### Purpose

This report informs the Governing Body about national/local developments in the past month.

### Collaborative Partnership Board

Further to my report at the last meeting I attach further documents of interest from this month’s meeting:

- Minutes of the meeting held 12.01.18
- National Update – CEO ACS report – shown as paper B
- Planning Guidance Appendix – 2 papers both shown as paper F
- Planning Guidance summary – shown as paper G

### Rotherham Equipment and Wheelchair Service (REWS) Update

Further to the confidential Governing Body Meeting on the 24th Jan 2018, the CCG can confirm that a decision was has made to re-procure the Rotherham Equipment and Wheelchair Service (REWS). This has also been now been agreed through Rotherham Borough Council’s governance arrangements as this will be a joint procurement process. A comprehensive project plan has now been developed and agreed which includes, user/stakeholder engagement and market engagement. The timeline is due to conclude in December 2018, when a new contract will be issued. Commissioners have planned engagement through on-line surveys, interviews and telephone calls to understand service user’s needs and demand. Engagement with staff and key partners has already commenced to ensure the service specification is fit for purpose and delivers the appropriate outcomes for the people of Rotherham.

### Communications Update

- There has been interest from the local media in changes to the Rotherham Equipment and Wheelchair Services (REWS) after notice was served by the current provider.
- Pulse magazine has recently reported on referral incentives within the Rotherham GP quality contract. This was an article based on an FOI enquiry from the publication.
- The campaign to encourage patients to buy their own over the counter medication continues with the launch of the next phase. Two separate leaflets have produced and distributed across Rotherham; one covering paracetamol, vitamin D and hayfever medication and a second with advice and guidance on emollients for dry skin.
South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

12 January 2018

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

Decision Summary

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<tr>
<th>Minute reference</th>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>6/18</td>
<td>Public Health Dashboard</td>
<td>Lisa Wilkins</td>
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<tr>
<td></td>
<td>Lisa Wilkins agreed to liaise with Chris Edwards outside this meeting to discuss the evaluation work vis-à-vis the health and social prescribing indicators (step 1 of the next steps identified above).</td>
<td>The Chair /Helen Stevens</td>
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<tr>
<td></td>
<td>The Chair will meet with Helen Stevens to discuss the formulation of a successful intervention that SYB ACS could implement and promote in our shadow phase, this subject will be discussed at a future meeting.</td>
<td>The Chair /Lisa Wilkins</td>
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<tr>
<td></td>
<td>The Chair and Lisa Wilkins will discuss the level of clarity required in the development the public health dashboard.</td>
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<td>8/18</td>
<td>Communications and Engagement</td>
<td>Helen Stevens</td>
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<td></td>
<td>The Chair requested Helen Stevens to produce a draft communication and engagement plan to share with members regarding the launch of the shadow ACS in April.</td>
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<tr>
<td>9/18</td>
<td>Finance Update</td>
<td>Jeremy Cook</td>
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<td>A query was made regarding tranche one of winter monies vis-à-vis the control totals and Jeremy Cook agreed to gain clarification from the national team and report this information back to members.</td>
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<tr>
<td>10/18</td>
<td>Hospital Services Review Update</td>
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<td></td>
<td>Alexandra requested that members should forward any</td>
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</table>
comments directly to her regarding the Stage 1B report by Monday, 15th January 2018. A revised version based upon the comments received will be drawn up and circulated to members next week.

The Chair added that he will liaise with Helen Stevens regarding the issues identified in comments from members at this meeting.

| 11/18 Draft workforce strategy for England |
| Mike Curtis and Kevan Taylor volunteered to draft a response via the Local Workforce Action Board and would bring the draft to a Collaborative Partnership Board for members to approve. |

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<thead>
<tr>
<th>Author</th>
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<tbody>
<tr>
<td>All</td>
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<tr>
<td>Alexandra Norrish</td>
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<tr>
<td>The Chair/Helen Stevens</td>
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<table>
<thead>
<tr>
<th>Author</th>
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<tr>
<td>Mike Curtis and Kevan Taylor</td>
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South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

12 January 2018

The Boardroom, NHS Sheffield CCG
722 Prince of Wales Road, Sheffield, S9 4EU

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<td>Sir Andrew Cash</td>
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<td>Ben Jackson</td>
<td>Academic Unit of Primary Medical Care, Sheffield University</td>
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<td>Will Cleary-Gray</td>
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<tr>
<td>1/18</td>
<td>Welcome and introductions</td>
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<td></td>
<td>The Chair welcomed members to the meeting.</td>
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<tr>
<td>2/18</td>
<td>Apologies for absence</td>
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<td>The Chair noted the apologies for absence.</td>
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<tr>
<td>3/18</td>
<td>Minutes of the previous meeting held 8th December 2017</td>
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<td>The minutes of the previous meeting were agreed as a true record.</td>
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<tr>
<td>4/18</td>
<td>Matters arising</td>
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<td></td>
<td>Will Cleary-Gray added that a matrix will be produced and circulated following Collaborative Partnership Board meetings.</td>
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The matrix will guide members on the dissemination of papers post CPB meetings helping to ensure there is consistent communication of information across the ACS and that members of Governing Bodies and Boards are well informed.

**Integrated Operational Report**
Richard Jenkins informed members that he is working through this issue with support from Sheffield Teaching Hospitals.

**Workstream Priorities:**

**Estates**
Chris Edwards informed members that the estates workstream is still awaiting the publication of the Estates National Guidance which has been deferred.

**Finance**
Jeremy Cook is working on the early stages of the analytical review and he will involve Richard Jenkins (and others) at the appropriate stage of the review.

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**5/18 National Update**

**CEO ACS Report**
The Chair gave his Chief Executive Officer report to the meeting.

This monthly report provides members with an update on:

- The work on the ACS CEO over the last month.
- A number of key priorities not covered elsewhere on the agenda.

In addition to his report the Chair added the following updates:

The Chair informed members that the work of SYB ACS could be divided into the three following elements for the 2018-19 year:

1. Issues for the ACS.
2. Issues that are business as usual for partners.
3. Transformation issues.

The Chair added that everyone should ensure they have exact clarity regarding the aforementioned three elements.

The Chair highlighted that in the next twelve months the ACS will be:

- establishing its management structure and its way of operating,
- implementing the Hospital Service Review,
- commissioning reform and establishing partnerships in ‘place’,
- ensuring that its constitution rights and financial basis are
firmly established,
- beginning to work on a small number of key transformational issues.

The Chair added that central government is keen for SYB ACS to succeed.

The Chair noted that it is important for the ACS to be ready and able to engage in anything in 2018-2019.

The Chair informed members that SYB ACS has met with Greater Manchester ACS to share learning and establish strong relationships as both develop and mature.

Lesley Smith updated members on the ACS Development Day that she attended on 13th December 2017 in London. The event brings together the eight ACSs in England. The members present on the day discussed the various elements of being an ACS e.g. they noted that guidance was required regarding the size of the footprint to be an ACS, the specialised commissioning functions required, regulations in the future and capacity to take on regulations and functions, terminology concerning accountable care and the confusion with the USA model, how models of ACSs are unfolding and what they could look like in the future. SYB ACS was in the spotlight on the day as the oversight framework of SYB ACS was presented at the event. She added that looking into the future it was likely that there will be 18 ACSs across the whole of England.

Alison Knowles added that NHSE/I will need to draw out a nomenclature for the future to identify exactly what is required as a system and what is required as a partnership.

The Chair noted that SYB ACS would await the nomenclature from NHSE/I.

**SYB ACS Workshop**

The Chair informed members that the ACS workshop is planned for 2nd February 2018 at the New York Stadium in Rotherham. The invitations to this workshop will be revisited as it has been decided to have two workshops, the first workshop would be a small group of Chief Executives and Accountable Officers followed by a second workshop, invitations to the second workshop will be extended to a wider group of stakeholders.

**2018/2019**

The Chair informed members that NHSE/I has asked for thoughts from the ACSs moving from a conceptual model into an integrated ACS and how this would affect the governance of the ACS.

The Chair gave a short presentation entitled ‘Integrated ACS vision system and place’, and information contained therein identified:
• Integrated SYB ACS – Vision System
• Integrated SYB ACS – Place vision
• Emerging ACS priorities and functions
• Focus areas for the SYB system working together in phase 1 – 2018/19
• Maturing ACS governance identifying the current governance arrangements for the ACS and ACPs in 2017-18 and giving draft options for 2018/19 for phase 1.

Will Cleary-Gray added that the Audit Chairs and Governance Group met in December 2018 and started preparatory discussions around future governance of the ACS and we will share our current thinking with NHSE/I.

The Chair said that there are a number of items that need to be worked through regarding the future governance of SYB ACS and this subject will be discussed and developed at the workshop on 2nd February 2018.

The Collaborative Partnership Board noted the update.

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<tr>
<th>6/18</th>
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<tr>
<td>The Chair invited Greg Fell and Lisa Wilkins to present the public health dashboard information to the meeting.</td>
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<tr>
<td>Greg Fell informed members that the public health dashboard is currently work in progress. The dashboard has been developed with Lisa Wilkins and it sets out the key SYB ACS actions that will give the largest impact in terms of public health.</td>
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<tr>
<td>The dashboard is a first draft and more information will be added to give a more fuller picture regarding public health before the workshop on 2nd February 2018.</td>
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<td>Lisa Wilkins gave her presentation to the meeting.</td>
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<td>She highlighted that the dashboard has three sections:</td>
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<tr>
<td>1. Population /deprivation and overarching health outcomes.</td>
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<td>2. System wide public health priorities – focus on collective action.</td>
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<td>3. Place based wider determinants and health improvement – local priorities.</td>
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<td>Lisa informed members that the next steps will be to:</td>
<td></td>
</tr>
<tr>
<td>1. Confirm work and health and social prescribing indicators.</td>
<td></td>
</tr>
<tr>
<td>2. Find out Public Health England publishing timetable and agree reporting frequency / timing.</td>
<td></td>
</tr>
<tr>
<td>3. Incorporate into overall ACS dashboard and format accordingly.</td>
<td></td>
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<tr>
<td>4. Identify analytical capacity to populate.</td>
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</tbody>
</table>
The Chair thanked Greg Fell and Lisa Wilkins for the excellent work they had produced and indicated that SYB ACS should seek to create a simple public health dashboard.

Discussion ensued regarding the interventions that SYB ACS could progress in 2018/19 that would produce a positive public health impact. Members agreed that smoking cessation would be the primary intervention to progress.

A query was raised regarding the reduction of health inequalities and where it would emerge in this dashboard from the data. Greg Fell responded saying that health inequalities should not solely be linked to the healthy lives box, health inequalities must be linked to all workstreams.

Lisa Wilkins agreed to liaise with Chris Edwards outside this meeting to discuss the evaluation work vis-à-vis the health and social prescribing indicators (step 1 of the next steps identified above).

The Chair will meet with Helen Stevens to discuss the formulation of a successful intervention that SYB ACS could implement and promote in our shadow phase, this subject will be discussed at a future meeting.

The Chair and Lisa Wilkins will discuss the level of clarity required in the development the public health dashboard.

The Chair thanked Lisa Wilkins and Greg Fell for their attendance at this meeting.

7/18 Workstream Priorities –

Prevention

Greg Fell presented the prevention workstream top 3 priorities for the Collaborative Partnership Boards approval as:

- Embedding the treatment of tobacco dependence in secondary care.
- Systematic quality improvement in the identification and management of clinical risk factors for cardiovascular disease.
- Expansion of social prescribing.

Greg advised members that each of the workstream top 3 priorities will be developed and delivered through the plans in ‘place’. He added that the priorities are areas of work that are currently being actively taken forward at an ACS programme level.

Greg stated that SYB ACS must focus its energies where the need is greatest regarding the 3 top priorities.
Greg highlighted that there has been a large number of contacts in primary care in previous years regarding tobacco dependence and prevention strategies. However, secondary care has not had the same history or the same level of contacts but it is recognised that secondary care does have a huge role to play in tobacco dependence and prevention strategies.

The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented.

Cancer

Lesley Smith presented the Cancer workstreams top 3 priorities for the Collaborative Partnership Boards approval as:

- Early diagnosis – taking specific action to improve early diagnosis.
- CWT/63 day – delivering the 62 day referral to treatment target and working towards faster diagnosis standard.

The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented.

Primary Care

Karen Curran presented the Primary Care workstream top 3 priorities for the Collaborative Partnership Boards approval as:

- Increased investment in primary care in order to deliver service transformation – national commitment to increase investment into primary care by at least £2.4bn by 2020/2021.
- Wider workforce – national targets to increase, retain and return clinical workforce and introduce new workforce models.
- Local care networks – National: Local Care Networks to be established covering populations of c.30000-50000.

