020/21. Individual CCG allowances will reflect differential population growth, and are included in the allocations notification.

Other considerations for financial planning

Specialised co-commissioning incentive scheme

25. CCGs are encouraged to collaborate with specialised commissioning to improve service efficiency. NHS England is developing an incentive scheme that will allow CCGs to share in the benefits that flow from joint working.

Value as a guiding principle

26. Value – realising the best possible benefit for patients with the resources we have – is a useful lens through which to view and deliver the transformation agenda. Whether it is the development of sustainability and transformation plans (articulating both the common vision and how to get there) or taking decisions about service models or interventions, demonstrating value can help provide the necessary assurance to populations, patients and taxpayers that we are spending money wisely in the pursuit of higher quality care. It is an enabler of widespread transformation; by adopting a value mind set, all organisations can be confident of going in the right direction in a way that doesn't need to be overly prescribed.

27. Value is being used as a means of evaluating progress on the national vanguard programme, ensuring that the initiatives that do the most for patients at scale are properly supported and developed. On a more day to day basis, NHS RightCare and similar tools and approaches can be used to put value into what the service is doing more broadly. A value-based decision effectiveness framework has been developed as part of the Future-Focussed Finance programme's "Best Possible Value" initiative. It should be used to support and assure all key decisions, and in the development of Sustainability and Transformation Plans.

RightCare Programme

28. Across all services there is scope to improve the use of resources to deliver better outcomes at lower cost. The RightCare programme uses systematic data analysis and facilitated clinically-led improvement workshops to help areas understand how they could change spending patterns, and adopt proven best practice, to achieve better overall value. A number of CCGs have already used the RightCare approach to improve patient value and health outcomes, and to release funding for reinvestment.

29. In Wave 1 of the RightCare rollout, 60 CCGs have been selected to take part. Work will begin in January 2016, with all 209 CCGs and related direct commissioning areas involved by the end of 2016/17. All CCGs are encouraged to use the RightCare materials (available at the RightCare website) as part of their planning to support the early identification of value improvement opportunities.

Appendix 1: NHS Operational Planning measures 2016/17

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

In addition, we are developing a new CCG assessment framework for 2016/17 (the “CCG scorecard”), and we will expect CCGs to make progress against the metrics included in that framework.

NHS England will consult on this in January.

Also see Technical Annex 1 for detail on related activity templates.

NHS Constitution Standards	Standard	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
A&E waits				
A&E Waiting Times – Total time in the A&E department	95%	Monthly	Yes	Yes
Cat A Ambulance Calls				
Ambulance clinical quality – Category A (Red 1) 8 minute response time	75%	Monthly	Yes	Yes
Ambulance clinical quality – Category A (Red 2) 8 minute response time	75%	Monthly	Yes	Yes
Ambulance clinical quality – Category A 19 minute transportation time	95%	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
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	93%	Monthly/	Yes	Yes

suspected).		Quarterly		
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
NHS Constitution Standards	**Standard**	**Monthly/ Quarterly/ Annual Total**	**Technical Guidance**	**Planning Trajectory**
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

NHS Constitution Supporting Standards	**Standard**	**Monthly/ Quarterly/ Annual Total**	**Technical Guidance**	**Planning Trajectory**
Cancer				
One-year survival from all cancers	N/A	Annual	Yes	See note 1

Infection	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Healthcare acquired infections (HCAI) measure (Clostridium Difficile Infections)	Monthly	Yes	Yes

Activity	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
Total referrals (All specialities)	Monthly	Yes	Yes
Consultant led1St Outpatient attendances	Monthly	Yes	Yes
Consultant led Follow up outpatient attendances	Monthly	Yes	Yes
Total elective admissions (spells)	Monthly	Yes	Yes
Total non-elective admissions (spells)	Monthly	Yes	Yes
Total A&E attendances	Monthly	Yes	Yes
Total Endoscopy tests*	Monthly	Yes	Yes
Total Diagnostics tests (excluding Endoscopy)*	Monthly	Yes	Yes
RTT admitted activity	Monthly	Yes	Yes
RTT non-admitted activity	Monthly	Yes	Yes

Mental Health	Expectation	Monthly/ Quarterly/ Annual Total	Technical Guidance	Planning Trajectory
IAPT Roll-Out	15%	Quarterly	Yes	Yes
Estimated diagnosis rate for people with dementia	66.7%	Monthly	Yes	Yes
IAPT Recovery Rate	50%	Quarterly	Yes	Yes

IAPT Waiting Times - The proportion of people that wait six 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	See note 1

Better Care Fund	**Expectation**	**Monthly/Quarterly/ Annual Total**	**Technical Guidance**	**Planning Trajectory**
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

Transforming Care	**Expectation**	**Monthly/Quarterly/Annual Total**	**Technical Guidance**	**Planning Trajectory**

Reliance on inpatient care for people with a learning disability and/or autism*	An overall reduction in the number of inpatients who have either a learning disability and/or an autistic spectrum disorder (including Asperger's syndrome) throughout 2016/17.	Quarterly	Yes	Yes

* Added for 2016/17 Planning Round

Note 1: Trajectory for this indicator must be reflected in CCG plans, although it will not be formally collected in UNIFY. It will be monitored in-year, and CCGs will be held to account for their performance against this indicator.