Karen Curran added that a meeting is taking place next week with members from the five Clinical Commissioning Groups to determine if we want to submit one application on a SYB/ACS footprint for the international recruitment and the recruitment of overseas doctors to address some of the workforce issues we have. There are 36 overarching organisations, 5 Clinical Commissioning Groups and one ACS and by aggregating tasks and performing tasks once it will not mean detracting from place but it will mean that added value to the ACS as a whole will be
achieved.

The Collaborative Partnership Board approved the top 3 priorities for this workstream as presented.

The Chair thanked the presenters for the information regarding their workstreams top 3 priorities.

### 8/18 Communications and Engagement

Helen Stevens updated members on the communications and engagement of SYB ACS. Helen said that the Hospital Services Review had held a very successful event in December 2017. The communications and engagement team will continue to give their ongoing support the Hospital Services Review.

Helen added her team will carry on supporting the SYB ACS workstreams. The communications and engagement team will also continue to carefully work through the detail required to produce an updated communications plan for 2018.

The Chair requested Helen to produce a draft communication and engagement plan to share with members regarding the launch of the shadow ACS in April.

The Chair thanked Helen Stevens for her update.

### 9/18 Finance Update

Jeremy Cook, Interim Director of Finance SYB ACS, presented his finance report to the meeting. The report informs members on a number of items e.g. Directors of Finance meetings and other general updates, capital, winter funding, and financial reporting.

The Collaborative Partnership Board noted the contents of the report and in particular the timetable to develop the ACS prioritised capital plan.

A query was made regarding tranche one of winter monies vis-à-vis the control totals and Jeremy Cook agreed to gain clarification from the national team and report this information back to members.

Lesley Smith raised the point that at 2.2 of the finance report the focus and understanding on the benefits of the emergency department development at Doncaster would not only be to Doncaster but would be to the whole of South Yorkshire.

The Chair thanked Jeremy Cook for his report and for presenting the information.
Chris Welsh had three key messages to convey at this meeting:
1. The Hospital Services Review Team are not working to a predetermined plan, they are following information received from clinicians, the public and data.
2. The HSR is reviewing the medium to long term sustainability of services and will not be resolving current and new pressures on services.
3. The HSR will not be modelling services at a business case level as this is not possible within the time and resources available to the HSR team and also the legalities involved before having to go out to public consultation.

Alexandra Norrish updated the group on progress on the Hospital Services Review (a copy of her presentation will be circulated to members).

The report summarises the key problems identified for each of the 5 services, and highlights the main themes for solutions emerging.

Alexandra requested that members should forward any comments directly to her regarding the Stage 1B report by Monday, 15th January 2018. A revised version based upon the comments received will be drawn up and circulated to members next week.

Members made the following comments regarding the Stage 1B report:
- Hospitals fit into a much broader system and this aspect did not come across in the draft report HSR.
- Consideration should be given to the language used when referring to GP thresholds regarding tasks.
- Funds should stay in the NHS and therefore the NHS options available should be identified in the report.

Members noted that work should be initiated now to inform the Joint Oversight and Scrutiny Committee and Health and Well Being Boards regarding possible consultation of the final report.

The Chair added that he will liaise with Helen Stevens regarding the issues identified in comments from members at this meeting.

The Chair thanked Alexandra Norrish and Chris Welsh for their presentation and attendance at this meeting.

Mike Curtis introduced the workforce strategy for England. Launched by Health Education England (HEE), Facing the Facts, Shaping the Future, A health care workforce strategy for England
to 2027, this sets out the proposed strategy to ensure patients have access to the health and care staff they need to provide a high-quality service.

Mike Curtis encouraged individual organisations to submit their own response to the draft strategy. However, he added that it would be appropriate for South Yorkshire and Bassetlaw Accountable Care System to forward their organisations response to the draft strategy. Mike Curtis and Kevan Taylor volunteered to draft a response via the Local Workforce Action Board and would bring the draft to a Collaborative Partnership Board for members to approve.

The Collaborative Partnership Board duly noted the report and looked forward to receiving the draft response to the strategy at their next meeting.

<table>
<thead>
<tr>
<th>12/18</th>
<th>To consider any other business</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>There was no other business brought before the meeting.</td>
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<tr>
<th>13/18</th>
<th>Date and Time of Next Meeting</th>
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<tbody>
<tr>
<td></td>
<td>The next meeting will take place on 9th February 2018 at 9.30am to 11.30am in the Boardroom, NHS Sheffield CCG, 722 Prince of Wales Road, Sheffield, S9 4EU.</td>
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</table>

Mike Curtis and Kevan Taylor
**Summary of key issues**

This monthly paper from the ACS CEO provides an:

- Update on the work of the ACS CEO over the last month
- Update on a number of key priorities not covered elsewhere on the agenda

**Recommendations**

The Collaborative Partnership Board is asked to note and discuss the update.
1. **Purpose**

This monthly paper from the ACS CEO provides an:

- Update on the work of the ACS CEO over the last month
- Update on a number of key priorities not covered elsewhere on the agenda

2. **Report – February 2018**

2.1 **ACS workshop with chief executives and accountable officers**

The workshop, which was facilitated by Chris Ham, chief executive of the King’s Fund, covered a range of areas including the planning guidance, finance and what a control total means, how we organise ourselves for the year ahead, streamlining and simplifying how we do things, and reviewing our priorities.

Discussions took place on the developing single assurance framework which will allow us to assure once as a system. Covering performance, transformation, quality and regulatory compliance, the framework is based on mutual accountability with an assurance process within the ACS, with embedded roles from NHS England and NHS Improvement.

The session also looked at governance and how we might streamline and simply the ways of working that we currently have to remove duplication, reduce confusion and enable greater efficiency. In addition, functions for the ACS from 1 April were explored - eg clinical, population health management and primary care, strategy planning and transformation, patient and public involvement, provider reform, finance, contracting and estates, integrated assurance and delivery improvement and workforce and OD - with senior leadership of up to two days a week for the functions coming from within the system.

Colleagues supported the direction of travel and to review our operating plan for 18/19, governance, draft refresh of the Sustainability and Transformation Plan and how we take the ACS forward at the March Collaborative Partnership Board.

2.2 **Meeting of the Joint Health Overview and Scrutiny Committee**

The Joint Health Overview and Scrutiny Committee (JHOSC) covering South Yorkshire, Wakefield, Nottinghamshire and Derbyshire councils (in line with the footprint for Commissioners Working Together) met on Monday, 29 January at the County Hall in Matlock, Derbyshire.

As well as giving an update on the review of hospital services, commissioning colleagues discussed with the councillors and scrutiny officers the decision taken at the November meeting of the joint committee of clinical commissioning groups to change the way hyper acute stroke services are delivered across the region. The meetings are led by the council representatives, held in public and the full agenda, including the group's updated terms of reference can be found on the Derbyshire County Council website [here](http://example.com).
2.3 Update from the Local Maternity System board

The Local Maternity System (LMS) board met in January and had discussions around:

- Developments in perinatal mental health - Jason Rowlands who is supporting the mental health workstream in this area took members through a proposed way forward for improving care and outcomes for people in Doncaster, Rotherham & Sheffield – through a shared service model. All agreed with the approach and supported the bid for funding to the national team.
- An update on the NHS England submission and the communications and engagement around it, including a plain English version of the plan which will be used to explain the work to wider audiences and to encourage more mums to get involved.
- The wide-ranging engagement underway with clinical staff and the public on the hospital services review, which includes maternity and children's services.
- An update from the Yorkshire and Humber LMS.

2.4 National ACS primary care leads

Lisa Kell, director of commissioning and Tim Moorhead, chair of Sheffield CCG, attended a national ACS primary care leads session in London last month. The day was split into two parts, with discussions around developing the national support offer around commissioning and Tim, along with GP colleagues from integrated partnerships across the country, attending a discussion at No.10 around supporting new models of primary care, developing integrated teams and supporting newly qualified GPs.

2.4 South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance

On Wednesday 17 January members of the Cancer Alliance attended the Barnsley BEST cancer event to speak with GPs and practice nurses about the alliance and its workstreams. Cancer Alliance Programme Director, Julia Jessop, opened the event by giving an overview of the Alliance and the priorities of each work stream. Dr Louise Merriman, GP Clinical Lead, spoke about vague symptoms, including what is classed as a vague symptom and the suggested pathways for patients presenting with these.

Delegates also heard from Cancer Research UK Facilitator, Ben Towler and Cancer Research GP Clinical Lead, Dr Steph Edgar, who spoke on behalf of the Cancer Alliance about early diagnosis of cancers and safety netting. As well as hearing about what the Alliance is doing to detect and prevent cancers, the audience also heard what is being done to support those living with and beyond cancer. Richard Metcalfe, Programme Lead, spoke about the Macmillan Living With and Beyond Cancer Programme and the importance of supporting patients throughout their cancer journey.

The Alliance will be attending events for Doncaster GPs in February where they will be covering the same topics.

2.5 Visit by Professor Don Berwick

Professor Don Berwick will be making a visit to South Yorkshire and Bassetlaw on Tuesday March 13 as part of his work with the King’s fund to support developments in the leading accountable care systems.

Don will be meeting with clinical leaders in South Yorkshire and Bassetlaw and we are currently scheduling an agenda for him to meet with clinicians who have been and are involved in some of the transformation work across the region.
A paediatrician by background, Don was for 19 years the founding CEO of the Institute for Healthcare Improvement. In 2010, he was appointed by President Barack Obama as the Administrator of the Centers for Medicare and Medicaid Services (the federal agency overseeing Medicare and Medicaid), a position that he held until December 2011. He has served on the faculties of the Harvard Medical School and Harvard School of Public Health. In 2013 he carried out a review of patient safety in the NHS on behalf of Prime Minister David Cameron.

3. **Recommendations**

The Collaborative Partnership Board is asked to note and discuss the update.

*Date 5 February 2018*
NHS ENGLAND – BOARD PAPER

Title:
NHS Planning and Financial Allocations for 2018/19

Lead Directors:
National Directors

Purpose of Paper:

1. The NHS already has two year baseline local funding allocations, two year service priorities, a two year national tariff, and two year commissioner-provider contracts, all in place and effective for 2018/19. So in updating planning for next year, rather than ‘starting from scratch’, the task for CCGs and providers is now to make quick and modest updates to local operating plans and contracts for the year ahead. This paper sets out how that is to be achieved.

2. Refreshed planning guidance (attached) has now been published for 2018/19. It gives effect to the 2018/19 ‘deliverables’ already agreed in last March’s Next Steps on the NHS Five Year Forward View, and the approach to post-Budget service prioritisation agreed by the Board at our public meeting on 30 November 2017.

3. Since our post-Budget Board meeting on 30 November, the Government has now confirmed that 2018/19 revenue for NHS England will grow by £2.14 billion over the 2015 Spending Review figure. This comprises the £1.6 billion announced in the Autumn Budget in November 2017, and a further £540 million that the Department of Health and Social Care (DHSC) has subsequently agreed to make available. Alongside the planning guidance, NHS England therefore needs to make formal allocations of these additional funds to CCGs and others for 2018/19. Proposals for so doing are detailed in this paper.

The Board invited to:

- Note the publication of planning guidance for 2018/19; and
- Agree the proposed allocation of funds between areas of commissioning spend, and the proposed methodology for additional allocations to CCGs.
PLANNING AND FINANCIAL ALLOCATIONS FOR 2018/19

Purpose

1. The NHS already has two year baseline funding allocations, two year service priorities, and a two year national tariff, all effective for 2018/19. So in planning for next year, rather than ‘starting from scratch’, the task for CCGs and providers is now to make quick and modest needed adjustments to local operating plans and contracts for the year ahead. This paper sets out how that is to be achieved.

2. Part A of this paper asks the Board to note the updated planning guidance (attached) that has now been published for 2018/19. It gives effect to the 2018/19 ‘deliverables’ already agreed in last March’s Next Steps on the NHS Five Year Forward View, and the approach to post-Budget service prioritisation agreed by the Board at our public meeting on 30 November 2017.

3. Part B of this paper asks the Board to agree the proposed deployment of additional funds to CCGs and others for 2018/19.

PART A: REFRESHED NHS PLANNING GUIDANCE FOR 2018/19

4. Since our post-Budget Board meeting on 30 November, the Government has now confirmed that 2018/19 revenue for NHS England will grow by £2.14 billion over the 2015 Spending Review figure. This comprises the £1.6 billion announced in the Autumn Budget in November 2017, and a further £540 million that the Department of Health and Social Care (DHSC) has subsequently agreed to make available.

5. In framing refreshed planning guidance for the NHS jointly with NHS Improvement, we have therefore taken account of:
   - this improved funding outlook;
   - the already agreed 2018/19 ‘deliverables’ contained in the Next Steps document;
   - the priorities set by Government in the recent November Budget and the expected Mandate; and
   - insight from ongoing public engagement, involvement and feedback including from Healthwatch.

6. The Board also agreed at our public meeting on 30 November five “considerations to guide decisions” in finalising plans for 2018/19. (Board paper PB.30.11.2017/04). The Planning Guidance Refresh gives effect to those five principles as follows:

   a) Funding should “Deal with current levels of unfunded care (deficits) that need funding going into next year”.

   We are proposing allocating an additional £1.05 billion to support costs of care currently being provided. This comprises £650 million of additional Provider Sustainability Funding and an equivalent £400 million for CCGs. (Details in Part B below). As a result, the CCG sector is expected to achieve budget balance in 2018/19, and NHS Improvement has specified that the trust sector will do the same.
b) “Set realistic activity plans for growth in emergency care”

CCG purchasing power has been set on the basis of being able to fund realistic levels of emergency activity growth next year – see Appendix 1. The target is for improved A&E performance next year, with the £2.45bn provider sustainability fund strongly incentivising improved performance each quarter next year compared to the same quarter the prior year, and the CCG Quality Premium incentivising CCGs to constrain non-elective activity growth to levels at or below locally agreed plans.

c) “Seek to protect planned investment in mental health, cancer and primary care”

This package avoids introducing new targets or expectations, but instead funds the ‘Next Steps’ service improvements in mental health, cancer, primary care and other national priorities. Details are in Annex 1 of the Planning Guidance Refresh. In each of these areas, CCG and STP plans will be scrutinised for their impact on population health and inequalities reduction.

On mental health, given the approach to relieving pressure on CCGs unavoidably in deficit (as set out at Para a) above), for next year we are for the first time going to require each and every CCG to meet the Mental Health Investment Standard (where mental health spending grows faster than its overall funding growth). Furthermore this will be subject to independent validation by the CCG’s auditors. Doing so will support further expansions next year in children and adolescent mental health services, crisis and emergency mental health care, talking therapies, and a range of other improvements.

On cancer, the funding package includes completing the national upgrade of radiotherapy machines, faster diagnostics including for lung, prostate and colorectal cancers, and a new bowel cancer screening programme.

On primary care, the package enables the 2018/19 GP Forward View funding and service commitments to be met. It enables the development of primary care networks covering 30,000-50,000 populations; the rollout across England of extended evening and weekend GP appointments; and primary care workforce expansions including 600 international GP recruits, another 500 clinical pharmacists, and 1500 mental health therapists working in primary care.

d) “Be realistic about what can be expected from the remaining available funds”

The overall funding growth for 2018/19 means that it is now possible to plan for a substantially bigger annual increase in NHS-funded elective operations than in recent years. CCGs and providers are therefore being asked to secure a step change in elective activity such that the overall national waiting list stabilises, and where locally possible reduces, alongside a halving of the number of patients nationally waiting over 52 weeks.

e) “Ensure that where government sets pay rises above the currently budgeted 1% cap these are separately funded”

This is the basis on which these plans and allocations are being made for 2018/19.

Next steps on care integration

7. The refreshed planning guidance also signals ‘full speed ahead’ for the deeper care redesign, population health and community engagement work set out in the Forward
View and being led by Integrated Care Systems. It sets out new system incentives and flexibilities available to the first group of ICSs that ‘go live’ in April, and invites applications from other areas to join the next group of ICSs. For those parts of the country not covered by ICSs, the guidance lays out the important role of STP leadership in reviewing and supporting system working between organisations as 2018/19 plans are finalised.

PART B: REVISED ALLOCATION OF RESOURCES FOR 2018/19

8. The Government has now confirmed that 2018/19 revenue for NHS England will grow by £2.14 billion over the 2015 Spending Review figure. This comprises £1.6 billion announced in the Autumn Budget in November 2017, and a further £540 million that the Department of Health and Social Care (DHSC) has subsequently agreed to make available.

9. As a result of the additional £2.14 billion funding being made available to NHS England, percentage growth figures are now higher than those cited in the paper on 2018/19 planning discussed at the November 2017 board meeting. The extra funding now provides funding growth of 2.4% in real terms compared to 2017/18. Factoring in England’s growing and ageing population, age-weighted revenue growth per person becomes 1.4% in 2018/19.

Table 1: Funding growth for 2018/19

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<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
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<tbody>
<tr>
<td>As at October 2017</td>
<td>109,300</td>
<td>111,800</td>
<td>114,846</td>
</tr>
<tr>
<td>Revised expected budget</td>
<td>109,637</td>
<td>113,940</td>
<td>115,746</td>
</tr>
<tr>
<td>Cash change on previous budget</td>
<td>337</td>
<td>2,140</td>
<td>900</td>
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<tr>
<th></th>
<th>%</th>
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<th>%</th>
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<tbody>
<tr>
<td>Real terms growth</td>
<td>2.0%</td>
<td>2.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Real terms growth per age cost weighted capita</td>
<td>0.9%</td>
<td>1.4%</td>
<td>-0.8%</td>
</tr>
</tbody>
</table>

Notes
Budget figures are RDEL including ring-fenced depreciation

10. Despite these additional resources, delivering our objectives including financial balance will still require considerable efficiency improvements and other savings to be secured by CCGs, providers and STPs.

Allocation of additional funding

Clinical Commissioning Groups

11. Additional funding is required for CCGs to fund realistic levels of emergency activity in plans, the additional elective activity necessary to stabilise waiting lists, universal adherence to the Mental Health Investment Standard, and transformation commitments for cancer services and primary care.
12. The overall resources available to CCGs will therefore be increased by £1.4 billion. This additional funding is made available in the following ways:

- The requirement for CCGs to underspend 0.5% of their allocations has been lifted for 2018/19, releasing £370 million of CCGs' resources to fund local pressures and transformation priorities
- £600 million is added to CCG allocations for 2018/19. The proposed approach to the distribution of this funding is discussed below, and
- A new £400 million Commissioner Sustainability Fund (CSF) will be created, to enable CCGs to return to in-year financial balance, whilst supporting and incentivising them to deliver against their financial control total.

13. The CSF and £600 million additional allocation appear in the revised commissioning stream allocations set out in table 2 below.¹

14. The CSF will be a targeted fund to support those CCGs that would otherwise be unable to live within their means for 2018/19. All CCGs will be expected to plan against fixed control totals communicated at the outset of the planning process. Any CCG that has been set a deficit control total will be eligible for the CSF, the value of which will be set to bring the CCG back to a position of in-year financial balance as long as the in-year control total is delivered.

15. The Board is asked to approve the establishment of the Commissioner Sustainability Fund.

16. The planning guidance sets out a requirement for each system to develop winter plans using allocated funds. No additional funding will be available.

**Distribution of additional CCG allocations**

17. The Board considered funding distribution and the pace-of-change policy in December 2015 as part of setting the 2016/17 to 2020/21 allocations. CCGs have already established two-year plans based on these allocations, and we do not propose to revisit the previously published allocations or pace-of-change policy for 2018/19. For the same reason, we will not change CCG running cost allocations.

18. We therefore recommend that the additional £600 million available for core CCG allocations should be distributed to all CCGs in proportion to a CCG’s overall fair share of funding according to the target allocation formula. This ensures that the distribution takes account of factors including population, age, health need, and unmet need/health inequalities.

19. We have updated target allocations from those published in 2016. The key changes are to reflect the latest GP registered lists and ONS population projections, take account of CCG mergers and use new data where available.

20. The agreed methodology for the health inequalities/unmet need adjustment has been retained in these updated target allocations, with the Standardised Mortality Ratio for those aged under 75 measure (SMR<75) which drives this adjustment updated with the most recent (2011-2015) data.

¹ The impact of the change to the 0.5% underspend requirement is not shown, as this provides additional spending power within the existing published allocations
21. We also wish to ensure that no CCG is more than 5% below its updated target allocation, in line with the principle established in previous allocations rounds. This requires additional funding to be allocated to one CCG.\(^2\)

**Provider Sustainability Fund**

22. At the end of Q2, the provider sector was forecasting an aggregate full year deficit for 2017/18 of £623 million, after taking account of the existing £1800 million Sustainability and Transformation Fund.

23. It is therefore necessary to continue to allocate the planned £1800 million for provider sustainability in 2018/19. In addition, to ensure that the overall plan for the NHS can deliver a balanced position and to make it possible to withdraw the requirement on CCGs to hold a system risk reserve, we propose to increase the funding available by £650 million to £2450 million. To avoid confusion this is now renamed the Provider Sustainability Fund (PSF).

24. The additional funding must deliver a pound-for-pound improvement in the aggregate provider position and will be reflected in 2018/19 provider control totals. NHS Improvement has agreed that the provider sector will plan for and deliver a balanced income and expenditure position for 2018/19 after deployment of the £2.45 billion of available PSF funding.

25. The Board is asked to approve the expansion of the PSF and (as with this year) to delegate allocation and release of specific amounts to individual trusts to the Chief Executive and Chief Financial Officer in partnership with NHS Improvement, the Department of Health and Social Care and HM Treasury.

**Specialised services**

26. Our previous plan allocated funding growth of 4.4% for specialised services commissioning in 2018/19. A key driver of this was a relatively low level of assumed growth in expenditure on effective but expensive new drugs and devices. Our latest assessment of pressures on specialised commissioning, including an updated review of new drugs likely to receive NICE approval, concludes that it will be necessary to set aside a higher level of funding to meet these legally mandated requirements.

27. Nevertheless, delivering within this budget will still require the achievement of a substantial programme of planned efficiencies and the consideration of affordability constraints through the application of the Budget Impact Test to new medicines with significant aggregate cost. Similarly, as discussed at our 30 November 2017 board meeting, new advisory NICE guidelines will in future be expected to be accompanied by a clear and agreed affordability and workforce assessment at the time they are drawn up.

**General Practice**

28. The planned 2018/19 allocation for general practice has been maintained to enable the expected cost uplifts in the 2018/19 GP contract to be funded, as well as the funding commitments set out in the General Practice Forward View on extended access and investment in estates and technology.

\(^2\) South Worcestershire, which is allocated an additional £1.1m.
29. Local general practice allocations are unchanged from those previously published for 2018/19, and no changes to the funding formula have been implemented.

**Other Direct Commissioning**

30. The other Direct Commissioning allocation covers dental, optical services, pharmacy, armed forces, public health and health & justice commissioning undertaken by NHS England. Our initial plan was for this allocation to fall to reflect planned savings, efficiency requirements, and growth in income from prescription and dental charges.

31. Our revised assessment, following a review of income forecasts and other financial assumptions, is that a small cash increase in this allocation is required. This does not affect the underlying requirement to deliver significant efficiencies and cost savings in these areas of commissioning.

**Other NHS England funding**

32. Other NHS England funding comprises central transformation resources for key priority areas such as cancer and mental health, cover for non-recurrent drawdown of historic CCG surpluses, as well as core programme and management budgets. The slight increase on previous plans reflects a number of adjustments. The most notable are the provision of additional Government funding for specific purposes (e.g. costs associated with the Mental Health Green Paper) and the necessary reserves for legacy Continuing Healthcare claims.

**Allocation Overview and Assumptions**

33. Table 2 below sets out our recommended distribution of funds at commissioning stream level. Appendix A describes our assumptions in more detail.

<table>
<thead>
<tr>
<th></th>
<th>2017/18 initial allocation ((\text{\textsterling}m))</th>
<th>2017/18 adjusted allocation ((\text{\textsterling}m))</th>
<th>2018/19 adjusted allocation ((\text{\textsterling}m))</th>
<th>Previously planned growth ((\text{\textsterling}m))</th>
<th>2018/19 additional allocation ((\text{\textsterling}m))</th>
<th>2018/19 final allocation ((\text{\textsterling}m))</th>
<th>Total growth ((\text{\textsterling}m))</th>
<th>Revised growth %</th>
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<tr>
<td>Clinical Commissioning Groups</td>
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<td>73,450</td>
<td>74,996</td>
<td>1,546</td>
<td>603</td>
<td>75,599</td>
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<td>8,127</td>
<td>312</td>
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<td>Specialised Services</td>
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<td>16,602</td>
<td>17,339</td>
<td>737</td>
<td>354</td>
<td>17,693</td>
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<td>Provider Sustainability Fund</td>
<td>1,800</td>
<td>1,800</td>
<td>1,800</td>
<td>0</td>
<td>650</td>
<td>2,450</td>
<td>650</td>
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<tr>
<td>Other Direct Commissioning</td>
<td>6,641</td>
<td>6,684</td>
<td>6,553</td>
<td>-32</td>
<td>71</td>
<td>6,724</td>
<td>39</td>
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</tr>
<tr>
<td>Other NHS England funding</td>
<td>3,022</td>
<td>2,949</td>
<td>2,886</td>
<td>-63</td>
<td>61</td>
<td>2,947</td>
<td>-2</td>
<td>-0.1%</td>
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<td><strong>Total</strong></td>
<td><strong>109,193</strong></td>
<td><strong>109,300</strong></td>
<td><strong>111,800</strong></td>
<td><strong>2,500</strong></td>
<td><strong>2,140</strong></td>
<td><strong>113,940</strong></td>
<td><strong>4,640</strong></td>
<td><strong>4.2%</strong></td>
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Note: 2017/18 adjusted allocation excludes the non-recurrent additional funding provided in the Autumn Budget.

**Recommendations**

34. The Board is invited to:

- Note the publication of planning guidance for 2018/19; and
- Agree the proposed allocation of funds between areas of commissioning spend, and the proposed methodology for additional allocations to CCGs.

**Author**  National Directors
APPENDIX A

Pressures in commissioning streams

Cost pressures
The financial modelling supporting the 2018/19 allocations and planning is based on a set of assumptions, which where applicable are aligned to those reflected in the National Tariff for 2017 to 2019. We discuss the key drivers of these assumptions below. In developing the specific commissioning stream pressures these assumptions are adapted them as appropriate for each commissioning stream.

Activity
The activity assumptions are intended to be both affordable and deliverable under the revised allocations. The allocations for 2018/19 allow for:

- **Non-elective.** 2.3% growth in non-elective admissions and ambulance activity and 1.1% growth in A&E attendances. This is in aggregate for England and reflects recent trends, but activity growth patterns to be reflected in plans will in practice vary by commissioner and provider. However the aggregate 2.3% non-elective growth figure masks an important trend: non elective admissions actually needing an **overnight** admission to hospital (i.e. spells with a 1 day+ length of stay) are growing at a modest 1% year to date, whereas ‘zero day’ non-elective spells are reportedly growing at 7.3%. NHS Improvement has recently issued clarifying guidance on accurate counting so as to remove some of the ‘noise’ in these ‘zero day’ numbers.

- **Elective.** 4.9% growth (0.4% per working day) in total outpatient attendances and up to 3.6% growth (2.7% per working day) in elective admissions. GP referrals will increase by 0.8% (no change per working day).

Pay
The pay assumptions are based on estimates calculated by the DHSC of the underlying pay pressure in the system assuming a 1% headline pay settlement, and therefore do not reflect any increased pressure should the pay settlement be greater than 1%. The pay pressure assumption is consistent throughout all commissioning streams, weighted accordingly.

Drugs
Secondary care, non-specialised drugs expenditure is assumed to grow in line with forecasts used for the 2017-19 tariff. Growth in specialised excluded drugs is based on detailed work performed by NHS England.
Underlying growth in primary care drugs expenditure is assumed to be offset by prescribing efficiencies, including reforms to the prescribing of drugs available over the counter. The current high level of discretionary prices for generic drugs in short supply is assumed not to persist into 2018/19.

Other
For the majority of other pressures we have included an assumption cost increase in line with the GDP deflator. This includes secondary care procurement pressure for non-pay non-drugs related costs.
We have funded commissioners for the projected increases in Clinical Negligence Scheme for Trusts (CNST) contributions reflected in the National Tariff.
Revised allocations take account of additional costs as a result of the delegation for 2018/19 of Primary Care IT Enabling Services (PCES).
Cost and volume pressures on Continuing Healthcare, including any increases to Funded Nursing Care rates, are taken into account and assumed to be partly mitigated by efficiency opportunities. NHSE and NHSI are both clear that no extra in-year funding is available for ‘winter’ 2018/19 over and above these allocations and contracts agreed at the start of the year. This fact is communicated clearly to CCGs and NHS providers in the refreshed planning guidance.
Refreshing NHS Plans

for 2018/19

Published by NHS England and NHS Improvement
Refreshing NHS plans for 2018/19

Version number: 1.0

First published: February 2018

Prepared by: NHS England and NHS Improvement

This document is for: Foundation Trusts, NHS Trusts, Direct Commissioners and CCGs and should be read in conjunction with the NHS Operational Planning and Contracting Guidance

Publications Gateway Reference: 07705 and 07706

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1 Introduction

1.1 The NHS already has two-year contracts and improvement priorities set for the period 2017/19. These were based on the NHS Operational Planning and Contracting Guidance 2017-2019 published in September 2016 and reflected in the March 2017 document Next Steps on the NHS Five Year Forward View.

1.2 The November 2017 budget announced additional NHS revenue funding of £1.6 billion for 2018/19, which will increase funding for emergency & urgent care and elective surgery. In addition, for other core frontline services such as mental health and primary care, the Department of Health & Social Care (DHSC) is making a further £540 million available through the Mandate over the coming financial year. It is now our collective responsibility to ensure we deliver the best possible health service within the funds available. This joint NHS England and NHS Improvement updated guidance sets out how these funds will be distributed and the expectations for commissioners and providers in updating their operational plans for 2018/19.

1.3 In line with the priorities set out by the NHS England Board on 30 November 2017, for 2018/19 we will build on the progress made in 2017/18 and protect investment in mental health, cancer services and primary care in line with the available resources and agreed plans. Recognising the scale of unmet need in mental health, the importance of cancer services and the intense pressures on primary care we believe it would be unacceptable to compromise progress on these services. This means a continued commitment to deliver the cancer waiting time standards, achievement by each and every CCG of the Mental Health Investment Standard, service expansions set out by the Mental Health Taskforce and General Practice Forward View commitments, consistent with the expectations already set out in the 2017-19 planning guidance.

1.4 Given that two-year contracts are in place, 2018/19 will be a refresh of plans already prepared. This will enable organisations to continue to work together through STPs to develop system-wide plans that reconcile and explain how providers and commissioners will collaborate to improve services and manage within their collective budgets. Additional freedoms and flexibilities, described in this guidance, will support the most advanced Integrated Care Systems to lead this process.

1.5 Our energies must remain focused on improving the quality of care for patients and maintaining financial balance, whilst working in partnership to strengthen the sustainability of services for the future.

2 Financial Framework

Financial Framework for CCGs

2.1 The resources available to CCGs will be increased by £1.4 billion, principally to fund realistic levels of emergency activity in plans, the additional elective activity
necessary to tackle waiting lists, universal adherence to the Mental Health Investment Standard and transformation commitments for cancer services and primary care. This additional investment will be made available in the following ways:

- the requirement for CCGs to underspend 0.5% of their allocations has been lifted for 2018/19, releasing £370 million of CCGs’ resources to fund local pressures and transformation priorities. The requirement to use a further 0.5% of CCGs’ allocations solely for non-recurrent purposes has also been lifted;
- £600 million will be added to CCG allocations for 2018/19 (which otherwise remain unchanged), distributed in proportion to CCGs’ target allocations (which have been updated to reflect the latest population estimates and other data); and
- a new £400 million Commissioner Sustainability Fund (CSF) will be created, partly mirroring the financial framework for providers, to enable CCGs to return to in-year financial balance, whilst supporting and incentivising CCGs to deliver against their financial control totals.

2.2 CCGs will be expected to plan against financial control totals communicated at the outset of the planning process alongside revised allocations. CCGs collectively will be expected to deliver financial balance after the deployment of the Commissioner Sustainability Fund, and control totals will be set on this basis. Drawdown of cumulative underspends will be available subject to affordability, and where agreed with the relevant NHS England regional team.

2.3 CCGs’ control totals will take into account each CCG’s financial performance in 2017/18. Any CCG that is overspending in 2017/18 will be expected to improve its in-year financial performance by at least 1% of its overall allocation, and those with longer standing and/or larger cumulative deficits will be given a more accelerated recovery trajectory.

Commissioner Sustainability Fund

2.4 Where it is agreed that a CCG is unable to operate within its recurrent allocation for 2018/19 it will be required to commit to a credible plan, agreed and aligned at STP level, to deliver a stretching but realistic deficit control total set by NHS England and it will then qualify to access the Commissioner Sustainability Fund provided it delivers its financial control total.

2.5 All CCGs will be expected to achieve a minimum of financial balance with zero deficits, following deployment of any CSF allocations. Full details on the operation of the CSF will be published shortly.

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1 Revised CCG allocations have been published alongside this document on a provisional basis and for planning purposes, subject to confirmation at the NHS England public Board meeting on 8 February 2018.
2 CCGs will be informed of their control total by NHS England in writing, shortly after this guidance is published.
Provider Sustainability Fund and Financial Framework for NHS Providers

2.6 £650 million will be added to the £1.8 billion Sustainability and Transformation Fund to create an enhanced £2.45 billion Provider Sustainability Fund, targeted at the same objectives as the existing Sustainability and Transformation Fund. The additional £650 million must deliver at least a pound-for-pound improvement in the aggregate provider financial position and will be reflected in 2018/19 provider control totals. As in 2017/18, 30% of the total £2.45 billion fund will be linked to A&E performance. Full details will be published separately via an update to the existing Sustainability and Transformation Fund guidance. To access the performance element, each provider will need to achieve A&E performance in 2018/19 that is the better of either 90% or the equivalent quarter for 2017/18. The provider sector will plan and deliver a balanced income and expenditure position for 2018/19 after deployment of the £2.45 billion Provider Sustainability Fund.

2.7 Providers will be expected to plan on the basis of their 2018/19 control totals. Provider plans must make clear whether the Board has confirmed acceptance of its control total. NHS Improvement will use the completed financial planning template to capture this decision. If the control total has not been accepted, this is likely to trigger action under the Single Oversight Framework.

2.8 Providers who accept their control totals and so have access to the Provider Sustainability Fund for 2018/19 will continue to be exempt from the application of an agreed range of contractual performance sanctions, as set out in the existing NHS Standard Contract. NHS England will shortly consult on changes to the Contract to extend this exemption to all national contractual performance sanctions except those relating to mixed sex accommodation, cancelled operations, Healthcare Associated Infections and the duty of candour, on the basis that continuing NHS Improvement oversight, including the NHS Improvement Single Oversight Framework, will ensure that NHS providers continue to perform to acceptable levels against all national standards. Neither providers nor commissioners should include the expected impact of contractual sanctions in their plans, whether or not the provider has accepted its control total and so has access to the Provider Sustainability Fund. Providers who accept control totals (and associated conditions) will also be eligible to be considered for any discretionary capital allocations.

Capital and Estates

2.9 The 2017 Autumn Budget provided an extra £354 million of public capital in 2018/19 and set out the Government’s commitment to delivering its share of the NHS property and estates investment recommended in the Naylor review. NHS England and NHS Improvement are working together with DHSC and HMT to prioritise the allocation of additional STP capital. In updating 2018/19 operational plans, STPs and providers should not assume any capital resource

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3Providers will receive a letter from NHS Improvement informing them of changes to their previously notified 2018/19 control totals shortly after this guidance is published.
above the level in the current 2018/19 operating plans unless NHS England and NHS Improvement have given written confirmation of additional resource.

2.10 The approval of additional STP capital will be contingent on the STP having a compelling estates and capital plan. The STP plan must be fully aligned with the overarching strategy for service transformation and financial sustainability. This plan must set out how the individual organisations in the STP will work together to deploy capital funding to support integrated service models, maximise the sharing of assets and dispose of unused or underutilised estate. In addition, plans will need to demonstrate both value for money and savings to the STP over a reasonable payback period, taking full account of the life cycle costs associated with any new asset. STPs will also be expected to ensure that they maximise opportunities for self-funding of schemes using their own capital and receipts from land disposals and are fully considering the use of private finance where this provides value for money. Further information on the next steps regarding STP capital will be communicated separately.

2.11 Providers are asked to actively consider the requirement for funding critical estate backlog within their capital plan and explain their strategy for investment in backlog work and risk mitigation including how they will reduce operational expenditure relating to estate and facilities.

National Tariff

2.12 The two-year National Tariff Payment System which came into effect from 1 April 2017 remains in place for next year. Local systems are encouraged to consider local payment reform, in particular to complement the introduction of ‘advice and guidance’ services. Local systems are also encouraged to introduce appropriate local tariffs for emergency ambulatory care where they have not already done so, to replace the current A&E and non-elective tariffs for appropriate conditions. The next round of interventions eligible for direct reimbursement through the Innovation and Technology Payments, a programme designed to incentivise take-up of the latest innovations across the NHS, will be published by 31 March.

Underlying Assumptions

2.13 Local systems are expected to continue to implement the priority efficiency programmes within the 10 Point Efficiency Plan. This includes taking every opportunity to maximise provider operational productivity, guided by the Model Hospital portal, and to participate fully in associated programmes. It also includes the implementation of Getting It Right First Time recommendations; participation in networked arrangements for procurement, corporate services and diagnostic services; achieving best practice in clinical and other workforce productivity standards (including reducing agency staff usage); and improving the safety and efficiency of providers’ estate and facilities. Providers and STPs should also consider how to make best use of the digital and technological systems and innovations available to them. In addition to the moderation of emergency demand discussed below, the use of RightCare, elective care
redesign, urgent and emergency care reform, medicines optimisation, and more integrated primary and community services are also key areas of focus.

2.14 CCGs should assume that the current high level of discretionary prices for generic drugs in short supply will not persist in 2018/19. In 2018/19, CCGs will receive the remaining period of temporary benefit from changes made to Category M generic drug prices designed to recover excess community pharmacy margin from previous years (i.e. the Cat M clawback will not continue beyond 2017/18). Beyond this, no assessment has yet been made of whether upward or downward adjustments to generic drugs prices will be needed in 2018/19 to reflect under or over-delivery of community pharmacy margin delivered in 2016/17 and 2017/18. So no allowance for this should be included in CCG plans.

2.15 In December 2017, NHS England issued guidance on *Items that should not routinely be prescribed in primary care: Guidance for CCGs*. This guidance is aimed at reducing the routine prescribing of 18 ineffective and low clinical value medicines, such as some dietary supplements, herbal treatments and homeopathy. It is assumed CCGs will save up to £141 million a year from this programme. NHS England has also launched a public consultation (closing 20 March 2018) on reducing prescribing of over-the-counter medicines for 33 minor, short-term health concerns, as well as vitamins and probiotics. Depending on the outcome of the consultation, it is assumed this could save the NHS up to £136 million a year. CCGs should consider how to locally implement guidance on the 18 ineffective and low clinical value medicines and consider the potential impact of any developments concerning over the counter medications following the consultation.

2.16 It is assumed that all CCGs continue to work with the NHS England Continuing Healthcare strategic improvement and QIPP programmes to increase standardisation of processes and adopt best practice to deliver the targeted reduction in growth, thus mitigating cost and volume pressures, including the impact of any increases to Funded Nursing Care rates.

2.17 Where the activity, cost and efficiency assumptions made by an STP do not enable each of its organisations to meet the control totals set by NHS England and NHS Improvement, the STP will need to agree additional cost containment measures and highlight any implications. This includes potential impacts on the range or level of services to be provided, and where surpluses will be created to offset any unavoidable deficits within the STP. When considering options to deliver control totals, STPs must ensure the alignment of commissioner and provider assumptions. They must also ensure that plans continue to meet the requirements for A&E, RTT and cancer set out in this letter and that patients are able to exercise choice as set out in the NHS Constitution.

2.18 We are working through the implications of the Government’s commitment on NHS pay described in the 2017 Autumn Budget and will publish further guidance in due course. Until this is available the impact of any changes to NHS pay beyond the 2017-19 published assumptions should be excluded from
plans. It is essential that the 2018/19 pay costs in financial planning returns are an accurate reflection of the cost of the current, published pay assumptions.

2.19 Further details about CQUIN, Quality Premium, national contract and winter planning are set out in section 6.

Specialised Commissioning

2.20 The contracting approach for specialised services continues into 2018/19, aligned to implementation of the Carter review. Specialised commissioners and providers will need to review the 2018/19 activity plans and agree any contract variations required in accordance with the contractual process and to the national timetable. Activity plans for 2018/19 will be reviewed as part of routine in-year contract management, incorporating delivery of QIPP planning and appropriate CQUIN benefit realisation. Locally priced services reform to reduce cost per weighted activity unit, multi-year medicines optimisation approach underpinned by CQUIN, and further reforms to the medical device supply chain, will continue. It remains a priority to have robust and high quality data flows to support accurate reimbursement, in particular of tariff-excluded high cost drugs and devices.

3 Planning Assumptions for Emergency Care and Referral to Treatment Times

Emergency Care

3.1 The combination of clarity on control totals for providers and commissioners, underpinned by the increased provider sustainability fund and the new commissioner sustainability fund, paid for using additional budget funding, should enable health systems to fund and plan for this year’s activity in a way that enables improved A&E performance in 2018/19. In addition, the allocations for 2018/19 allow for 2.3% growth in non-elective admissions and ambulance activity and 1.1% growth in A&E attendances. This is in aggregate for England and reflects recent trends, but activity growth patterns to be reflected in plans will in practice vary by commissioner and provider.

3.2 Our expectation is that the Government will roll forward the goal of ensuring that aggregate performance against the four-hour A&E standard is above 90% for the month of September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019, and that the NHS returns to 95% overall performance within the course of 2019. STPs, commissioner and providers should review assumptions for levels of A&E attendances and non-elective admissions to ensure they reflect recent trends, adjusting as appropriate for demand management and other efficiency schemes that have been agreed between CCGs and providers. Given the differential implications for both bed capacity and cost, organisations will be required to plan and report non-elective admissions of less than one day separately from those of one day or more. Plans will also be collected on planned bed numbers to ensure
sufficient capacity is available throughout the year to meet anticipated demand for emergency and elective care.

3.3 Commissioner and provider plans will be expected to demonstrate how they will complete the implementation of the integrated urgent care strategy that was commenced this year, and how sufficient capacity will be available to meet planned activity growth through a combination of additional beds and/or:

- reductions in delayed transfers of care (DTOCs), both through reducing NHS-driven DTOCs and through continuing to work with local authorities to reduce social care DTOCs, with the aim of reducing the proportion of beds occupied by DTOC patients to 3.5%;
- reductions in average length of stay, including a focus on those patients with the longest length of stay as identified in the stranded patients metrics.

3.4 It is clear that there is significant variation in length of stay between providers, particularly in the number of patients with a length of stay over seven days (stranded patients) and a length of stay over 21 days (super stranded patients). We expect all providers and commissioners to work together to focus on reducing their length of stay, and particularly the very long lengths of stay, to release capacity for patients who are legitimately waiting for a hospital bed.

3.5 To further support progress in these areas and free-up capacity, providers of community services will be invited to participate in a new local incentive scheme in conjunction with their CCG whereby they will be able to reinvest savings from acute excess bed day costs to expand community and intermediate care services. This will benefit ‘stranded’ and ‘super-stranded’ patients in particular.

3.6 A total of £210 million of CCG Quality Premium incentive funding will be contingent on performance on moderating demand for emergency care. This payment will be conditional on the CCG meeting or improving on the levels jointly planned with providers. The principal metric for this purpose will be the level of growth in non-elective activity compared to the agreed plan.

**Referral to Treatment Times**

3.7 The 2018/19 allocations now allow for improvements in the volume of elective surgery being funded next year, and improvements in the number of patients waiting over 52 weeks. A more significant annual increase in the number of elective procedures compared with recent years means commissioners and providers should plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced. Numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible. The planning assumption for England as a whole is for 4.9% growth in total outpatient attendances (4.0% per working day) and up to 3.6% growth in elective admissions (2.7% per working day). It is also assumed that GP referrals will increase by 0.8% (i.e. no change per working day). The planned growth levels required will vary locally and therefore activity plans should be reviewed
to ensure delivery of these objectives, adjusting as appropriate for demand management and other efficiency schemes which have been jointly agreed between commissioners and providers. Systems will be expected to plan and report separately on day case and inpatient elective activity, based on their trend performance, the profile of expected referrals and the composition of their existing waiting list. Systems will be expected to demonstrate to regional teams that their RTT plans are robust and realistic, and that they make best and flexible use of available capacity across their STP footprint in order to optimise delivery against the objectives above.

3.8 Provider plans will need to consider the capacity required to deliver the growth in non-elective and elective activity and the impact on workforce, finance and productivity. Alongside these capacity considerations it remains essential that providers manage within their agency ceilings.

4 Delivery of Next Steps Priorities

4.1 The NHS is already working to two-year priorities as set out in last year’s planning guidance and the March 2017 Next Steps on the Five Year Forward View. This document confirms the deliverables for 2018/19. These are set out in Annex 1, together with the progress made against 2017/18 deliverables.

5 Integrated System Working

5.1 In 2018/19, we expect all STPs to take an increasingly prominent role in planning and managing system-wide efforts to improve services. STPs should:

- ensure a system-wide approach to operating plans that aligns key assumptions between providers and commissioners which are credible in the round;
- work with local clinical leaders to implement service improvements that require a system-wide effort; for example, implementing primary care networks or increasing system-wide resilience ahead of next winter;
- identify system-wide efficiency opportunities such as reducing avoidable demand and unwarranted variation, or sharing clinical support and back office functions;
- undertake a strategic, system-wide review of estates, developing a plan that supports investment in integrated care models, maximises the sharing of assets, and the disposal of unused or underutilised estate; and
- take further steps to enhance the capability of the system including stronger governance and aligned decision-making, and greater engagement with communities and other partners, including where appropriate, local authorities. STPs should also take steps to resource their own ‘infrastructure’. Although these should be mainly drawn from their constituent organisations, NHS England will be making a further non-recurrent allocation within each STP to support its leadership in 2018/19 on the same basis as last year.
Integrated Care Systems

5.2 We will reinforce the move towards system working in 2018/19 through STPs and the voluntary roll-out of Integrated Care Systems. Integrated Care Systems are those in which commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations.

5.3 We are now using the term ‘Integrated Care System’ as a collective term for both devolved health and care systems and for those areas previously designated as ‘shadow accountable care systems’. An Integrated Care System is where health and care organisations voluntarily come together to provide integrated services for a defined population.

5.4 We see Integrated Care Systems as key to sustainable improvements in health and care by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
- supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.

5.5 There are currently eight areas designated as ‘shadow’ accountable care systems, plus the two devolved health and care systems based on STP footprints (Greater Manchester and Surrey Heartlands). These systems should prepare a single system operating plan narrative that encompasses CCGs and NHS providers, rather than individual organisation plan narratives. The system operating plan should align key assumptions on income, expenditure, activity and workforce between commissioners and providers. System leaders should take an active role in this process, ensuring that organisational plans underpin and together express the system’s priorities. All Integrated Care Systems are expected to produce together a credible plan that delivers the system control total, resolving any disputes themselves, and no ‘shadow’ Integrated Care System will be considered ready to go fully operational if it is unable to produce such a plan.

5.6 To reinforce this approach to system planning, NHS England and NHS Improvement will focus on the assurance of system plans for Integrated Care Systems rather than organisation-level plans. We expect that Integrated Care Systems will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.
NHS England and NHS Improvement will support system leaders in this task. We have developed a new approach to oversight and support for Integrated Care Systems, based on the principles of setting system-wide goals, streamlining the oversight and support provided by NHS England and NHS Improvement (supported by an integrated framework that brings together the separate frameworks for trusts and CCGs), and working with and through the local system leadership to provide any support or interventions in individual providers or localities.

5.7 Integrated Care Systems will be supported by new financial arrangements:

- all Integrated Care Systems will work within a system control total, the aggregate required income and expenditure position for trusts and CCGs within the system, as communicated by NHS England and NHS Improvement. They will be given the flexibility, on a net neutral basis, and in agreement with NHS England and NHS Improvement, to vary individual control totals during the planning process and agree in-year offsets of financial over-performance in one organisation against financial under-performance in another;

- in 2018/19, systems are encouraged to adopt a fully system-based approach to the PSF and CSF under which no payment will be made unless the system as a whole has delivered against its system control total. If the system achieves its control total, but individual trusts or CCGs do not, the system will still retain its full share of the PSF (£2.45 billion in aggregate) and any applicable CSF awards, but NHS England and NHS Improvement will agree with the leadership how those trusts’ and CCGs’ shares will be apportioned between local organisations;

- systems adopting this full incentive structure will operate under a more autonomous regulatory relationship with NHS England and NHS Improvement. NHS England and NHS Improvement will also support fully authorised Integrated Care Systems by exercising their intervention powers alongside the system leadership. For example, where there is a case for regulatory intervention in a trust or CCG to address financial underperformance or issues of quality, the leadership of the Integrated Care System will play a key role in agreeing what remedial action needs to be taken; and

- all approved Integrated Care Systems will be required to operate under these fully-developed system control total incentive structures by 2019/20. However, in 2018/19 systems that are not ready to proceed with full system incentives and shared intervention arrangements will alternatively be allowed to adopt an interim approach under which only the additional funding that has been put into the PSF (£650 million in aggregate) will be linked to system financial performance. On this option, no payment will be made from this enhanced funding unless the system as a whole meets its control total. If individual trusts or CCGs miss their organisational control totals, but the system still achieves overall, their share will be apportioned in consultation with the system leadership. However, on this interim option

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4 Integrated Care Systems will be informed of their system control total by NHS England and NHS Improvement in writing, shortly after this guidance is published
if the individual trusts or CCGs meet their organisational control totals, but
the system does not overall, they will retain access to the relevant share of
the existing £1.8 billion PSF and any applicable CSF awards.

New Integrated Care Systems

5.8 There is strong appetite amongst other systems to join the Integrated Care
System development programme and we anticipate that additional systems will
wish to join during 2018/19 as they demonstrate their ability to take collective
responsibility for financial and operational performance and health outcomes.
STPs that can demonstrate their readiness to join the programme should speak
to their regional teams to confirm expressions of interest from all organisations
in the STP. We will aim to review any applications to join the programme by
March 2018. We envisage that over time Integrated Care Systems will replace
STPs.

5.9 The next cohort of Integrated Care Systems will be selected from STPs with:

- strong leadership, with mature relationships including with local
government. The leadership team should have effective ways of involving
clinicians and staff, the third sector, service users and the public. It should
also have the right capability and infrastructure to execute on priorities;
- a track record of delivery, with evidence of tangible progress towards
delivering the priorities in Next Steps on the Five Year Forward View.
These systems should be meeting NHS Constitution standards or provide
confidence that by working as an integrated system they are more likely to
be recovered;
- strong financial management, with a collective commitment from CCGs
and providers to system planning and shared financial risk management,
supported by a system control total and system operating plan;
- a coherent and defined population that reflects patient flows and, where
possible, is contiguous with local government boundaries; and
- compelling plans to integrate primary care, mental health, social care and
hospital services using population health approaches to redesign care
around people at risk of becoming acutely unwell. These models will
necessarily require the widespread involvement of primary care, through
incipient networks.

Public Engagement

5.10 As systems make shifts towards more integrated care, we expect them to
involve and engage with patients and the public, their democratic
representatives and other community partners. Engagement plans should
reflect the five principles for public engagement identified by Healthwatch and
highlighted in the Next Steps on the Five Year Forward View.
6 Process and Timetable

6.1 The task for commissioners and providers is to update the 2018/19 year of existing two-year plans to take account of the points set out above and to ensure that operating plans:

- are stretching and realistic, and show a bottom line position consistent with the control totals set by NHS England and NHS Improvement;
- are the product of partnership working across STPs, with clear triangulation between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions – and with assurance from STP leaders that this is the case whilst ensuring the updated plans and contracts are aligned between commissioners and providers. As a result of the activity moderation incentives in the new Commissioner Sustainability Fund and the revised Quality Premium scheme, it is now more critical than ever that activity and finance plans are aligned between commissioners and providers; and
- include appropriate phasing profiles to reflect seasonal changes in demand, especially related to winter, and ensuring efficiency savings are not back-loaded into the later part of the financial year.

Contract Variations

6.2 Where the 2018/19 plans have changed and these changes need to be reflected in the finance, activity or other schedules for the second year of two-year contracts, a contract variation should be agreed to this effect, and signed no later than 23 March 2018.

6.3 The NHS Standard Contract sets out clear rules relating to the updating of a contract for a second year, and our expectation is therefore that there should be no disputes between commissioners and providers about these variations.

6.4 Where commissioners and providers fail to reach timely agreement the dispute resolution process in the contract should be followed. Starting with escalated negotiation, the process then moves into mediation. Mediation may be undertaken within STPs if both parties are in agreement, or where this is not possible, it may be arranged with a third party. Where, exceptionally, agreement is not reached through mediation, organisations will be expected to follow the Expert Determination process set in the dispute resolution guidance, which will be published shortly. NHS England and NHS Improvement will view use of mediation, and in particular determination, as a failure of local system relationships and leadership. This guidance also provides detailed advice about the rules within the Contract on varying a contract for its second year.

6.5 On 3 January 2018, NHS England published a National Variation to the Standard Contract. This was principally to give effect to changes to the ambulance response standards, but took the opportunity to incorporate other national policy requirements which had been announced since the 2017-19 planning round. In particular, these related to: prohibiting the sale of sugary
drinks on NHS provider premises; prohibiting the provision or promotion of
certain legal services from NHS provider premises; and mandating participation
by NHS providers in the Nationally Contracted Products Programme.
Commissioners and providers are legally bound to incorporate these changes
into local contracts.

Plan Submissions

6.6 All commissioners (CCGs and direct commissioning including specialised) and
all providers are required to submit a full suite of operating plan returns to the
deadlines in the national timetable (see below); and also adhere to the contract
variation deadlines and processes. We will update technical planning guidance
to support the submission of templates to ensure plans are completed on a
consistent basis and to a high standard. The data collected will be used to
inform decision making and will also form the plan against which 2018/19
delivery is judged. All organisations must ensure submissions are accurate,
detailed and consistent with their Board approved plans.

6.7 For providers the first and final plan submission will include finance, activity,
workforce and triangulation returns alongside an update to the existing two-year
plan narrative. For providers that are part of an Integrated Care System the
provider plan narrative will be updated with a system plan narrative that
describes the key changes to the existing plan, which will be assured jointly by
NHS England and NHS Improvement.

6.8 Provider workforce plans will need to consider the significant workforce supply
and retention challenges in the NHS. For 2018/19, providers are expected to
update their workforce plans to reflect latest projections of supply and retention,
taking into account the supply of staff from Europe and beyond, changes to
NHS nursing and allied health professional bursaries, improvements expected
in agency and locum use. Plans should also be updated to take account of the
strengthening of bank arrangements and opportunities identified for improved
productivity and workforce transformation through new roles and/or new ways
of working. It is important that workforce plans are detailed and well-modelled –
and align with both financial and service activity plans – to ensure the proposed
workforce levels are affordable, efficient and sufficient to deliver safe care to
patients. The workforce plans submitted will be used nationally for pay
modelling during the year.

6.9 Commissioners will need to submit draft and final commissioner operating plan
updates, using the financial, performance activity and milestone plan templates.
These and the supporting guidance will be issued separately. Draft and final
finance, performance and activity plans must be consistent, and triangulated
with provider expectations.

6.10 For STPs, para 2.17 sets out the requirement to ensure alignment in activity,
income and expenditure assumptions across STPs. Building on the 2017/18 in
year contract alignment approach, we will be asking STP leaders to return a
contract and plan alignment template to demonstrate that updated plans and
contracts are aligned financially between commissioners and providers.
CQUIN and Quality Premium

6.11 NHS England will shortly be publishing an update to the 2017/19 CQUIN guidance. This update is required to provide indicator thresholds for some indicators for year 2 of the scheme. As part of the update, NHS England will clarify the requirements around the influenza vaccination indicator. In addition, NHS England has made some changes to the anti-microbial resistance indicator to take account of supply issues. The sepsis indicator will also be updated to require providers to replace locally devised protocols with a National Early Warning Score (NEWS) by March 2019. In September 2017, the National Quality Board strongly endorsed NEWS as a standardised system between clinicians in the acute setting to help early detection of deterioration/identification of sepsis. Organisations will also be required to make a one-off data return in relation to the healthy food and drink indicator at the end of Q4.

6.12 In addition, in light of the specific challenges around delivering provider side balance, NHS England has agreed with NHS Improvement to offer a temporary relaxation of an element of the scheme for acute providers. Our shared position is that this concession is being made in 2018/19 only. On the basis that there are multiple initiatives supporting the discharge agenda, we have agreed to suspend the ‘proactive and safe discharge’ indicator for acute providers, with the remaining five indicators in the scheme increasing their weighting from 0.25% to 0.3% as a temporary measure for 2018/19.

6.13 This change will have implications for the linked indicators in Community and Care Home settings. We are issuing an updated indicator for Care Home providers. For Community providers, we expect CCGs to either take this opportunity to include a local CQUIN indicator in their contracts, or increase the weights of the remaining five indicators in the scheme to 0.3%.

6.14 The 0.5% risk reserve CQUIN will be withdrawn in 2018/19. The 0.5% will be added to the engagement CQUIN, which will increase as a result to 1%.

6.15 Our collective expectation is that the degree of conditionality in CQUIN will return to its 2017/18 levels from 2019/20. These temporary suspensions are not an indication of our future intentions for the CQUIN scheme, in respect of the quantum, the number of indicators, or their respective weightings.

6.16 In line with our policy intent that CQUIN is ‘realistically earnable’, NHS England and NHS Improvement will be trialling a new triangulated provider/commissioner finance return, to confirm whether CQUIN awards have been earned during the year.

6.17 As previously indicated, the 2018/19 Quality Premium scheme will be restructured to include an incentive on non-elective demand management. Given the significant emphasis we wish CCGs to give to this issue, the non-elective measure will make up the majority of the Quality Premium scheme, with a potential award of £210 million nationally. We will retain a number of the existing quality measures, which will be linked to the remainder of the potential...
Quality Premium funding, and we will continue to moderate payment through the operation of the existing Finance and Quality gateways. We will shortly publish updated guidance which will set out the full details of the revised scheme.

**Winter Demand & Capacity Plans**

6.18 There will be no additional winter funding in 2018/19. To ensure that winter preparation has been undertaken well in advance and using existing funds, systems will need to demonstrate that winter plans are embedded both in their system plans and in individual organisations’ operating plans, including realistic phasing of non-elective and elective activity across the year.

6.19 To support this there is a requirement for each system to produce a separate winter demand and capacity plan, triangulating the finance and activity implications along with the actions and proposed outcomes. Guidance on submitting these winter plans will be available by March 2018.

**Timetable**

<table>
<thead>
<tr>
<th>Item</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICS system control total changes and assurance statement submitted</td>
<td>By 1 March 2018</td>
</tr>
<tr>
<td>Local decision to enter into mediation for 2018/19 contract variations</td>
<td>2 March 2018</td>
</tr>
<tr>
<td><strong>Draft 2018/19 Organisational Operating Plans submitted</strong></td>
<td><strong>8 March 2018</strong></td>
</tr>
<tr>
<td>Draft 2018/19 STP Contract and Plan Alignment template submitted</td>
<td>8 March 2018</td>
</tr>
<tr>
<td>National deadline for signing 2018/19 contract variations and contracts</td>
<td>23 March 2018</td>
</tr>
<tr>
<td>2018/19 Expert Determination paperwork completed and shared by all parties</td>
<td>27 April 2018</td>
</tr>
<tr>
<td><strong>Final Board or Governing Body approved Organisation Operating Plans submitted</strong></td>
<td><strong>30 April 2018</strong></td>
</tr>
<tr>
<td>2018/19 Winter Demand &amp; Capacity Plans submitted</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>Final 2018/19 STP Contract and Plan Alignment template submitted</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>Final date for experts to notify outcome of determinations for 2018/19 update</td>
<td>8 June 2018</td>
</tr>
</tbody>
</table>
Annex 1: 2018/19 Deliverables

Reminder of 2018/19 deliverables – drawn from ‘Next Steps on the NHS Five Year Forward View’ published in March 2017

The NHS already has two-year priorities, set out in last year’s Planning Guidance and the March 2017 publication of the Next Steps on the NHS Five Year Forward View. This Annex confirms these deliverables for 2018/19.

For national targets we will, where appropriate, provide disaggregated STP and CCG-level improvement targets and templates to ensure plans are completed on a consistent basis.

1. Mental Health

<table>
<thead>
<tr>
<th>Overall Goals for 2017-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>We published Implementing the Mental Health Forward View in July 2016 to set out clear deliverables for putting the recommendations of the independent Mental Health Taskforce Report into action by 2020/21. The publication of Stepping Forward to 2020/21 in July 2017 provides a roadmap to increase the mental health workforce needed to deliver this. Making parity a reality will take time, but this a major step on the journey towards providing equal status for mental and physical health. These ambitions are underpinned by significant additional funding for mental health care, which should not be used to supplant existing spend or balance reductions elsewhere.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Progress in 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>• On track to ensure an extra <strong>35,000 children and young people</strong> are able to access services this year.</td>
</tr>
<tr>
<td>• <strong>70 new or extended community eating disorder services</strong> funded and commissioned.</td>
</tr>
<tr>
<td>• <strong>81 new beds</strong> for Children and Adolescent Mental Health Services (Tier 4) and at least another <strong>50 beds</strong> will open by Deliverables for 2018/19</td>
</tr>
<tr>
<td>Additional funding has now been built into CCG 2018/19 allocations to support the expansion of services outlined in this planning guidance and the specific trajectories set for 2018/19 to deliver the Five Year Forward View for Mental Health. Progress to be made against all deliverables in the Next Steps on the NHS Five Year Forward View and the Implementing the Mental</td>
</tr>
</tbody>
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end of March 2018.

- Expanded **specialist perinatal care** with over 5,000 additional women accessing these services between April and December 2017. Contracts awarded for four new Mother and Baby Units.
- Continued to meet the waiting time standard for **early intervention in psychosis**.
- **Physical health checks and interventions** for patients with severe mental illness in secondary care, with 60% of people in inpatient settings and 42% in community mental health teams receiving this to date.
- Health Education England (HEE) expects to provide over 600 training places for Improving Access to Psychological Therapies (IAPT) practitioners. At least **800 practitioners in primary care** settings by March 2018.
- 10 mental health **new care models** up and running and an additional 7 go live by April 2018.
- CCGs have continued to meet the **dementia diagnosis standard**, which was at 68.3% by December 2017.
- Seven **Global Digital Exemplar** Mental Health Trusts, funded to identify trusts which they will partner with as ‘fast followers’.

Health Forward View in 2018/19 with all CCGs and STPs required to:

- Each CCG must meet the **Mental Health Investment Standard** (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall programme funding. CCGs’ auditors will be required to validate their 2018/19 year-end position on meeting the MHIS.
- Ensure that an additional 49,000 **children and young people** receive treatment from NHS-commissioned community services (32% above the 2014/15 baseline) nationally, towards the 2020/21 objective of an additional 70,000 additional children and young people. Ensure evidence of local progress to transform children and young people’s mental health services is published in refreshed joint agency Local Transformation Plans aligned to STPs.
- Make further progress towards delivering the 2020/21 waiting time standards for **children and young people’s eating disorder services** of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases.
- Deliver against regional implementation plans to ensure that by 2020/21, **inpatient stays for children and young people** will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds.
- Continue to increase access to **specialist perinatal mental health services**, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.
• Continue to improve access to **psychology therapies** (IAPT) services with, maintaining the increase of 60,000 people accessing treatment achieved in 2017/18 and increase by a further 140,000 delivering a national access rate of 19% for people with common mental health conditions. Do so by supporting HEE’s commissioning of 1,000 replacement practitioners and a further 1,000 trainees to expand services. This will release 1,500 mental health therapists to work in primary care. Approximately two-thirds of the increase to psychological therapies should be in new integrated services focused on people with co-morbid **long term physical health conditions** and/or medically unexplained symptoms, delivered in primary care. Continue to ensure that access, waiting time and recovery standards are met.

• Continue to work towards the 2020/21 ambition of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals subject to hospitals being able to successfully recruit.

• Ensure that 53% of patients requiring **early intervention for psychosis** receive NICE concordant care within two weeks.

• Support delivery of STP-level plans to reduce all inappropriate adult acute **out of area placements** by 2020/21, including increasing investment for Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21. Review all patients who are placed out of area to ensure that have appropriate packages of care.
2. Cancer

**Overall Goals for 2017-2019**
Advance delivery of the National Cancer Strategy to promote better prevention and earlier diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience by 2020/21.

- Deliver annual **physical health checks** and interventions, in line with guidance, to at least 280,000 people with a severe mental health illness.
- Provide a 25% increase nationally on 2017/18 baseline in access to **Individual Placement and Support** services.
- Maintain the **dementia** diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care.
- Deliver their contribution to the **mental health workforce** expansion as set out in the HEE workforce plan, supported by STP-level plans. At national level, this should also specifically include an increase of 1,500 mental health therapists in primary care in 2018/19 and an expansion in the capacity and capability of the children and young people’s workforce building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence based interventions by 2020/21.
- Deliver against multi-agency **suicide prevention** plans, working towards a national 10% reduction in suicide rate by 2020/21.
- Deliver **liaison and diversion** services to 83% of the population.
- Ensure all commissioned activity is recorded and reported through the Mental Health Services **Dataset**.
### Progress in 2017/18

- **Cancer survival** at its highest ever with latest figures showing that one-year cancer survival is up by over 2,000 people a year.
- 95.1% of people seen by a specialist **within two weeks** of an urgent GP referral for suspected cancer, with 5.1% more patients being seen in the 12 months to November 2017 than in the previous 12 months.
- Ten **multidisciplinary rapid diagnostic and assessment centres** in place across the country by March 2018, supporting patients with complex symptoms through to diagnosis.
- We are on track to deliver the **largest radiotherapy upgrade programme in 15 years modern radiotherapy** have now funded 26 new machines in 21 trusts in 2017/18.
- Half of the country’s Cancer Alliances have begun to roll out **personalised follow-up** after cancer treatment.
- Added 22 more drugs to the Cancer Drugs Fund, which have benefitted nearly 7,500 more patients, taking the total since the reformed CDF launched in July 2016 to 15,700 patients having benefited from 52 drugs treating 81 different cancers.

### Deliverables for 2018/19

- Ensure all **eight waiting time standards** for cancer are met, including the 62 day referral-to-treatment cancer standard. The ‘10 high impact actions’ for meeting the 62 day standard should be implemented in all trusts, with oversight and coordination by Cancer Alliances. The release of cancer transformation funding in 2018/19 will continue to be linked to delivery of the 62 day cancer standard.
- Support the implementation of the new **radiotherapy service specification**, ensuring that the latest technologies, including the new and upgraded machines being funded through the £130 million Radiotherapy Modernisation Fund, are available for all patients across the country.
- Ensure implementation of the nationally agreed **rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers**, ensuring that patients get timely access to the latest diagnosis and treatment. Accelerating the adoption of these innovations helps meet the 62 days standard ahead of the introduction of the **28 day Faster Diagnosis Standard** in April 2020.
- Progress towards the 2020/21 ambition for **62% of cancer patients to be diagnosed at stage 1 or 2**, and reduce the proportion of cancers diagnosed following an emergency admission.
- Support the rollout of FIT in the **bowel cancer screening programme** during 2018/19 in line with the agreed national timescales following PHE’s procurement of new FIT kit, ensuring that at least 10% of all bowel cancers diagnosed through the screening programme are detected at an early stage, increasing to 12% in 2019/20.
- Participate in pilot programmes offering low dose CT scanning based on an assessment of lung cancer risk in
### 3. Primary Care

**Overall Goals for 2017-2019**
Stabilise general practice today and support the transformation of primary care and for tomorrow, by delivering *General Practice Forward View* and *Next Steps on the NHS Five Year Forward View*.

<table>
<thead>
<tr>
<th>Progress in 2017/18</th>
<th>Deliverables for 2018/19</th>
</tr>
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<tbody>
<tr>
<td>52% of the country now benefitting from <strong>extended access</strong> including appointments on evenings and weekends, beating the target of 40% for 2017/18.</td>
<td>Progress against all <em>Next Steps on the NHS Five Year Forward View</em> and <em>General Practice Forward View</em> commitments. This includes all CCGs:</td>
</tr>
<tr>
<td><strong>Primary care workforce:</strong></td>
<td>• Providing <strong>extended access</strong> to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.</td>
</tr>
<tr>
<td>o Over 770 additional GP trainees started specialist training since 2015 baseline (3,157 in total in 2017/18);</td>
<td>o Delivering their contribution to the <strong>workforce commitment</strong></td>
</tr>
<tr>
<td>o Begun GP international recruitment, with the first 100 GPs being recruited;</td>
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</tbody>
</table>

CCGs with lowest **lung cancer** survival rates.

- Progress towards the 2020/21 ambition for **all breast cancer patients to move to a stratified follow-up pathway** after treatment. Around two-thirds of patients should be on a supported self-management pathway, freeing up clinical capacity to see new patients and those with the most complex needs. All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring by the end of 2018/19.
- Ensure implementation of the **new cancer waiting times system** in April 2018 and begin data collection in preparation for the introduction of the new 28 day Faster Diagnosis standard by 2020.
to have an extra 5,000 doctors and 5,000 other staff working in primary care. CCGs will work with their local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19. At national aggregate level we are expecting the following for 2018/19:

- CCGs to recruit and retain their share of additional doctors via all available national and local initiatives;
- 600 additional doctors recruited from overseas to work in general practice;
- 500 additional clinical pharmacists recruited to work in general practice (CCGs whose bids have been successful will be expected to contribute to this increase);
- An increase in physician associates, contributing to the target of an additional 1000 to be trained by March 2020 (supported by HEE);
- Deliver increase to 1,500 mental health therapists working in primary care.

- Investing the balance of the £3/head investment for general practice transformation support.
- Actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000.
- Investing in upgrading primary care facilities, ensuring completion of the pipeline of Estates and Technology Transformation schemes, and that the schemes are delivered within the timescales set out for each project.
- Ensuring that 75% of 2018/19 sustainability and resilience funding allocated is spent by December 2018, with 100% of the allocation spent by March 2019.

- Investment in general practice continues to increase on track to deliver the pledged additional £2.4 billion by 2021.

- CCGs investing in line with expectations set out in the 2017/18 NHS’s Planning Guidance, for additional primary care transformation investment (£3/head) over two years.

- Invested in upgrading primary care facilities, with 844 schemes completed and a further 868 schemes in development.

- Launched the GP Retention Scheme;
- Recruitment of an additional 505 clinical pharmacists, in addition to the 494 already in post.
• Ensuring every practice implements at least two of the high impact ‘time to care’ actions.
• In all practices, delivering primary care provider development initiatives for which CCGs will receive delegated budgets, including online consultations.
• Where primary care commissioning has been delegated, providing assurance that statutory primary medical services functions are being discharged effectively.
• Lead CCGs expected to commission, with support from NHS England Regional Independent Care Sector Programme Management Offices, medicines optimisation for care home residents with the deployment of 180 pharmacists and 60 pharmacy technician posts funded by the Pharmacy Integration Fund for two years.

4. Urgent and Emergency Care

Overall Goals for 2017-2019
Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time.

Progress in 2017/18
- More patients able to speak to a clinician about their urgent and emergency care needs when calling NHS 111 – 40% of answered calls now receive clinical input, up from 22% last year.
- Piloted and evaluated NHS 111 Online in a number of areas, with 27% of the population now able to access urgent and emergency care advice through this online portal.

Deliverables for 2018/19
- Ensure that aggregate performance against the four-hour A&E standard is at or above 90% in September 2018, that the majority of providers are achieving the 95% standard for the month of March 2019. Also Trusts are expected to improve on their performance each quarter compared to their performance in the same quarter the prior year in order to qualify for STF payments.
- 110 Urgent Treatment Centres (UTCs) designated according to the revised standard specification.
- Ambulance Response Programme implemented in all English mainland ambulance trusts.
- 105 Trusts received capital funding of £96.7 million to implement front-door clinical streaming. Over 90% of Trusts now have this in place.
- 1,491 beds have been freed up as a result of reducing delayed transfers of care (DTOC).
- £30 million awarded to 74 areas to increase number of acute hospitals meeting the ‘Core 24’ standard for 24/7 mental health liaison teams.
- 97% of A&Es, 98% of the initial cohort of UTCs and 96% of e-prescribing pharmacies now have access to primary care records through either summary care records or local record sharing portals.

- Implementation of the NHS 111 Online service to 100% of the population by December 2018.
- Access to enhanced NHS 111 services to 100% of the population, with more than half of callers to NHS 111 receiving clinical input during their call. Every part of the country should be covered by an integrated urgent care Clinical Assessment Service (IUC CAS), bringing together 111 and GP out of hours service provision. This will include direct booking from NHS 111 to other urgent care services.
- By March 2019, CCGs should ensure technology is enabled and then ensure that direct booking from IUC CAS into local GP systems is delivered wherever technology allows.
- Designate remaining UTCs in 2018/19 to meet the new standards and operate as part of an integrated approach to urgent and primary care.
- Work with local Ambulance Trusts to ensure that the new ambulance response time standards that were introduced in 2017/18 are met by September 2018. Handovers between ambulances and hospital A&Es should not exceed 30 minutes.
- Deliver a safe reduction in ambulance conveyance to emergency departments.
- Continue to make progress on reducing delayed transfers of care (DTOC), reducing DTOC delayed days to around 4,000 during 2018/19, with the reduction to be split equally between health and social care.
- Continue to improve patient flow inside hospitals through implementing the “Improving Patient Flow” guidance. Focus specifically on reducing inappropriate length of stay for admissions, including specific attention on ‘stranded’ and

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6 [https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/](https://improvement.nhs.uk/resources/good-practice-guide-focus-on-improving-patient-flow/)
‘super stranded’ patients who have been in hospital for over 7 days and over 21 days respectively.

- Continue to work towards the 2020/21 deliverable of all acute hospitals having **mental health crisis and liaison services** that can meet the specific needs of people of all ages including children and young people and older adults; and deliver **Core 24 mental health liaison standards for adults** in 50% of acute hospitals, subject to hospitals being able to successfully recruit.

- Ensure that fewer than 15% of NHS **continuing healthcare full assessments** take place in an acute setting.

- Continue to progress **implementation of the Emergency Care Data Set** in all A&Es (Type 1 and Type 2 by June 2018; and Type 3 by the end of 2018/19).

- Increase the number of patients who have consented to share their additional information through the **extended summary care record** to 15% and improve the functionality of e-SCR by December 2018.

- Implement a **proprietary appointment booking system** at particular GP practices, 50% of integrated urgent care services and 50% of UTCs by May 2018, supported by improved technology and clear appointment booking standards issued by December 2018.

- Continue to rollout the **seven-day services four priority clinical standards to five specialist services** (major trauma, heart attack, paediatric intensive care, vascular and stroke) and the **seven-day services four priority clinical standards in hospitals** to 50% of the population.
## 5. Transforming Care for People with Learning Disabilities

### Overall Goals for 2017-2019

Our goal is to transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.

### Progress in 2017/18

- **22% increase in the number of annual health checks**
  delivered by GPs to improve access to community alternatives to hospital and tackle premature mortality.
- **New and expanded community teams** to support people with a learning disability at risk of admission to hospital, backed by £10 million transformation funding.
- **6% reduction in inappropriate hospitalisation** of people with a learning disability, autism or both, between March and November 2017, totalling a 14% reduction since March 2015. In addition, over 100 people previously in hospital for 5 years or more were discharged between March and November 2017.
- **Tackling premature mortality** by beginning to systematically review and learn from deaths of patients with learning disabilities by March 2018.

### Deliverables for 2018/19

All Transforming Care Partnerships (TCPs), CCGs and STPs are expected to:

- Continue to **reduce inappropriate hospitalisation** of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. As part of achieving that reduction we expect CCGs and TCPs to place a particular emphasis on making a substantial reduction in the number of long-stay (5 year+ inpatients).
- Continue to improve access to healthcare for people with a learning disability, so that the number of people receiving an annual health check from their GP is 64% higher than in 2016/17. CCGs should achieve this by both increasing the number of people with a learning disability recorded on the GP Learning Disability Register, and by improving the proportion of people on that register receiving a health check.
- Make further investment in community teams to avoid hospitalisation, including through use of the £10 million transformation fund.
- Ensure more children with a learning disability, autism or both get a community Care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital, such that 75% of under 18s admitted to hospital have either had a pre-admission CETR or a CETR immediately post admission.
### 6. Maternity

**Overall Goals for 2017-2019**
Continue to make maternity services in England safer and more personal through the implementation of the *Better Births.*

<table>
<thead>
<tr>
<th>Progress in 2017/18</th>
<th>Deliverables for 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continuing the year on year <strong>safety improvements</strong> to maternity services including, since 2010, a 16% reduction in stillbirths, 10% reduction in neonatal mortality and 20% reduction in maternal deaths.</td>
<td>• Deliver improvements in <strong>safety</strong> towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019.</td>
</tr>
<tr>
<td>• Seven maternity ‘early adopters’ established covering 125,000 births a year to implement specific elements of <em>Better Births</em> and service improvements. Pilots of <strong>continuity of carer</strong> established to over 3,000 women.</td>
<td>• Increase the number of women receiving <strong>continuity</strong> of the person caring for them during pregnancy so that by March 2019, 20% of women booking receive continuity.</td>
</tr>
<tr>
<td>• 44 <strong>Local Maternity Systems</strong> established bringing together commissioners, providers and service users to lead and deliver transformation of maternity services in every part of the country.</td>
<td>• Continue to increase access to <strong>specialist perinatal mental health services</strong>, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%.</td>
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<td>• We will exceed the planned goal of 2,000 more women receiving <strong>specialist perinatal care</strong> in 2017/18, with over 5,000 additional women accessing these services between April and December 2017. Four new mother and baby units also funded.</td>
<td>• By June 2018, agree trajectories to improve the <strong>safety, choice and personalisation</strong> of maternity.</td>
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N.B. This is not a comprehensive list of ‘Next Steps’ deliverables for 2018/19, simply an ‘aide memoire’ covering these service improvement areas. CCGs and STPs should also continue to work to reduce inequalities in access to services and in people’s experiences of care.
BRIEFING NOTE ON NHS PLANNING LETTER - 2018/19 – 2 FEB 2018

SUMMARY

2018/19 plans are a refresh of existing 2 year plans. This means a continued commitment to deliver the cancer waiting time standards, achievement by each and every CCG of the Mental Health Investment Standard, service expansions set out by the Mental Health Taskforce and General Practice Forward View commitments, consistent with the expectations set out in the 2017-19

The task for commissioners and providers is to update the 2018/19 year of existing two-year plans to take account of the points set out below to ensure that operating plans:

- are stretching and realistic, and show a bottom line position consistent with the control totals set by NHS England and NHS Improvement;
- Is the product of partnership working across STPs, with clear triangulation between commissioner and provider plans and related contracts to ensure alignment in activity, workforce and income and expenditure assumptions; and with assurance from STP leaders that this is the case whilst ensuring the updated plans and contracts are aligned between commissioners and providers? As a result of the activity moderation incentives in the new Commissioner Sustainability Fund and the revised Quality Premium scheme, it is now more critical than ever that activity and finance plans are aligned between commissioners and providers; and
- Include appropriate phasing profiles to reflect seasonal changes in demand, especially related to winter, and ensuring efficiency savings are not back-loaded into the later part of the financial year.

The key milestones are:-

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<th>Item</th>
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<tr>
<td>ICS system control total changes and assurance statement submitted</td>
<td>By 1 March 2018</td>
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<tr>
<td>Local decision to enter into mediation for 2018/19 contract variations</td>
<td>2 March 2018</td>
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<tr>
<td>Draft 2018/19 Organisational Operating Plans submitted</td>
<td>8 March 2018</td>
</tr>
<tr>
<td>Draft 2018/19 STP Contract and Plan Alignment template submitted</td>
<td>8 March 2018</td>
</tr>
<tr>
<td>National deadline for signing 2018/19 contract variations and contracts</td>
<td>23 March 2018</td>
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<tr>
<td>2018/19 Expert Determination paperwork completed and shared by all parties</td>
<td>27 April 2018</td>
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<tr>
<td>Final Board or Governing Body approved Organisation Operating Plans submitted</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>2018/19 Winter Demand &amp; Capacity Plans submitted</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>Final 2018/19 STP Contract and Plan Alignment template submitted</td>
<td>30 April 2018</td>
</tr>
<tr>
<td>Final date for experts to notify outcome of determinations for 2018/19 update</td>
<td>8 June 2018</td>
</tr>
</tbody>
</table>

FINANCIAL FRAMEWORK

The resources available to CCGs will be increased by £1.4 billion, principally to fund realistic levels of emergency activity in plans, the additional elective activity necessary to tackle waiting lists, universal adherence to the Mental Health Investment Standard and transformation commitments for cancer services and primary care. This additional investment will be made available in the following ways:

- Lifting the requirement in 2018/19 for CCGs to underspend 0.5% of their allocations and to commit a further 0.5% of CCGs’ allocations solely for non-recurrent purposes;
• £600 million (new money) will be added to CCG allocations for 2018/19 (which otherwise remain unchanged), distributed in proportion to CCGs’ target allocations.

• The creation of a new £400 million Commissioner Sustainability Fund (CSF) partly mirroring the financial framework for providers, to enable CCGs to return to in-year financial balance, whilst supporting and incentivising CCGs to deliver against their financial control totals.

CCGs collectively will be expected to deliver financial balance after the deployment of the Commissioner Sustainability Fund, and control totals will be set on this basis.

Control totals will take into account each CCG’s financial performance in 2017/18. Any CCG that is overspending in 2017/18 will be expected to improve its in-year financial performance by at least 1% of its overall allocation, and those with longer standing and/or larger cumulative deficits will be given a more accelerated recovery trajectory.

**Commissioner Sustainability Fund (CSF)**

For CCGs where it is agreed they are unable to operate within their recurrent allocation for 2018/19, they will be required to commit to a credible plan, agreed and aligned at STP level, to deliver a stretching but realistic deficit control total set by NHS England. Access to the CSF will be dependent on the CCGs delivering its financial control total.

All CCGs will be expected to achieve a minimum of financial balance with zero deficits, following deployment of any CSF allocations.

**Provider Sustainability Fund and Financial Framework for NHS Providers**

Provider Sustainability Fund (PSF) to be increased from £1.8bn to £2.45bn. £650m new money needs to result in equivalent improvement in aggregate provider financial position and will be reflected in 2018/19 provider control totals.

30% of the total £2.45 billion fund will be linked to A&E performance in 2018/19 that is the better of either 90% or the equivalent quarter for 2017/18.

The provider sector is required to plan and deliver a balanced income and expenditure position for 2018/19 after deployment of the £2.45 billion PSF. Access to PSF and discretionary capital allocations will be dependent on providers accepting their control totals.

**EMERGENCY CARE**

Allocations allow for aggregate growth of 2.3% for NEL and ambulance activity and 1.1% for A&E. Local rates to be agreed at STP, commissioner and provider level based on current trends, adjusted for agreed demand management and efficiency schemes.

• Aggregate performance expectations against the four-hour A&E standard are rolled over from 2017/18 i.e. above 90% in September 2018, that the majority of providers are achieving the 95% standard in March 2019, and that the NHS returns to 95% overall performance within the course of 2019.

• Plans for 2018.19 to separate between NEL admissions of less than one day from those of one day or more. Drive behind this is to target reductions in LOS of stranded patients. Plans will be collected on planned bed numbers which have been agreed on a system basis, taking account of planned
reductions in DTOC (3.5% target) and LOS of longest stay patients as identified in stranded patient metric.

- To further support progress in these areas and free-up capacity, providers of community services will be invited to participate in a new local incentive scheme in conjunction with their CCG whereby they will be able to reinvest savings from acute excess bed day costs to expand community and intermediate care services. This will benefit ‘stranded’ and ‘super-stranded’ patients in particular.
- £210m CCG Quality Premium incentive funding will be contingent on moderating demand for emergency care. This payment will be conditional on the CCG meeting or improving on the levels jointly planned with providers.

RTT

- RTT waiting list will be no higher in March 2019 than in March 2018 and, where possible, they should aim for it to be reduced.
- Numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible.
- OP planning growth assumption is 4.9%, for electives 3.6% and for GP referrals 0.8%. Day case and elective in-patients should be planned and reported separately.
- Systems will be expected to demonstrate to regional teams that their RTT plans are robust and realistic, and that they make best and flexible use of available capacity across their STP footprint in order to optimise delivery against the objectives above.

DELIVERY OF NEXT STEPS PRIORITIES

STPs to take an increasingly prominent role in planning and managing system-wide efforts to improve services.

Integrated Care Systems

Integrated Care System’ (ICS) is now the collective term for both devolved health and care systems and for those areas previously designated as ‘shadow accountable care systems’

Integrated Care Systems are key to achieving sustainable improvements in health and care by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
- supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and home-based services, including in partnership with social care, the voluntary and community sector; and
- All Integrated Care Systems are expected to produce together a credible plan that delivers the system control total, resolving any disputes themselves, and no ‘shadow’ Integrated Care System will be
considered ready to go fully operational if it is unable to produce such a plan. NHSE and NHSI will support system leaders with this work.

To reinforce the approach to system planning, NHSE & NHSI to assure ICS plans at system level rather than organisation-level plans. Integrated Care Systems will assure and track progress against organisation-level plans within their system, ensuring that they underpin delivery of agreed system objectives.

Financial Framework for ICSs.

All Integrated Care Systems will work within a system control total, the aggregate required income and expenditure position for trusts and CCGs within the system

In 2018/19, systems are encouraged to adopt a fully system-based approach to the PSF and CSF under which no payment will be made unless the system as a whole has delivered against its system control total. Systems adopting this full incentive structure will operate under a more autonomous regulatory relationship with NHS England and NHS Improvement, including working with NHSI & NHSE regarding exercising intervention powers.

All approved Integrated Care Systems will be required to operate under this fully-developed system control total incentive structures by 2019/20. In 2018/19 systems that are not ready to proceed with full system incentives and shared intervention arrangements will be allowed to adopt an interim approach under which only the additional funding that has been put into the PSF (£650 million in aggregate) will be linked to system financial performance. On this option, no payment will be made from this enhanced funding unless the system as a whole meets its control total. If individual trusts or CCGs miss their organisational control totals, but the system still achieves overall, their share will be apportioned in consultation with the system leadership.

The next cohort of Integrated Care Systems will be selected from STPs with:

- Strong leadership, with mature relationships including with local government.
- The leadership team should have effective ways of involving clinicians and staff, the third sector, service users and the public. It should also have the right capability and infrastructure to execute on priorities;
- A track record of delivery, with evidence of tangible progress towards delivering the priorities in Next Steps on the Five Year Forward View. These systems should be meeting NHS Constitution standards or provide confidence that by working as an integrated system they are more likely to be recovered;
- strong financial management, with a collective commitment from CCGs and providers to system planning and shared financial risk management, supported by a system control total and system operating plan;
- a coherent and defined population that reflects patient flows and, where possible, is contiguous with local government boundaries; and
- Compelling plans to integrate primary care, mental health, social care and hospital services using population health approaches to redesign care around people at risk of becoming acutely unwell. These models will necessarily require the widespread involvement of primary care, through incipient networks.

PROCESS AND TIMESCALE

NHS Standard Contract rules for updating current contracts should be followed – expectation there will be no disputes related to variations. Disputes that do arise will follow a dispute resolution process (document to follow shortly).
- Providers that are part of an ICS will produce an updated narrative at the system level
- STP Leaders will return a contract and plan alignment template to demonstrate that updated plans and contracts are aligned financially between commissioners and providers.
- Further guidance on CQUIN and Quality Premium will be available soon.
- There will be a temporary relaxation of the element for acute providers related to proactive and safe discharge – this has implications for linked indicators in Community and Care Home setting.
- The 0.5% risk reserve CQUIN will be withdrawn in 2018/19. The 0.5% will be added to the engagement CQUIN, which will increase as a result to 1%.
- There will be no additional winter funding in 2018/19. A separate winter demand and capacity plan will be submitted on 30th April (guidance will be available by March 2018.)